34. Management of Medication Policy and Procedure

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Purpose

To ensure participants have the option to request support to assist in administering their medication and that they are supported by staff who are trained and competent to ensure participant safety and health.

Scope

This policy is universal and applies to all Skymac clients and employees.

Policy

Skymac is committed to assisting those participants who request assistance with their medication, as per the doctor's instructions. The participant must make this request in writing, by completing the *Assistance with Medication Request Form.* In line with Section 8 of the *Residential Services (Accreditation) Regulation* 2018, if residents ask for help in taking their medication in accordance with medical directions, help is given in accordance with the *Guideline for Medication Assistance* in residential services with level 3 accreditation, published by the department on the department's website.

Procedures

Request to assist with medication

A written request must be made by the resident, their guardian, or Enduring Power of Attorney, prior to assistance with medication commencing. This is achieved by completing and signing the *Assistance with Medication Request Form.*

Staff Training

Staff assisting residents with medication will be required to obtain a Certificate of Completion for Assistance with Medication through NGO Training Centre Online. This training must be refreshed annually, and each instance of refresher training must be recorded on the employee's file. Exceptions will be made for those workers who have completed a Bachelor of Nursing, or Doctor of Medicine and maintain their registration status with the *Australian Health Practitioner Regulation Agency (Ahpra)*.

Additionally:

- Staff must hold a current First Aid certification (renewed every 3 years) and CPR certification (renewed annually),
- Management will provide employees with Skymac's Management of Medication Policy and Procedure, and staff must record their acknowledgement of understanding and receipt.
- Management will supervise and observe staff competently assisting a participant with medication. Review of performance in assisting with medication will be undertaken annually, where it will be identified if there are areas in need of improvement and opportunities for training and development.
- Once successful, staff will be able to assist participants with medication in line with the 7 Rights of Medication outlined in the *Guideline for Medication Assistance - Residential Service Providers (Level 3 Services)*.

Prior to taking a Participant on an excursion

When a resident is temporarily off-site (e.g., social outing, short-stay family visit, excursion) and will require doses of medication, the resident's originally dispensed medication or a separately dispensed supply sufficient for the period of the absence should be provided and appropriately labelled by a pharmacist.

A *Resident Going Away Checklist* or *Checklist for Supporting a Resident on an Excursion* must be completed prior to departure.

THINGS TO CONSIDER:

- Is a cool storage device required to keep the medication at a certain temperature?
- Do you need a measuring cup?
- Do you need water?
- Do you have the medication chart/signing sheet?
- Do you have a working pen?
- Is there insulin to pack?
- Does the participant need a blood glucose monitor, lancets or strips?
- Does the participant have an inhaler?
- Is there anything else you need to think about?
- Have you notified the participants family, guardian, facility manager, kitchen staff to let them know you are taking the participant out and when you are expected to arrive home?

- Have you notified the participants family, guardian, facility manager, kitchen staff of your return and of any issues/feedback from the outing?

If an incorrect dose of medication has been taken by a resident, or their medication has not been taken at all, inform the prescribing medical practitioner of the error and follow the advice or instructions given. All errors or omissions in self-administering medications must be recorded on a *Medication Incident Report* form.

Assisting a Participant to take their Medication

- Where practicable, all medication is to be handled using the Blister Pack (Webster Pack) System and followed as per Blister Pack format.
- Any prescribed syrup or other medications not in the Blister Pack system must have a label clearly listing the participant's name, the drug/s name, and clear instructions on the dose and time of day to take the dose.
- The participant must have a medication signing sheet to document important information such as:
  - The name of the drug
  - The time
  - The quantity
  - If a PRN (e.g., when requiring medication such as Panadol) this needs to be listed as well, separately to ongoing medication.
- Staff to wash hands prior to assisting with medication and immediately after
- Prompt the participant, if required, to get out the required medication ready for taking
- Prompt them to have the water, signing sheet and working pen ready
- Ask them what medication they are required to take.
- Prompt the participant to read the label from the pharmacy to ensure the details, including the time of day, are correct
- Prompt the participant to look at the signing sheet to check when the last dose was and make sure it's not an overdose. Ensure the details match from the medication box or Blister Pack to the signing sheet
- Prompt the participant to take the correct dose. After taking oral medication, remind them to have a good amount of water (even inhalers)
- **Whether in the home, or on an outing, if medication was refused, or there was a medication error, this must be noted on the participant's Medication Signing Chart and a *Medication Incident Report* must be completed as soon as is practicable.**
- Send any excess or unused medication, back to the chemist for repacking, if appropriate.

- Staff to retain and file old medication signing sheets, and present to treating GP each consultation.

7 Rights for safe medication

To reduce the risk of a resident experiencing a medication error, it is recommended that staff assisting with medication follow the principles of the seven 'rights' for safe medication administration that have been developed within the healthcare sector and are widely used:

1. **Right person** – check the resident's photo identification to ensure the medication is for the right person. Check that the name on the medication container label matches the resident's name. When the resident is commenced on a new medication, check that they have no previous allergy to the medication.
2. **Right medication** – cross check the medication name in the Medication Record with the medication label. Check the medication has been stored correctly, and where an expiry date is visible check the medication has not expired.
3. **Right dosage** – for dose administration aids, check the right number of capsules or tablets are contained in the section that is to be used. For other medication packaging, ensure the dose is clearly documented on the pharmacist's label on the medication container.
4. **Right time** – ensure medication is taken as close as possible to the prescribed time. Some medications have further instructions that should be adhered to, e.g., 'with food', 'half hour before food' or 'after other medications' (this additional information is provided by the dispensing pharmacist). Confirm the time since the last dose is appropriate, particularly for 'when required' (PRN) medications (prescribed medication that is taken only if needed and is not intended/scheduled for regular continuous use).
5. **Right route** – ensure medication is taken or applied via the prescribed route, e.g., oral, topical, inhalation. Instructions for the specific route should be provided in writing by the resident's medical practitioner, which staff are to follow.
6. **Right to refuse** – the resident has the right to refuse to take a medication. If a resident refuses to take their medication, this must be recorded on the Medication Distribution Record, and contact should be made with the resident's medical practitioner or pharmacist and their instructions followed.
7. **Right documentation** – ensure that the medication is signed for by the staff member on the relevant form and that the correct code for specific circumstances is used when applicable.

When assisting with medications, avoiding interruptions will also help to reduce the risk of error.

Participants have the Right to Refuse

- As indicated above, participants have the right to refuse medication.

- Staff must record this on their signing sheet, or encourage the participant to do so, then document it in the Daily Diary. It is also advisable to contact their doctor if they do not wish to continue with a particular medication, so it is not dispensed, assisting the participant to make an appointment if necessary.
- Staff must be aware of the risk of withdrawal effects in instances where a resident has refused to take their medication. The Consumer Medicines Information (CMI) leaflet that is available for prescription medications and some non-prescription medications may also contain information on what should be done if a dose is missed. CMI may be found in the medication container or via the MedSearch app that all staff are required to download to their mobile phone.

Medication Errors

- All errors are to be recorded on a Medication Incident Report.
- Staff must telephone the participants doctor, or encourage the participant to do so, if the error involved taking the wrong medication. If the doctor is not available, then contact the Queensland Poisons Information Centre on 13 11 26.
- Staff to call Emergency Services on **000** if they are concerned in any way.

Needle Stick Injuries and Exposure to Blood and Body Substances

1. Immediately after the incident, staff must wash the affected area/s with soap and water thoroughly. Report the incident to the supervisors or management immediately so they can follow the organisations protocol for handling these incidents.
2. Management will assess the risk of infection based on factors such as the type of needle, the client's medical history and the nature of the exposure. This evaluation helps determine the appropriate course of action.
3. Staff may be asked to undergo blood tests to check for the presence of bloodborne pathogens. These tests will help determine if post-exposure prophylaxis (PEP) is necessary. The organisation will support the staff member to attend a Pathology Clinic. Should the testing require a fee, the organisation will reimburse the staff member the full cost.
4. If there is a significant risk of infection, healthcare providers may prescribe PEP. PEP is a treatment regimen that involves taking antiviral medications to reduce the likelihood of contracting certain bloodborne infections after an exposure.
5. Regular follow-up visits with healthcare providers are essential after a needle stick injury. This ensures proper monitoring of your health and any potential signs of infection.
6. The organisation will review any related policies and procedures and implement control measures to reduce or eliminate any further incidents relating to needlestick injuries and blood and body substance exposure.

Medication Reactions

Should staff identify or suspect that a resident is experiencing an adverse reaction to medication, or the resident reports this to staff, the resident's medical practitioner must be contacted, and staff should act in accordance with the medical practitioner's instructions. This could include:

- Call an ambulance immediately if the resident is in distress or showing signs of requiring hospitalisation, for example difficulty breathing, chest pain, unexpected drowsiness, dizziness, change in consciousness, seizures, or extreme changes in behaviour
- Administer first aid as required, if qualified to do so
- If an ambulance is not required, seek advice by phoning the prescribing medical practitioner and continue to observe the resident for changes in behaviour or well-being
- If a medical practitioner is unavailable, seek advice from either:
    - The resident's pharmacist, or
    - The Adverse Medicines Events Line on 1300 134 237 (Monday to Friday, 9am to 5pm AEST), or
    - Health Direct Australia on 1800 022 222 (available 24 hours), or
    - The Queensland Poisons Information Centre on 13 11 26.

The Consumer Medicines Information (CMI) leaflet that is available for prescription and some non-prescription medications can also be referred to for information about common reactions to medications. Staff should consult the MedSearch app if a CMI has not been made available by the dispensing pharmacy.

A Medication Incident Report should be completed as soon as possible after the incident, but no later than by the end of the shift.

Medication Storage and Safety

- Skymac will store medication safely and securely in accordance with the pharmaceutical storage instructions. Residents administering their own medication must also ensure that it is stored safely and securely and is not accessible to other residents.
- If a staff member becomes concerned about the safety of a participant taking their medication, staff are to assist the participant to set up a safe environment for the medication and inform their supervisor, or the residents GP, for instructions.

Disposal of Medication

- All medication must be housed in its original pharmaceutical packaging. Any medication unused or left behind by a vacating resident must be disposed of within 2 working days to the dispensing pharmacy.
- Medication of any sort found loose or not in its original pharmaceutical packing must be stored safely in the medication room and returned to the pharmacy at the next opportunity. A Medication Incident Report must be completed stating where the medication was found, the date and time the medication was found and a description of the medication. It must also be documented in the day diary.
- Unused medication still sealed in its original packaging needs to be returned to the pharmacy.
- Out of date medication needs to be returned to the chemist by:
    - Contacting dispensing pharmacy to advise of collection of unused or left behind medication by a resident
    - Staff member returning medication to pharmacist must document in daily diary
- All needles to be disposed of in the appropriate Sharps Container in the doctors' consultation room by the user e.g., resident, doctor.
- All medication that is no longer required, or is unwanted, ceased or has expired should be stored in a secure container separate to other medications, and be returned promptly to a pharmacist for safe disposal. Under no circumstances should medication intended for disposal be kept for use by any other resident. It is not legal to provide a resident's medication to another person.

Self-Administration of Medication

- Participants wishing to manage their own medication will be made aware of their responsibilities and obligations by completing a *Self-Managing Medication Declaration* form.
- Participants must ensure that the medication is securely locked away in their rooms.
- Participants will be responsible for providing a lockable device to house their medication.
- Participants will be made aware that should their room and lockable cabinet containing their medication be found by staff to be unlocked, the room will be locked immediately. Management, participant and case manager or doctor to be notified if required, and a *Medication Incident Report* to be completed by the staff member.
- Should management become aware that a resident is misusing medication or not taking medication in accordance with their treating doctor's directions, management will notify resident's treating doctor immediately.

- If a resident is going away and they need their medication to take with them, then as soon as the resident or their carer is handed the medication, they are responsible for it.
- Skymac and its staff do not take responsibility for residents or their responsible external carer, managing their own medication.

Related documents

- Assistance with Medication Request Form
- Self-Managing Medication Declaration Form
- Medication Incident Report
- Resident Current Medication List (Scriptrite)
- Medication Signing Chart (Scriptrite)
- PRN Medication Signing Chart (Scriptrite)
- Support Care Plan
- Staff compliance supporting evidence (see individual profiles on Employment Hero)
- Medication Record – Temporary Off-site Form

References

- Guideline for Medication Assistance
- Residential Services (Accreditation) Act 2002
- Residential Services (Accreditation) Regulation 2018
- Health (Drugs and Poisons) Regulation 1996
- Australian Privacy Principles (APP)
- Privacy Act 1988
- Guideline for Medication Assistance – Residential Providers (Level 3 Services)