Medication Administration for the Disability Sector

A comparison of methodologies with a focus on Sachet and Blister Systems

the centre for cerebral palsy
celebrating potential, creating possibilities

NDS
National Disability Services
Western Australia

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Foreword

The *Medication Administration for the Disability Sector* project has been developed as a joint project between The Centre for Cerebral Palsy (TCCP) of Western Australia and National Disability Services (NDS) Accommodation Subcommittee.

This report is designed to provide information about best practice systems for medication administration within the disability sector that are:

- Universal in application
- Of minimal risk
- Portable
- Cost effective
- Socially unobtrusive
- Capable of being introduced on a sector wide basis
- Able to meet accreditation requirements and the Disability Services Standards.

This report discusses different types of medication administration aids, their benefits and disadvantages and provides examples of medication administration procedures.

To guide and support the development of this project, a Steering Committee comprising staff representatives from each partner organisation was established. The contribution of all committee members is acknowledged and appreciated:

Project Steering Committee

- Christopher Kumar — Project Chair and General Manager Community Living, The Centre for Cerebral Palsy
- Berenice Charlton — Project Officer, The Centre for Cerebral Palsy
- Gail Palmer — Manager DisAbilities, Hills Community Support Group
- Monique Williamson — Manager Policy, National Disability Services

The significant funding contribution of the Disability Services Commission of Western Australia for this project, as part of the Service Improvement Grants for 2006, is gratefully acknowledged.

EXECUTIVE SUMMARY

Medication administration is a complex subject with many considerations to ensure that medicines are safely administered. Currently, throughout the disability sector, medications are distributed in a variety of forms, and there is inconsistency in the method of administration of medications to clients.

Policies and procedures about medicine administration vary between service providers. There is no accepted use of medication abbreviations throughout the industry, and doctors, nurses and pharmacists use a plethora of acronyms that can further confuse the administration of medications.

Consultation with people with disabilities, health professionals, care workers and service providers found that they wanted a medication administration aid that was safe, practical, minimised errors and was cost tenable. Evaluation of the different methods of medication administration discussed in this report found that sachets and blister packs provided many advantages over the older methods in which medicines are dispersed from their original container to the consumers or from a dosette box.

This report recommends that medication administration aids such as the blister pack system and the sachet system be implemented as the preferred system of medication delivery for service providers of people with disabilities. It is anticipated that standardisation of medication administration and procedures will potentially reduce medication errors, assist with training requirements, and help staff to become competent and confident about their role in the administration of medicines to clients.

The advantages of these systems include photo identification of the client and clear labelling of the name of the medicines. The number and description of the medication is provided, the time and day of administration is identified, and any special instructions, such as medicines to be given with food, are given.

Anticipated benefits of the medication administration aids include reduction in the time taken to administer medicines and reordering medications. It is hoped that use of these systems will reduce medication errors and increase compliance with medication.

It is believed that medication administration aids reduce, but do not entirely eliminate, the need for consumers and staff to dispense medicines from their original containers, a practice considered to be more prone to error according to research.

Like all systems, however, medication administration aids are not error proof. The doctor, the pharmacist, the nurse, the client or care worker can all make mistakes. Rigorous checking procedures are still essential, and ongoing support and access to health professionals' advice is required. Training of staff must be conducted and ongoing competencies maintained.

A limitation of this study is that costing of medication administration aids and other associated expenditure, such as the time taken to administer medication and training, was not undertaken.

SECTION 1: PROJECT OVERVIEW

1.1 Rationale for the Project

For many people, including people with disabilities, medication constitutes an important part of their daily life. People with disabilities may require assistance with their medication, and care workers, who are not health professionals, are often required to help administer medicines.

Dispersion of medication, however, has significant potential for error and the availability of a medication administration aid that minimises error and is cost effective for consumers will be a helpful tool for people with disabilities, carers and service providers.

Pharmacy errors can occur at the site of packing in both the blister packs and in the sachet rolls. In both systems the highest percentage of errors was made by staff dispensing the medications: errors (not listed in any particular order) include:

- Medication to the wrong client
- Forgetting to give the medication
- Medication given at the incorrect time or day
- Not giving all medications at the time due
- Staff forgetting to sign the medication charts
- Dropped medications.

Staff being interrupted during the administration of medication is cited in the literature as a reason why some medication errors occur.[1]

1.2 Objectives

The aim of this project is to determine which medication administration system(s) can be used to administer medicines to people with disabilities. The objectives are to:

- Determine the benefits and weaknesses of each identified medication administration aid
- Determine which system(s) is best suited for carers, who are not health trained professionals, to administer medicines to people with disabilities
- Recommend a medication system which minimises the risk of error, is cost effective and practical for the administration of medication for both care workers and people with disabilities
- Identify medication administration procedures for care workers.

[1] Dr B. Scott, Mrs B. Horner, Assoc, Professor J. Downie. *Report of an Evaluation of Two Medication Management Systems*. February 2004. http://cra.curtin.edu.au/productsServices/CoPharmacyFinalReportFeb2004.pdf.

1.3 Methodology

The *Medication Administration for the Disability Sector* project has been overseen by the Centre for Cerebral Palsy and National Disability Services (NDS) Accommodation Subcommittee.

This has been a qualitative study and research for the project has included consultation with West Australian Disability Service Provider organisations, interstate organisations, people with disabilities, and staff who are responsible for the administration of medication.

Information and sample medication packaging plus associated documentation has been obtained from the Eastern States and local pharmaceutical companies. Internet research was also undertaken in order to seek any other innovative methods that are not currently available in Australia, and to help support findings with relevant literature.

SECTION 2: RESEARCH

2.1 Literature Review

Freemasons Centre for Research into Aged Care Services

In 2004, the Freemasons Centre for Research into Aged Care at Curtin University conducted an evaluation of the AutoMed (sachet) and Artromick medication (from original medication containers) systems at two Aged Care facilities.[2]

The Artromick medication system is the traditional method of medication administration in which medications are supplied in their original containers and dispensed by nurses into a pill cup. In the AutoMed system, the pharmacist provides sachets of pre-packed medications for distribution to clients.

It was concluded from this study that the AutoMed system was a quicker, more efficient method of medication administration which staff readily accepted. The potential for medical error was considered in this study to be lower with AutoMed, although this finding was not based on quantitative data.

Community Services Commission

In 2001, the Community Services Commission (NSW) produced a submission that expressed concern about the administration of medication by non-parental caregivers to children and young people with disabilities in accommodation facilities.

The submission highlighted the range of risks associated with the prescription, administration and management of medication. The document suggested a number of areas where greater policy and practice guidance, and options for promoting the development of staff competences were needed.

The overall information gained from this submission, particularly in the area of staff competencies in administering medication, was pertinent to this project.

The Australian Pharmaceutical Advisory Council (SPAC)

The Australian Pharmaceutical Advisory Council, a consultative forum of medical, nursing and pharmacy professions as well as industry, consumers and government, produced 'Guiding Principles for Medication Management in the Community' in June 2006.[3]

The aim of the principles was to promote quality use of medicines and better medication management in the community. It is intended that the principles will assist service providers to develop or evaluate policies and procedures, support those involved in assisting consumers, and support consumers to manage their medicine(s).

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[2] Dr B. Scott, Mrs B. Horner, Assoc, Professor J. Downie. *Report of an Evaluation of Two Medication Management Systems*. February 2004. http://cra.curtin.edu.au/productsServices/CoPharmacyFinalReportFeb2004.pdf.

[3] Australian Pharmaceutical Advisory Council. *Guiding Principles for Medication Management in the Community*. June 2006.

The guiding principles for medication management in the community are:

Guiding Principle 1 - Information Resources
All health care professionals and care workers require access to current and accurate information about medicines to assist them to provide well-informed advice to consumers.

Guiding Principle 2 - Self-administration
Consumers should be encouraged to manage their own medicines safely and effectively for as long as possible.

Guiding Principle 3 - Dose Administration Aids
Dispensed medicines should be kept in the original manufacturers' or other dispensed packaging, unless a Dose Administration Aid is required.

Guiding Principle 4 - Administration of Medicines in the Community
Health care professionals, care workers and service providers should help people in the community take their medicines safely, and ensure clients receive accurate advice about their medicines.

Guiding Principle 5 - Medication Lists
Consumers should be supported in maintaining a current and accurate record of all their medicines. This list should be easily accessible to the consumer and all those involved in the consumer's care.

Guiding Principle 6 - Medication Review
Consumers are encouraged to have their medicines regularly reviewed by a health care team.

Guiding Principle 7 - Alteration of Oral Formulations
If oral formulations must be altered, for example, tablets broken or crushed to aid administration, safe alternatives should be provided. Some medicines cannot be altered and the consumer should be assisted to ensure that their medicines are managed safely and effectively.

Guiding Principle 8 - Storage of Medicines
Consumers should be encouraged to store their medicines safely and in a manner that maintains the quality of the medicine, and safeguards the consumer, their family and visitors in their home.

Guiding Principle 9 - Disposal of Medicines
The consumer or their carer should return ceased or expired medicines to the local pharmacist.

Guiding Principle 10 - Nurse-initiated Non-prescription Medicine
Service providers should develop policies and procedures about safe practices related to initiation of non-prescription medicines by nurses.

Guiding Principle 11 - Standing Orders
The use of standing orders in the community for the administration of prescription medicines is generally discouraged. However, in special circumstances where standing orders are required, service providers should have policies and procedures for them.

Principle 12 - Risk Management for the Use of Medicines in the Community
Health care professionals, care workers, service providers, consumers and/or carers should work together to manage risks and incidents associated with medicine use in the community.

Aged Care Services of Australia
In 2005, the Aged Care Services of Australia documented their National Policy Position on Medication Management. This document holds a great deal of relevance in the field of disability. The policy looks at medical practitioners who prescribe, pharmacists who dispense, and nurses and care workers who manage and administer the medications.

Amongst other relevant information, the document looks at State/Territory legislation and regulations while also exploring medication training in Certificate III in Aged Care, Certificate III in Home and Community Care, and Certificate IV in Aged Care work.

2.2 Feedback from Stakeholders

As part of this project, the following organisations, providers and consumers were consulted:

- Community Accommodation and Respite Agency, Woodville, South Australia
- Hills Community Support Group Wahroonga (Mundaring) Centre for Administration, Home and Community Care Support Services, Centre-Based Respite, and Community Living
- Senses Foundation Service Provider and Advocate for Western Australians who are deaf, blind, and people who are vision impaired with an additional disability
- Nulsen Haven Association supporting people with intellectual disabilities, Cannington, Western Australia
- NDS WA National industry Association for Disability Services
- The Centre for Cerebral Palsy of Western Australia
- Disability Services Commission of Western Australia
- Phylos units, Belmont, Western Australia
- Activ Foundation
- Home and Community Care Services in Western Australia
- Healthlink Pharmacy, Kiara
- MPS Health Management System Australia
- Venalink Australia
- Webster Care
- CoPharmacy

Set out below is a summary of key outcomes from these consultations:

Australian Cerebral Palsy Association (ACPA)
In May 2003, the Australian Cerebral Palsy Association adopted a recommendation for the 'Least Restrictive Principles and Practices for the Administration of Medication to People with Disabilities in Community Based Settings'[4].

[4] Australian Cerebral Palsy Association. *Recommended Least Restrictive Principles & Practices for the Administration of Medication to People with Disabilities in Community Based Settings*. May 2003.

Recommend key principles included:

- Individual client assessment in consultation with the client, family, doctor and other health professionals
- A clear Health Care Plan/written medication order from the medical practitioner
- Authorisations from the client, family, guardian or statutory health attorney
- Provision of health professional's advice and support for clients when needed
- Competency based training for staff
- Ongoing assessment and monitoring of staff practices by management staff
- An internal self-auditing process and written recommendations for improvement.

Recommended key practices included clear guidelines on:

- Obtaining, recording and updating authorisation
- Recording medication data and access to client's health records
- Prescription, storage, administering medication and data records
- Provision of expert advice about medication for staff
- Staff's role on medical visits and supporting clients with informed decisions
- Managing risk by accessing 24 hour phone support from health professionals
- Client involvement in administering own medication
- Storing medication
- Staff competencies and training
- Assessment of staff skill levels by health professionals using competency based assessment tools.

Disability Health Care and Support Service

Disability Health Care Support Service's paper on the Safe use of 'Medications in the Community' discussed the types of medication management systems available, and made recommendations about their use in accommodation, respite and day service options for people with disabilities.

The Disability Health Care Support Service supports medication systems and policies that are aligned to the National Medicines Policy 2000, including procedures that maintain[5]:

- Timely access to medications
- Affordability
- Quality use of medications.

The Disability Health Care Support Service supports the Quality Use of Medication through training and competency based assessment model for care workers. The Disability Health Care Support Service recommends:

- Supporting consumer choice and the inclusion of consumers in choosing safe medication administration practices
- Decreasing the risk of error by choosing established and trialed medication management practices such as MediSache for community accommodation, respite and accommodation services

[5] Australian Government. Department of Health & Ageing. *National Medicines Policy*. 2000

- Consumers who access day options and live at home may either provide original pharmacy labelled containers, or use a system of their choice in consultation with their pharmacist
- Exploring the alternative of the pharmacy dispensing for day service only, for example, MediSache or single medication container
- Limiting the requirement for dispensing medications into a single dose container.

Disability Service Providers Needs
Service Providers want a medication delivery system that is safe, cost effective and can be managed in the home, at work or in the community.

Cost is an important consideration for Service Providers and this includes the cost of the medication administration aid, possible associated expenses such as pharmacy charges, time spent in giving medications and completing medication documentation, and training time and costs.

Service Providers identified care workers' training and maintenance of ongoing competencies as the main way to reduce medication errors.

Service Providers recognised that the person who packages the medication administration aid, such as the pharmacist, can also make errors.

Feedback from Nurses
Discussion with an informal focus group of nurses found that there could be a reluctance to delegate the administration of medication to care workers. Nurses are well aware of the potential for errors in medication administration, and concern was expressed about care workers' training, the maintenance of on-going competencies and monitoring of practices. There may have also been a sense of relinquishing control of medication administration, a role traditionally performed by nurses.

Feedback from People with Disabilities
The key components of a medication administration aid identified by people with disabilities were that the aid must be practical and easy to use. It must be flexible to use in various places and times, so that people with disabilities and their carers could use the device at home, in the community, at recreation activities and at work. It must be cost tenable, as the health costs of people with disability were already considerable. It must be safe, and minimise the risk of errors for both the consumer and carers assisting with the administration of medicines.

SECTION 3: MEDICATION SYSTEMS

3.1 Systems Available

There are four main methods of the packaging of medications:

a) Medications packed by a pharmaceutical company using **Blister Packs**
b) Medications packed by a pharmaceutical company using the **Sachet System**
c) Medications packed in **Dosette boxes** by the individual, their family or care staff
d) Medications packed in the **original plastic/glass/cardboard containers**.

This report focuses on the use of the systems outlined in points a) and b) above (Blister Packs and Sachet systems) which meet the criteria for best practice in medication administration. As outlined earlier in this report, the criterion for a best practice system is that it meets the following requirements:

- Universal in application
- Socially unobtrusive
- Of minimal risk of medication management to all parties
- Portable
- Cost effective
- Capable of being introduced on a sector wide basis
- Able to meet accreditation requirements and the Disability Services Standards.

Accordingly, the systems described in points c) and d) above, (that is, Dosette boxes and original containers) have been discounted as best practice medication administration models for people with disabilities who live in a variety of accommodation options and engage in a variety of daily opportunities. Specifically, these systems are not suitable for the following reasons:

Medication packed in Dosette boxes by the individual, their family or care staff

Some organisations and individuals who live in their family home use a Dosette Box system, which they pack from the original containers of medications. A Dosette box is used for storing prescribed medicine and tablets. There are a number of different designs but normally it is a hard plastic box grid with sliding clear plastic windows that are labeled with days of the week and down the side are times of the day.

A Dosette box enables the user to take tablets at regular intervals or enables a carer to make sure that the person they are caring for takes the right tablets at the right times. The box is usually packed on a weekly basis by the individual or care person rather than a pharmaceutical company.

This system has been shown to have a number of inherent problems:

- Considerable physical and cognitive dexterity is required to open the Dosette box on the right day and time, and not drop the tablets

- If the box is dropped the medications can fall out
- The sliding lid can become dislodged allowing access to multiple tablets
- Errors may occur when the medications are dispensed from the original container
- Signing sheets are not provided with Dosette boxes.

This method is therefore not considered the safest and most effective method for use in disability services.

Medications Packed in the Original Containers

Medications are obtained from the pharmacist in their original packaging under a variety of different brand and generic names. The client must be able to access the medication from the packaging, read the instructions, remember what dose to take, and when to take the medicine. This can prove difficult for many people with disabilities. It is also difficult for the carer to monitor when the client is taking the medication.

The disadvantages with this system include:

- Errors can occur when medications are dispensed into different containers when the clients are away from their home
- Staff cannot verify the medications if they are dispensed from the original containers
- Clients may experience difficulty in coping with a number of different medicine containers
- Clients may experience difficulty in remembering if they have taken the medications and/or the correct dose
- Wastage of medication can occur when there are frequent changes, as almost a whole container may need to be discarded
- It is more time consuming than other systems
- Carers cannot readily check if the client has taken the medication at the right time and day
- Reordering of medication requires considerable time and liaison between the client, family and/or staff member, doctor and pharmacist.

It is advised that only trained health professionals administer medications from their original containers in disability services. Accordingly, this method is not recommended for disability service providers.

The following sections provide an outline of Blister Packs and the Sachet System as preferred models for the administration of medication for people with disabilities living in supported accommodation.

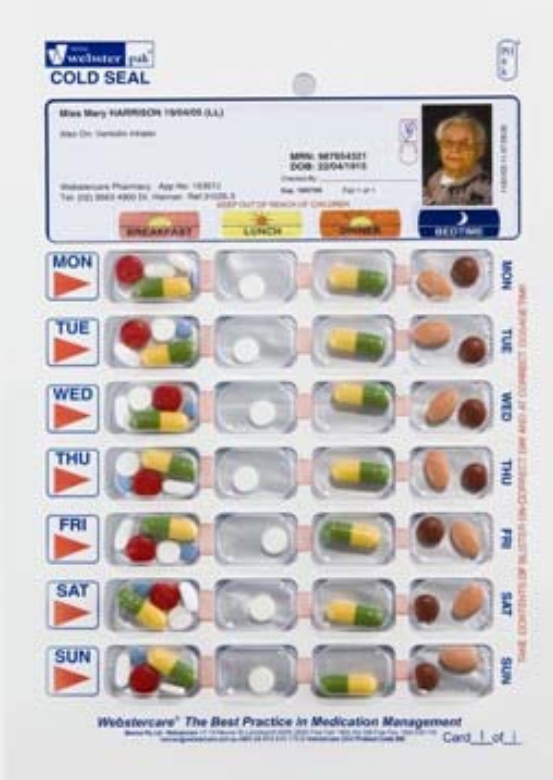
3.2 Blister Pack Systems

A blister pack is a disposable, multi-dose, individually prepared medication administration aid. The pack is divided into 28 separate blister wells in four rows of seven, which are the doses to be taken at breakfast, lunch, dinner and bedtime on each day of the week.

The blister package consists of a piece of bubble plastic attached to either an adhesive coated paperboard or foil. The paper and plastic are joined together by a blister sealer. The multi-dose system is an individually prepared blister pack, which is filled by the pharmacist. The pharmacist records on the pack the name of the client; and the names, description and quantities of the tablets that are sealed in the blister wells, using a special computer program and printer.

A photo of the client, the day, date and the time medications are due can be placed on the pack. Up to seven tablets can be contained in each compartment.

The system illustrated below is the Cold Seal Webster-pak®. The pressure sensitive adhesive offers a secure seal, which assists to make tampering evident.



Key features of the blister pack system are as follows:

- This multi-dose system is an individually prepared blister pack which is filled by the pharmacist
- The pharmacist records on the pack the name of the client, and the names, descriptions and quantities of the tablets
- A photo of the client and the day, date and time medications are due are identified on the pack
- Up to seven tablets can be contained in each sealed compartment
- The clear blister pack acts as a visual reminder of which medication is to be taken next and when
- This system can be administered by a Registered Nurse, appropriately trained care staff, the client's family or the client
- The pharmacist is able to provide a computerised medication chart transcription

service to minimise the risk of medication error during chart transcription

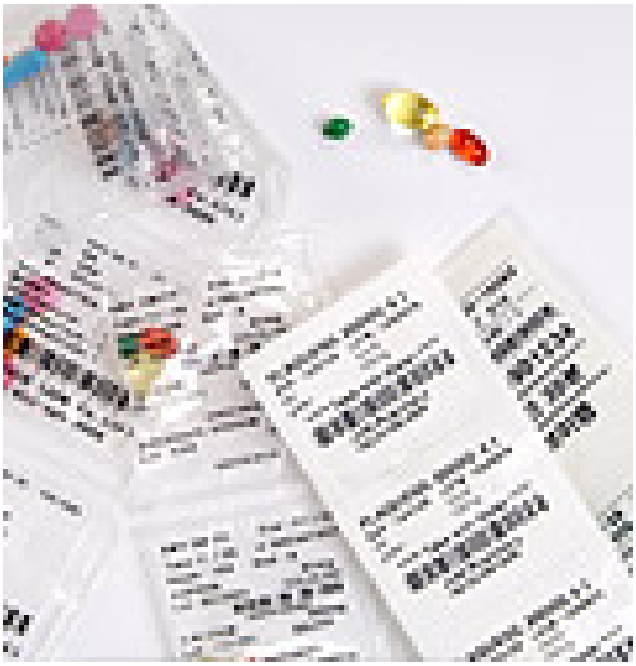
- As the client's doctor sends the prescription directly to the pharmacist this provides considerable time saving for staff and doctors
- Clients are able to take clearly labelled individual blisters with them when they go out
- Time is saved as staff do not need to repack medications for the clients to take with them
- Signing sheets accompany the blister packs to document medication administration
- Specifically designed medications trolleys that meet the Workplace Health and Safety requirements are available for the storage and administration of the blister packs.

Table 1 – Advantages and Disadvantages of Blister Systems

Advantages	Disadvantages
• Medications are pre-packed, which saves time for clients and staff • There are a number of different types of blister packs offering a choice of systems • Non-regular medications are also pre-packed in additional sets of different coloured blister packs from regular medications • Each pack shows time due, number, name and description of medications • Each pack has a photo, date, time, name of client and prescribing doctor • Blister packs can indicate other non packed medications such as asthma inhalers • Blister packs can indicate what the individual medications are prescribed for • Contents of the week's blister pack can be verified against a medication chart • A number of pharmacies dispense medications in blister packs, which offers some choice to facilities, families and clients • Having a number of pharmacies able to fill packs allows for a quick turn around when medication changes are made by the doctor • Medications are easy to dispense from blister packs • Information on the blister pack can be printed in Braille for people with vision impairment • General care staff who are trained in medication administration and deemed competent can give medications from this system.	• Small pills can get caught in the blister and be overlooked • As the blister pack holds a maximum of 7 tablets, a second pack may be required for additional medications • If the blister is full the medications can be difficult to identify • Unlike the sachet system, individual blisters cannot be separated from the pack, so medications must be dispensed into another container if they are required away from the client's home • If medications need to be crushed they must be tipped into another container • The storage and handling of multiple blister packs may be an issue, but may be resolved if staff use the specifically designed trolley.

3.3 Sachet Systems

The Sachet System is a roll of sachets pre-packed with medications by a pharmaceutical company using machinery specifically designed for this purpose. Medication in each sachet is easily identifiable and the medication is supplied in multi-dose sachets dispensed in a continuous roll from a rigid sided cardboard box.



Key features of the sachet system are:

- The name, dose and description of each medicine are printed on the back of each sachet
- One or more sachets are supplied for each episode of medication administration
- PRN (as required) oral medications are not sachet-packed but are supplied in the original container or blister pack, with the standard identifying information
- The printed adhesive label shows the client's name, the doctor's name, and the medication name according to the doctor's prescription (brand or generic)
- The box of sachets has a small plastic wallet on top imprinted with the client's name, photograph and allergies, and the doctor's name
- Each sachet is individually labelled
- As individual sachets can be separated from the roll this is a very portable system, and staff do not have to repack medications for outings etc
- The medications can be dispensed directly from the sachet saving the use of pill cups
- The pharmaceutical company provides prescription reports directly to General Practitioners
- Regular packed medication is provided weekly and staff are not required to have any involvement in sourcing or locating prescriptions
- The pharmaceutical company is able to provide a computerised medication chart transcription service, helping to minimise the risk of medication error during chart transcription, and providing considerable time saving for staff and doctors

- Specifically designed medication trolleys that meet the Workplace Health and Safety requirements are available for the storage and administration of the sachet systems.

Table 2 – Advantages and Disadvantages of Sachet Systems

Advantages	Disadvantages
• This system does not take up much space • Regular medications are pre-packed by the pharmaceutical company which saves staff time • Sachets are quick to dispense to clients • Each sachet is identified with the client's name and name of medications • Medications in a sachet are easy to count and identify • Tablets can be crushed while still in an unopened sachet • A single sachet of medications can be separated from the roll making this system very portable and flexible • Specifically designed medication trolleys are available • Care staff who have been trained and deemed competent in medication management are able to administer medications from this system.	• Fewer pharmacies provide the sachet system • Considerable care needs to be taken when tearing a sachet off the roll as it is easy to rip the sachet, or tear the next sachet on the roll, allowing spillage of pills • When medications are checked on delivery from the pharmacist the roll must be removed from the box and unwound • Medications, which are taken sporadically, are not packed in the sachet system, therefore different systems of administration may be required for the same client with greater potential for error • Small pills may remain in the corner of the sachet and be overlooked.

Comparison of the Blister and Sachet Systems

Both Blister and Sachet systems provide disposable, multi-dose medication administration aids for oral medications. Neither system can accommodate liquids, and some tablets, such as anginine, cannot be stored in these systems. Medications which are taken sporadically, are often supplied in their original containers.

Photo identification is provided in both systems. The number, colour and shape of medicines can be identified in the Blisters packs and Sachets, although when the Blister pack is full it is more difficult to check the tablets. The Blister system is more bulky than the thin Sachets.

Unlike the Sachets, the individual Blisters cannot be easily separated from the Blister pack. Therefore, the medication must be dispersed into another container if the consumer requires their medicines outside the house. Single Sachets can be readily separated from each other.

If individual tablets are dropped or unusable for some reason, re-ordering of the medication is required with both systems. The medication would then need to be taken from the appropriate following day's medication. More pharmacies supply the Blister packs than the Sachet system. Both Blister packs and Sachet systems have comprehensive signing sheets.

SECTION 4: MEDICATION ADMINISTRATION PROCEDURES

4.1 Scope of the Procedure

The following provides guidance for the development of procedures for the administration of medication within the context of the client living in supported accommodation. It covers medications that are given orally or locally such as creams and lotions. Further procedures and staff training will be required for other methods of administering medication.

4.2 Getting the Medication

Prescription
Once a client has been seen by the doctor, a prescription will be written if medication is required. On presentation of the prescription, the pharmacist will pack the required medication. Depending upon the medication system used, agencies will need to establish delivery protocols with the pharmacy.

Delivery and Checking of Medication
For repeat prescriptions, the pharmacy will provide delivery times for medications and their contact details. Medication should be delivered 48 hours before the medication is due to be given, to allow time for staff to check the medication.

Arrangements can be made to deliver Blister packs / Sachets to the client's home. On delivery of the medications staff must check each Blister pack / Sachet against the client's Medication Chart. Staff must sign if the delivered medications are correct or follow the relevant procedure if an error or suspected error is found.

All medication must be stored at the recommended temperature.
Medication/treatments that have past the expiry date must not be used and should be returned to the pharmacy.

In the event of an error regarding the medication supplied, a Medication Error form must be sent to the relevant pharmacy. In the case of an error, medication or documentation (or both) will need to be reissued. Staff must document all such errors on the relevant incident form.

Signing Sheet
A signing sheet will normally be provided with the medication provided by the pharmacy. This sheet provides a safeguard for recording the administration of medication by staff to clients over a four-week period. Samples of signing sheets are attached in Appendices 1 and 2. If medications are changed a new signing sheet is issued by the pharmacy to ensure a full and complete list of the client's current medications.

The signing sheet normally provides for four dosage times per 24 hour period. Once a dose has been administered, the staff member signs the medication sheet accordingly, to demonstrate that the medication has been given. Omissions in medication administration are also documented. In this context, the signing sheet

may assist in the identification of specific and ongoing errors, which can be used to identify and address staff training needs.

The signing sheet has the provision for:

- Client's and doctor's names
- The name of the medication, the dose, a description of the tablets and the time of administration
- A start date
- A photograph of the client
- A colour image of the medication.

4.3 Staff Training

It is recommended that all staff involved in administering medications attend medication administration training and have been deemed competent. It is recommended that reassessment be undertaken annually.

Care Staff must refer to the client's care plans to take into account his / her role in the administration of the client's medication. Generally, unless specified on the client's care plan, medications should not be left with the client.

4.4 Administration of Medication from a Blister Pack or Sachet Pack

Set out below is the suggested procedure for the administration of medication using Blister packs or Sachets, within a range of environments. In all circumstances, it is important to ensure that the staff member is not interrupted during administration of medications, except in the event of an emergency. Interruptions during medication administration represent a common cause of errors in this area.

4.4.1 Procedure for Giving Medications in the Client's Home

- Wash and dry hands thoroughly
- Take Blister pack/Sachet (and water if required) to the client
- Check the Blister pack/Sachet for the person's name and photo (photo should be current and be a good likeness of the client)
- Check the name of the medication, the number of tablets, the description of the tablets, the time it is to be given and any special instruction, such as to be taken with meals
- Check Blister pack/Sachet for the correct day and time
- Remove the contents of the appropriate Blister/Sachet into a pill cup or similar container. Do not handle the tablets
- Check that all medications have been removed from the Blister/Sachet
- Check that the recipient of the medication is the correct person
- Administer the medications
- Check that the person has swallowed all the medications
- Sign the client's medication sheet
- Having dispensed every client's medication, re-check each Blister pack/Sachet to

ensure that all medications have been correctly administered
- Return Blister packs/Sachets to the medication cupboard
- Lock the medication cupboard.

4.4.2 Procedure for Giving Medications when Client is going Out of Home

- Individual medication blisters/sachets can be taken from the Blister pack/Sachet roll by tearing off the required number of blisters/sachets along the perforated edges
- Check the Blister pack/Sachet for the person's name and photo to ensure that the recipient of the medication is the correct person
- Check the Blister pack/Sachet for correct day and time of administration
- Having removed the required blisters/sachets, re-check each Blister pack/Sachet to ensure that all appropriate medications have been correctly removed from the Blister pack/Sachet roll
- Return the Blister pack/Sachet roll to medication cupboard/trolley
- Lock medication cupboard/trolley
- Put medication and copy of current signing sheet plus current photo of client in suitable container to prevent loss or damage to medications.

It is the responsibility of the staff person taking the client out to check that they have the appropriate medication and signing sheets with current photo to cover the time out. Where the client is going out with family it is the responsibility of the staff person at the home to ensure that the client has sufficient medication with them and that the family know when it is to be given.

To administer the medication, follow the same procedure outlined in section 4.3.1 above.

4.5 Administration of Liquid Medication

As previously discussed, liquid medication is not supplied using the Blister or Sachet systems. The previous checking process remains the same, however the administration procedure for liquids varies as follows:

- Wash and dry hands thoroughly
- Check the label on the bottle against the client's medication chart to ensure that the name of the medicine, strength, amount, and time is correct for that client
- Shake the bottle to mix ingredients (or as per label instructions)
- Hold measuring glass at eye level and pour from the bottle with the label uppermost to avoid staining the label
- Measure the required amount of the liquid
- Administer the medication to the client ensuring that there is no spillage and that all the medication has been swallowed
- Clean the neck of the bottle with a cloth (not water) and firmly replace the lid
- Before replacing the bottle in medication cupboard/trolley, check again that the name of the medicine, strength, amount, and time is correct for that client
- Sign the medication chart
- Lock the medication cupboard/trolley.

4.6 Antibiotics and Short Term Medication

These medications are usually packed by the pharmacy similarly to regular medication. Details of antibiotics / short-term medication are provided with dose, frequency and method of administration.

Supporting documentation/care plans drawn up by a senior staff person must be supplied for inhalers, nebulisers, eye/ear drops etc. The client's Signing Sheet for Antibiotics / short-term medication is divided into date / time of administration / quantity administered and staff signature and must be signed when medication is given.

4.7 PRN (use as required) Medication and Treatments

The term PRN refers to medications that are to be administered on an 'as required' basis, for example, creams for the treatment of skin rashes, and paracetamol. Such treatments should be documented and signed for on a PRN chart as shown in Appendix 3. The client's name, known allergies, address and photograph are identified on this document. PRN medication charts must specify the name of the medication / treatment, when the medications are to be given, the dose, the route or how the medication is to be administered.

The care plan should indicate where on the client's body creams and lotions are to be applied. The client's signing sheet for PRN medication will specify the date, time of administration, quantity administered and the signature of the person giving the PRN medication.

4.8 Non-Packed Regular Medication/Treatments

Regular treatments (such as a scalp treatment, oral hygiene etc), which may occur weekly or in a regular pattern, will be documented and signed for on the relevant chart. The client's name, allergies, address and photograph are provided on this document. Details of non-packed regular medication include dose, frequency and method of administration. The signing sheet for non-packed regular medication is divided into dosage times. Staff administering the medication sign in the appropriate space.

4.9 Frequently Asked Questions about Medication

What if I drop or spill the medicines onto the floor?
Medications that are dropped onto the floor should not be given to the client. Medication can be taken from another blister or sachet. Check that the blister or sachet contains the same tablets that were to be given, at the same time as it was prescribed.

The client's name, medication name, description of the medicine, dose and time of administration must be rechecked before the medication is given to the client. The soiled tablets should be kept, stored in a secure place and returned to the pharmacy.

The staff member should then complete a 'Medication Error' form and send a copy to

the pharmacist. The individual blister or sachet will then be replaced with the next delivery. The staff member should inform their supervisor of the incident.

What if there is the wrong number of tablets, or they look different from the client's usual medication?

- Explain to the client that you need to contact the pharmacist to check the medication
- If there will be some delay, check with the pharmacist/doctor/nurse if the client can wait for their medication, or what action needs to be taken
- If necessary, send the medications to the pharmacist to repack.

What if the client refuses to take some or all of their medication?

- The client has a right to refuse medication
- Try to determine why they are refusing to take the medication
- If the client is confused, gentle persuasion may help, or wait a little while and try again
- If the client is mentally alert try to persuade them
- Contact a health professional to determine if a delay in administration of the medication may cause adverse reactions
- If the client continues to refuse the medication, inform their GP promptly
- Complete a 'Medication Incident' form and ring your supervisor.

What if the client wants to take some medications and leave the rest until later?

- Explain to the client that you not permitted to leave medications with a client unless this has been specified in their care plan
- Ask the client to let you know when they wish to take the medication and you will bring it to them at that time (within 30 minutes)
- Document in the client's notes and on a Medication Incident Form and forward to the supervisor for investigation and follow-up
- Contact a health professional to determine if a delay in administration of the medication may cause adverse reactions
- If this is a common occurrence talk to the client's GP for reassessment of the medication, or for assessment for self-administration of medication.

What if the client wants you to leave all their medications with them to take at a later time?

- Explain to the client that under no circumstances are you permitted to leave medications with a client (other than in a specific situation, which is explained in this procedure).
- Offer to bring the medications to the client within the next 30 minutes
- If client still refuses to take their medication, follow the procedure for refused medication
- Report to the supervisor, and follow-up with the client's GP to see if the client can be assessed for self-administration of medications
- If the client is unable to self-medicate and still wishes to have the medications left, then this must be followed up with their GP.

What if the client spits out some or all of their medications, or vomits their medication?

- Put on gloves and safely dispose of the medication
- Reassure the client and help clean up any vomit
- Try to determine why the client could not take their medicine, for example, the person may be unwell or the tablet may be too large to swallow
- Contact a health professional to determine if the medication must be re-given
- Document in the client's notes and on a Medication Incident form, and forward to the supervisor.

Medication Error, for example, giving medication to the wrong client, at the wrong time, or from the wrong Blister/Sachet

- Reassure the client
- Try to identify which medicine(s) have been given
- Seek urgent medical advice from the client's GP, pharmacist or community nurse
- Ring the supervisor and seek assistance
- Further advice can be sought from the Poisons Information Centre
- Do not induce vomiting unless advised to do so by a health professional
- In an emergency ring for an ambulance
- Document in client's notes and on a Medication Incident form.

What if you notice gaps in the signing record

- Quickly try to determine if the medication has been given
- If you believe the medication has not been given, seek medical advice from the client's GP, pharmacist or a nurse
- Complete a Medication Incident form
- Ring the supervisor.

What if you find a tablet on the floor

- Try to identify the tablet
- Seek medical advice
- Complete a Medication Incident form
- Secure the tablet in a container labelled, 'Medication for Disposal' and return to the pharmacy.

What if you are not sure if the medicines are correct, or you cannot clearly identify them?

- Remove the tablets from the pack and decide if you can clearly identify the medicines
- If you are unsure if the medicines are correct do not give them
- Do not assume that the medicines must be correct
- Contact the pharmacy to check the medicines
- Consult a health professional with your concerns.

What if the client is in pain and wants you to give Panadol?

Some service providers instruct their staff that they cannot administer any medications, including over the counter medications, without a doctor's prescription. Service providers need to consider their respective policy positions on this issue. If the agency's policy is that such medications cannot be given without a prescription, the following action can be taken:

- Explain to the client that you will contact their doctor to seek medical advice for pain relief
- Sometimes pain is a symptom of a serious medical condition so it is important to seek advice from a health professional.

4.10 Emergency Contact Numbers

- Poisons Information: 13 11 26
- Royal Perth Hospital: 9224 2244
- Princess Margaret Hospital: 9340 8222
- Sir Charles Gairdner Hospital: 9346 3333
- Joondalup Health Campus: 9400 9400
- Fremantle Hospital: 9341 3333
- Ambulance: 9334 1234 (non emergency transport)
- Police/Fire/Ambulance Emergency: 000, or 112 from a mobile phone.

SECTION 5: TRAINING

5.1 The Importance of Training

Training in medication administration is an important aspect of medication administration best practice. The side effects of some medication can be life threatening, therefore it is essential that people only take prescription medications that have been specifically ordered by their doctor. The correct administration of medication is also essential to obtain its full benefit, as well as to reduce the risk of side effects and possible life threatening problems that can occur from incorrect usage. To obtain optimum results and reduce the risk of side effects, many medications must be taken at a specific time, with or without food, and over a set period of time.

It is therefore essential that staff receive initial competency based training, regular ongoing training, and that safeguards are in place in regards to the supply, packaging and administration of medication.

It is critical to acknowledge the individual circumstances in which medication is administered. For example some people may administer their own medication with assistance, some types of medication may be in liquid rather than tablet form and some people may require medication to be administered through gastronomy mechanism. It is therefore recommended that training be provided regarding general principles related to medication administration and then further training is provided regarding the individual needs of people with a disability, as required.

The training available to support workers should include:

- Staff induction program including training on all aspects of administration of medication and organisation policy;
- Orientation to individual client's needs regarding medication;
- Access to additional training arranged through appropriate professionals, such as dietitian, doctor, speech pathologist, as and when required;
- Assessment of staff skill levels by health professionals (such as registered nurse, medical practitioner) using competency-based assessment tools
- Staff performance reviews, including monitoring of administration of medication
- remedial training, as and when required. (ACPA 2003:5)

Training can be assessed and accredited through a registered training organisation.

5.2 Accredited Training Courses

A number of Service Providers in Western Australia provide training in the field of disability, which includes a section on medication administration, but all appear to have different criteria and different presentations.

Certificate III is available through TAFE Colleges and has a specific core section reserved for information and training in the administration of medications for care workers. The unit describes the skills and knowledge required to assist clients to self-

medicate in a home or in a community setting. Assistance with self-medication is provided with:

- The relevant Commonwealth and State/Territory legislation including the Drugs and Poisons Act and Regulations
- Relevant industry standards and guidelines
- Organisational policies and procedures written in accordance with the relevant legislation, and reflecting the scope of role and accountability for the level of worker in that jurisdiction.

The contents of the section include:

- Introduction to service delivery
- Assist with self medication
- Comply with organisation's procedures for handling the range of contingencies which may arise.

In order to be assessed as competent the trainee will need to provide evidence demonstrating that they can perform the required competencies to the required standard.

5.3 Situation Specific Training

While the TAFE training is an essential part of Certificate III, further individual staff training is still required within a Service Organisation where care workers are required to administer medications.

People with disabilities may take their medication in different ways according to the nature of the disability. For example, the medication may need to be crushed or given on a spoon mixed with jam or similar for ease of swallowing. Clients who self-administer medicines should also be advised about safe medication practices.

In Western Australia, Silver Chain provides this level of staff training and ensures that the staff person is deemed competent before they are permitted to give any medication.

Some pharmacies will provide detailed procedures and assist with training staff, however this would require negotiation between the disability organisation and the pharmacist.

Staff require regular ongoing training to ensure that their skills are maintained, and to reassess their medication competency. Where errors are occurring in the administration of medication, further competency based training is indicated.

SECTION 6: SCHEDULE OF APPENDICES

Appendix 1: Signing Sheets for Sachets (Sample)

Appendix 2: Signing Sheets for Blister Packs (Sample)

Appendix 3: PRN Medication Record Chart (Sample)

Appendix 4: List of Agencies Contacted for this Project

Appendix 1: Signing Sheets for Sachets (Sample)

HEAVEN NURSING HOME **Sachet Medication Signing Sheet** **Page 1 of 1**

Patient, Sample

CoSach

B, 12

Medications are Crushed

Dr A Sample

Printed: 18/06/2007 2:32:13 PM

S1/1

Regular Medications - Sachet Packed				Administration Times and Number of Doses				
Generic	**NC**	**StartDate**	**EndDate**	**Freq**	**1000**	**1400**	**1800**	**2200**
Docusate/senna Tab 50mg/8mg	☐	18/08/2006			2.00			2.00
Paracetamol Tab 500mg	☐	18/08/2006			2.00	2.00	2.00	2.00

Sign in box below to record that the indicated number of sachets were provided to client at the indicated time.

Mon 18/06/07	Tue 19/06/07	Wed 20/06/07	Thu 21/06/07	Fri 22/06/07	Sat 23/06/07	Sun 24/06/07
1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach
1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach
1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach
2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach

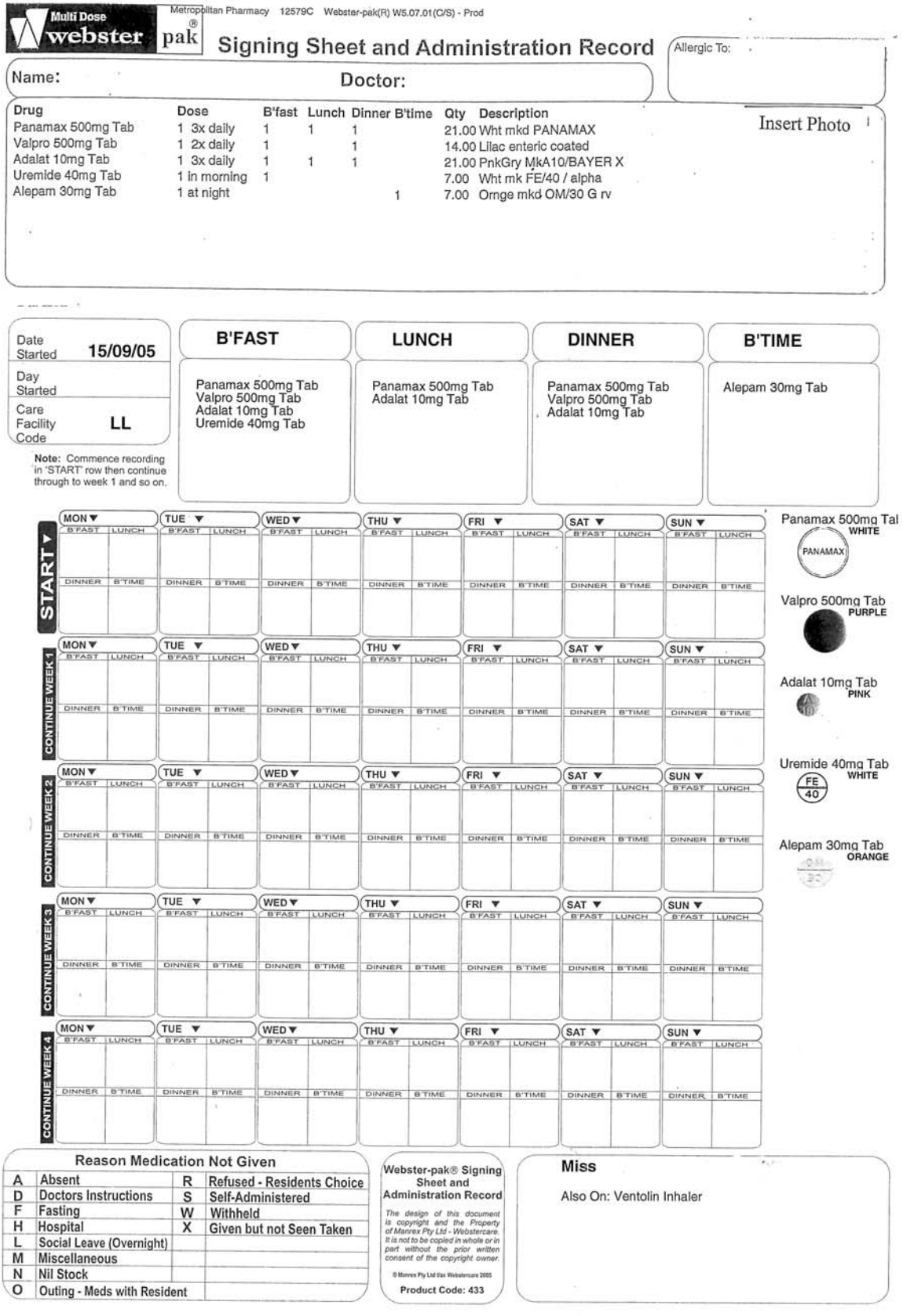
Mon 25/06/07	Tue 26/06/07	Wed 27/06/07	Thu 28/06/07	Fri 29/06/07	Sat 30/06/07	Sun 01/07/07
1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach
1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach
1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach
2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach

Mon 02/07/07	Tue 03/07/07	Wed 04/07/07	Thu 05/07/07	Fri 06/07/07	Sat 07/07/07	Sun 08/07/07
1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach
1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach
1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach
2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach

Mon 09/07/07	Tue 10/07/07	Wed 11/07/07	Thu 12/07/07	Fri 13/07/07	Sat 14/07/07	Sun 15/07/07
1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach	1000 x1sach
1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach	1400 x1sach
1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach	1800 x1sach
2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach	2200 x1sach

OMISSIONS:
N/S = NO STOCK** **H** = HOSPITAL **SL** = SOCIAL LEAVE **U** = UNWELL* **R** = REFUSED* **A** = ABSENT
W = WITHHELD* **SM** = SELF MEDICATES ** Determine why & rectify if possible. * Enter details in notes/Care plan.
All Medication Incidents are to logged on Medication Incident Form.
Signature is a record that the contents of the blister were given.

Appendix 2: Signing Sheets for Blister Packs (Sample)



Multi Dose webster pak® — Metropolitan Pharmacy 12579C Webster-pak(R) W5.07.01(C/S) - Prod

Signing Sheet and Administration Record

Allergic To:

Name: Doctor:

Insert Photo

Drug	Dose	B'fast	Lunch	Dinner	B'time	Qty	Description
Panamax 500mg Tab	1 3x daily	1	1	1		21.00	Wht mkd PANAMAX
Valpro 500mg Tab	1 2x daily	1		1		14.00	Lilac enteric coated
Adalat 10mg Tab	1 3x daily	1	1	1		21.00	PnkGry MkA10/BAYER X
Uremide 40mg Tab	1 in morning	1				7.00	Wht mk FE/40 / alpha
Alepam 30mg Tab	1 at night				1	7.00	Ornge mkd OM/30 G rv

Date Started 15/09/05

Day Started

Care Facility Code LL

Note: Commence recording in 'START' row then continue through to week 1 and so on.

B'FAST	LUNCH	DINNER	B'TIME
Panamax 500mg Tab Valpro 500mg Tab Adalat 10mg Tab Uremide 40mg Tab	Panamax 500mg Tab Adalat 10mg Tab	Panamax 500mg Tab Valpro 500mg Tab Adalat 10mg Tab	Alepam 30mg Tab

START ▼ / CONTINUE WEEK 1 / CONTINUE WEEK 2 / CONTINUE WEEK 3 / CONTINUE WEEK 4

MON ▼ | TUE ▼ | WED ▼ | THU ▼ | FRI ▼ | SAT ▼ | SUN ▼

B'FAST | LUNCH | DINNER | B'TIME

Panamax 500mg Tab WHITE (PANAMAX)

Valpro 500mg Tab PURPLE

Adalat 10mg Tab PINK

Uremide 40mg Tab WHITE (FE 40)

Alepam 30mg Tab ORANGE

Reason Medication Not Given

A	Absent	R	Refused - Residents Choice
D	Doctors Instructions	S	Self-Administered
F	Fasting	W	Withheld
H	Hospital	X	Given but not Seen Taken
L	Social Leave (Overnight)		
M	Miscellaneous		
N	Nil Stock		
O	Outing - Meds with Resident		

Webster-pak® Signing Sheet and Administration Record

Product Code: 433

Miss

Also On: Ventolin Inhaler

Appendix 3: PRN Medication Record Chart (Sample)

RECORD OF PRN/AS REQUIRED MEDICATION GIVEN

ONLY MEDICATION PRESCRIBED BY A DOCTOR TO BE ADMINISTERED

Name: _____

Allergies: _____

Date	Time	Medication	Dose	Route (e.g. oral)	Reason given	Given by (Signed)	

Appendix 4: List of Agencies Contacted for this Project

Community Accommodation and Respite Agency Inc. (CARA) Woodville, South Australia

Hills Community Support Group

Senses Foundation Inc.

Nulsen Haven Association

National Disability Services WA (NDS)

The Centre for Cerebral Palsy of Western Australia

Disability Services Commission of Western Australia

Phylos – Belmont, Western Australia

Department of Health and Ageing WA - websites

Activ Foundation Inc.

Home and Community Care (HACC) Services in Western Australia

Healthlink Pharmacy, Kiara

MPS Health Management System Australia

Venalink Australia

Webster Care

CoPharmacy

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