CLINICAL PROTOCOL

SELF - ADMINISTRATION OF MEDICINES AND ADMINISTRATION OF MEDICINES SUPPORTED BY FAMILY/INFORMAL CARERS OF PATIENTS IN COMMUNITY NURSING

RATIONALE

Medication errors can cause unnecessary pain and harm to patients and are a main source of inappropriate admissions to hospital (NPSA 2007).

RESPONSIBILITIES

Registered nurses are responsible for the initial and continued assessment of patients and their informal carers, where the carers are helping the patient administer their medicine. This includes ensuring patients take their medicines as they are intended by the prescriber. Over the Counter and alternative medicines taken by the patient must also be reviewed for known contraindications with prescribed medicines. Registered nurses also have continuing responsibility for recognising and acting upon changes in a patient’s condition, with regard to safety of the patient and others. It is important that patients continue to get the most benefit from medicines as this:

- Improves health outcomes through optimal medicine use
- Reduces adverse events related to medicines
- Reduces unwanted and unused medicines
- Is an opportunity for partnership working - to encourage and support patients, their supporting family and informal carers to develop confidence and competence in self medicating
- Empowers the patient, their supporting family and informal carers.
- Promotes accurate recording of medications where there are multiple carers

TARGET GROUP

All registered nurses employed by the Trust

AIMS

This protocol aims to outline the registrant’s responsibility to assess the capability of the patient, and/or their supporting family and informal carer to safely administer
medicines. This includes providing ongoing support and continual evaluation of their capability and competency. The guidelines in this protocol are based on the Nursing and Midwifery Council Standards for Medicine Management (NMC 2010)

OUTCOMES

- All patients, family members / carers will receive appropriate and timely advice on the safe administration of medicines in partnership with the multidisciplinary team

- All patients, family members / carers are aware of their role and accountability in the administration of medication

- Patients will be referred for a medication review by the practice pharmacist if required (see Appendix One)

- All registered nurses working in community nursing will comply with this clinical protocol.

RELATED TRAINING FOR COMMUNITY NURSING STAFF

- Medicines Management Training
- Three Day Essential Learning

KEY RELATED POLICIES

- Safe Handling and Administration of Medicines Policy
- Incident Reporting Policy
- Standard Operating Procedure for Medicine Administration in Community Nursing.

ASSESSMENT

The patient should be assessed by the Registered Nurse for suitability for self administration and were appropriate a decision may be reached that the patient, is able to accept full responsibility for the storage and administration of the medicinal products.

Patients can be assessed for suitability at the following levels (adapted from Nursing and Midwifery Council Standards for Medicine Management (NMC 2010)

Level 1
The registrant is responsible for the supervision and safe administration process ensuring the patient understands the medicinal product being administered. Nurses must follow medicines related Trust policies and procedures.
Level 2
The registrant supervises the patient who will then self-administer the medication ensuring the patient understands the medicinal product being administered. Nurses must follow medicines related Trust policies and procedures.

Level 3
The patient accepts full responsibility for the storage and administration of the medicinal products. The registrant checks the patient’s suitability and compliance verbally Nursing and Midwifery Council Standards for Medicine Management (NMC 2010)

For patients with a physical disability, a risk assessment would need to be undertaken to make sure the patient is not at risk of additional medication errors and to clarify the patient fully accepts responsibility for the safe storage and administration of medicinal products and verbally clarifies an understanding of what the medication is for and when it is to be taken. All discussions need to be recorded in the Patients’ Health Records. Seek further advice from line managers as required.

ASSESSMENT PROCESS FOR PATIENTS

The registered nurse is responsible for ensuring that the patient understands the following before commencing self-medication:

- the name of the medicine
- the indication i.e. for what symptom or condition the medicine is prescribed for
- the correct route
- the correct dose e.g. quantity of topical cream, number of puffs, number of drops, number and strength of tablets or capsules
- the correct frequency
- special instructions e.g. take with food, not to be taken with grapefruit juice flushing between medicines via an enteral tube.
- duration or course of the medicine
- common side effects and what to do if they occur
- any known contraindications, cautions
- how to store the medicine safely
- how to dispose of unwanted/ unused medicines
- how to obtain a repeat prescription
- how to seek further advice

The assessment can be supported with the use of the ‘Patients Own Medication Record Chart’, as it allows the patient (or carer) to clarify what a medication is for and how often the medication needs to be taken.

ASSESSMENT PROCESS FOR INFORMAL CARERS

For patients who have been assessed as unsuitable for self medication the registered nurse should then assess any supporting family member or informal carer
who is prepared to take responsibility for the administration of medication to the patient.

The supporting family member or informal carer should be assessed for suitability using the same levels 1 to 3. The results of any assessment should then be recorded in the patient record. The registered nurse is also responsible for ensuring that the carer understands the medication as detailed above.

The registered nurse needs to check the patient / family members / carer’s suitability and compliance verbally and that the patient is taking the medication appropriately as it has been prescribed.

The assessment should include consideration of:

- Patient / family member / carer’s mental capacity
- Patient / family member / carer’s competency e.g. if the medication is administered via an injection, the person should be assessed as competent to do so safely
- The patient’s medical history, any known drug misuse or severe mental health conditions.

During the assessment the following points should be considered, explained and documented:

- Family / carers can withdraw their consent at anytime.
- The pharmacy will supply medicines fully labelled, with directions for use to every patient who is involved in self administration
- If informal carer is going on holiday or other arrangement – plans needs to be in place to clarify who is administer the medication safely

Information given and supervision should be tailored to individual patient need.

The registrant needs to assess the capability of the patient, supporting family member or informal carer to confirm they are able to open the medicine containers or use the administration method proposed. A referral to a pharmacist for a use review may be required regarding any concerns about compliance aids, poly pharmacy, and concordance.

Whilst the registered nurse has a duty of care towards all patients, the registered nurse is not liable if a patient makes a mistake self-administering, as long as an assessment was carried out and appropriate actions were taken to prevent re-occurrence of the incident (Nursing and Midwifery Council Standards for Medicine Management (NMC 2010))
**RISK MANAGEMENT**

When there is any uncertainty regarding the safe administration / self administration of a medicine to/by a patient all staff need to take reasonable steps to ascertain the facts prior to any intervention, to include seeking senior staff advice and support with a risk assessment as required.

**MEDICATION CARE PLAN**

This would be required for complex clinical situations or when there are multiple informal carers administering medicines as this increases the risk of medication errors. The requirement for a medication care plan needs to be based on clinical judgement and the level of risks involved.

**ADMINISTRATION OF MEDICATION FROM MONITORED DOSAGE SYSTEMS (MDS) i.e. Nomad or Vena link**

Patients who are receiving their medication via a monitored dosage system must have a record of the colour, shape and if required markings of their individual tablets and capsules, sufficient to enable individual medicines to be identified. The dispensing pharmacist can supply this. It is usually written on the MDS pack.

**MEDICINES ADMINISTRATION RECORD CHARTS**

Some dispensing pharmacists may be willing to produce a Medicines Administration Record Chart (MAR chart). Using a MAR chart can reduce the risk of omissions and duplications of medicines. If a MAR chart is available, supporting family members or informal carers should be encouraged to record all medicines given on the MAR chart to minimise risks according to potential risk of medication error.

**ADMINISTRATION OF CONTROLLED DRUGS BY FAMILY MEMBERS/ INFORMAL CARER**

There are risks associated with endorsing the involvement of family members or carers in the administration of controlled drugs, especially where this may duplicate the role of health professionals already providing care to the patient. There are additional risks associated with carers taking on an enhanced role and competence related to specific scenarios should not be assumed simply because they have a health professional qualification.

If a registered health professional was considering being actively involved in the administration of controlled drugs to a family member or carer under his/her direction, the following risk assessment should be undertaken and documented:

- **Are other health professionals involved in administrating medicines to the patient?** Have they been informed of the family member or carer’s involvement in the package of care?
- **How would administration by the family member or carer be documented?** And could this be guaranteed? There is a serious risk that a community nurse
could duplicate a dose that was due without being aware of previous family member or carer’s administration. In addition, the District Nurse will consider any stat doses administered during the previous 24 hours when titrating syringe driver doses. If any ‘when required’ drugs have been administered and not documented this could mean the patient may not receive enough medication to control their pain and symptoms via the syringe driver.

- **What prompted the family member or carer to make the request?** If there are concerns with adequate or timely pain control then this should result in a discussion with the GP and nursing team and include information on how to access support should the carer be concerned.

- **How will you be assured of their competence?** Family members or carers can be responsible for the administration of quite complex medicines regimes, for example to children. However this will always be with training, support and guidance from specialist nursing staff. It should not be assumed that carers are competent simply because they are also health care professionals, particularly if they are no longer practising.

- **Do you have any assurance that a health professional family member or carer would only administer in line with your directions?** particularly if clinically there was a difference in opinion.

- **How would the family member or carer manage their distress should a dosing error be made?**

- **Would the family member or carer be able to remain objective whilst caring for a loved one?** Involvement in personal care is appropriate but medication administration, particularly via syringes drivers, requires a clear head and robust documentation to avoid error.

- **Have you considered the pressure on the individual should their beloved wish to die and implore them to help?**

- **In the light of the Shipman Enquiry, should anything go wrong what are the medico-legal implications and for whom?** Dr Shipman’s legacy is that any fatality as a result of controlled drug usage will be high profile and be investigated (House of Lords 2006)

If a situation arises where carer administration of controlled drugs is raised this must be discussed with a senior manager and any risks discussed and managed, all actions to be fully documented in the patient’s healthcare records. The Medicines Management Team to be informed and included in any risk management assessment.

**STAFF WILL DEMONSTRATE THE PROTOCOL IS BEING ACHIEVED IF THE PATIENT IS SELF ADMINISERING MEDICATION AS:**

- The nurse will have assessed and evidenced that it is appropriate for the patient to self administer medication in the health care records

**STAFF WILL DEMONSTRATE THE PROTOCOL IS BEING ACHIEVED IF FAMILY OR CARERS ARE ADMINISTERING MEDICATION AS:**

- Patient’s health records will include a record of all current medication using a ‘Patients Own Medication Record Chart’
A Comprehensive Nursing Assessment will have been undertaken
A medication care plan will specify the arrangements for the administration of
medication and a system to record all medicines given as required.
There will be evidence in the health records that the nurse has confirmed that
all aspects of safe medicines administration have been discussed with family
members / informal carers to administer medication to the patient.

ADDITIONAL RESOURCES AND SUPPORT

There are a range of additional support mechanisms in the community as applicable
- Assistive Technology
- Joint package of care
- Medication review
- Advice from medicines management team
- Advice from Team Leader/ Service Manager
- Vulnerable Adults Lead

All reasonable steps would need to be considered to maintain and promote patient
safety. Community nurses are expected to assess, plan and co-ordinate care using
this protocol as a guide.

ANY CONCERNS

If there is any concerns regarding the safe administration of medicines staff should
refer to their line manager for advice and the medicines management team

CLINICAL INCIDENTS

Any clinical incidents or near misses must be reported following Trust incident
reporting policy

REFERENCES

Services. March.

House of Lords Health Bill 76 (2006)


in the NHS
### Appendix One

**TARGET GROUP** *(Guide to Medication Review, 2008, National Prescribing Centre)*

<table>
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<th>Targeting medication reviews</th>
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| Older people (>75 years)    | Complex medication regimen  
|                            | Multiple drugs (polypharmacy)  
|                            | Multiple diseases (co-morbidity)  
|                            | Compliance issues  
|                            | Physical problems (swallowing, arthritis)  
|                            | Resident in care home  
|                            | Mental state (confusion, anxiety, depression, forgetfulness)  
|                            | Living alone or poor carer support  
|                            | Frequent hospital admissions |
| **Condition-related triggers**|  |
| Long-term or complex conditions | Newly diagnosed long-term condition  
|                                | Polypharmacy  
|                                | Co-morbidity  
|                                | Drugs that need special monitoring  
|                                | Adverse effects and/or drug interactions  
|                                | Care plan is not up-to-date  |
| Complex conditions           | Co-existing physical and mental ill health problems  
|                            | Care plan not up-to-date  |
| **Medication-related triggers**|  |
| Medication regimens          | Four or more medicines  
|                                | More than 12 doses in a day  
|                                | More than 4 changes in medication in the past 12 months  
|                                | Recent changes to medication regimen  
|                                | Medicines from more than one prescriber  |
| "Specialist" drugs           | Narrow therapeutic index e.g. warfarin, amiodarone, lithium  
|                                | Drugs not commonly used in primary care  
|                                | Drugs that need special monitoring  |
| Medication-related event     | Recent falls  
|                                | Adverse drug reaction  
|                                | Unexpected or exaggerated reaction to one or more medicines  
|                                | High incidence of self-medication with non-prescription medicines or alternative remedies  |
| **Environmental triggers**    |  |
| Change in care provider      | Newly registered patient  
|                                | Recent discharge from hospital  
|                                | Transfer to a care home  |
| Core homes                   | Polypharmacy  
|                                | Enteral feeding  
|                                | Inappropriate use of homely remedies  
|                                | Longstanding prescription of psychotropic medication e.g. antipsychotics/hypnotics  |