ADMINISTRATION OF MEDICATION

Introduction:

This policy provides guidelines on the administration of medication at Full Care Lifetime (FCLT). In accordance with Disability Services Medication Management Framework.

FCLT employees must have a current Medication Administration Certificate to administer medication.

ALERT – Has the client, their family or important people in this person's life been consulted about:

- How they wish to be communicated with on health matters
- The involvement they wish to have in decision making about health matters
- Do these requests comply with legal requirements?

Has this information been transferred to the alert sheet in the person's medical file? The following procedures must be strictly adhered to.

Applicability

When

- Applies to all situations where service is delivered

Who

- Applies to all people at or associated with these work locations including clients, client's families, employees, outsource suppliers, contractors, and the public

Procuring/obtaining medication for a participant

- For each client, the pharmacist is provided with a prescription from the client's doctor
- The pharmacist transfers information from the doctor's prescription to the Webster/Medico Pak or medication containers
- A copy of the Medication Administration Record Sheet (Doctors Summary Sheet) is supplied by FCLT to the day service the client attends
- The doctor's summary sheet should include purpose of medication being prescribed
- Any medication changes made by the doctor are to be reported to the Service Coordinator, recorded on the appointment information form, and recorded in the health diary of the client, by the employee person who attended the doctor's visit
- Support workers are responsible for a copy of updated Medication Administration Record Sheet to be supplied to day service

Collecting medication from the pharmacy

- Medications/Webster and Medico Paks are collected from the pharmacy weekly
- Before collecting, check to see if Signing and Administration Record Sheet (SARS) is required from the pharmacy
- The support worker collecting the medication checks the number of tablets and times correspond with the Doctors Summary Sheet (MARS) – this is to be completed before leaving the pharmacy
- A second support worker is to also check that the number of tablets and times correspond with the MARS once medication has been delivered to the client home
- Any errors found are to be returned to the pharmacy on that day to be corrected
- All errors are to be reported to the Service Coordinator, recorded on an online Medication Error Report and the medication error process followed

Change of medication halfway through signing forms (SARS and DACS)

- All changes to be recorded in health diaries
- Another SARS will be required from the pharmacy
- The drug administration chart:
    - Needs to be completed and signed by the doctor
    - Rule a line, using red biro, from cease date to the end of the month
    - On the next line, rule a line using red biro, from the beginning of the month to the start date of medication
    - An updated copy of the MARS (Doctors Summary) is to be given to the Day Support Service. It is the responsibility of the support worker who attended the doctor's visit

Sending medication with a person to a day service

- The pharmacist places each daily dose in a separate container with a label that clearly states:
    - Name
    - Medication
    - Day
    - Date
    - Dose
    - Time to be administered
    - Reason for medication
    - And special directions i.e., taken before food/taken with food
- These containers are checked on pick-up, by FCLT support workers, against the information on the back of the Webster/Medico Pak

- The day service or family and support workers sign a Medication Transfer Sheet for these containers and these sheets are kept in the front of the client's medication folder
- FCLT support workers record the return of empty containers on the clients Signing and Administration Record Sheet (SARS).

Sending medication with a client on an outing

(This could be Day Support/Families/Support Workers etc.)

- The pharmacist places the required medication in a separate container with a label that clearly states:
    - Name
    - Medication
    - Day
    - Date
    - Dose
    - Time to be administered
    - Reason for medication
    - And special directions i.e., taken before food/taken with food
- These containers are checked on pickup by FCLT support workers and/or family against the information on the back of the Webster/Medico Pak
- Day service or Family and Support Workers sign a Medication Transfer Sheet for these containers. These sheets are kept in the front of the client's Medication folder
- FCLT support workers record the return of empty containers on the clients Signing and Administration Record Sheet (SARS)

Storage of medication in the home

- All prescription medication is to be kept in individual Webster/Medico Pak or containers clearly marked with clients:
    - Name
    - Medication
    - Day
    - Date
    - Dose
    - Time to be administered
    - Reason for medication
    - And special directions i.e., taken before food/taken with food
- Medication Folders are to have client name clearly marked on front of folder
- All photos and names are to be clear and legible
- All medications are to be stored in a locked cupboard, in the container in which it was dispensed by the pharmacist
- All medications are to be stored in separate areas for each client

- Medication that needs to be refrigerated must be in a lockable container
- Support workers must check records at the start and end of every shift to ensure that all medication has been taken and signed for – This includes taking the medication pack out of the clear slip/cover and checking the front and back of the pack for signs of damage or being opened

Administering medication

- Medication is administered by the support worker/s on shift at the time the medication is required – when support worker is on shift alone, supporting 2 clients with complex support needs, at the time of administration of medication, call Service Coordinator or On-Call and talk through steps while administering medication
- Medication must be administered by the support worker that dispenses it
- If there are two support workers on shift, medication must be administered by both staff working together as a confirmation of the process and steps
    - Wash hands and wear gloves
    - Check previous shifts for any medication administration discrepancies
    - Check medications have not been given
    - One client at a time
    - Ensure there are no distractions for client
    - Explain the procedure to the client

Steps for administering medication

- One support worker reads from the Signing and Administration Record Sheet (SARS) while the other checks the Medication Administration Record (signed Doctors Summary) to ensure they correspond. Both support workers check for the 5 R's person-drug-dose-time-route and any special instructions e.g., before meals, after meals, allergies etc
- This also applies when working alone, each step must be checked off
- Ensure only 1 medication folder is removed from medication cupboard at a time, and folder is clearly labelled with client name
- If support worker is supporting 2 clients with complex support needs, they will be notified if they need to contact the Service Coordinator or On-Call person to talk through steps while administering medication
- Both support workers check Secure Dosage Administration Aid (SDAA) against SARS
    - For the 5 R's
    - Check expiry date
    - Remove medication from Webster/Medico Pak using Pill-Bob and place into medication cup
    - Both support workers check medication cup against SARS
- (For the 5 R's) both support workers check medication cup against SDAA
- (For the 5 R's) before assisting the person checks

- (For the 5 R’s) ensure medication has been taken
- Fill in SARS, writing and circling the number of tablets administered, both support workers sign (in black or blue biro)
- Return clients medication folder and medication to locked cupboard

Note effect, side effects, and report any adverse reaction to the Service Coordinator

Preparing to give medication from original packaging

1. Wash hands and wear gloves
2. Check previous shifts for any medication administration discrepancies
3. Check medications have not been given
4. One client at a time
5. Ensure there are no distractions for client
6. Explaintheproceduretotheclient

Steps for administering medication from original container

- (Check the 5 R’s) check the drug chart to ensure doctor's instructions are signed and current
- Check original container against the Drug Administration Chart:
    - for the 5 R’s
    - check expiry date
    - place medications in dispenser (medication cup)
- (For the 5 R’s) check medication cup against Drug Administration Chart
- (For the 5 R’s) check medication cup against original container
- (For the 5 R’s) before assisting client check
- Ensure medication has been taken
- Sign Drug Administration Chart (in black or blue biro)
- Return clients medication folder and medication to locked cupboard

Note effects, side effects, and report any adverse reactions to the Service Coordinator.

At the beginning and end of each shift, all employees must check records to ensure all medication has been given and signed for.

In the event of missing signatures, the support worker responsible for the error will be contacted to confirm that the medication was given and asked to return to the house and sign any relevant form that has been missed.

Under no circumstances can workers sign for each other.

Self-administration

Where there is uncertainty about an individual's ability to safely manage and administer their medication, a competency assessment must be undertaken by a suitably qualified health care professional in consultation with the individual and those involved in the individual's care. Capacity may vary over time and a reassessment may be required if the individual appears to be having difficulty in managing their medication.

If a person can participate in any of the steps, such as holding the medicine cup to receive the medication, and/or taking their own medication themselves, this should be encouraged. However, support workers are to be present throughout the entire process.

Support workers are responsible for all steps in this process.

The client will initial, if possible, in the given space on the Signing and Administration Record Sheet or Drug Administration Chart.

Alteration of oral formulations

Some individuals may need to have oral formulations altered, for example, tablets broken or crushed to aid administration or mixed with food or liquids e.g., for use with PEG feeding tubes. The alteration is intended to assist administration and ensure that individuals receive necessary medications. Always check with a pharmacist first before altering the form of medications as this practice may have unsafe consequences.

Some medications cannot be altered because this may reduce effectiveness, create a greater risk of toxicity or other harm: an unacceptable presentation to the individual in terms of taste or texture, make it difficult to ensure appropriate dosage and risk to work health and safety. Cross-contamination of medications is also a risk. If an individual is having difficulty taking their medications, or they require an alteration to the standard dosage form, the individual might need alternative formulations or different medications instead.

PRN medication (prescribed or "as directed")

PRN medication must not be given without contacting the Service Coordinator.

If PRN medication is prescribed for behaviour support, a Behaviour Support Plan/PRN Protocol must be in place for the client. The BSP will meet the requirements of the NDIS Quality and Safeguards Commission.

An Incident Report is required if the PRN medication was administered for behaviour support

A Drug Administration Chart is used for signing of all PRN medications, including liquid forms such as eye drops, nose sprays, creams and any other PRN medication that is not in a Webster/Medico Pak. The Drug Administration Chart is signed by the doctor stating:

- Procedure for administration
- How and when the medication should be administered
- Purpose of medication
- Circumstances under which a further dose can be administered
- The maximum PRN dose in 24 hours
- Circumstances in which the doctor should be notified

The Drug Administration Chart is kept in the clients Medication Folder. The steps for Administering from Original Packaging must be adhered to when administering PRN medications.

Inform the next shift that PRN medication has been administered and document all information in the clients Health Diary.

PRN medication (prescribed or “as directed”)

These medications can be given without a doctor’s prescription: however, all these medications must be on the Drug Administration Chart for the doctor to sign off on every three months.

In circumstances where support workers feel administration of such medication is warranted, the following procedures must be followed:

- Contact the Service Coordinator
- Where clients are already taking regular medications, the doctor or pharmacist must be contacted to determine if the PRN is compatible with other medication already being taken
- If the support worker is unable to contact the client’s doctor or pharmacist, they must consult with the Poisons Information Centre on 13 11 26 or the medical assistance line Health Direct on 1800 022 222 – These numbers are kept by the phone in all homes.
- Support workers must document all information/steps taken in clients health diary
- Complete the Drug Administration Chart
- Return medication folder and medication to locked cupboard
- Inform next shift that PRN medication has been given

Examples of non-prescription medications include cough mixtures, simple analgesics, and antacids. Some non-prescription medications can be sold only by pharmacies (pharmacist only) or in a pharmacy (pharmacy only), others can be sold through non-pharmacy outlets such as supermarkets. Non-prescription medications are also known as “over the counter” medications.

Complementary and Alternative Medications (CAMs) include herbal, vitamin and mineral products, nutritional supplements, homeopathic medications, traditional and indigenous medications, and some aromatherapy products. Other terms sometimes used to describe CAMs include natural or holistic medications. CAMs can be obtained easily from a wide range of sources.

Individuals may self-select or ask others to select and provide CAMs. Like all medications, CAMs and non-prescription medications are capable of causing adverse reactions and medication interactions and need a doctor to sign off every three months.

PRN medication (non-prescribed)

These medications can be given without a doctor's prescription: however, all these medications must be on the Drug Administration Chart for the doctor to sign off on every three months.

In circumstances where support workers feel administration of such medication is warranted, the following procedures must be followed:

- Contact the Service Coordinator
- Where clients are already taking regular medications, the doctor or pharmacist must be contacted to determine if the PRN is compatible with other medication already being taken
- If the support worker is unable to contact the client's doctor or pharmacist, they must consult with the Poisons Information Centre on 13 11 26 or the medical assistance line Health Direct on 1800 022 222 – These numbers are kept by the phone in all homes.
- Support workers must document all information/steps taken in clients health diary
- Complete the Drug Administration Chart
- Return medication folder and medication to locked cupboard
- Inform next shift that PRN medication has been given

Examples of non-prescription medications include cough mixtures, simple analgesics, and antacids. Some non-prescription medications can be sold only by pharmacies (pharmacist only) or in a pharmacy (pharmacy only), others can be sold through non-pharmacy outlets such as supermarkets. Non-prescription medications are also known as "over the counter" medications.

Complementary and Alternative Medications (CAMs) include herbal, vitamin and mineral products, nutritional supplements, homeopathic medications, traditional and indigenous medications, and some aromatherapy products. Other terms sometimes used to describe CAMs include natural or holistic medications. CAMs can be obtained easily from a wide range of sources.

Individuals may self-select or ask others to select and provide CAMs. Like all medications, CAMs and non-prescription medications are capable of causing adverse reactions and medication interactions and need a doctor to sign off every three months.

Medication error

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

- Identify the error, i.e., incorrect medication has been given, medication has been missed, client vomits after medication is administered
- Contact the Service Coordinator
- Contact the client's doctor to seek advice. If the doctor is unavailable, call the after-hours doctor and or the medical assistance line Health Direct on 1800 022 222 or Poisons Information Centre on 13 11 26
- Observe the client for signs of distress. Call an ambulance if the client is in distress or showing signs as described by the doctor or Poisons Information Centre or Medical Assistance. If in doubt, call an ambulance.
- Record the error on the clients Signing and Administration Record Sheet/Drug Administration Chart and the incident details in the clients Health Diary
- Complete a Medication Error Report form and follow the reporting process. You will also be asked to submit an Incident Report if required, including for a serious medication error considered reportable to the NDIS Quality and Safeguards Commission
- Support workers will need to have a Medication Error Review by an appointed assessor before administering medication to another client
- The person conducting the Medication Error Review follows FCLT Medication Error Review Guide

Refusal to take medication

A client must not be forced to take medication against their wishes. However, every effort must be made to give medication as prescribed. If a client refuses to take their medication, the support worker administering the medication must:

1. Think about why the client may not want to take their medication
2. Ask the client why they do not want to take their medication
3. Explain to the client the reason for taking the medication and the possible side effects to their health if their medication is not taken.
4. Wait 15 minutes and ask client to take their medication again
5. Use the FCLT Emergency Contact list to report the problem. If the client still refuses, then the prescribing doctor must be contacted for instructions
6. Observe the client for changes in behaviour or well-being as the result of the medication refusal and report any changes to the Service Coordinator and Doctor
7. Document all details in the clients Health Diary

8. Ensure the next shift is aware of the incident
9. Complete a Medication Error Report form (missed medication) and follow the reporting process

Invasive procedures

Support workers do not perform invasive medical procedures unless specifically trained and certified for such procedures. The use of sharps is an invasive procedure.

Medication audits

Support workers on the last day of EVERY month are responsible for auditing all:

- First Aid Kits – making a list of what has been used, what needs replacing and check use by dates
- Check medication cupboard for any creams, ointments, eye drops, lotions etc. that may be damaged or out of date
- Check that medication containers are not damaged
- Follow Disposal of Medication guidelines for any medication that needs disposing
- Storage procedures are correct
- Medication Administration Charts/Sheets records and reconcile with the medications taken
- Report any abnormalities to the Service Coordinator/Manager immediately

Medication audits

- Out of date medication or medication no longer required or that shows signs of deterioration will be returned to the pharmacy to be disposed of professionally
- Sharp waste is classified as bio-hazardous waste and must be carefully handled
- Sharps should always be:
    - Placed in an appropriate sharps disposal container that has rigid walls is resistant to puncture and is sealed or can be securely closed
    - Disposed at sharps collection facility or sharps disposal bin

Review of medication

- Client will have a formal review of their medication
- Support workers will take an Appointment Report form to all doctor’s visits
- Medication reviews will be arranged by the Service Coordinator to include doctor, support employee, advocate and any other specialist involved

Consent to medical treatment

The Service Coordinator will be responsible for seeking consent for medical or dental treatment from the clients “person responsible”

Administration of alternative therapies

The Service Coordinator is responsible for seeking consent for alternative therapies from the clients “person responsible”

Forms and aids used in conjunction with these procedures

Pill-Bob

This is used to remove medication from Webster or Medico Paks and then medication is placed in medication cup

Signing and Administration Record Sheet (SARS)

This is used to record the administration of medication. SARS is provided from the pharmacist software and support workers need to check it corresponds with the SDAA on collection form the pharmacy. Support workers who have dispensed and administered medication then write the number of tablets in the allocated space, circle, and then sign. The second employee person signs also after witnessing the administering of the medication.

Secure Dose Administration Aids (SDAA)

This is a sealed device to assist with medication management. It has individual doses i.e., Webster or Medico Pak

Medication Administration Record Sheet (MARS)

This is the doctor’s medication summary and must be signed and updated every three months and a copy provided to day service.

Drug Administration Chart DAC

Medication and Health Sheet	Has important health information for staff
Menstruation Sheet	To be completed as required
Medication Transfer Sheet (Including Midazolam Vials)	To be used when medication leaves the home i.e., Day Service/Family Support Workers
Bodily Functions Sheet	To be completed daily
Seizure Record Sheet	To be completed as required
Weight Record Sheet	To be completed 1st day of every month
Ventilation Cleaning Schedule	To be cleaned weekly

C Pap Machine Instructions	Daily and weekly care
Midazolam Count Sheet	To be counted daily and signed
Recording Sheets	i.e., Fluid, behaviours, sleep in
Medical Appointment Sheet	To be completed on all medical visits (Doctors, dentists, specialists etc.)
Immunisation Records	Flu Vacs etc.
Collection of Medication from Pharmacy	To be completed when medication is checked off on return to location
Guidelines for Doctors Visits	To be checked prior to any medical appointment

Protocols for S8 Medication

These protocols are focused on the storage and administration of S8 medication. FCLT employees must have a current Medication Administration Certificate to administer S8 medication.

S8 medication shall be administered and stored according to procedures in FCLT Administration of Medication in Shared Homes.

Clients supported by FCLT who are being administered S8 medications will have a Health Care Plan and/or an S8 Medication Protocol in place.

An S8 Drug Register is required to record the receipt, administration, and any other transactions of S8 medications. The S8 Drug Register must be a bound book with numbered pages.

The medication count must be made as soon as practicable after the administration or transaction occurs. A medication count shall occur at the beginning and end of each shift. Medication Check Sign Off Form needs to be completed at the beginning and end of each shift in accordance with direction on this form.

The record must include the following in biro:

- Date
- Time of the day
- Resident's name
- Amount received
- Amount used
- Amount discarded for any reason

- Balance of stock remaining after the medication has been administered
- Signature of the person making the entry
- Signature of the person who witnessed its receipt and administration
- Name of the prescriber

The person making an entry in the S8 Drug Register must adhere to the following:

- No false or misleading entries
- No alterations
- If a mistake is made, it must be left as is, marked with an asterisk and the entry rewritten as appropriate. A note explaining the error must be made in the margin or at the foot of the page, initialled and dated.
- A Service Coordinator must be contacted and informed of any error
- A Service Coordinator must be contacted if a medication tally is incorrect

S8 medication cannot be stored or administered without the above protocols in place
(Including if a client returns home from hospital at short notice with S8 medication required)

Complex Health Care Plans (CHCP)

Where complex and/or invasive techniques or procedures are required for the administration of medication a Complex Health Care Plan must be prepared. A CHCP sets out written instructions specific to a particular individual describing what procedures are to be performed, details how procedures are to be performed and the requirements necessary to ensure employees are competent in those procedures.

The plan must be prepared by a relevant health care professional (e.g., a medical practitioner, a diabetes educator, or registered nurse) in consultation with the individual, the Person Responsible (if applicable), GP and relevant support employee. Careful consideration should be paid to the individual's needs, lifestyle and aspects relating to affordability of medications and delivery systems for the individual.

Meanings of abbreviations that the doctor may use:

a.c.	Taken before food
c.c.	Taken with food
p.c.	Taken after food
b.d.	Taken twice daily
m	Taken in morning
mane	Taken in mornings

N	Taken at night
Nocte	Taken at night
O	Taken orally by mouth
Po	Taken orally by mouth
q.i.d.	Taken four times daily
Stat.	Taken at once
t.d.s.	Three times a day
s.l.	Means sublingual to place under the tongue
p.r.n.	Means to be taken when necessary
PR	Given via rectum
PV	Given via vagina