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This policy covers the following areas:

- **Buccal Midazolam**
- **Diabetes and the Use of Insulin and Glucagon Administration**
- **Safe Administration and Management of Medication**
- **Topical Medicines**

1.0 PURPOSE:

The purpose of this policy is to provide guidance to all Sunbeam House Services (SHS) staff in Medication Management.

2.0 SCOPE:

This policy applies to SHS employees responsible for administration and management of medication.

3.0 ROLES AND RESPONSIBILITIES:

Organisation:

- SHS will provide Medication Training for all Social Care staff.
- SHS will ensure that this policy is in line with current standards and policies of regulatory bodies and health service providers.

Senior Service Managers (SSM) and Client Service Managers (CSM):

- CSMs to ensure that all their staff adhere to the Medication Management Policy.
- CSMs must ensure that all their staff attend Medication Training.
- CSMs must ensure that their staff attend Refresher courses every two years or sooner if necessary.
- CSMs must not allow any staff working in their location to administer any medications if they have not completed Medication Training and up-to date with Refresher Training.
- SSMs must ensure overall implementation of this policy and that the appropriate mechanisms are in place to support this.
- It is the responsibility of Senior Service Managers to review this policy and procedure at regular intervals.

SHS staff:

- It is the responsibility of each employee to comply with the Medication Management Policy.
- All staff are accountable for their own practices.

Risks and Considerations

When a potential risk is identified, staff must report to the CSM and a risk assessment carried out.

Where it is a life-threatening event, medical advice and intervention must be sought immediately.

4.0 BUCCAL MIDAZOLAM – ADMINISTRATION FOR EPILEPSY

4.1 DEFINITIONS

Epilepsy: A tendency to recurrent seizures originating in the brain (Brainwave).

Status Epilepticus: Seizures occurring continuously or reoccurring for at least 30 minutes.

Buccal Cavity: Buccal applies to the area between the lower gums and the inner cheek of either side of the mouth.

4.2 GUIDELINES

These guidelines provide a plan for the safe prescription and administration of Buccal Midazolam for prolonged seizures which can lead to status epilepticus.

If the client has been prescribed Buccal Midazolam, it should be administered according to the client's Buccal Midazolam Care Plan, SHS Policy, and Client Specific Procedures for Buccal Midazolam. It is essential that **Client specific General Practitioner (GP) instructions** are incorporated into the care plan.

Buccal Midazolam is a short-acting benzodiazepine that is administered via the buccal cavity. It is considered to be a less invasive procedure than the administration of rectal diazepam and is therefore an effective alternative.

Buccal Midazolam is a controlled drug and staff must follow statutory requirements in relation to storage and transport.

It is not licensed for use in the treatment of seizures by the IMB (Irish Medicines Board) and it's use in control of seizures is considered to be "off label", which is defined as 'the use of an authorised medicine outside the terms of its product authorisation'.

Registered medical practitioners are given statutory authority to prescribe an unlicensed product and have a professional responsibility for their use. An administrator of a medication for 'off-label' use should be aware of the indications for the medication's intended use in providing care to the client.

Buccal Midazolam is prescribed for a minority of clients who require emergency treatment for seizures to prevent status epilepticus which can result in brain injury or death.

Treatment with Buccal Midazolam is recommended for administration five minutes after seizure commences in order to prevent the client from developing a prolonged seizure which can progress to status epilepticus.

Some clients known to suffer prolonged seizures may be given Buccal Midazolam immediately or even at the first indicative sign of seizure onset which will be stated in their care plan.

Staff must be responsible and accountable in checking the product before they leave to go out with the client. The pack must be discarded if the solution is not clear or there is evidence of white particles in the liquid.

In the event of the client having a seizure and the product is found to be faulty, staff should contact emergency services. Contact numbers are detailed on the client's care plan.

Half of the prescribed dose is administered to each side of the buccal cavity between the gum and the lower cheeks. If this is not possible then the entire dose is administered to the buccal cavity on one side of the mouth.

The Joint Epilepsy Council of the UK and Ireland recommend that each client should have written individualised care plans regarding management of seizures.

The care plan identifies the following:

- Client's name
- Signature of GP
- Seizure description and triggers
- When Buccal Midazolam should be administered
- How much is to be given
- What is the usual effect (if known)

- Time interval for repeated dose, if prescribed
- When emergency services should be requested
- Other people who need to be contacted or informed
- Plan review date

In order to ensure the safe movement of this product within the service, staff are required to sign the Midazolam Checklist when the product is removed and received from locations

4.2.1 TRAINING

All staff administering Buccal Midazolam must attend in-house training every two years. Training is provided by SHS Medication Trainer.

CSMs must ensure that staff involved in administering Buccal Midazolam must be up to date with their training.

Staff are required to maintain their knowledge in relation to epilepsy awareness and update training in this area every two years provided by SHS Medication Trainer.

On completion of training staff should be able to:

- Describe the reason why the person requires midazolam;
- Identify and describe the equipment required to administer midazolam;
- Identify the potential hazards in giving midazolam and describe the appropriate action to be taken to overcome these hazards;
- Describe the process of recording the seizure in the person's care plan.

4.3 PROCEDURES

4.3.1 ADMINISTRATION

- Check the dosage of Buccal Midazolam against the prescription sheet.
- A copy of the prescription and care plan should follow the client wherever they go.
- Open the bottle by pressing down on the lid and turning it anti-clockwise.
- Insert the syringe firmly into the bung on the top of the bottle.

- Supporting the bottle, tip the bottle upside down and slowly pull the plunger on the syringe, until you have withdrawn the prescribed amount.
- Remove the syringe from the bottle.
- Replace cap to prevent the liquid evaporating.
- Support the person's head by holding their chin. Stand behind them if the person has no head support, i.e. if in a chair. Do not press on their throat.
- Gently open the person's mouth by holding their chin and gently applying downward pressure on their lower lip.
- Insert the syringe gently into the buccal cavity of the mouth.
- Administer half the prescribed dose and remove the syringe.
- Administer the other half into the buccal cavity on the other side of the mouth.
- Do not administer the dose below the tongue since the teeth may clamp shut and break the syringe in the mouth.
- Screw the child-resistant cap back on the bottle.
- Put the bottle back in the carton containing the remaining syringes.

4.3.2 AFTER ADMINISTRATION

- Maintain close observation after administration and monitor the person's breathing.
- The client should be encouraged to rest following a seizure.
- All equipment must be disposed of safely.
- Appropriate people, as per care plan, must be informed that Buccal Midazolam has been administered.
- Appropriate documentation must be completed by staff.

5.0 DIABETES AND THE USE OF INSULIN AND GLUCAGON ADMINISTRATION

5.1 GUIDELINES

- These guidelines enable staff, where necessary, to supervise and/or administer insulin to Clients who have diabetes and are prescribed insulin treatment.

- These guidelines also provide information on the use of glucagon for severe hypoglycaemia.

- Only staff who have been properly trained in the whole area of diabetes and the administration of insulin/glucagon are allowed to support a Client who is diabetic.

- Training involves attendance every two years at SHS Diabetes Training and one on-site assessment carried out, if required. These assessments monitor competency both in insulin and glucagon administration.

- No diabetic medication, i.e. insulin and other, should be administered to a Client unless there is a clear prescription and SHS medication kardex, written and signed by GP, in place.

- In the event of an error, medical intervention is to be sought immediately and Client Service Manager informed.

- For unstable blood sugars and further advice, the attending hospital must be contacted for medical guidance.

- All locations that support a client must have hospital and GP contact details readily available.

- When insulin is in transit with a client, it is staff responsibility (day and residential) to ensure that there is sufficient amount of insulin in pen available for use.

- For day staff who receive insulin with client, they must check that there is sufficient amount available for daily use and ensure safe storage as per guidelines.

- Please refer to Needlestick Injury and Other Exposure Incident Guidelines for guidance on **safe disposal of sharps**.

- Please refer to Hypoglycaemia and the Use of Glucagon Guidelines for the treatment of **hypoglycaemia.**

- Insulin dependent Clients must have a Risk Assessment to identify risks in administration of insulin and this should be updated yearly or more frequently, if required.)

5.2 DEFINITIONS

5.2.1 WHAT IS DIABETES

Our body needs food and nutrients for energy to keep healthy. All starchy and sugary foods provide the body with the nutrient carbohydrate. These foods containing carbohydrate are broken down into glucose in the blood. The body uses this glucose to make energy. Diabetes is a common condition in which the body cannot use the glucose to make energy.

There are two main types of diabetes:

Type 1 diabetes is a condition in which the pancreas doesn't produce any insulin at all. This type of diabetes can only be treated with insulin injections.

Type 2 diabetes is a condition in which the pancreas can still produce some insulin, but not enough for the body's requirements, or where the insulin produced doesn't work properly. This type of diabetes can be treated with diet and lifestyle changes, such as increasing activity levels. Insulin is prescribed if diet or lifestyle changes are not sufficient to control diabetes.

5.2.2 WHAT IS INSULIN

Insulin is a hormone that is produced during digestion to control blood glucose. There are two different aspects to this control. When a meal is ingested blood glucose rises, so insulin is needed to counteract this. But there is also a background level of glucose which occurs because the liver constantly produces glucose from stores of fat and carbohydrate. This level also needs to be controlled between meals to prevent the development of diabetic ketoacidosis (see below). The main types of insulin are designed to control meal-times and background blood glucose levels.

5.2.2.1 EXAMPLES OF INSULIN USED

- **Lantus** is a long-acting background insulin. It is different from other insulin because it is more slowly absorbed and therefore the effects of the dose last longer – around 24 hours in duration. It is taken only once a day. It doesn't peak, therefore reduces the risk of getting a hypo. It is clear in appearance as opposed to cloudy like other long-acting insulins.
- **Novarapid** is a rapid-acting insulin. This insulin can be injected five to fifteen minutes before eating, when eating or immediately after eating. It can last for between two and five hours but, being very short-acting, it may not last quite long enough to control blood glucose levels between meals and may need to be mixed with a longer-acting insulin. This insulin is clear. If you see 'frosting' around the bottle or particles in the insulin, do **not** use it.
- **Short-acting** for example **Actrapid** is also known as soluble insulin. It works quickly to lower your blood glucose and is usually taken 15 to 30 minutes before a meal to cover the rise in glucose that occurs after eating. It has its peak action within two to six hours after injecting and it can last for up to eight hours. This insulin should always appear clear. If it is cloudy or lumpy, do **not** use.
- **Medium and long-acting** for example **Insulatard**. This insulin works over several hours to keep blood sugar under control between meals. It has a peak activity between four and 12 hours after injecting and can last for 8 to 24 hours. It is often used in combination with a short-acting insulin. This type of insulin usually look cloudy. If the cloudiness is uneven, or clumps are seen floating, do **not** use.

5.2.2.2 SIDE EFFECTS OF INSULIN

- Hypoglycaemia
- Allergic reactions – such as fast pulse, low blood pressure, perspiration, rash over the entire body, shortness of breath, shallow breathing, or wheezing
- Insulin site problems such as lumps and soreness caused by injecting in the same site
- Weight gain

5.2.2.3 PROCEDURE FOR ADMINISTERING INSULIN

- **Subcutaneous route:** insulin is administered via the subcutaneous route into the fatty layer just beneath the skin, where there is little blood flow. This ensures that the medication will be absorbed by the person at a slow, continuous rate.
- **Assemble equipment**
    - Drug administration chart
    - Insulin pen with needles
    - Glucometer
    - Sharps bin
    - Small tissue
    - Gloves
- Staff must double-check the following - right drug, right person, right time, right dose and right route as per medication policy
- Wash and dry hands thoroughly if client not self-administering
- Put gloves on if client not self-administering
- Check blood sugar reading with glucometer
- Show to second staff member and record
- Check prescribed sliding scale
- Shoot off two units of insulin to prime device
- Check insulin pen has returned to zero
- Check prescription for insulin on drug chart
- Assess units of insulin required as per sliding scale
- Check amount with second staff member
- Dial appropriate amount of units on insulin pen as directed by sliding scale or direct client to do so.
- Check dialled amount with second staff member
- Check expiry date
- Remove safety cap from pen
- Insert needle at a 90 degree angle

The administration of insulin can also be carried out by one staff member but only when working alone.

5.2.3 WHAT IS SLIDING SCALE

A Sliding Scale is a medical prescription by a specialist practitioner that indicates the amount of insulin to be administered depending on blood sugar readings.

Sample Sliding Scale for Novarapid

Blood Glucose mmol/l	Pre-Breakfast	Pre-lunch	Pre-dinner	Bedtime
<2.5	**Eat first 10 iu**	**Eat first 10**	**Eat first 6**	
2.5 to 5.0	11 iu	11 iu	7 iu	
5.1 to 7.5	12 iu	12 iu	8 iu	
7.6 to 10.0	13 iu	13 iu	9 iu	
10.1 to 12.5	14 iu	14 iu	10 iu	
12.6 to 15.0	15 iu	15 iu	11 iu	
15.1 to 17.5	16 iu	16 iu	12 iu	
17.6 to 20	17 iu	17 iu	13 iu	
>20	18 iu	18 iu	14 iu	

< = less than >= greater than iu = international units

Please note that in this scale for a blood glucose reading below 2.5, the Client must eat first and then insulin is administered. A signature section maintained with scale must be signed by staff in conjunction with the prescription chart.

Sample dosage guidelines for Lantus

Blood Glucose mmol/l	Pre-breakfast	Pre-lunch	Pre-dinner	Bedtime
< 5.0			**20 iu**	
5.1 to 10.0			**20 iu**	
> 10			**20 iu**	

5.2.4 WHAT IS HYPOGLYCAEMIA (HYPO)?

Hypoglycaemia (Hypo) is a low blood sugar level. Normal blood sugar (glucose) level is between 4.0 and 7.0 mmol/l. If the level falls below 4.0 a person may start to feel unwell. If blood sugar is not corrected quickly, a person may lose consciousness.

Note: Normal blood sugar level is 4.0 – 7.0 mmol/l
A person may be given their own range depending on treatment

Signs and Symptoms of Hypoglycaemia

Nervousness	Intense Hunger
Sweating	Double vision/changes in vision
Trembling	Difficulty in concentration
Palpitations	Tingling of lips and tongue
Tiredness	Slurring of speech
Headache	Unsteadiness and drowsiness
Irritability	Loss of consciousness and seizure
Pallor	

5.2.5 WHAT IS GLUCAGON?

This is a hormone produced by the pancreas. It acts on the liver to release glucose and therefore raise blood glucose levels.
The glucagon in a GlucaGen Hypokit is identical to the natural hormone produced in the human body.
It can be **used in emergency situations** when someone is in severe 'hypo' and medical help is unavailable.
It is used when the client cannot take carbohydrate orally e.g. confusion or unconsciousness.
It is available as a single dose pack and contains a vial of glucagon powder (1mg) and a syringe pre-filled with sterile water.

5.2.6 WHAT IS HYPERGLYCAEMIA?

When the glucose (sugar) level in blood rises high temporarily, this is known as hyperglycaemia. The opposite condition - low blood sugar is called **hypoglycaemia.**

5.2.7 WHAT IS DIABETIC KETOACIDOSIS?

This is an emergency situation that requires hospitalisation and is usually caused by illness or undiagnosed diabetes. It occurs because the body has insufficient insulin to process glucose into fuel, so the body breaks down fats to use for energy. When the body breaks down fat, ketones are produced as by-products. The delicate balance of body chemistry is upset. Some ketones are eliminated via the urine, but not all. Until the person is rehydrated, and adequate insulin is restored, ketones remain in the blood and continue to rise. Ketones in the blood cause nausea, headache, fatigue or vomiting. Blood sugar levels rise dramatically, and the person may lose consciousness. It requires immediate prescribed treatment with insulin and fluid.

5.3 PROCEDURES

5.3.1 PROCEDURE ON HOW TO TREAT MILD/MODERATE HYPOGLYCAEMIA

- Once hypoglycaemia has been identified, treatment is to be initiated immediately using a carbohydrate snack. Examples are 5-6 glucose tablets, 100-120 mls of lucozade, 150-200 mls of coke/pepsi/orange juice.
- Recheck blood glucose after 10mins
- If the client remains hypoglycaemic, repeat as above.
- Follow up the hypoglycaemic event with a snack or a meal if it is due. The snack may consist of one slice of bread, one biscuit, one piece of fruit or a yogurt.
- Retest after one hour. High blood sugar does not need to be corrected.
- Record the event clearly in daily notes.
- **NOTE :** Do not omit the next dose of insulin – but seek medical advice on the dose to be given.

5.3.2 PROCEDURE ON HOW TO TREAT SEVERE HYPOGLYCAEMIA/GLUCAGON ADMINSTRATION

- Check blood sugar level
- If the client is semi or fully unconscious and unable to take carbohydrate orally, then glucagon needs to be administered.
- The GlucaGen Hypokit should be stored in the fridge
- Check the expiry date on the kit
- Remove the orange plastic cap off the bottle. Pull the needle cover off the syringe. Insert the needle through through the rubber disc of the bottle. Inject all the liquid from the syringe to bottle.
- Without withdrawing the syringe and needle, shake the bottle until completely dissolved and the solution is clear.
- Ensure the plunger is depressed and withdraw the entire solution back into syringe
- Remove air and inject into upper outer muscle of thigh
- If insufficient recovery after 10 minutes, call an ambulance
- If sufficient recovery follow up with oral carbohydrate food
- All staff working with clients who have insulin dependant diabetes are required to be educated on indication for use and how to administer glucagon.
- Training will be refreshed yearly and competence monitored
- No staff to administer glucagon without training

5.3.3 PROCEDURE ON THE USE OF A GLUCOMETER

Glucometers do not diagnose diabetes. Only blood tests at a hospital laboratory can do this. Glucometers monitor glucose levels in blood and provide information to guide treatment. Glucometers use test strips to measure glucose levels. The meters also store previous test results for review.

- Get supplies together: meter, testing strips, lancets (short needles for pricking skin), lancet device for the needle, cotton wool or tissue, control solution
- Make sure the strips are in date
- Match code numbers. Code number on the testing strips bottle needs to match the number on the meter. If the numbers to not match follow the directions with the meter for changing the code number. Some meters must be coded every time you open a new vial of test strips. Each meter has its own coding technique.
- Not all meters need to be coded and some newer models just involve the insertion of a test strip.
- Follow the instructions with the meter. All meters have detailed instructions for performing the test.
- Wash hands
- Insert a clean needle (lancet) into lancet device
- Remove a test strip from the bottle of testing strips. Replace the lid immediately to prevent moisture from affecting the other strips.
- Insert the test strip into meter to activate it.
- Check code on meter matches code on bottle of testing strips (only applies if using strips that require coding)
- Use the lancet device to stick the side of the fingertip with the lancet. Do not stick the tip of the finger as it will be more painful and not enough blood may be available to do test accurately.
- Put a drop of blood on the correct spot of the test strip
- Using a clean cotton ball or tissue apply pressure to finger to stop bleeding
- Generally blood glucose result will appear on meter within seconds
- Record the results
- Follow with required treatment e.g. insulin determined by sliding scale.

5.3.4 GUIDELINES TO BE FOLLOWED AFTER HYPOGLYCAEMIC EVENT

- Clients may have a headache after severe hypoglycaemic event.
- Clients may vomit following glucagon administration.
- Blood glucose readings may rise significantly after treatment. It is not advised to inject extra insulin to treat this rise. Clients may need a reduction in insulin dose over the next day to prevent further episodes. Contact diabetic unit at hospital/GP for further advice.
- Units to have a supply of glucagon on site and staff need to take this supply with them when in transit with client. Glucagon can be stored at room temperature when in transit or when the client is on leave but must be returned to fridge on return to unit.
- Expiry date to be checked on glucagon monthly and prior to administration. An expiry date form must be maintained on unit and signed by staff checking glucagon.
- Glucagon to be reordered from pharmacy if it has been used.
- Try to identify a cause for the 'hypo.' Possible explanations include -
    - Too much insulin
    - Not enough food
    - Late for meal
    - Decreased appetite
    - Excessive exercise

5.3.5 PROCEDURE FOLLOWING GLUCACGON ADMINSTRATION

- Inform CSM if glucagon has been administered. If CSM is unavailable then SSM must be informed.
- Inform GP following administration and clarify follow-up care. This needs to be dated and documented in client's notes. If next dose of insulin is changed, get re-prescribed. Do not give unless prescription is accurate.
- Administration procedure and documentation will be reviewed by medication trainer following glucagon administration and report forwarded to SSM.
- Staff training, storage and relevant documentation will be reviewed with general medication audit on a yearly basis.
- Expiry date of glucagon to be checked and signed for once a month.
- Staff must have a competency assessment prior to being a named administrator

6.0 SAFE ADMINISTRATION AND MANAGEMENT OF MEDICATION

6.1 GUIDELINES FOR PRESCRIBED MEDICATION DOCUMENTATION

All medicines administered by staff to Clients must be prescribed and signed on an individual medication record which is to be known as an IMP or Individual Medication Plan by a qualified medical practitioner.

In all areas a nominated person will be nominated to be an overseer of the medication management system within that location. This person, with support from the CSM, will have an allocated period of time to review and oversee the documentation and dispensing/storage areas of medication.

This person will have access to peers in other locations and be facilitated with extra training and upskilling by the Medical and Health Trainer until they are competent in transcription. Once deemed competent, they may then use the email, E-IMP format to send in and out to GP surgeries for validation.

6.1.1 HOME CLIENTS ATTENDING SERVICE LOCATIONS

For Clients who live at home and attend day service, an agreement will be made between family/Client and service provider on who is responsible for the updating of the IMP. This will be entered and signed on the record itself. If staff are looking after this, best practice would state the review dates are entered into the location diary to ensure the reviews are carried out within the time limit.

Even if the family opt to look after written record updates, the keyworker will be responsible for checking that this has been done as per review date and should make a request for the up to date records for the day service files.

6.1.2 HOME SUPPORT CLIENTS

For those Clients who SHS staff support in their own homes and do not attend day service. Clarification of the input around medication support, if necessary, should be clearly agreed with the Community Staff and Client. Following this, a localised agreement must be drawn up. It is always best practice to have systems in place to ensure any medication plan is up to date and relevant and that there is an agreed nominated person to take ownership of ensuring all documents are in

date. The input may include self-medication assessment, medication supports and education or simply a nominated check-in time to discuss medication usage and issues. The CSM, key worker and Client should agree on this locally and this plan should be clearly documented. A clear reporting structure should be evident within the plan and a clear pathway of reporting concerns incorporated into the plan so staff can actively highlight any concerns to the relevant personnel and address emerging issues.

6.1.3 RESPITE CLIENTS

All Clients' using this service require a working up to date Kardex as with all other SHS Clients. All medicines including Over the Counter medications which are taken at intervals must be prescribed on a medication record for respite – including self-medicating Clients. Any Client and their family will be reminded of this prior to using the Respite Service and where will be a clear agreement to provide an up to date written IMP of currently used medications. Whereby the family/Client prefers, the Respite location can liaise directly with the GP or pharmacist to obtain an updated medical prescription and this will be indicated on the IMP form and then signed off by the GP within the 72hr limit. Transcription can only be done by the CSM/Nurse.

6.1.4 HOLIDAYS

All medicines must be prescribed on a medication kardex for holidays including self- medicating clients. Please see above for guidance.

6.1.5 RESIDENITAL CLIENTS IN DAY SERVICE

For Clients in day service from other locations within SHS, the medication Kardex can be a photocopy only when medication is not administered during the day. In this incidence it is prescribed to be administered during the day. Then the residential location must send the original MARs (medication administration recording sheet) and the medication so the original can be signed as appropriate and there can be no discrepancy regarding administration, PRN administration or maximum dosage in 24hrs. The Day Service may opt to keep a copy on file for their own records if they so wish.

6.1.6 CLIENTS ON MEDICATION BUT WHO DO NOT TAKE THIS MEDICATION DURING OUR CONTACT HOURS

It is always best practice to understand and be supportive of a Client's biopsychosocial needs. Therefore in case of emergency or in the case of deteriorating health/required medical review (in conjunction with Client/family permission) accurate records of a Client's medication plan should be stored within the main service provider's records. The mechanism of how this is written is at the CSM's discretion. However it should be noted that should any medication be required to be given at any time by SHS staff, then this requires a legal prescription and thus an SHS Medication Kardex before staff can administer. Staff should be proactively liaising with families around this and, where possible, support families to secure administration times outside service times to avoid unnecessary documentation or GP visits. As an example a new antibiotic could be given at 9am, 6pm and 10pm.

6.1.7 THE INDIVIDUAL MEDICATION PLAN

Each medication plan is an individualised and person centred support plan. On it the Prescriber will highlight the frequency of the required review interval and staff will then ensure this is carried out. This is primarily the Keyworkers responsibility but the CSM is responsible for ensuring there are good practice guidelines in place within the Unit in this area.

All Clients attending any SHS service require an IMP in keeping with good practice around documentation and record keeping and in response to Health Information Quality Authority (HIQA) standards regarding Medication Management Practices.

In specialist areas where care or medical needs differ from the general client population, a location specific Kardex is permitted for use in agreement with the relevant SSM.

Staff are required to take SHS individual medication plan (IMP) to medical appointments for signing and updating any time the Client visits a medical practitioner.

6.1.7.1 INDIVIDUAL MEDICATION PLANS WILL REGARDING ON-GOING MEDICATION

- The Name of the Client, their PIN, Date of Birth and Address/Service location
- Photograph ID
- The Medication Administration Records (MARS signing sheet) must contain name and PIN
- The name of the medicine
- The date prescribed
- The dose to be taken
- The strength (if appropriate)
- The frequency of administration
- The route of administration
- Any special indications for usage
- They must be signed and dated by Prescriber
- The duration for which the medicine is to be taken (if appropriate e.g. antibiotics or steroids this means no return for discontinuation is required)
- Allergies or sensitivities **must** be recorded on front page of IMP in red pen and starred. Any allergies must also be highlighted in medical part of any folder and any prescribing staff informed at all times.
- If dosette boxes are used, the pharmacy should clearly highlight start date on each box and any allergies.

6.1.7.2 SUPPLEMENTARY PRN MEDICATION REQUIREMENTS

- Staff must ensure that the GP fills in the "Reason for Medication" section when prescribing PRN medication. This should highlight the reason staff are to administer a PRN.
- The maximum usage in 24 hrs is also required to be filled in.
- When PRN medication is administered and symptoms persist, medical advice/assessment should be sought unless instructions state otherwise.
- There is an area on the PRN section of the IMP which states how many doses/times a PRN can be used before review. Please ask the prescriber what would be indicative of a medical review for each medication.

- The review of PRN medications is also recorded on the front page of the IMP.

6.2 GUIDELINES FOR PRN PSYCHOTROPIC MEDICATION

Psychotropic PRN medication should only be used as a last resort. PRN psychotropic requires an in-house usage protocol which should be individual, Client centred and agreed by the team and the Client. Positive Intervention Guidelines must be adhered to **before** the administration of psychotropic medication. However, it is important to know the correct time and symptoms which indicate that it is time for such a medication to support Client's in times of extreme distress

- When PRN psychotropic is used, a Record of Administration Form should be completed by the person who administered it.
- This form should be completed by the CSM and forwarded to the SSM for auditing of medication used in this way.

- All PRN medication should be at longest interval reviewed every six months by a medical practitioner or sooner if usage becomes increasingly regular or if dictated by the IMP.
- A PRN Medication Storage/Return Record is required to account for all PRNs stored in a location.

6.2.1 PERSONALISED PRN PSYCHOTROPIC PROTOCAL

Guidelines for staff on the proposed use of PRN psychotropic medication should be clearly documented in each location and filed in the Health and Well-Being section of the Personal Profile. These can be drawn up and evidenced by the prescriber as required in each location. An example of a medication protocol may be downloaded from the SHS server.

Such guidelines should clearly state:

- Proactive PBS strategies used and where to refer to in the Client folder
- Specific triggers or stressors for that particular individual
- Positive interactive strategies between staff and Client
- Specific personalised indicators of or escalation in loss of emotional control/increased distress levels

- Prescribed medications' effects and side effects
- Observation or support levels post incident by staff for the Client
- Reflection on precipitating factors to be recorded in Client notes and for team learning

6.3 MEDICATION MANAGEMENT – WRITTEN RESPONSIBLITIES

6.3.1 GUIDELINES FOR TRANSCRIPTION

Transcribing is the act of transferring information from one medication chart to another. This includes electronic prescriptions supplied by some pharmacies sent in with Clients to day services from parents or rewriting a medication Kardex which has become difficult to read or has run out of room. **In almost all cases there will be little need for transcription as the medication reviews will allow the Prescriber the opportunity to re-write the plans.**

- **In locations where social care staff are employed only, the CSM may carry out transcription. It should only be carried out by the CSM if they feel competent and comfortable to do so.**
- Nursing staff who transcribe are professionally accountable for their decision to transcribe and the accuracy of the transcription and must at all times work within their scope of practice.
- Where possible a second staff member should check transcribed record.
- Transcription must be in clear legible handwriting, preferably in block capitals or type in black ink only.
- Medical Practitioner must sign transcribed medication on prescription IMP at the very earliest convenience not more than 72 hours after transcription. Staff should always ask for an electronic, faxed or copy of confirmation of prescription of any new medication regime to accompany a transcribed Kardex. This should be attached to the IMP until GP actually confirms and signs in person.
- Only in the event of bank holiday weekends, medical practitioner must sign transcribed medication on prescription IMP 5 days after transcription.

6.3.2 GUIDELINES FOR VERBAL/TELEPHONE ORDER

- **In emergency situations only and exclusive to nursing locations,** where a medical practitioner is not available to sign the prescription IMP at that time and a verbal/telephone order is given, the nurse must primarily ensure that they have explored all avenues of using their regular doctor or on-call doctor after hours to obtain a written medication prescription. If this is not possible then the nurse can take a verbal/telephone medication order.
- A nurse who accepts a verbal/telephone order in these situations should consider her/his own competence and accountability.
- A record of the verbal or telephone order should be documented in the client's file with a detailed explanation of the date, time and reason for the order and should include the prescriber's full name and his/her confirmation of the order.
- The justification and rationale for accepting a verbal/telephone order is documented by the nurse to establish the clinical judgement exercised in the emergency situation.
- If possible the medical practitioner should repeat the order to a second nurse and it is then confirmed between them.
- The order is indicated on the Drug Prescription Record, dated and signed by nurse and indicating that it is a verbal/telephone order by the relevant medical prescriber. The comments section of the Drug Administration Record is used by staff to highlight the use of a verbal order.
- It should be requested, when possible, that the prescribing officer scans or faxes a copy of their original prescription at the time of the nurse/CSM receiving the verbal order. This will act as a paper trail for the prescription and reinforce the correct prescription being taken.
- Should a doctor refuse to fax/scan and email the prescription, then the nurse must take the full name of the doctor, their work location/Irish Medical Officer(IMO) number, the date and time and record in Client's file.
- The original prescription should be requested to be put in an addressed envelope and posted to the location at that time.
- It is always best practice that a Client requiring emergency medication out of hours is reviewed by their own GP the next day or in the case of a bank holiday weekend, within no more than 5 days.

6.3.3 GUIDELINES FOR FAXING OF PRESCRIPTIONS

- As always this should not be permitted unless there is no other available option at the time of need.
- A faxed copy of an original prescription from a hospital/GP surgery will be accepted for administration of medication when urgent medication changes are required. SHS IMP which are legal prescription must be signed by a medical practitioner within three days to complete the prescription paperwork. Only in the event of bank holiday weekends, medical practitioner must sign transcribed medication on prescription IMP 5 days after transcription.

6.3.4 GUIDELINES FOR SPECIFIC MEDICAITON REQUIRING AUGMENTED DOCUMENTATION, INTERMITTEND DISPENSING RECORDING OR SUPERVISION

Some medications will be prescribed in a way and must be dispensed in a way that does not follow the usual rule of ongoing everyday administration and consistent dosage. Examples of such are Warfarin, Clozaril, hormones e.g. thyroxine or contraceptive pill, other differences in daily recording of the same medication may be prevalent with steroids and Insulin which may require a a sliding scale dosage. Another reason for changes in administration and dosage is if a doctor is titrating up the dose of a new medication or reducing down a medication for discontinuation. **All staff should always be clear on any specific instructions of a medication regime.** It is the responsibility of each unit to ensure that correct protocols, storage and staff recording reflects such medications if there is additional training required the staff should contact the Health trainer to support them and organise correct documentation.

6.3.5 GUIDELINE FOR USE OF CLOZARIL WITHIN SHS SERVICE

Clozaril is an anti-psychotic medication which has the potential to have serious side effects and therefore requires a care-plan in house detailing the Client's specific monitoring needs. In the early prescription and increasing of dose Clozaril users will require specific supports and monitoring. The nature of the monitoring will vary based on the newness of the prescription, the dosage and the blood results from the Clozaril Patient |Monitoring Service which in the case of SHS Clients in run through Newcastle Hospital Clozaril Clinic**.**

- If Clozaril is newly prescribed staff must ensure the prescriber and the local designated service have set up the relevant registration of the Client and that SHS has a copy of this protocol.
- Any observations physical, psychological or side effects should be discussed with the prescriber and the Community Psychiatric nurse who should be liasing with staff/family.
- CSM must ensure that the prescribing doctor's recommendations are strictly followed.
- Guidelines on Clozaril support and the level of monitoring is dependent on the guidelines from the prescriber and also where the Client is in their titration programme. The Clozaril clinic and Clozaril nurse at Newcastle Hospital in Co. Wicklow should be contacted if there is any confusion on this medication.
- Any client who is prescribed Clozaril as a therapy will have a integrated personalised plan of care based on their usage of the medication, their blood results and their specific need for monitoring. The medication trainer should be informed and consulted regarding this plan.
- Staff must always report any incidences of a client on Clozaril experiencing temperature, cough, colds, flu symptoms, sore throat etc straight away to the clinic in Newcastle and to the prescriber **and prior** to administering the medication. Clozaril should NOT be automatically dispensed if the Client is showing any signs of malaise or ill health.

6.4 MEDICATION MANAGEMENT: ADMINISTRATION COMPETENCIES

6.4.1 GUIDELINES FOR DISPENSING OF GENERAL MEDICATIONS

- In the case of nurse-led locations, the keys to the medication storage unit should be held on the nurse's person at all times as per An Board Altranais guidelines. For non-nursing locations, there should be a clear storage area for the medication keys that is safe and secure. All staff must be aware of the storage area. The management of this should take into account the type of location, the HIQA designated Centre guidelines and the ability level of those living within the location. Evidence of risk management and rationale for the storage of the keys will be evident and CSM guided.

- In SHS locations where there is a skill mix of both Nursing and Qualified Social Care Staff who have completed the Responsible and Safe Management of Medication Course, successfully completed the written assessment and have passed their Medication Administration Assessment; SHS acknowledges that the aforementioned Social Care staff can carry and have access to the medication keys in compliance with the policy.
- All medications for non self-medicating Clients require dispensing by a qualified pharmacist.
- Dispensed medications will be clearly labelled and the label will contain:
    - The name and contact details of the pharmacist
    - The client's name
    - The name of the medication (preferably generic name other than AED)
    - The dose to be administered
    - The frequency of administration (if required)
    - The expiry date (if required)
    - The storage regulations (if required)
    - Special requirements – e.g. taken with food etc.
- Medicines supplied for individual Clients are the property of the named person and not for use by other Clients. Each medication should therefore be clearly labelled.
- Where Clients self-medicate and are deemed to have full capacity with their own medicinal products, a risk assessment should they use day services may still be required. This assessment should look at the safety of the medication in the specific environment and if there are concerns outside of this named person, an agreement should be made regarding storage when using SHS day/respite services for the safety of all Clients. Staff and CSM must address this issue on an individual and location basis.
- When Clients are leaving a location second dispensing should only be undertaken by staff in exceptional circumstances i.e. where the sending of the required medication cannot be reasonably accommodated in its pharmacy dispensed package.
- Dispensing practice must be recorded on medication administration record; MARs

- If dispensing a medicinal product for a later time the product should be:
    - stored in an accepted container/packaging
    - not compromised in any way
    - clearly dated and signed by staff dispensing
    - clear instructions for time of taking, medicine and dose and the person's name should be on it
- Dispensing practice will be subject to audit both internally and externally.
- Consultation with community pharmacist should be considered for guidance.
- It is advised that a pharmacy-led labelling system for second dispensing should be obtained from the dispensing pharmacist and relevant Client details added in addition to staff signatures (initials can be used if signature log is maintained in location).
- Compliance Aids are devices which make it easier for the Clients to take their medicines correctly. Compliance aids include easy-open containers, Monitored Dosage Systems (MDS) and Dosette boxes. Dispensing pharmacist will be able to support a client's need for a compliance aid.
- The compliance aid should be clearly labelled in line with the above criteria.
- Liquid medication can be dispensed into a bunged syringe or medication pot with lid for immediate use in the location.
- Medication cannot be accepted by SHS if second dispensed by families for Clients on respite/holidays. It must be in original or blister containers supplied by the pharmacist and clearly labelled. (See Respite Procedure for medications)
- If medication is supplied by staff to Clients in the form dispensed by community pharmacist, for example, if medication arrives to location from pharmacy in pre-packed containers, then it must be supplied in these containers to the client for leave etc and **NOT** removed and placed into different containers. This practice needs to be recorded in the Medication Administration Record. Please refer to dispensing guidelines above if medication has to be removed.

6.4.2 GUIDELINES FOR ADMINISTRATION OF MEDICATIONS

- A valid medication record is required. (The IMP is the new term for the Kardex) Please see prescription standards as per An Bord Altranais guidelines 2007.
- The medication record must be dated and signed by a Medical Practitioner.

- The five rights of medication administration must be considered on administration:
    - The right medication. Staff are required to match the prescription order against the dispensed medication and to be aware of look-alike and similar sounding medications
    - The right client. Staff are required to be certain of the identity of the person who is receiving medication. This involves checking the PIN, name, date of birth and photograph of the person.
    - The right dosage. Staff are required to use the appropriate equipment when measuring dosage and to give the dosage prescribed.
    - The right route. Staff ensure that medication is given via the correct route.
    - The right time. Staff ensure timing, frequency, duration and signature of the prescribed medication is adhered to. The timing can be critical for maintaining specific therapeutic blood-drug levels (e.g. antibiotics) and avoiding interactions with other medications.
    - Record that medication has been administered after administration.
    - Restore medication in a safe manner.
      Some Organisations have added in another R which stands for the right to refuse

- CSW staff can undertake the administration of oral and topical and inhaled medication once they have completed the Safe Administration of Medication Training.

- It is good practice to always write clearly when opened and when the discard date is due on any preparations like this to avoid them passing their expiry date post opening.

- Some preparations may require fridge storage so always check.

- Any extra training needs must be highlighted to the Medication Trainer by the CSM or any staff and a subsequent training session will then be designed and delivered to support staff in their

locations as required. Currently Community Support Workers (CSW) are not generally trained to administer medication via injection (except insulin), PEG tube or rectally or vaginally. Should the need arise then the Staff trainer and/or community PHN will devise a relevant high standard and personalised training plan for staff in question.

6.4.3 PROCEDURE FOR MEDICATION ADMINISTRATION

- When medicines are transported within the location, it must be done so in a secure manner and care must be taken that they can be quickly and securely locked away in the event of an emergency.
- The best way to administer medicines is directly from the original packaging; medication can be placed in a small pot after removing it from this packaging as a way of hygienically handing it to the person.
- It is good practice to administer medication to one person at a time.
- It is also good practice to sign the record form as each medication is taken.
- Ensure that the medication is not left unattended if the person is not ready to have it.
- Clients must be closely supervised when taking their medication by the administrator of the medication. They must make sure that the Client has swallowed all his/her medication before administering medication to the next Client.
- Where there is any concern about the legibility of a prescription or a prescription label, the person administering the medication will consult the medical practitioner who prescribed the medication or the pharmacist who dispensed.
- Medication prescribed for one Client should never be administered to another Client.
- Adverse reactions to medication will be observed, recorded (in Client's file) and reported immediately to the Medical Practitioner and where an allergy is suspected, this should be reported and documented (in red pen) both in the file and on the IMP.
- The staff member administering medications will legibly sign the medications administration record immediately following administration.

- As a quality control measure, a list containing the signature and initial's of all staff who administer medication in each location will be stored in the medication IMP file.
- A staff member is always responsible for checking a medication is within date and correct in line with the prescription guidelines.

- **One exception to general prescription guidelines is as follows:**

- **The only time a medication is permitted to be given to a Client without a prescription is in the event of a cardiac arrest whereby the staff member in question has been trained to respond to such an event with the administration of a single dose 300mg Aspirin. This can only be carried out if the staff member is fully certified and up to date in this area of Occupational First Aid training. If you carry this out, it is essential that you are satisfied the Client in question has no allergy or contraindication to receiving Aspirin prior to dispensing and that you then follow up by reporting to ambulance staff and with GP/Doctor prescribing in the once only section of the Kardex.**
- **All locations should have a list of all those administering medications with their names in block capitals, signature and initial's for best practice in record keeping.**
- **Any extra training needs or errors should be reported to the Medication trainer as part of good practice and safeguarding.**

6.4.4 GUIDELINES FOR REFUSAL/NON-COMPLIANCE OF MEDICATION

- Clients have a right to refuse their medication. It is important to identify, where possible, the individual's reasons for refusal and assess their level of understanding on how this might impact on their health and well-being.
- Documentation should detail the reason for refusal (if known), all actions taken by the staff member, the personnel contacted and the advice given.
- If refusal of medication persists, arrangements are to be made for a review of the treatment with the prescribing medical practitioner and with other relevant personnel.
- Where refusal of medication could result in serious physical or psychological consequences, staff must inform the Client's GP or doctor on call and family members, if appropriate and the SSM on call.

This would be particularly important for example in the areas of diabetes medication, anti-seizure medication and other highly important and regular preventative medications.

- Potential factors contributing to a client refusing medication:
    - Complex medication regimes
    - Unpleasant side-effects
    - Feel it is ineffective
    - Have difficulty taking the medication (e.g. swallowing tablets)
    - Have inadequate understanding of their medication regime
    - Have little perception of the seriousness of their condition
    - Dislike the taste
    - Informing the staff administering the medication that it has already been administered
    - Experiencing delusions or paranoia and requiring a review in their mental health.

Staff may also be mindful that medication refusal may be an indicator of emotional upset and therefore should always be available to address this in order to support the Client to make an informed choice on medication and to understand the potential effects of missing medications prescribed.

6.4.5 GUIDELINES FOR SELF ADMINSTRATION OF MEDICATION

This is the right of a Client to take responsibility for his/her medication where possible. There are situations when a person is able to take complete control of his/her medicines. However self-administration of medicines is not an 'all or nothing' scenario. For example, if the person has the capacity to collect their own prescription and take it to the pharmacy for dispensing, they have a right to choose where the prescription is dispensed.

In residential settings SHS has a responsibility to ensure the safety of the Client who wishes to self-administer and the safety and well-being of others who share their accommodation.

Self-administration carries a number of potential risks, including over-dosage and non-compliance. There is also the risk that drugs are mislaid, acquired by a third party and subsequently abused. Before self-administration can be agreed, an assessment of the Client's competence to self-administer must be carried out.

6.4.5.1 SELF-MEDICATION ASSESSMENT

The process should commence when a Client is showing a wish to learn about their medication or is transferring to a lesser supported service or is building skills in this area through their Personal Plans.

The assessment should include the following:

- The Client's understanding of medication – what it is for, the side effects, how and when it should be taken (e.g. in the morning, after food, avoiding alcohol).
- The Client's understanding of the need to secure medicines safely.
- A review of current levels of compliance – e.g. attends for medication without prompting
- A person centred approach to building capacity using visuals, timers, routines, colour codes, blister packs and all other available aids to ensure safety

Competence to self-administer will be enhanced by the provision of appropriate education, safe systems, support and supervision. Clients should be provided with simple and clear guidelines. A written (or recorded) copy of the guidelines should always be provided and a record maintained detailing the advice provided.

An on-going evaluation of a Client's ability to perform this activity should be reviewed periodically as this may decrease under certain circumstances. The review should be three times a year at a minimum and more frequently if required. Review dates set on the self-medicating assessment form and the outcome of each review documented. Should a Client require more intermittent reviews, this should be documented and signed off with reasons given.

- Following risk assessment, it is the Client's responsibility to ensure that their medication is safely stored and not accessible to other Clients.
- For Clients are sharing their home with other people, their medication should be stored carefully and locked away in their bedroom and access limited to that Client and staff.
- For Clients who live alone in their own home, they should store their medication safely out of access to others.

- Clients who bring their medication to work are advised to have it clearly labelled with details of their name, medication, dosage and date. It should be noted that although the Client may be assessed as fully competent in carrying their medication, a risk assessment within the location may still be relevant if there are Client's with various levels of need. It is for the CSM to decide on the storage of any medications safely within their locations at any time.
- A secure locked container can be used to transport medication.
- Residential CSM's/Staff must communicate with Clients, Clients' families or day services in order that they are fully aware of the type and dose of medication that is taken by individual clients during the day. Notification must be sent to day service when medication is changed.
- The Day Service CSM must delegate to a member of staff the task of supporting specific Clients in self-medication. It is this staff members' responsibility to ensure the safe storage of medication and to ensure that the Client(s) take their medication at the appropriate time if this support is required.
- Day staff must reinforce with relatives etc. the importance of them informing staff of any changes of medication and that Kardexes are up to date and reflect latest medication prescriptions.
- Wherever possible independence and support should be tailored to need. This may mean at times a person may require more supports, e.g. when under stress, or less supports, e.g. in their regular day service.

6.4.6 GUIDELINES FOR RECORDING OF MEDICATION

- The Medication Administration Record Sheet (MARs) is a working document which is signed to record administration of medicines.
- The Client's name, PIN, location, DOB must be identified on the record.
- The signature of a person administering the medicine must be linked to a specific list on the medication file which has the name in block capitals, the signature and the initials of each staff member involved in dispensing at the Location. This is to facilitate audits as a later date and to endure that the records are clear.
- Only codes to be used are as follows:
  O/L - on leave

O - omitted: this should be used only in case of a medication not been given due to drowsiness, suspected allergy or other medical reason. It is not used to explain omitted during pill free week for example.
R - refused

- The comments section must always be used when administering PRN.
- The comments section should be used if the time of administration has deviated from the norm to ensure next dose is given with a safe 4 hour spacing in between.
- In locations where they have a specific kardex they use a numbering system instead of codes/
- **It is essential for each code used that a circle surrounds it to differentiate from the general A, B, C, code for a medication**.
- The comment box should **always** be used when there is any difference or any issue out of the usual prescription/administration routines as in the above and a reason given. An example would be the reason for PRN.
- In addition to the above abbreviations and reason, a staff signature with date range and / time is required in the comments section of MAR.

6.4.7 GUIDELINES FOR OFF-LABEL USE OF MEDICATION (TABLET CRUSHING AND CAPSULE OPENING)

- 'Off-label' use occurs when prescribers choose to use indications, doses and/or routes of administration that are outside those recommended in the licence or even override any contra-indications, precautions or warnings in the Summary of Product Characteristics (SPC).
- The opening of a capsule or crushing of a tablet before administration will in most cases render its use to be 'off-label' (that is, the product was not intended to be used that way). Crushing of tablets and opening of capsules incurs additional liability and risk and as such the practice should generally not be endorsed.
- Medication should only be crushed after consulting with the medical practitioner who must then document in writing his/her wishes regarding the medication alteration and the reasons why.
- The Pharmacist should be informed by staff and GP and reminded to work in tandem with the prescriber to ensure the intended effect of the prescription is still possible in this dispensing mode.

6.4.8 GUIDELINES FOR COVERT ADMINISTRATION OF MEDICATION

- It is important to distinguish the facilitation of medication ingestion by administering it with a drink or yogurt, in crushed formulation, etc, where the Client is aware of this, as opposed to not knowing.

- Covert administration is the term used when medicines are administered in a disguised form without the knowledge of the person receiving them e.g. in food and drink.
- If the person lacks mental capacity, the decision to administer covert medication must take place within the context of existing legal and best practice frameworks to protect the person receiving the medicines and the staff involved in giving the medicines and this requires documentation and a rights review/restrictive committee practice input.
- Any staff administering medicines must **not** take a decision about covert administration on their own. There should be a multidisciplinary approach to the decision which should include the person using the service if he or she is able to participate, their advocate if one is appointed, relative, any legally appointed representative, GP, CSM, key-worker.

  Covert administration should be documented and reviewed in the Client's Personal Profile it should also be logged as a rights restriction and referred to rights review committee.

6.4.9 GUIDELINES FOR STORAGE OF MEDICINES

- All medication must be stored in line with current legislation and **An Bord Altranais Guidelines 2007.**
- Medication must be stored in a secure manner and separate from antiseptics, disinfectants and other cleaning products.
- Use of a fixed metal cabinet to wall is practiced in SHS units. The cabinet should be locked at all times except when in use and it should never be left unattended while open, under any circumstances. The cabinet may have two or more compartments. Excess/Stock medication may be stored in location but must also be locked in a secure manner.
- In locations where staff do not meet during change-over of shift, there should be a secure and secret place where staff only know the key location.
- The key should not be part of the master system for the location.
- In Nurse led locations, nursing staff must carry the medication keys. SHS acknowledge that in extreme cases in the event of no nurse being available, due to staff shortages or sick leave, the medication keys will be carried by qualified Social Care Staff who have completed the Responsible and Safe Medication Management Course, written assessment and have passed their Medication Administration Assessment.

- Medication that requires refrigeration should be stored in a separate secured fridge.
- The temperature of the fridge is not automatically recorded unless the pharmacist specifically indicates an exact temperature for a particular product
- A separate fridge may not be necessary in a small location unless there is a constant need to refrigerate medicines that a client takes regularly, for example insulin, however this medication cannot be left free within the fridge and must be secured to protect all client using the fridge. The pharmacist must advise on a suitable container or staff make seek storage receptacle from the Pharmacy.
- In general storage of medicines should be at room temperature appropriate for medication storage, not exceeding 25^0C unless refrigeration is required.
- Only prescribed drugs are to be taken to or stored in day locations with any emergency drugs that may be required. The only exception for extra medication is if clients are going away for a period of time directly from the day location, for example, respite.
- Medication must be accounted for on the **Medication Storage Record** on arrival to location and signed by two staff if available.
- Any discrepancies in stock ordered from pharmacy must be reported to CSM and investigated. Inaccurate medication delivered can be indicated on the Storage Record and liaison with pharmacist noted. Drug Error form should be completed.
- Out of date drugs or drugs left at the end of a prescribed period, or after discontinuation or alteration, should be returned to the supplier and recorded on Storage Record, and again signed by two staff if available.
- A monthly medication Audit is required for all locations. as it is a solid quality control tool. Where there are a lot of medication in use a pharmacist should be asked to provide audits of medication stock and evidence of audit recorded. The best practice guideline is to use the medication audit document in between the ordering/delivery timeframe to allow for returns to be organised and an ongoing stock check system to be in place.

6.4.9.1 BUCCAL MIDAZOLAM STORAGE

This medication should be checked in and out everyday and from Day service Units using this from (Hyperlink). It is essential staff **open the box** and view the medication checking it is in date and also if there is any reordering required. The care-plan for this should be held within the medication folder as this is the

instructions for use for that individual a copy can be kept in the box for community/home/respite use.

6.4.9.2 DAY SERVICE STORAGE OF MEDICATION FOR RESPITE CLIENTS

If a Client is coming for Day Service and then onto Respite and has their Respite medications with them then these should be in a sealed/locked container. The bag can be signed in and out without opening so long as the staff record that it is intact and unopened.

There may be cases where it is in the best interest of the Client for the day service to open and check the container in order to avert mistakes and highlight to the Respite Unit a need for clarification. In this instance a medication stock record form is filled out and signed by Day Service for each medication received. The reason for any mistake or discrepancy should then be followed up by the Respite Unit to ensure respite can still be provided at the agreed time and also family support given as required.

There may be a need for minimal storage of PRN medications or emergency seizure medications to be held in the day service to support best possible health. If this is the case then the Day Service must utilise the correct forms and audit mechanism to ensure safe practice.

6.4.10 GUIDELINES FOR MEDICATION TRANSPORT

- Medication for Clients who are on leave/or travelling must be clearly labelled and transported in a locked container/sealed transport bag if they are not self-medicating.
- A copy of the Prescription kardex is not necessary for general transport.
- The Prescription kardex must always accompany medication on holidays/leave/respite if Client is travelling with SHS staff.
- Clients who are not self-medicating should never be given medicines to carry in transit. Medication should be given to parents or locations from staff or visa versa. Unless there is a locked receptacle and Staff can sign off to confirm competency in this area.
- On receipt and delivery of medication, from home and during transport process escort staff and locations are required to sign for it on Transport Medication Checklist Form.

6.4.10.1 DRUG ERRORS AND NEAR MISSES

- Drug errors are defined as preventable events that may cause or lead to inappropriate medication use or client 'harm' while the medication is in the control of the health care professional or client themselves.
- A 'near miss' may also happen with medications, where the error does not reach the client and no injury results, for example an incorrect dosage is prescribed but is recognised and adjusted before the medication is administered or the pharmacist supplies the wrong medication.
- If a medication error or near miss has been identified, interventions should be implemented immediately to limit potential adverse effects. The following guidelines apply:
  - Notify GP, CSM/SSM immediately
  - Keep client under observation.
  - Record on CID as a Drug Error for CSM review.
  - CSM to complete necessary action plan on CID for SSM review
  - SSM to review Drug Error on CID to ensure action plans are appropriate.
- The CSM must be satisfied that staff are competent in identifying and administering medication. However, the CSM cannot be held responsible for any errors that the staff may make in his/her absence.
- Following a drug error and if deemed necessary by the CSM, further Medication Training and Competency Assessment should be carried out.
- The CSM must ensure that all staff complete the **Medication Training Programme and refresher every two years.**

6.4.11 GUIDELINES FOR MEDICATION DISPOSAL

- All medication that has not been used, is out of date or has been contaminated must be returned to the community pharmacist and noted in the medication storage record.
- For singular medication that has been found on location i.e. on floor, in bed etc, please return to pharmacy and document in storage record.
- The storage record should be sent to Pharmacy who can stamp to say they have received the returned medication.

- A sharps bin must be used for disposal of needles and syringes. Once full, liaise with the appropriate contracted waste disposal company (accessed through accounts) regarding disposal.

6.4.12 GUIDELINES FOR MEDICATION RETURNS

- All unused or not required medications should be either sent home or returned to pharmacy in a secure box.
- It is staff responsibility to ensure the return is documented and, in the case of the Pharmacy, a signature or stamp should be obtained on the returns form to indicate that the medication was returned and received.

6.4.13 GUIDELINESE FOR USE OF SCHEDULED CONTROLLED DRUGS (CD)

- The Misuse of Drugs Act (MDA) and accompanying regulations is the legislation governing controlled drugs.
- Controlled Drugs are categorised into five schedules with different controls applicable to each category. The legal term for these drugs is the abbreviation MDA accompanied by the appropriate schedule of the drug. For example Morphine or Ritalin are MDA Schedule 2 drug, Phenobarbitone is an MDA Schedule 4 drug. Regulations govern their control in degrees of security depending on what schedule the drug comes under.
- There is a place on the IMP for a prescriber to record if the medication is a control or psychotropic drug so non-nursing units can be aware of the Classification of each medication.
- Locations should only keep controlled drugs prescribed for an individual person.
- Controlled drugs must be stored in the designated CD cupboard which meets the legislative requirements in the Misuse of Drugs Act. This legislation specifies the quality, construction, method of fixing and lock and key for the cupboard. The security of the location also needs careful consideration.

- Additional recording procedures in a CD Register are required for MDA Schedule 2 drugs such as Ritalin and Morphine. The administration of a MDA Schedule 2 drug should be witnessed by a second staff member. Where there is a changeover of staff, then the two staff at handover must check, record and sign that the correct amount of the controlled drug remains in stock. **Where there is lone working, Sunbeam House Services acknowledge that a lone staff member (nursing and non-nursing staff) can administer the drug without a second staff member**

present. The lone worker needs to check the medication and sign that it is correct, both at the beginning and end of their shift.

- **Should there be any discrepancies, the CSM/SSM must be contacted immediately and a Drug Error report must be completed. An investigation will be commenced.**

- In the event that **Schedule 2** drugs are prescribed, then the CSM and the SSM must be contacted and involved in developing a local written guideline for the administration process.

6.4.14 GUIDELINES FOR THE USE OF ALTERNATIVE AND OVER THE COUNTER (OTC) MEDICINES

- Over-the-counter and alternative medications are medications that can be purchased without a prescription.
- SHS have a responsibility to oversee the administration of these medications, as they can be dangerous if taken to excess and can lead to liver failure and can have severe adverse reactions if combined with certain other medications.
- SHS believes that in the interests of safety, over-the-counter and alternative medications should be prescribed with SHS client's consent to reduce the risk of adverse interactions with other medications.
- No staff member should administer, encourage or advise a client to take un-prescribed medication without a prescription.
- Any prescribed alternative medication must be ordered only by the location staff as provenance cannot be verified.

6.4.14.1 HEALTH REVIEW

- Each Client must have a Health and Well-Being Plan as part of their Personal Profile for on-going education about medication and related health issues. (hyperlink)
- All Clients who are on antipsychotic medication will have regular reviews by a medical practitioner. Reviews can be from weekly to monthly depending on Client needs but should not exceed six months. These reviews will be indicated on the IMP form by the prescribing doctor.
- SHS requires a clear, instruction on why the person is prescribed antipsychotic/psychotropic medication.
- Where a client continues to be on poly-pharmacy and shows no improvement, then SHS will consider a second medical opinion.
- All Clients will be facilitated to attend Health Clinics as any medical condition dictates.

- All Clients in need for allied health appointments such as chiropody, physiotherapy etc will be facilitated and supported to attend.
- A yearly medical assessment will be facilitated for any Client not regularly seeing a medical practitioner unless the family/Client declines this facility. In the case of decline a letter offering same and the family/Client decision will be kept on file.
- Staff who feel they require any extra training or supports in facilitating best possible health through education, documentation or other supports should approach their CSM for assistance from the Health and Medications trainer.
- SHS support a proactive health promotion approach and all SHS service users will have their health needs linked to their Personal outcomes and daily support services will reflect the health and well-being needs highlighted in the personal plans.

6.4.15 GUIDELINES ON POSITIVE INTERVENTION PLAN AND USE OF PSYCHOTROPHIC MEDICATION

- Clients who are prescribed Psychotropic Medication for a clearly diagnosed mental illness do not need a Positive Intervention Plan unless they are behaving in a disturbed manner resulting in them being a danger to themselves or others.
- Clients who do not have a mental health diagnosis and who are written up for Regular and PRN psychotropic medication for unsafe behaviour should have a Positive Intervention Plan. If the behaviour has stopped, then the medication should be reviewed I relation to frequency or dosage.
- "Tegretol", for example, is used to treat Epilepsy and can also be used to control behaviour. If it is prescribed for Epilepsy only, then no Positive Intervention Plan is required but if it is used to control behaviour, a Positive Intervention Plan is needed.
- A Rights Restriction Form must be completed for every Client who is taking psychotropic medication, for any reason outside of a mental health diagnosis, and this form should be forwarded to the Rights Review Committee.
- Positive intervention plans can also be very effective with Clients who lack communication skills causing them frustration resulting in unsafe behaviour. (This can be either with or without prescribed psychotropic medication). All staff must endeavour to promote positive mental health and coping mechanisms in their Clients and constantly work

towards ways of enhancing communication skills and capacity building skills.

6.4.16 GUIDELINES ON RESPITE MEDICATION MANAGEMENT

- The purpose of these guidelines is to provide direction on safe practice for the management of medication for Clients using SHS respite care.
- It is the families' responsibility to have the Medication Kardex written up correctly by their GP otherwise respite will be refused.
- If the family wishes to defer this medication documentation responsibility to the respite unit where the Client is a regular user of the service, there must be a local and written agreement.
- It is the families' responsibility to supply medication to the service in a safe manner.
- Any medication sent in with the Client must be correctly labelled, stored and identified. Staff will request that all medication be brought to the respite service in original packaging as dispensed by the pharmacy.
- On arrival at respite staff must ensure that the medication and documentation is correct.
- Clients who take sole responsibility for their medical issues must be given a medication chart and it must be clearly explained to them that they will not be given respite unless this chart is completed correctly by their GP and has a date within the previous 6 months.
- Incorrect documentation and medication can result in respite being cancelled.
- CSM must ensure that an in-house system is implemented so all kardexes for Clients using respite house are confirmed as up to date every six months and clearly indicate this has been done.

6.4.16.1 MEDICATION TRAINING

- Induction training for staff will include medication management principles.
- This will include best practice guidelines, administration, accountability, documentation, education on health support and medication roles, in house and national policy; Client centred care and developing strong links with Multi Disciplinary Team (MDT) in this area.
- Prior to administering medication, staff must attend Medication Training Course with the Nurse Trainer

responsible and have practical support provided at local level.

- The training course will follow the Safe Administration of Medication (SAM) curriculum and include practical scenarios, SHS policies and specific medication practices.
- Staff attending their first training will complete group work and also a short written paper to ensure knowledge has developed.
- Competency checks will be initiated for each new staff member during training.
- For existing staff members trained in administering medication, it is recommended that a refresher course should be undertaken at least every two years.
- Staff must attend a practical skills and knowledge based assessment at a location agreed by the Medication Trainer.
- Competency will be assessed for existing staff members as the need arises by the CSM.
- Should a particular area of need develop the medication/health trainer may provide in-house training on conditions which require enhanced learning needs for staff and clients and the trainer will also utilise community practitioners to augment these programmes. Examples might be relating to diabetes, stoma care or epilepsy.
- Medication management is an ongoing and evolving process it is not a one stop acquired skill. Staff are expected to continue to learn, observe and assess all aspects of their Clients medication experience and request any training as required.

7.0 TOPICAL MEDICATION (EARS, EYES, NOSE)

7.1 DEFINITION

Topical Medicine: The topical route consists of medicine administration via the epidermis (outer layer of the skin) and external mucous membranes, therefore including administration into the eyes, ears and nose.

7.2 PROCEDURES

7.2.1 EYES

- All topical medication is used for one person only.
- Wash hands prior to procedure
- Eyedrops and eye ointments should be applied with the face horizontal, the person preferably lying flat.
- Looking up reduces the blink effect (Kelly 1994), as well as making it easier to apply the drops or ointment into the correct place.
- Slowly squeeze the bulb when applying drops and drop vertically, from as near to the client as possible, without actually touching the eye.
- Always put the drop inside the lower lid (Watkinson and Seewoodhary 2008). This holds the drop for approximately three times longer than the globe of the eye.
- Eyedrops can sting and sometimes leave an after-taste in the back of the throat (Marsden 1998)
- Ensure the eye is kept shut for sixty seconds after application, and always instil drops before an ointment (Marsden and Shaw 2003), if both are being used, as the ointment leaves a film over the eye, preventing the drops being absorbed.
- Eye ointment should be applied to the inside of the lower lid and the eye held closed afterwards for a short time, where possible, enabling the ointment to settle. Applications of ointment to the eye are therefore usually applied at night. Vision may be blurred afterwards.
- Wipe any excess medication away with a clean tissue.
- **NB Please note** – If eye medication is being applied to both eyes, use separate products for both eyes, ensuring bottles and tubes are labelled R and L (Watkinson and Seewoodhary 2008).
- Apply to the least affected eye first, to reduce the risk of spreading the infection.
- If more than one medication is being used, leave at least 3 – 5 minutes between applications (Watkinson and Seewoodhary 2008)
- Expiry date is usually 28 days, but good practice is to check PIL leaflet with medication or check with pharmacist.

7.2.2 EARS

- Wash hands prior to application.
- The drops should be at room temperature before using.
- For application into ears, lying with the ear to be treated uppermost is most effective.
- If required, clean the outer ear with cotton swabs, not the ear canal.

- A small piece of cotton wool may be required to block the ear canal so the medication does not leak out.
- When some time has elapsed, removed the cotton wool from the ear and dispose correctly.
- Expiry date is usually 28 days, but good practice is to check PIL leaflet with medication or check with pharmacist.

7.2.3 NOSE

- For nasal sprays the person should be upright.
- Nasal sprays should be administered 20 minutes before food so that the nasal passages are clear, which makes eating easier.
- Encourage the person to blow their nose or clear their mouth or throat before administration, and follow closely any special instructions accompanying the spray.
- Expiry date is usually 28 days, but good practice is to check PIL leaflet with medication or check with pharmacist.
- Refrigerate if indicated on PIL leaflet

7.2.4 SKIN

- Gloves must be worn if someone other than the client is applying the medication. This is partly to prevent cross-infection from the applicant to the client and vice versa, but also to prevent the applicant from absorbing any of the medication applied into their own skin.
- Encourage the person to apply topical medicine themselves to promote independence and reduce the risk of cross-infection, although this will not always be possible.
- Some manual dexterity is necessary to apply topical medicine, so the client should be assessed for their ability to manage this treatment themselves.
- All stages of the skill will need to be taught, with hand washing carefully explained so that the medicine is not inadvertently transferred to other parts of the body.
- Creams and ointments should be gently massaged in the direction of hair flow (Selli 1995).
- Steroid creams this the skin so are to be applied sparingly
- The client may require advice about clothing and instructions about possible staining or soiling.

7.3 AFTER TREAMENT IS COMPLETED

If symptoms still persist after treatment with topical medication, the GP should be contacted.