Medication Supports Policy, Guidelines & Framework

Current Version

Service Area	Disability, Aged, Community	**Version**	1.2
Process Owner	Governance Lead | CEO | COO	**Date of Issue**	May 2023
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Modification History

Version	Date	Author	Approved by	Description of change
1.0	5/2018	Natashia Telfer	Employsure	Broaden coverage across community
1.1	5/2021	Tahla Small	CEO	Additional resources added
1.2	7/2022	Jacky Yanik	CEO	Rights of medication updated

In conjunction with:

- ALL National Policies

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ALL Medication Management Policy

POLICY STATEMENT
To ensure the safety of client/participants by appropriate prescription, administration, storage and disposal of drugs that complies with relevant legislative requirements.

To ensure that all administrating employees safely undertake the administration of medication within the role of his or her scope, responsibility, and registration requirements.

SCOPE
This policy applies to all registered employees of National.

Client/participant Responsibilities:

- Client/participants receive individual medication assessment (where appropriate) and where appropriate this assessment is undertaken in conjunction with the client/participant, family, doctor, and other health professionals.
- Client/participants have a clear, individual medication support plan.
- The client/participant or carer, family, or guardian completes a consent form.
- Client/participants with more complex health care needs have access to an appropriate health professional to provide back-up advice and support, as and when needed. There is an organisational commitment to ongoing assessment and monitoring of staff practices.
- When possible, the client/participant/carer is responsible for organising appropriately packaged medications. (Webster packs/one dosage liquids etc.) as well as signing sheets from their pharmacy
- Client is responsible for updating NCC of any medication changes: in particular when schedule 8 drugs are included.

National Responsibilities:

- Regularly liaises with client/participant, supporting network, or if applicable- general practitioners, pharmacists and other health professionals with regard to medications as required.
- Ensure client/participants have a clear, individual medication support plan, signing sheets and obtain a consent form is completed by the client/participant or carer, family, or guardian.
- Provide employees with access to training that provides them with the necessary skills and knowledge to confidently assist client/participants with medication support and/or administration.
- Report any critical incidents to appropriate channels.
- Provide annual medication refresher education
- National Community Care will not assign carers to a high-risk medication service. Registered Nurses only.
- National will provide all staff with a general medication side effects fact sheet to assist staff to recognise if a participant may be having a side effect to a medication. This is available through the employees online resources

Employee Responsibilities:

- Understand the legal obligations around safe medication administration
- Work within your scope of practice and legal boundaries
- Before involvement in the administering or support of client/participant medication a support worker must have achieved the medication competencies (See Mandatory
    - Training Policy)
- Attend all mandatory training and updates
- Report any incidents or accidents immediately (see Incident and Accident Policy and Incident and Accident Form located through employee logins to National's Website in the "Documents" folder)
- Follow best practice and the "Medications Procedure" accordingly
- Document accordingly on the client/participant's medication signing sheet
- If medication support is being provided, the client/participant retains all responsibility for their medications.
- If medication administration is being provided, the support worker is responsible for ensuring that the client/participant takes their medications. (NOTE: If a client/participant refuses to take their medication refer to the procedure for refusals below.

DEFINITIONS

Consumer/Client/participant: Person receiving service.

Carer: A person such as a family member, friend or neighbour, who provides regular and sustained care and assistance to another person, without payment for their caring role other than a pension or benefit.

Primary Carer: The person who provides the most informal assistance to the care recipient. **Home Support:** Client/participants in a group setting/ group house/ SIL property in which NATIONAL provides care.

Community Setting: Client/participants who live within their own homes within our community

Container: A container includes any receptacle used for the storage of medication and all dose administration aids such as dosette box, blister pack, Webster pack, sachets and other medication aids.

Medication: medication includes medicines prescribed for the client/participant by a doctor or health professional and medicines purchased over the counter. These medicines include capsules, eardrops, eye drops, inhalants, liquid, lotion and cream, nose-drops, patches, powder, tablets, wafers, suppositories, oxygen, pessaries, nebulisers, schedule 8 drugs, vaginal cream by applicator, sprays (e.g. nitro lingual spray) and insulin (by pen or pre-filled syringes).

(Source: Adapted from the Certificate III CHCCS303A Module Provide Physical assistance with medication within the Australian Qualification Framework).

Chemical Restraint: Under the NDIS, chemical restraint is the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition; any restraint is required to be reported to NDIS Quality and Safeguard Commission as per their stipulation.

Primary Carer - The person who provides the most informal assistance to the care recipient.

Home Support – Client/participants in a group setting/ group house in which National provides 24/7 care for.

Community Setting – Client/participants who live within their own homes within our community
Medication Administration: is the actual giving of medication and may involve:

- storing the medication
- opening the medication container
- removing the prescribed dosage, and
- giving the medication to the client/participant as per instructions.

Medication support is the prompting and/or assisting the client/participant with self-medication and may involve:

- reminding and/or prompting the client/participant to take the medication
- assisting (if needed) with opening of medication containers for the client/participant, and
- other assistance not involving medication administration, for example, preparing glass of water, food if medications require to be taken with food etc.

Pro Re Nata (PRN) Medication: is medication that is not needed or taken on a predetermined regular schedule but is taken in response to particular symptoms or complaints.
Support Worker: A support worker is an employee employed to provide personal care services, which shall include assisting client/participants with hygiene and grooming, dressing and undressing, fitting of appliances, mobility and exercises, toileting, fluid intake, feeding and preparation of meals, assisting enrolled nurses, registered nurses or others to manage client/participants where necessary, socialisation including talking with client/participant and family and managing and or administering
(in line with the DoHA National Medicines Policy 2000) prescribed medications as per client/participant service plan; and environmental services, which shall include limited housekeeping, bed making, laundry, shopping, sewing, transport, assistance with correspondence, care of pets and pot plants and basic home maintenance; but does not include an employee who is substantially employed to perform domestic housekeeping work.

Guiding Principles

Information resources
All health care professionals and care workers should have access to current, accurate and balanced information about medicines. This will assist health care providers and care workers to provide consumers with appropriate information, including Consumer Medicine Information (CMI), and advice about medicine use, in a timely manner.

Self-administration Consumers should be encouraged to maintain their independence for as long as possible, including managing their own medicines in a safe and effective way.

Dose Administration Aids Dispensed medicines should be retained in the original manufacturers' or other dispensed packaging unless a Dose Administration Aid (DAA), for example Webster-Pak®, could help to overcome specific problems that a consumer or care worker might face.

Administration of medicines in the community Health care professionals, care workers and service providers all play an important role in making sure that consumers who live at home receive suitable information and/or assistance so that they take their medicines correctly.

Medication lists Client/participants should be supported in maintaining a current list of all their medicines. This list should be available and easily accessible to the consumer and all those involved in the consumer's care guiding principles for medication management in the community.

Medication review Client/participants are encouraged to have their medicines reviewed by members of the health care team. These reviews should follow the relevant professional guidelines.

Alteration of oral formulations Some client/participants might need to have oral formulations altered, for example, tablets broken or crushed to aid administration. However, some medicines cannot be altered and the consumer might need alternative formulations or different medicines instead. These consumers should be given the help they need under the direction of their doctor and pharmacist to guarantee their medicines are managed safely and effectively.

Disposal of medicines Participants and/or their carers should be encouraged to return any unwanted, ceased or expired medicines to their local community pharmacy for safe disposal (see Return Unwanted Medicines at http://www.returnmed.com.au/)

Storage of medicines Consumers using medicines in the community are encouraged to store their medicines in a manner that maintains the quality of the medicine and safeguards the consumer, their family and visitors in their home. Upon commencement with NCC, a medication storage fact sheet is provided to the consumer.
Health care professionals and care workers should advise consumers that it is important to store medicines properly and in accordance with any instructions on the medicine label. Generally, medicines should be stored away from heat, moisture, and sunlight. Medications should remain in their original container in a cool, dry and secure place stored below 25C. The stability/effectiveness of some medicines depends on storing them at the correct temperature, for example, those medicines requiring refrigeration. In the event refrigeration is required, individualised procedures will be available within the consumer's home.
For SIL properties, National is responsible for ensuring storage maintains the quality of the medicines and safeguards employees, consumers, families, and visitors, for example medications will be stored in locked boxes with codes known to the registered nurses. In the event refrigerator medication is required, SIL properties will implement regular daily temperature checks and document accordingly.

Administering High Risk Medications High Risk Medications include insulin, warfarin and Schedule 8 (controlled) medications. National Community Care will only assign Registered Nurses to administer High Risk Medications where possible. We request all clients/participants and brokers package any S8 or nigh risk medication in a separate webster pack to ensure the risk is removed from carers.

In instances this is unavoidable, see **Schedule 8 community Check Procedure.**

- Refer to the Webster Care® Standard Operating Policy and Procedure: Administering High Risk Medications.

- Client/participant who is on WARFARIN should have INR regularly checked. The INR result needs to be recorded on medication chart. The frequency of monitoring INR is depending on instruction of the Medical Practitioner. Withhold WARFARIN if the INR result is high and there is a risk of haemorrhage. Inform the Medical Practitioner after withholding the medication.
- Client/participant on INSULIN should have Blood Glucose Levels checked regularly. The frequency of monitoring BGL is depending on instruction of the Medical Practitioner.
    - Normal BGL are between 4.0 – 7.8 mmol/L. The general HbA1c target in people with type 2 diabetes is ≤ 7%. Target ranges are set by the Medical Practitioner, and may differ depending on the client/participant, the type of diabetes, their medications and overall health. Withhold insulin if BGL is low (<4 mmol/L) or outside the range set by the Medical Practitioner. Inform the Medical Practitioner after withhold the medication. NOTE: Should a client/participant refuse BGL monitoring, reapproach later and try again. If this fails, try a different staff member. If all attempts fail, notify CC, family/EPOA and GP. Immediate notification is essential because of the risk to the client/participant from potential complications due either to hypoglycaemia or hyperglycaemia.
    - *A carer can assist in preparing insulin pen only with the client/participant able to verify the dose is correct and the client/participant is to place the needle on and administer to self, and remove needle and dispose of within sharps container.*
- Client/participant on SCHEDULE 8 medications should have their pain assessed and documented regularly as per local Facility policy. If a PRN medication has been given regularly for more than 7 days, notify the Medical Practitioner/Nurse Practitioner to review the client/participant. Monitor the client/participant for side effects of opioid medications including: constipation, nausea, vomiting, pruritis, sweating, sedation
    - (increasing falls risk), headache, delirium/confusion, clouded vision, dizziness, xerostomia (dry mouth), bladder dysfunction (e.g. urinary retention) and postural hypotension (Rogers et al 2014).

POLICY

All participants will have an individualised, relevant comprehensive holistic care plan developed through reviewing all supporting documentation received by National Community Care through support coordinators, allied health, subjective and objective information, and observations to ensure all supports implemented are meeting the current needs/requirements of the participant. This is inclusive of medication charting/ prescribing.

Administering team will be skilled and competent to deliver medications and recognising health body systems and responses/ reactions to medications as required.

National understands the responsibilities regarding restrictive practice reporting inclusive of chemical restraint requirements as per NDIS Mandatory reporting obligations for NDIS participants and have identified mandatory reporters within the National Team. These Notifier's and Approvers are:

National Clinical Lead 0429 599 548
NCC Management: 0401 439 798

Training Requirements

All service delivery employees are required to hold a valid First Aid and CPR. Employees are required to undertake annual refresher of CPR and First Aid 3rd yearly. This is a part of the employee's contractual obligations and at the cost of the employee, not National.
Medication competencies will be provided on an annual basis face to face and have online platform access 24/7 along with additional supporting training modules such as diabetes management, seizure management.

Medication Procedures:

Medication Dispensing Procedure

- Employees must read from the CLIENT/PARTICIPANT MEDICATION SHEET and check against the Webster-Pak® INFORMATION SHEET on the Webster-Pak®.
- Before dispensing anything, ensure all future medications in pack are intact, unbroken. (Should there be any discrepancies such as missing medications/additional medications/ broken blisters etc. DO NOT PROVIDE MEDICATION and contact National Community Care Coordinator immediately for further direction.
- Ensure medications are being administered in order and ensure 8 rights of administration are being followed:
    - Right person, are you administering to the right person?
    - Right Medication, is it the right medication?
    - Right Dose, is it the right dose?
    - Right Route, is it being given via the right route? Oral, NGT?
    - Right Time, Is the medication being given at the right time?
    - Right Documentation, sign for medication administration after medication has been administered?
    - Right Reason, is there a rationale to administer the medication?
    - Right Response, has the medication achieved the appropriate response?
- If the participant has identified schedule 8 medications within their webster, this will be identified within the clients service guide / care plan and you will be directed to contact the RN on-call to verify the schedule 8 drugs prior to administration.
- Dispense the medication into a medication cup. Ensure the client/participant has a glass of water for tablets. NOTE: If the medication is not packed in a Webster-Pak® staff may only remove the lid of the medication bottle and provide to the client/participant for self-administration. Do not remove individual or multiple tablets from a bottle and had to a client/participant.
- Ensure that the client/participant has swallowed all oral medication.
- The support worker should administer the medication and sign in the “given by” space on the CLIENT/PARTICIPANT MEDICATION SHEET immediately after it is given.
- The CLIENT/PARTICIPANT MEDICATION SHEET is a legal document and should only be signed in blue or black biro. Do not use pencil. Whiteout must never be used.
- The CLIENT/PARTICIPANT MEDICATION SHEET will be kept in the Client/participant Medication Folder and stored with the medication.
- At the beginning and end of each shift, all staff should check that medication has been given and signed for.
- In the event of missing signatures, the support worker responsible will be contacted by National to confirm that the medication was given and asked to return to the house to sign the CLIENT/PARTICIPANT MEDICATION SHEET. Under no circumstances can support workers sign for each other.

Schedule 8 Community Drug Check Procedure

It is acknowledged that when medication, including Schedule 8 drugs are appropriately packaged by a pharmacy into a sealed webster pack, the medication can be administered by a carer. However, at NCC, we also wish to ensure the safest practices. As such, we have multi-step processes to facilitate safe medication administration.

In addition to the general medication administration procedure:

- The drug must be checked three (3) times prior to administration for correct drug, strength, dosage, expiry date and client/participants name;
    - **1- Carer to cross check the webster pack. Ensure webster blisters are intact. The medications must match what is prescribed on the back of the website.**
    - **2- Carer to cross check the medications listed and packed also match the signing sheet.**
    - **3- If participant is capable, should also be present and encouraged to assist in verifying the medications.**
- In the event of identified reoccurring medication incidents, as an additional safety measure, the clinical lead will review current process and review the factors and variables that NCC can minimise and/or remove. This can include the implementation of the additional step of crosschecking with a registered nurse:
    - **4- Call the on-call RN for Schedule 8 drug check**
        - Prior to removing the medications from the blister, carer is required to facetime the on call registered Nurse on 0400 976 753 and relay what medications are being administered and the number of tablets in the blister.
        - Medications are to then be disprensed into cup and shown to the on-call nurse. The on-call Nurse is required to record when this occurs and has access to do so in the on –call folder at Alex House.
        - Upon RN approval, carer may administer the medications to the participant with the RN still on the call.

Self-Administration

If a client/participant can participate in any of the steps, such as holding the medicine cup to receive the medication, and/or, taking the medication themselves, this should be encouraged.
However, employee is to be present throughout the entire process and are responsible for all steps in this process.

Nurse-initiated non-prescription medicines Procedure

- Medical officer reviews nurse-initiated list, amends or strikes through medications that are not appropriate for the participant, signs and dates the form.
- If a participant reports minor aliments or illness, the RN is to attend a clinical assessment ‘head to toe’ prior to consideration of administrating an approved nurse-initiated medication.
- The RN is to review the participants regular medication list to ensure the assessed nurse initiated medication is not listed as a regular medication. This is to ensure the maximum dosage of a medication is not exceeded.

- The RN is to check participants list of allergies, if listed as an allergy do not administer, contact medical officer to remove from the approved list.
- The RN is to adhere to the following 'principles for safe medication administration'
- Safe and accurate medication administration requires the 8 Rights.
- RN is to clearly document in the participants progress notes, drug, dose, time and clinical reasoning to administration. Medical officer should be informed via communication systems.
- nurse-initiated medication should not be administered on a continual and / or ongoing basis unless it is reviewed and ordered by an authorised prescriber.

Rights of Medication Administration

1. Right patient

- Check the name on the order and the patient.
- Use 2 identifiers.
- Ask patient to identify himself/herself.
- When available, use technology (for example, bar-code system).

2. Right medication

- Check the medication label.
- Check the order.

3. Right dose

- Check the order.
- Confirm appropriateness of the dose using a current drug reference.
- If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route

- Again, check the order and appropriateness of the route ordered.
- Confirm that the patient can take or receive the medication by the ordered route.

5. Right time

- Check the frequency of the ordered medication.
- Double-check that you are giving the ordered dose at the correct time.
- Confirm when the last dose was given.

6. Right *documentation*

- Document administration AFTER giving the ordered medication.
- Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

7. Right reason

- Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
- Revisit the reasons for long-term medication use.

8. Right response

- Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
- Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.
- Safe medication administration and reducing medication errors should be a goal of everyone involved in healthcare. The rights of medication administration help ensure patient safety and consistency in nursing practice.

Rights of Medication Administration Reference

Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.

Nebuliser Administration Procedure (Extracted from ACT Health)

PURPOSE

To provide staff with clear guidelines on the safe and effective management of an adult patient, receiving nebulisation therapy. Where possible an inhaler device with a spacer is the preferred method of administration, as this provides better medication uptake and should be used instead of nebuliser therapy.

Nebulisation Therapy is prescribed to:

- Administer medications
- Assist in the removal of accumulated bronchial secretions
- Liquefy bronchial secretions
- Relieve bronchospasm & dyspnoea

Equipment

- Alcohol based hand rub (ABHR)
- Medication as prescribed
- Ampoule sodium chloride 0.9% or sterile water
- Nebulisation mask, mouthpiece and tubing
- Oxygen tubing (optional)
- Nipple adaptor for air or oxygen outlet or air compressor
- Personal protective equipment (PPE)

Procedure

- Patient identification
- Check medication order and collect required medications and equipment
- Attend hand hygiene before touching the patient by either hand washing or using ABHR
- Explain the procedure to the participant
- Obtain consent
- Don high filtration mask for certain drugs only
- Don PPE
- Assist the participant to a sitting or semi-recumbent position
- Attend pre-medication peak flow measurement if indicated
- Document in the participants clinical records
- Twist nebule to open
- Place the open end of the nebule well into the nebuliser bowl and squeeze it slowly until all the liquid has been emptied into the nebuliser bowl
- Add sodium chloride 0.9% or sterile water to make up a minimal volume of 4mL
- Reconnect the nebuliser
- Attach the tubing to the nebuliser, then to the air or oxygen outlet or air compressor
- If using an air pump, switch the power on
- For oxygen or air, adjust the flow rate (no less than 6L/minute and no more than 8L) to achieve a fine mist
- Ensure the mask is properly fitted to the patient's face
- Instruct the patient to breathe deeply and slowly

- If using a nebuliser with a mouthpiece, instruct the patient to close the lips firmly around the mouthpiece and to inhale through their mouth and exhale through the nose
- Observe for any of the following side effects, report to the MO/VMO and the MO/VMO will then decide if the nebulisation therapy should continue or be ceased. Document any of the below side effects:
  - Tachycardia/palpitations
  - Cyanosis
  - Flushing
  - Headaches
  - Fine muscle tremors (especially hands)
  - Vertigo
- Wash the nebuliser with tap water and leave to air dry following each usage
- Attend hand hygiene after touching the patient by using either hand washing or ABHR
- Remove PPE
- Attend hand hygiene after by using either hand washing or ABHR
- Record nebuliser administration on the medication chart
- Document in the clinical record noting any unusual response to the procedure, including pain/discomfort during and immediately after the nebuliser treatment.
- The Nebuliser set is classified as single patient use. They should be checked by staff and if the participant is having the nebulisation therapy long term then infection control best practice would recommend that the participant change the nebuliser and line once a week.

Reference

Asthma Management Handbook, 2014
http://www.nationalasthma.org.au/
Centre for Disease Control and Prevention, 2004
http://www.cdc.gov/ncidod/sars/
Esmond G, Update. Nebulisation Therapy, Professional Nurse, 1998; 14(1): 39
World Health Organization (WHO) Guidelines on Hand Hygiene in Healthcare, 2009.
http://www.who.int/en/
5 moments of Hand Washing- Hand Hygiene Australia, 2015
http://www.hha.org.au/

Tracheostomy Nebuliser Administration Procedure (Extracted from ACT Health)

There are different types of nebuliser units available. Refer to the manufacturer's instructions for specific information. They can be hired or purchased from community pharmacies.

Administration of Normal Saline via a Nebuliser
The administration 5 mls of normal saline via a nebuliser every four to eight hours while awake is recommended.

Equipment

- Tracheostomy mask.
- 'Sidestream' disposable nebuliser chamber.
- Oxygen tubing.
- 5ml syringe.
- Normal saline.
- Nebuliser unit.
- Tissues.

Procedure

1. Set up equipment.
2. Perform hand hygiene and don PPE
3. Draw up 5mls of normal saline into syringe. Remove top of 'side stream' disposable nebuliser and place normal saline into collection chamber, replace top.
4. Connect the disposable nebuliser to tracheostomy mask, remove the HME device or stoma cover, place the mask over the tracheostomy tube and secure around the neck with elastic.
5. Turn on nebuliser at switch.
6. Breathe slowly during administration of normal saline.
7. When normal saline has been administered (the treatment may take 5 to 10 minutes), turn off the unit and remove the tracheostomy mask.
8. Cough up secretions into a tissue.
9. Replace HME device (if applicable).
10. Wash hands.

Cleaning Nebuliser and Tracheostomy Mask

1. At the end of the day wash the nebuliser and tracheostomy mask in warm soapy water, rinse with tap water and allow airing dry on paper towel.
2. Two nebulisers and tracheostomy masks are used on alternate days so one is washed and drying while one is in use.
3. The nebuliser and tracheostomy mask are inspected daily for signs of wear and tear.
4. The nebuliser and tracheostomy mask can be used indefinitely in the above way if they remain intact.

Reference

Tracheostomy Management Adult Patients.docx

Adult Nebulisation Therapy.docx

Asthma Management Handbook, 2014
http://www.nationalasthma.org.au/

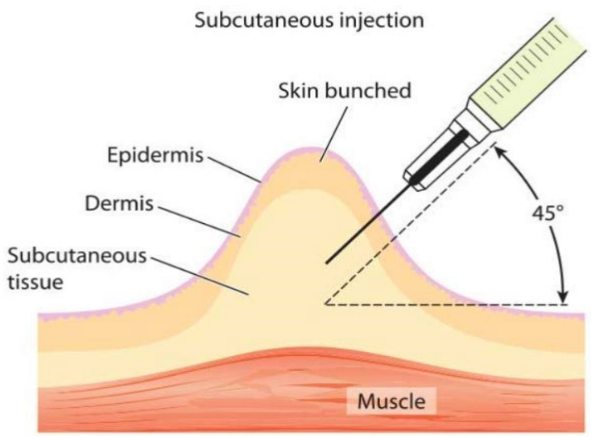
'High Risk' Medications

Subcutaneous Injection Procedure

SCOPE

Subcutaneous injections are classified as high-risk therefore all Subcutaneous injections are only to be prepared and administered by registered nurses and or a registered nurse and an enrolled nurse.

- Refers to injections that are used to administer medication into the fatty tissue layer between the skin and the muscle (subcutaneous tissue). Please refer to the image below.



Sourced from: https://www.ausmed.com.au/cpd/articles/subcutaneous-injections

- The needles used should generally be 16mm long and 25 to 27 gauge (DoH 2018)
- The needle must be injected into a site with a layer of subcutaneous tissue. Recommended areas include:
    - Umbilical region of the abdomen, about two inches from the navel (avoid the navel);
    - Back or side of the upper arm;
    - Top of the thigh; and
    - Top of the buttocks.

Method of Injection

1. Perform hand hygiene. While the WHO does not recommend wearing gloves for administering injections, use your own judgement. Wear gloves if bleeding is expected.
2. Prepare an appropriate syringe with the required dosage. Disperse any air bubbles.
3. Place the patient into a reclined position.
4. Choose the injection site.
5. Perform hand hygiene.
6. If required, cleanse the chosen injection site and wait for it to dry.
7. Hold the syringe with your **dominant** hand. With your **non-dominant** hand, lift a 5 cm fold of skin to separate the subcutaneous layer from the muscle tissue underneath.

8. Using a quick, dart-like technique, insert the syringe at a 45 to 90-degree angle - follow product information for specific guidelines for each medication.
9. Hold the barrel of the syringe firmly and inject the contents for 10 to 30 seconds. The plunger should be pressed all the way down.
10. Wait 10 seconds, then remove the needle and immediately dispose of it into a sharp's container.
11. Do not rub the injection site.
12. Apply a dressing if the site bleeds.
13. Record the injection using the required documentation.
14. Monitor for any adverse reactions or complications.
    (QLD DoH 2020; Shepherd 2018; John Hopkins Arthritis Center 2012; WHO 2010)

TRAINING REQUIREMENTS

Prior experience in administration of subcutaneous injections including insulin or
Undertake the Altura online module for 'clinical skills for RNs: venepuncture, administration of subcutaneous fluids, verifying death.

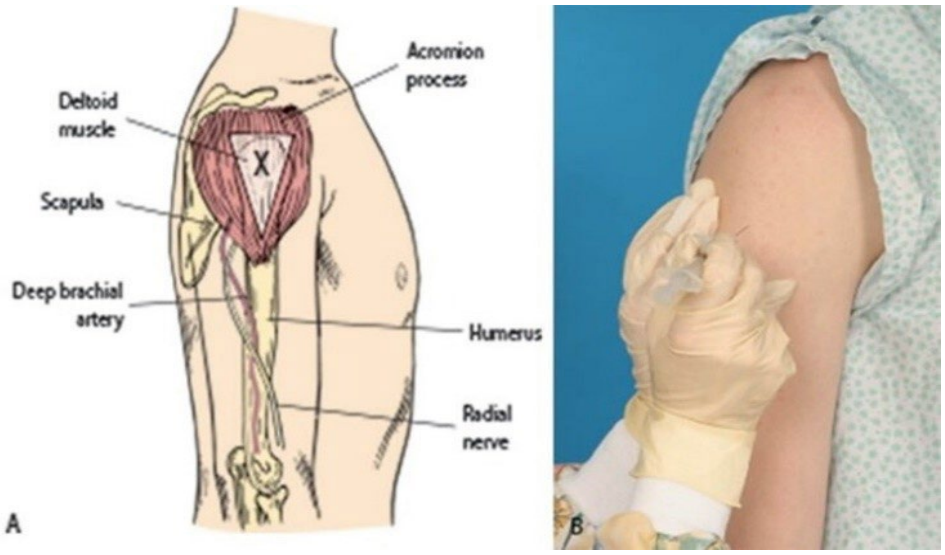
REFERENCES

http://www.health.act.gov.au/sites/default/files/202002/Subcutaneous%20Medication%20Management%20in%20the%20Care%20of%20the%20Palliative%20Patient%20%E2%80%93%20Adults%20Only.doc
World Health Organisation 2010, WHO Best Practices for Injections and Related Procedures Toolkit, World Health Organisation, viewed 23 June 2020, https://www.who.int/infectionprevention/publications/bestpractices_toolkit/en/
Queensland Government Department of Health 2020, Clinical Practice Procedures: Drug Administration/Subcutaneous, Queensland Government Department of Health, viewed 18 June 2020, https://www.ambulance.qld.gov.au/docs/clinical/cpp/CPP_Subcutaneous.pdf
https://www.ausmed.com.au/cpd/articles/subcutaneous-injections

Intramuscular Injections procedure (RN Only)

SCOPE: ***REGISTERED NURSES ONLY***

Intramuscular refers to an injection of medication delivered directly into the muscle. Please refer to the image demonstrating a deltoid intramuscular injection.



Procedure

1. Perform hand hygiene.
2. Engage in therapeutic communication.
3. Introduce self (name and function/designation).
4. Confirm the person's identity (Name and DOB)
5. State intent outline the procedure and answer any questions.
6. Assess the person for specific contraindications to receiving IM injections and advise the medical practitioner accordingly. Assess for factors such as muscle atrophy, reduced blood flow, skin condition and circulatory shock.
7. Assess the person's symptoms before initiating medication therapy.
8. Assess the person's knowledge regarding the medication to be received.
9. Assess the person's history of allergies, including any drug allergies, type of allergens and normal allergic reaction.
10. Review the person's previous verbal and non-verbal responses to injections.
11. Assess baseline vital signs and the person's medical and medication history.
12. Verify the medical practitioner's order.
13. Verify the person's actual admission weight in kilograms. Reweigh the person if appropriate.
14. Understand drug reference information pertinent to the medication's action, purpose, onset of action and peak action, normal dose, common side effects and nursing implications, if needed.
15. Obtain the medication and verify the expiration date.
16. Inspect the medication for particulates, discolouration or other loss of integrity. Do not use any medication that is cloudy or precipitated unless such is indicated by its manufacturer as being safe; otherwise, this may lead to harmful reactions.
17. Assemble appropriate-size needles, syringes and other administration supplies.

18. Perform hand hygiene in accordance with standard or transmission-based precautions.
19. Explain the procedure to the person and ensure that he or she agrees to treatment.
20. Check the Seven rights of medication safety, if mandated by local protocol or legislation with another suitably qualified healthcare professional (RN, RM, EN, medical practitioner or pharmacist), for the first time during dispensing (ACSQHC, 2017, Standard 4).
21. Label all medications, medication containers and other solutions that are both on and off the sterile field. The only exceptions are medications that are still in their original container or medications that are administered immediately by the person who prepared them. Medications or other solutions in unlabelled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabelled containers. This unsafe practice neglects basic principles of medication management safety, yet has been routine in many organisations.
22. Check the seven rights of medication safety, if mandated by local protocol or legislation with another suitably qualified healthcare professional, for the second time after calculation/preparation of the dose (ACSQHC, 2017, Standard 4).
23. Provide privacy for the person.
24. Check the seven rights of medication safety, if mandated by local protocol or legislation with another suitably qualified healthcare professional, for the third time at the bedside immediately before administration (ACSQHC, 2017, Standard 4).
25. Perform hand hygiene and apply gloves in accordance with standard and transmissionbased precautions.
26. Keep a sheet or gown draped over body parts not requiring exposure.
27. Select the appropriate site for injection based on the person's age, muscle tissue mass, and medication volume and viscosity.
28. Inspect the skin surface over sites for bruises, inflammation or oedema.
29. Note the integrity and size of the muscle. Palpate for tenderness or hardness and avoid hardened areas. If the person receives frequent injections, rotate sites.
30. Assist the person to a comfortable position that is appropriate for the chosen injection site (e.g. sitting, or lying flat, on side or prone).
31. Locate the injection site again using anatomic landmarks. The ventrogluteal site is a safe injection site for adults and children receiving irritating or viscous solutions and is the site of choice for administering IM injections to adults. In addition, this site provides the greatest thickness of gluteal muscle, is free of penetrating nerves and blood vessels, and has a narrower layer of fat.
32. Cleanse the site with alcohol or an antiseptic swab, as per the organisation's practice. Allow the skin to dry completely. Optional: Use a vapocoolant spray (e.g. ethyl chloride) for pain relief just before injection.
33. Hold a clean swab or dry gauze between the third and fourth fingers of the non-dominant hand.
34. Remove the needle cap by pulling it straight off.
35. Hold the syringe between the thumb and forefinger of the dominant hand as if holding a dart, palm down.
36. Administer the injection.
37. Z-track method
38. Position the ulnar of the non-dominant hand just below the site and pull the skin laterally. Hold this position until the medication is injected.

39. With the dominant hand, inject the needle quickly into the muscle at a 90-degree angle using a steady and smooth motion.
40. After the needle pierces the skin, use the thumb and forefinger of the non-dominant hand to hold the syringe barrel while still pulling on the skin. Move the dominant hand to the end of the plunger. Avoid moving the syringe.
41. Optional: If the person's muscle mass is small, grasp the body of muscle between the thumb and forefingers of the non-dominant hand while still pulling the skin laterally.
42. Pull back on the plunger. If no blood appears, inject the medication. If blood appears in the syringe, remove the needle, discard the medication, obtain a new syringe and try again.
43. Smoothly, quickly and steadily withdraw the needle and release the skin. Apply a dry cotton ball or gauze with light pressure for several seconds over the site.
44. Monitor the person for adverse and allergic reactions to the medication. Report rash, seizures and difficulty breathing.
45. Discard supplies, remove gloves and attend to hand hygiene according to the '5 moments for hand hygiene'.
46. Document the procedure and any assessment findings in the relevant care plan, progress notes or medical record and report any deterioration or abnormal findings to the healthcare professional in charge or the appropriate medical practitioner.

References

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https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Immunisation_of_inpatients/

PRN Medications

- Refer to the Webster Care® Standard Operating Policy and Procedure: PRN – As Required Medications
- "A PRN medication is a medication ordered and charted by a doctor for the defined treatment of intermittent symptoms or a short-term condition. PRN medications are not intended to be given as a regular dose or at specific times e.g. during a regular medication round.
- A Registered Nurse may administer a PRN medication based on clinical judgement or delegate administration to an Enrolled Nurse or a Care Worker who has the knowledge, skills and competence to administer medications and authorised by National to undertake such a role".

Crushing medications

CARERS ARE NOT TO DETERMINE IF A MEDICATION CAN BE CRUSHED. IN THE EVENT A MEDICATION REQUIRES CRUSHING WITHIN THE COMMUNITY THERE WILL BE AN INDIVIDUALISED CARE PLAN AND PROCEDURE IN PLACE

- Refer to the Don't; Rush to Crush handbook available in relevant properties and EMIMS on National devices.
- Consider an oral medication lubricant (e.g. Gloup®) or requesting the GP to prescribe an alternate drug in the same class, or an alternate form of the same drug. Medication lubricants are preferred over mixing medications in foods such as jams, yoghurts and fruit purees as the foods can potentially impact the efficacy, side effect profile and absorption of the medication. Use water to mix crushed medications for PEG feeding. Do not sprinkle powdered medications onto meals where portions of the meal may be left uneaten.
- Suitable crushing devices include: the Silent Knight, Rhino Crush™ Tablet Crusher and the Webster Care® Ergonomic Tablet Crusher. These tablet crushers employ a method whereby the device does not come in direct contact with the medications being crushed.
- Select medications for client/participant, ensuring they are identified as suitable for crushing (Australian Don't Rush to Crush 2012).
- Do not crush enteric coated, slow or sustained release medications. Many of these medications can be identified by postscripts to the product name such as CR, MR, XR, XL, CD, or SR which implies a treatment to modify the rate of release of the medication, such as 'CR' meaning Controlled Release (refer to the Institute for Safe Medication practices – Oral dosage Forms that should not be crushed 2016 accessed from www.ismp.org/tools/donotcrush.pdf on 26 March 2018
- Crush the tablets first, then open the capsule and add contents to the crushed tablets - this will avoid crushing sustained release or enteric coated pellets.
- Regularly monitor for possible adverse effects secondary to the crushed medication(s) e.g.
    - local irritation, nausea, heartburn etc.

Medication Error

In the event of any medication error, the nurse should do the following:

- Identify the error, i.e. incorrect medication has been given or medication has been missed.
- Contact CC immediately to report the error and for further instruction. Do not administer any medications until notified otherwise.
- Observe the client/participant for signs of distress. Apply first aid and call the ambulance if the client/participant is in distress or showing signs as described by the Doctor/RN or Poisons Information Centre. If in doubt, call an ambulance.
- Record the error on the CLIENT/PARTICIPANT MEDICATION SHEET and the incident details/medication Incident/Accident Form to be provided to the Clinical Coordinator at cc@nationalcommunitycare.com.au the same day of incident for all House incidents.

Refusal to Take Medication

- A client/participant must not be forced to take medication against his or her wishes. However, every effort must be made to give medication as prescribed.
- If a client/participant refuses to take their medication, the support worker administering the medication must:
  - i. Ask the client/participant why they do not wish to take their medication.
  - ii. Explain to the client/participant the reason for taking the medication and the possible effects on their health if medication is not taken.
  - iii. Wait 15 minutes and ask the client/participant to take the medication again. iv. Contact National to report the problem and await further instruction.
  - v. Observe the client/participant for changes in behaviour or wellbeing as a result of the refused medication and report these to National.
  - vi. Complete Incident/Accident form (found through employee logins under "Documents") submit via email to National at enquiries@nationalcommunitycare.com.au . Record all details.
- If a client/participant refuses to take a prescribed medication, write the letter 'R'' in the appropriate box on the medication chart - document the refusal and the client/participant's reason(s). Record the time, date and drug(s) that were refused in the client/participant's progress notes. Notify the EPOA/NOK as soon as practicable and destroy/discard the medication (if prepared) for administration. Notify National on the 24 Hour contact (0401 439 798 / 6242 4978).

Medication incidents – See Incident Reporting

- The Registered Nurse or Enrolled Nurse must know the medication administered - i.e.
- mode of action, contraindications, side effects, compatibility with other drugs and emergency treatment of possible adverse reactions.
- Refer to current MIMS / Pharmacist / Medical Practitioner/Nurse Practitioner if there are questions concerning the dosage, route or possible drug related problems. Do not give the medication until satisfied.
- If a medication incident occurs:
  1. notify *immediate uplining manger* / NOK at the time of the incident *(SIL only)*.
  2. monitor clinical status of client/participant

3. complete the National Incident Form within 24 hours of incident
4. document incident in the nursing notes

Blood Glucose Monitoring

Client/participants diagnosed with Diabetes may be required to monitor their blood glucose level, their medical practitioner will advise National of the frequency of checking the blood glucose levels and set clear parameters for the range and interventions required. Monitoring blood sugar levels require the following equipment:

- A blood glucose meter
- A lancet device with lancets or disposable lancets and sharps container
- Blood glucose strips (check expiry date)
- Tissue or cotton bud

https://www.ndss.com.au/about-diabetes/resources/find-a-resource/blood-glucosemonitoring-fact-sheet/

Process of checking a client / participant blood sugar level:

- Step 1. Check finger pads for signs of bruising and overuse once a finger is chosen (avoid using thumb and index finger).
- Step 2. gain consent to attend blood sugar level and set up BGL machine by inserting a strip.
- Step 3. Clean the finger with a clean gauze soaked in water and dry thoroughly.
- Step 4. Use the lancet to create a small pick on the side of the finger (pad) to draw blood.
- Step 5. Massage the finger to create enough blood to come to the surface of the skin.
- Step 6. Apply finger with blood to the BGL strip once the strip indicator is full remove the finger and apply a cotton bud with pressure.
- Step 7. Record the level in the client / participants BGL record chart. If recording is outside the set parameters call the Clinical Coordinator at once.

Administering insulin (RNs ONLY)

ONLY TO BE ADMINISTERED BY REGISTERED NURSE.
CARER CAN ASSIST A CLIENT/PARTICIPANT IN THE PREPARATION OF INSULIN

Employee to have a clear understanding of participant's requirements identified within participant care plan and administer insulin only as prescribed by Medical Practitioner.
Check BGL. Do not administer insulin if BGL< 4 mmol/L
Rock the vial gently before drawing up insulin
Do not inject closer than 2.5 cm from the navel
Always rotate the sites to prevent fatty lumps developing
Be aware that a heated site (e.g. after a hot shower) will speed up absorption of insulin and may cause a faster drop in blood glucose
Pinch skin to avoid injection into a blood vessel
Monitor for signs of hypoglycaemia including:

- Headaches
- Pounding heat, trembling, impaired vision
- Not being able to awaken
- Irritability
- Personality change
- Excessive sweating
- faintness, cold clammy skin.

If any of these symptoms are observed the BGL should be taken, and a sweet drink and/or sweet followed by a snack should be provided to client/participant if required.
Recheck BGL half hour later to ensure BGL is back to normal range. Inform Medical Practitioner if BGL is still lower than normal range. Document the hypoglycaemic incident
SC injections are generally given in the abdomen to achieve more rapid absorption and onset of action
Refrigerate unopened vials and protect from light
Always keep the vial currently in use at room temperature
Avoid extremes of heat or cold
Injecting cold insulin stings and the action is delayed for approximately half an hour
Mark the date the insulin was opened and discard after one month

Eye Drops

Whenever eye drops/ointments are to be administered staff must wear gloves (to prevent absorption of the medication into their own skin).

- Eye drops/ointments must be applied strictly as directed and only into the eye(s) prescribed.
- Eye drops/ointments must not be applied if the name of the client/participant is unclear or has been removed from the tube or bottle or the name of the substance is unclear.
- Eye drops/ointments must not be shared between client/participants
- All opened eye drops must be clearly marked with the date opened. Open eye drops should be discarded after 28 days.
- Avoid touching the bottle or dropper onto the client/participant's eyelids or eyelashes, as this can introduce bacteria to the eye
- Ask the client/participant to look away from the bottle to avoid the drop falling on the cornea – the most sensitive part of the eye
- Aim for the corner of the eye or into the pocket created on pulling down the lower eyelid.
- Once in, ask the client/participant to close eyes tightly or press firmly on the inner corners of the closed eyes with your fingertips. This closes off the puncta, or ducts that lead to the back of your throat, where the eye drops can be absorbed into your system.

from: https://www.theeyepractice.com.au/education-advice/eye-drops on 10 May 2018)

Complimentary medicines

The brokered Primary Service Providers should develop policies and procedures about the safe practices related to administration of Complimentary Medicines that National staff will adhere to when assisting their community client/participants.

Please note: Canberra Hospital and Health Services does not routinely recommend the use of non-evaluated complementary medicines, as their safety, efficiency, appropriateness and interaction with other drugs cannot be confirmed. For further information, see the Council of Australian Therapeutic Advisory Group Hospitals. Nursing staff will not be involved in the administration of complementary medicines unless prescribed by an authorised prescriber.

Creams and ointments

- Whenever medicated creams, lotions or ointments are applied to a client/participant's skin, staff must wear gloves (to prevent absorption of the medication into their own skin).
- Simple moisturising creams may be applied without gloves.
- Creams, lotions and ointments must be applied strictly as directed and only over the area of concern.
- Creams, lotions and ointments must not be applied if:
- the name of the client/participant is unclear or has been removed from the tube or bottle.
- the name of the substance is unclear.
- Creams, lotions and ointments eye drops must not be shared between client/participants.
- All opened creams, lotions and ointments must be clearly marked with the date first opened.

Cytotoxic medications

All clients/participants on cytotoxic medications are to notify NCC so we can implement addition PPE measures and reduce risk to carers/nurses. (example pregnant employees cannot attend) Refer to the Webster Care® Managing oral cytotoxic medicines in Webster Care® systems.
Cytotoxic medications must be handled in a manner which avoids skin contact and the liberation of the powdered agent into the air. Most tablets containing cytotoxic agents are either pressed or sugar coated, thus preventing exposure.

WARNING: NO EMPLOYEES THAT ARE PREGNANT &/OR IMMUNOCOMPRIMISED ARE TO ENGAGE WITH CYTOXIC CLIENTS

- dispense tablets into a disposable cup using a non-touch technique and cytotoxic gloves
- encourage the client/participant where possible to swallow tablets whole
- DO NOT CRUSH oral cytotoxic agents
- if client/participant vomits within 30 minutes to 1 hour following administration, notify the Medical Practitioner to determine whether the dose must be repeated
- dispose of cytotoxic gloves and equipment as cytotoxic waste
- wash hands following administration and disposal of cytotoxic agents and related waste

Requirements

- NCC will provide staff with purple nitrate gloves,
- NCC will ensure the client has a cytotoxic clinical waste bin available within the home,
- NCC will have an alert label (purple) stating cytotoxic precautions.

Injectable Medicines

Client/participants who are prescribed medicines that are injectable, require two registered nurses to perform the necessary medication checks, calculations and verifications prior to administration. Co-signature against the order is required at the time of administration.

- Employees to have an understanding of potential reactions and manage accordingly. This information can be located on the medication Consumer Medicine Information Pamphlet within the packaging alternatively on eMIMS and/or the Medicines Injectable Handbook. Refer to the medicines injectables handbook for evidence based best practice on administration processes. Book is kept on the general medical trolley.
- Registered Nurses must read from the CLIENT/PARTICIPANT MEDICATION SHEET and check against the Health practitioners prescribing orders
- Before dispensing anything, ensure all medications are in intact, unbroken. (Should there be any discrepancies such as missing medications/additional medications) DO NOT PROVIDE MEDICATION and contact National Community Care Coordinator immediately for further direction.
- Ensure medications are being administered in order and ensure all the following details must be checked by x2 registered nurses:
- Name of the person.
- Name of the drug.
- Dosage prescribed.
- Time/frequency to be taken.
- Route of administration.
- Any special instructions i.e. before meals.
- At the beginning and end of each shift, all staff should check that medication has been given and signed for.
- In the event, an emergency PRN injectable is required, the Registered Nurse is to facetime the clinical coordinator for emergency administration approval. Over the video chat, medication check can occur to ensure participant receives timely medication management, with the expectation the Clinical Coordinator is on the way to co-sign and provide a welfare check of participant.
- In the event of missing signatures, the employee responsible will be contacted by National to confirm that the medication was given and asked to return to the house to sign the PARTICIPANT MEDICATION SHEET. Under no circumstances can employees sign for each other.

CONTACTS:

Poisons Hotline
13 11 26

Ambulance
000

National Contacts
Clinical **0429 599 548**
Oncall 0401 439 798
Agency 0413 955 956

ACT Police
6256 7777

Work Cover NSW
13 10 50

Work Safe ACT
6207 3000
Worksafe.act.gove.au

NDIS Commission - 1800 035 544

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Medication Administration Procedure – Assistant in Nursing / Support Workers / Carers

PURPOSE:
At National, we believe those vulnerable and their carers have a right to remain living in the community for as long as possible. Client/participants should be encouraged to maintain their independence if possible, including managing their own medicines in a safe and effective manner. In endorsing these beliefs, National support staff will provide medication support and/ or administration and will abide by the policy and procedures outlined in this document. Support workers will have access to training to ensure that they have appropriate skills and knowledge to support and/or administer client/participant medication.

Client/Participant Self-Administration

If a client/participant can participate in any of the steps, such as holding the medicine cup to receive the medication, and/or, taking the medication themselves, this should be encouraged.
However, employee is to be present throughout the entire process and are responsible for all steps in this process.

Medication Administration

- Medication is administered by the competent employee on shift at the time the medication is required. The time is indicated on the signing sheet located in the Client/participant Medication Folder located near the medications.
- Medication must be administered to one client/participant at a time.
- Medication must be administered immediately after it is dispensed.
- Medication must be administered by the support worker who dispenses it.
- Medication signing sheet must be signed by the administering employee.

Medication Training and Competency

- External Medication competency training day.
- Internal Medication Assistance skill workshop held by NCC.
- Additional supporting modules available: Diabetes Management, Seizure Management
- Where required, implement a watch and learn buddy shift and a show and do buddy shift
- Attend individualised client competency at client discretion with assessor competency