

NORTH WEST RESIDENTIAL SUPPORT SERVICES INC
PROCEDURES FOR THE ADMINISTRATION OF MEDICATION IN SHARED HOMES

The following procedures must be strictly adhered to.

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Procuring Medication for a Client

1. For each client, the Pharmacist is provided with a Doctors prescription or orders from the clients Doctor.
2. The Pharmacist transfers information from the Doctors prescription or orders to the DOSETTE-WEBSTER PAK INFORMATION SHEET on the client Dosette Box, Webster Pack or Medication Containers.
3. A copy of the DOSETTE-WEBSTER PAK INFORMATION SHEET is supplied by NWRSS to the day service the client attends.
4. Any medication changes made by the Doctor are to be reported to the Supervisor who will arrange for an updated DOSETTE-WEBSTER PAK INFORMATION SHEET to be supplied to the day service.

Sending Medication with a Client to a Day Service

1. The Pharmacist places each daily lunch time dose in a separate container with a label that states clearly:
 - Name
 - Medication
 - Day
 - Time
 - Dose
2. These containers are checked on pick-up, by NWRSS support workers, against the DOSETTE-WEBSTER PAK INFORMATION SHEET on the back of the Dosette Box or Webster Pack.
3. Day service support workers sign a MEDICATION TRANSFER SHEET for these containers.
4. NWRSS support workers record the return of empty containers on the CLIENT MEDICATION SHEET.

Storage of Medication in the Home

All prescription medication is to be kept in an individual Dosette Box, Webster Pack or container clearly marked with:

- Client name.
- Medication name.
- Strength.
- Dose.
- Route.
- Number of tablets.
- Time to be taken.

All medication must be stored in a locked cupboard, in the container in which it was dispensed by the Pharmacist.

Administering Medication

Medication is administered by the support worker/s on shift at the time the medication is required.

Medication must be administered to one client at a time.

Medication must be administered immediately after it is dispensed.

Medication must be administered by the support worker who dispenses it.

Wherever possible, medication should be administered by two support workers as a confirmation of the process and steps.

Medication Dispensing - Steps

1. One support worker reads from the CLIENT MEDICATION SHEET while the other support worker checks the DOSETTE-WEBSTER PAK INFORMATION SHEET on the Dosette Box or Webster Pack and dispenses the medication into a medication cup. All of the following must be checked:
 - Name of the person.
 - Name of the drug.
 - Dosage prescribed.
 - Time/frequency to be taken.
 - Route of administration.
 - Any special instructions i.e. before meals.
2. The support worker dispensing the medication should administer the medication and sign in the "given by" space on the CLIENT MEDICATION SHEET immediately after it is given.
3. The support worker reading from the CLIENT MEDICATION SHEET should countersign the sheet after the medication has been given.
4. Ensure that the client has swallowed all oral medication.

The CLIENT MEDICATION SHEET should be signed in blue or black biro. Do not use pencil. Whiteout should not be used.

The CLIENT MEDICATION SHEET will be kept in the Client Medication Folder and stored with the medication.

At the beginning and end of each shift, all staff should check that medication has been given and signed for.

In the event of missing signatures, the support worker responsible will be contacted to confirm that the medication was given and asked to return to the house to sign the CLIENT MEDICATION SHEET. Under no circumstances can support workers sign for each other.

Self Administration

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

Support workers are responsible for all steps in this process.

The client is to initial in the "given by" space on the CLIENT MEDICATION SHEET if possible.

PRN Medication [Prescribed or “As Directed”]

PRN medication must not be given without first speaking to a Supervisor.

In the event of a client being prescribed a drug or medication to be given "PRN" the following applies:

Clear and precise written directions must be obtained from the Doctor covering:

- Circumstances under which the drug or medication must be given.
- Procedure for administration.
- Circumstances under which a further dose can be administered and what is considered a safe interval between doses.
- The maximum PRN dose.
- Circumstances in which the Doctor must be notified.

The written instructions should be kept on file in the Client Medication Folder.

Complete the PRN – PRESCRIBED OR AS DIRECTED SHEET.

PRN Medication [Non-prescription]

This medication can be given without a Doctor's prescription.

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

- Contact the Supervisor.
- Where a client is already taking regular medications, the Doctor or Pharmacist must be contacted to determine if the medications are compatible.
- If the support worker is unable to contact the clients Doctor or Pharmacist, they must consult with the Poisons Information Centre on **FREECALL - 131126**.
- All information received must be recorded in writing in the Client Health Diary.
- Complete the PRN – NON-PRESCRIPTION SHEET.

Medication Error

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

1. Identify the error, i.e. incorrect medication has been given or medication has been missed.
2. Use the Emergency Contact List to report the error.
3. Contact the client's Doctor to seek advice. If the Doctor is unavailable, call the after hours Doctor, Pharmacist or Poisons Information Centre.
4. Observe the client for signs of distress. Call the ambulance if the client is in distress or showing signs as described by the Doctor or Poisons Information Centre. **If in doubt, call an ambulance.**
5. Record the error on the CLIENT MEDICATION SHEET and the incident details in the Client Health Diary.

Refusal to Take Medication

A client must not be forced to take medication against his or her wishes. However; every effort must be made to give medication as prescribed.

If a Client refuses to take their medication, the support worker administering the medication must:

1. Ask the client why they do not wish to take their medication.
2. Explain to the client the reason for taking the medication and the possible effects on their health if medication is not taken.
3. Wait 15 minutes and ask the client to take the medication again.
4. Use the NWRSS Emergency Contact List to report the problem. If the client still refuses then the prescribing Doctor must be contacted for instructions. If the Doctor is unavailable, call the after hours Doctor, Pharmacist or Poison's Information Centre.
5. Observe the client for changes in behaviour or well being as a result of the medication mistake and report these to the Supervisor or Doctor.
6. Record all details in the Client Health Diary.

Invasive Procedures

Support workers do not perform invasive medical procedures unless trained and certified.

Preparation of Medication Sheets

Support workers on the afternoon/evening shift on the last day of every month are responsible for preparing the medication sheets for the coming month.

The support workers on shift the following morning are responsible for 'double checking' the prepared medication sheets.

Always begin with writing the client's name at the top of the sheet/s. Prepare the medication sheet/s for one client at a time.

Information from each client's medication container is transferred to the new CLIENT MEDICATION SHEET using a blue or black biro. Do not use pencil.

This is to include Client, Drug, Dose, Time/Frequency, Route, Number of tablets and any special instructions.

On completion of each new CLIENT MEDICATION SHEET, the support worker must sign in the appropriate space at the bottom of the sheet.

The support worker on shift the next morning must check the new medication sheets and sign in the appropriate space at the bottom of each sheet.

Audit of Medication

Monthly audits of medication will be carried out at the same time as the preparation of the medication sheets for the coming month and signed off in the place provided on the outgoing medication sheet. The audit will check that:

- Prescriptions held at the house are current.
- Use-by dates have not expired, [include ointments, creams, etc.].
- Medication containers are not damaged.

- Storage procedures are correct.
- Medication administration records reconcile with medications yet to be taken.

Any anomalies or medication for disposal should be reported immediately to the Supervisor or Manager.

Review of Medication

Clients will have a formal annual review of their medication.

All Doctor's visits including medical reviews will use a MEDICAL APPOINTMENT SHEET.

Medication reviews will be arranged by the Supervisor to include the client, Doctor, support staff, advocate and any other specialists involved.

Consent to Medical Treatment

The Supervisor is responsible for seeking consent for medical or dental treatment from the clients 'person responsible'.

Administration of Alternative Therapies

The Supervisor is responsible for seeking consent for alternative therapies from the clients 'person responsible'.

List of Forms Used In Conjunction with These Procedures:

1. DOSETTE-WEBSTER PAK INFORMATION SHEET.
2. CLIENT MEDICATION SHEET.
3. PRN – PRESCRIBED OR AS DIRECTED SHEET.'
4. PRN – NON-PRESCRIPTION SHEET.
5. MEDICAL APPOINTMENT SHEET.
6. MEDICATION AND HEALTH SHEET.
7. MEDICATION TRANSFER SHEET.
8. BODILY FUNCTIONS SHEET.
9. SEIZURE RECORD SHEET.
10. VENTILATION CLEANING SCHEDULE.

Version number: 01---Authorised by Neal Rodwell, General Manager.

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