Medication Safety for Carers of Palliative Care Patients at Home Procedure

1. Guiding Principles

a) Carers are to be assessed and educated to promote the safe administration of subcutaneous PRN medication.

b) Community based Palliative Care Nursing Services to provide ongoing support for palliative care patients and carers at home.

c) To ensure each situation is critically examined to support optimal patient outcomes and, evidence based best practice, for all stakeholders involved.

d) To ensure that service is provided in an environment of safety and security for staff, clients and carers.

2. Procedure

The Palliative Care Service recognises the significant role of carers in administering and monitoring oral and transdermal medications in response to symptoms throughout their caring role.

It is also recognised that the patient's care needs can change with significant increase of symptoms as the disease progresses, often requiring changes in medication administration and routes of medications.

Carers are involved in medication management and administration throughout the client's illness which includes oral, sublingual, transdermal and sometimes subcutaneous medications such as Clexane and insulin.

Importantly educating and supporting patients and carers transition to subcutaneous medications that are used in the palliative care setting, requires expert knowledge and ongoing access to specialist palliative care support.

For patients who have commenced the voluntary assisted dying (VAD) process and have been dispensed the VAD substance for self-administration, storage, handling and administration is comprehensively excluded from this policy and not the responsibility of the palliative care team. It is the responsibility of the patient. If administration of the VAD substance is by an Administering Practitioner, they have the responsibility regarding storage, handling and administration. Refer to the WACHS Voluntary Assisted Dying Policy for further information.

Implementation plan:

- This procedure is to take effect after notification and in-service of relevant staff.
- All stakeholders to be provided with education and information by the Clinical Nurse Manager.
- Information included in orientation package for new staff.
- Annual evaluation report to the Clinical Nurse Manager.

2.1 Assessment

- The palliative care team is prompted through the advance care planning process to understand place of care and preferred place of death in a timely manner.
- To fulfil the wish for a patient to die at home, there are several factors that need to be considered (but not limited to), the supply of appropriate equipment, in-home respite, personal care, client and carer education and the management of symptoms.
- When a patient is no longer able to tolerate oral medications, the palliative care Registered Nurse (RN) is to assess / evaluate the carer's preparedness to administer subcutaneous medications for pro re nata (PRN) use. Education and support to be provided for carers who are willing to safely administer subcutaneous medications.
- For patients and carers who choose not to participate, the palliative care team is to continue to support with educate around medication safety.
- A home visit risk assessment is completed for every patient (history of mental health, illicit or intravenous drug users, clients/family of concern) and the Clinical Nurse Manager is informed of identified risks. This is documented on updated daily handover sheets and the electronic patient care record which is utilised for handover.
- If there is a household of concern, then two nursing staff are allocated to the patient for safety. All nursing staff have mobile phones, the time of visits to at risk household is documented, together with the car registration number allocated.

2.2 Recommendation

- Carers are to be assessed and educated to promote the safe administration of subcutaneous PRN medication (Appendix 8, 8A and 9).

3. Definitions

PRN	Whenever necessary 'as needed' or 'as required' medication
Carer	Family carer not care workers Carers provide paid or unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carers Australia, 2015. Definition of carers. Canberra).
Unused medication	Medications no longer in use such as oral medications or all patient medications after the patient's death.
Excess medication	Medications that have been prescribed for the patient such as on authority script and have been released in bulk by the pharmacist instead of staggered amounts.

4. Roles and Responsibilities

When the need for subcutaneous medications is established, the palliative care RN is to:

- discuss with the patient and carer their choices to establish their willingness of administration.
- undertake an evaluation of a carer's preparedness to administer PRN subcutaneous medication.
- the palliative care RN is to discuss with the patient and carer their right to change their mind at any time regarding medication administration.
- prior to consultation with GP.

When the carer's willingness to administer the subcutaneous medications is established, the palliative care RN is to consult with the General Practitioner (GP) to:

- discuss signs and symptoms, medication management and to document plan of care.
- discuss client wishes regarding choice of preferred place of care and death.
- inform of the client and carer's willingness to administer medications.
- provide support and education to the carer(s) to promote safe handling and confidence with care.

To promote the safe use, storage and disposal of medications the palliative care nurse will:

- complete a carer evaluation is attended to identify carer's preparedness to administer subcutaneous medication as per an evaluation of Carers Preparedness to Administer PRN Subcutaneous Medication, includes Pre-education confidence rating. Refer to Page 1 of the Subcutaneous Medication Carer Education Checklist, attached in Appendix 8.
- discuss any concerning issues arising from the evaluation of the carer's preparedness with the GP and Nurse Manager to establish direction of management plan. Additionally, these concerns need to be further discussed at Clinical Handover to establish an appropriate plan of care.
- provide the GP with a letter identifying the carer(s) role and educational outcome regarding confidence with medication; and any outcomes of concern.
- The RN is to attach the medication order to the letter for the GP's information. Documentation in the health record regarding carer education: see WACHS Medication Prescribing and Administration Policy, section 5.9.
- Once the nurse has completed assessment to file records in the patient notes.

Equipment for utilisation by Registered Nurse

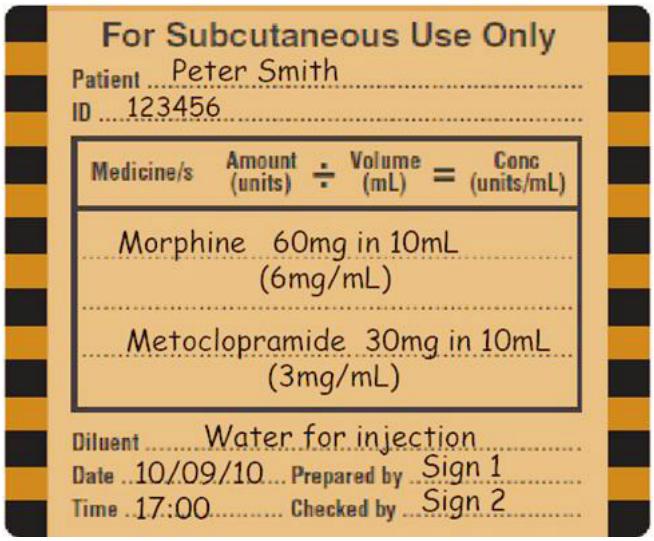
- The appropriate equipment is to be provided in the home to be utilised by the Registered Nurse (RN): as per Australian Pharmaceutical Advisory Council (APAC).
- Appendix 8A: Storage of Medications.

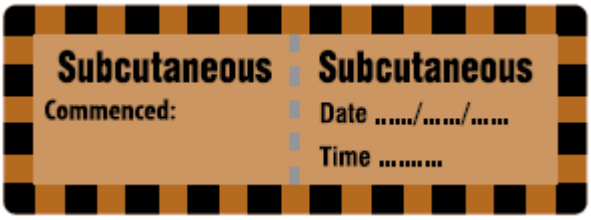
- A Subcutaneous Infusion Pump Box with infusion equipment including the subcutaneous beige coloured labels for the Infusion syringe and/or line as per the National Standards for User-applied Labelling of Injectable Medicines, Fluids and Lines 2015.
- Nurse's locked / coded box for 'patient's own' infusion pump medications – RN to keep key / aware of code.
- Medication Colour Coding and Stability Chart – laminated.
- A spare Subcutaneous Infusion Pump.

Equipment to be provided in the home to the carer

- Carer(s) locked / coded box – for patient's own PRN medications – carer(s) to keep key / code.
- Injection equipment supplies, includes user-applied labels for use on syringes containing drugs. (National Standards for User-applied Labelling of Injectable Medicines, Fluids and Lines, 2015.)
- Medications and Symptoms Chart Colour-Code for inside lid of locked box- laminated.
- Preparing and Giving a Subcutaneous Injection 10 Step Plan – Using a Blunt Needle Technique – laminated.
- Step by Step Guide Opening and Drawing Up from an Ampoule – laminated.

Please Note: The large beige Nationally Recommended User-applied labels are to be attached to the subcutaneous pump infusion syringe only. They are **not appropriate** for PRN injections labels. The smaller beige label is for the infusion line.





Carer education is undertaken as per the Subcutaneous Medication Carer Education Checklist, Appendix 8A, pages 2-6. Includes post – education confidence rating.

Review and monitoring of patient's condition and carer education is to be undertaken at each visit. The carer is to receive advice on possible side effects / adverse reactions, and how to respond. The carer is supported by the on call twenty-four-hour, seven day per week access to the Palliative Care RN via the reginal on call system.

The Variation Form (Appendix 9) is to be completed and variances discussed at Clinical Handover. The frequency of visits is to be determined as per clinical care plan determined through case discussion/ peer review and/or clinical handover processes.

The Palliative Care RN is to:

- encourage the carer to utilise the after-hours telephone support for ongoing education and information to address any concerns or problems.
- check all drawn, labelled medications for discolouration, cloudiness and precipitation as per attached Appendix 1.
- discard any suspect medications and record this in the medical record.
- check medication orders and remaining stock at each home visit and reorder as necessary.
- excess medication is to be returned to the patient's pharmacy (the pharmacy is to retain bulk of medication if suitable for patient location).
- assess patients potential PRN medication needs and supervise the carer to draw up the anticipated required amount of medication for effective timely symptom control until the next home visit.
- check battery charge on the Subcutaneous Infusion Pump and check the Nurses and Carer(s) Locked Boxes, and the Pump Box to ensure adequate stock of batteries.
- ensure all staff (especially on-call staff) are informed about the patient status and any concerns for the carer at morning and afternoon Clinical Handover.
- ensure 'on call' information is updated daily.
- encourage family to take any unused drugs back to their pharmacy as soon as possible. Inform the family of their responsibility to return surplus medication to pharmacy as per APAC 2006 Appendix 8A: Disposal of Medications.
- Recorded schedule 4 and schedule 8 injectable medications, when no longer required are returned to pharmacy and counter-signed to confirm the balance to zero.

5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

Annual audit utilising Appendix 10: Clinical Audit Tool:

1. The number of patients who choose to die at home.
2. Number of patients who received PRN subcutaneous medication at home.
3. The number of carers who declined to administer SC medications.
4. Number of incidents, medication errors.
5. Total number of patients with choice who died at home.
6. Total number of patients who died in hospital despite home choice.
7. Number of days on the service that patients received SC medication from carers at home.
8. Number of days in hospital by patients who did not continue care at home.
9. Percentage of days in hospital to total days at home of patient participants.

8. Standards

National Safety and Quality Healthcare Standards: 1.1, 1.13, 2.2, 4.1, 4.3, 6.1
National Standards for User-applied Labelling of Injectable Medicines, Fluids and Lines 2015

9. Legislation

Medicines and Poisons Act 2014 (WA)
Medicines and Poisons Regulations 2016 (WA)
Voluntary Assisted Dying Act 2019 (WA)

10. References

1. Anderson, B & Kralik, D. 2008. Palliative Care at Home: Carers and medication management. Palliative and Supportive Care. Vol.6, 349-356.
2. Anderson, B & Kralik, D. 2008. Sterility, Stability and Potency of Medications Administered by Carers in Home-Based Palliative Care. RDNS Research Unit. Issue 51, May 2008.
3. Australian Commission on Safety and Quality in Health Care (2015) National Standards for User-applied Labelling of Injectable Medicines, Fluids and Lines, ACSQHC, Sydney.
4. Australian Pharmaceutical Advisory Council (APAC): Guiding Principles for Medication Management in the Community 2006; Guiding Principle 2: Self-Administration; Guiding Principle 8: Storage of Medications; Guiding Principle 9: Disposal of Medications.

5. Caring@home project. A practical handbook for carers: Helping to manage breakthrough symptoms safely using subcutaneous medications. 2018 Brisbane South Palliative Care Collaborative.
6. Guidelines for the Subcutaneous Administration of Common Palliative Care Medications. Caritas Health Group Copyright 2004 Capitol Health Pharmacy Department. www.palliative.org/PC/ClinicalInfo/scchartFeb05.pdf
7. Healy, S; Israel,F; Charles, M; & Reymond, L. Supporting Carers of People Requiring Palliative Care at Home. Final report. Australian Government department Health and Ageing. May 2010
8. Palliative Care Australia Standards for Providing Quality Palliative Care for all Australians: 2005 Standards; 1,2,5,6,11.
9. Palliative Care Expert Group. Therapeutic Guidelines: Palliative Care. Version 4. Melbourne: Therapeutic Guidelines Limited; 2016.
10. International Organization for Standardization. User-applied labels for syringes containing drugs used during anaesthesia – colours, design and performance. 1st edition. ISO 26825:2008(E). Geneva: ISO; 2008.

11. Related Forms

Nil

12. Related Policy Documents

WACHS Medication Prescribing and Administration Policy
WACHS Voluntary Assisted Dying Policy

13. Related WA Health System Policies

MP0154/21 Managing Voluntary Assisted Dying Policy

14. Policy Framework

Clinical Governance, Safety and Quality Policy Framework

15. Acknowledgments

1. Brisbane South Palliative Care Collaborative
2. Cessnock Kurri Kurri Singleton

16. Appendices

Appendix 1 - Medication Colour Coding and Stability Chart
Appendix 2 - Medications and Symptom Chart - Colour Coding
Appendix 3 - Equipment for Medication Safety in the Home
Appendix 4 - GP Notification Letter
Appendix 5 - Preparing and Giving a Subcutaneous Injection
Appendix 6 - Guide to Opening and Drawing from an Ampoule
Appendix 7 - Equipment for Subcutaneous Infusion Pump Boxes
Appendix 8 - Carer Education- Evaluation of Carer's preparedness to Administer PRN Subcutaneous Medication
Appendix 8A - Subcutaneous Medication Carer Education Checklist
Appendix 9 - Post Education Rating
Appendix 10 - Clinical Audit Tool

This document can be made available in alternative formats on request for a person with a disability

Contact:	Clinical Lead Palliative Care Program		
Directorate:	Nursing and Midwifery Services	**TRIM Record #**	ED-CO-15-71052
Version:	3.00	**Date Published:**	1 September 2021

Appendix 1: Medication Colour Coding and Stability Chart

The following table is a guide based on the storage of medications for subcutaneous use by carers in palliative care home setting. The guide is based on medication stored in polypropylene syringes **with** interlink bungs on ends and **without** diluent.

The table is based on the medication stability reference site below.

The medications are colour coded as per *International Organization for Standardization. User-applied labels for syringes containing drugs used during anaesthesia – colours, design and performance.* 1st edition. ISO 26825:2008(E). Geneva: ISO; 2008.

Medication	Protect From Light	Store at Room Temperature	Notes	Stability: Number of days
Morphine	✓	✓		69
Metoclopramide	✓	✓		60
Midazolam	✓	✓		36
Glycopyrrolate	✓	✓		90 at 4-25C
Hyoscine Hydrobromide	✓	✓		Draw Daily
Hyoscine Butylbromide	✓	✓		Draw Daily
Dexamethasone	✓	✓		One (1) Draw Daily
Fentanyl	✓	✓		30
Haloperidol	✓	✓	Do **not** dilute	Unknown Draw Daily
Hydromorphone	✓	✓	Do **not** refrigerate	30 days diluted with Normal Saline

Appendix 2: Medications and Symptom Chart – Colour Coding

MEDICATION	SYMPTOM
Morphine or Hydromorphone	Pain, restlessness
Metoclopramide	Nausea & Vomiting
Haloperidol	Nausea, vomiting, agitation and vomiting
Glycopyrrolate or Hyoscine	Moist, noisy breathing
Normal Saline	Flush ½ ml
Midazolam	Agitation, restlessness
Dexamethasone	Drawn Daily – inflammation, pain

Source: International Organization for Standardization. User-applied labels for syringes containing drugs used during anaesthesia – colours, design and performance. 1st edition. ISO 26825:2008(E). Geneva: ISO; 2008.

Please Note:

This chart aims to simplify medication handling for the carers and reduce the risk of harm to the patient, and the carer. The chart does not determine the clinical judgement for the prescription of medications. The complexity of the individual patient symptoms remains the consideration of the General Practitioner in collaboration with the patient's specialist and the Palliative Care Nursing Team.

Appendix 3: Equipment for Medication Safety in the Home

- Subcutaneous Infusion Pump/storage of equipment– large box at rear.
- Nurses Locked / Coded Box - Black
- Sharps Disposal – Yellow
- Carer's Locked / Coded Box – Cream

Acknowledgment: Cessnock Kurri Kurri Singleton Palliative Care Hunter New England Health District

Appendix 4: General Practitioner Notification Letter

Attach Patient Sticker

Government of **Western Australia**
WA Country Health Service

_____Palliative Care Services

ATTENTION DR _____ DATE: _____

As per our discussion, the above patient / client has been prescribed PRN subcutaneous medication and the medical orders have been sent to your rooms for your signature. As it is the client and carer's wish to remain at home, we have discussed the carer(s) participation in the subcutaneous Medication Education Program, and agreed on evaluating the carer's preparedness to administer PRN subcutaneous medication for distressing symptoms.

The carer listed below has undertaken the subcutaneous Medication Education Program and found to be: **most confident** or **less confident** about their ability to administer PRN subcutaneous medications as prescribed in the attached medication order.

Carer name: _____

The Carer has agreed to: (Please tick)

☐ Participate with ongoing education and structural support
☐ Prior to administering subcutaneous medication, phone the on-call palliative care service
☐ Non-participation at this time due to: _____

Note: Complete one sheet for each carer.

Ongoing education and structured support are provided to enable care in the place of the patient's choice and to improve the safety of drug administration in the home setting. Participating carer(s) confidence to administer PRN subcutaneous medication is accessed regularly during home visits.

The carer is aware that they may change their minds at any time, and, if choices change we will contact you to discuss the patient's place of care options.

Please contact us if you have any concerns. Thank you for your support:

Doctor name: ..... Doctor signature: .....Date: .....

Nurse: ..... Designation: .....Date:.....

Signature: ..... Contact:.....

Appendix 5: Preparing and Giving a Subcutaneous Injection

Caring Safely at Home
palliative care education for caregivers

Preparing and Giving a Subcutaneous Injection
10 Step Plan – Using a Blunt Needle Technique

1. Wash your hands with soap and water and dry well.

2. Assemble the equipment in a clean container. You will need:

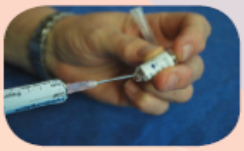
- Medication(s) ampoule(s) as well as normal saline for flushing
- Syringes
- Blunt drawing up needle(s) and small blunt needles
- Labels
- Alcohol wipe (optional)
- Sharps or hard walled container.

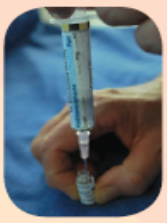
3. Attach the blunt drawing up needle to the syringe.

4. Open the plastic or glass ampoule.

5. Drawing up medication from an ampoule:

- Place the ampoule in a position that is comfortable for you, such as on a table, or turn the ampoule upside down. The medication should not come out of the ampoule when turned upside down
- Insert the needle into the ampoule
- Draw up the medication by slowly pulling back on the plunger of the syringe
- Once the medication is removed from the ampoule, hold the syringe with the needle pointing upright
- Flick the syringe with your finger to get all air bubbles to the top, then push the plunger up to expel the air bubbles from the syringe
- Slowly push the plunger of the syringe upwards until you have the correct dose/amount as instructed by the doctor/nurse
- Label syringe(s)
- Dispose of the ampoule directly into the sharps or hard walled container.





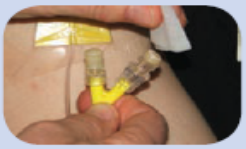
Developed by Brisbane South Palliative Care Collaborative with funding from the Australian Government Department of Health and Ageing - March 2011

Source: Brisbane South Palliative Care Collaborative Subcutaneous Medications and Palliative Care; A guide for caregivers

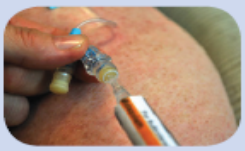
Appendix 5 continued….

6. Give the injection into the cannula:

- Take the prepared syringe(s) in a clean container, and a sharps or hard walled container to the person
- Rub the syringe between your hands if it has been in the fridge, as this will minimise stinging when injecting
- Check the injection site

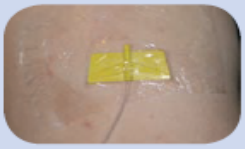


- Remove the drawing up needle and dispose of it into the sharps or hard walled container
- Place the blunt plastic needle on the end of the syringe using a twisting motion to secure it
- Swab the white rimmed cap at the end of the cannula with an alcohol wipe (optional)



- Push the blunt plastic needle into the centre of the white rimmed cap
- Slowly push the plunger of the syringe until the barrel is empty
- Remove the needle and dispose of it into the sharps or hard walled container
- Repeat the process as necessary. Flush the cannula with 0.5ml sterile normal saline.

7. Check the injection site for:



- Redness
- Tenderness
- Swelling
- Leakage.

8. Record the medication(s) given and check later that they have worked.

9. Safe storage and disposal of medication(s):

- Store medication(s) in a container in a cool place away from children and away from the view of the general public
- Store prepared labelled syringes in an airtight container in the fridge, either in a compartment in the door or in an out of the way position in the fridge; or as directed by your nurse

- Store sharps of hard walled container out of reach as directed by your nurse
- It is important to dispose safely of unused medication(s). Return unused medication(s) to your local pharmacist when they are no longer required.

10. Contact your nursing service / doctor if you have any concerns.

Contact details:_____

Developed by Brisbane South Palliative Care Collaborative with funding from the Australian Government Department of Health and Ageing - March 2011

Source: Brisbane South Palliative Care Collaborative Subcutaneous Medications and Palliative Care; A guide for caregivers

Appendix 6: Guide to Opening and Drawing from an Ampoule

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Step by Step Guide
Opening and Drawing Up from an Ampoule

Instructions

1. Wash your hands with soap and water and dry well.

2. Assemble the equipment in a clean container.

3. Attach blunt drawing up needle to syringe.

4. Opening an ampoule:
   a) For a plastic ampoule:
      • Simply twist the top of the ampoule until it is removed.

   b) For a glass ampoule:
      • Hold the ampoule upright with the pointed end at the top
      • Check all fluid removed from neck of ampoule
      • If not, gently flick the top of the ampoule until the fluid runs back into it
      • If there is a dot on the ampoule ensure the dot is facing away from you
      • Hold the ampoule in one hand, using the other hand to snap the neck of the ampoule away from you.

5. Drawing up medication from an ampoule:
   • Hold the ampoule in your non-dominant hand upside down at a slight angle or in a position that is comfortable for you such as on a table
   • The medication should not come out of the ampoule if you tip it upside down
   • Insert the needle into the ampoule
   • Draw the medication into the syringe by slowly pulling back on the plunger of the syringe
   • Once fluid is in the syringe, take the needle out of the ampoule.

6. Dispose of the ampoule directly into the sharps or hard walled container.

7. Point the needle to the ceiling, flicking the syringe with your index finger to get all air bubbles in the syringe to move to the top. Slowly push the plunger of the syringe upwards until you have the correct dose/amount as instructed by the doctor/nurse.

Developed by Brisbane South Palliative Care Collaborative with funding from the Australian Government Department of Health and Ageing - March 2011

Source: Brisbane South Palliative Care Collaborative Subcutaneous Medications and Palliative Care; A guide for caregivers

Appendix 7: Equipment for Subcutaneous Infusion Pump Boxes

Wipe box with anti-bacterial wipes after each client.

Item	Quantity	Checked √
Subcutaneous infusion Pumps	2	
Coloured stickers as per Australia / New Zealand Standard for use on syringes.		
Y connection (e.g. SAF-T-INTIMA)	4	
Palliative Care/Carer Education SC Meds		
Syringes Luer lock		
▪ 1mL	5	
▪ 2mL / 3ml	15	
▪ 5mL	4	
▪ 10mL	4	
▪ 30mL	5	
Infusion pump box		
▪ Additive label	20	
▪ Non-occlusive dressing (e.g. Opsite IV 3000 6cm x 8.5cm / Tegaderm IV 3M 7cm x 8.5cm)	10	
▪ Water for injection 10ml	5	
▪ Normal saline 10ml	10	
Infusion pump box		
• Ampoule breaker	1	
• Batteries	3	
• Minimum volume extension tubing	4	
• Red closing cap	10	
• 18G non bevelled drawing up needles (for carers and staff drawing up)	20	
• End cap (e.g. Alaris smart sites)	10	
• 25g S/C needle	4	
• Tape 2cm	1	
• Adhesive remover (e.g. Uni-Solve remover) wipes	5	

Appendix 8: Carer Education

Evaluation of Carer Preparedness to Administer PRN Subcutaneous Medication

These questions guide the Registered Nurse in evaluating the carer preparedness in administering PRN subcutaneous medications in the home. Pre-education rating to assess how the carer is feeling in regards to their confidence and ability.

Questions	Yes	No
Is the carer(s) willing to administer subcutaneous medication at home?		
GP aware and agrees to the carer giving the client PRN S/C Medication?		
Has the carer demonstrated understanding of the reasons for administering subcutaneous medication?		
Does the carer have any allergies? Any relevant health issues? Any cognitive impairment?		
Is the carer able to communicate their understanding of this procedure to you?		
Does the carer have any visual impairment that impedes their ability to perform this procedure?		
Does the carer have a history of drug use and/or abuse? Drugs of addiction prescribed or otherwise. Discuss with Team Leader/ Manager.		
Can the carer read the medication orders and ampoules?		
Is the carer able to open and close the carer(s) locked box? Carer(s) box to contain PRN S/C medications for breakthrough symptoms.		
Is the patient's GP aware of carer willingness and any issues of concern arising from this assessment?		

Please document any individual requirements or supports needed for the carer below, and discuss with Team Leader or Nurse Manager to develop management plan

_____

_____

Circle the number to measure how the carer is feeling about their confidence and ability pre-education.

1	2	3	4
Less Confident	Confident	Most Confident	Unwilling/unable

Circle the number to measure how the carer is feeling about their confidence and ability before education.

Name of carer: _____

Signature of carer: _____ Date: _____

Note: This tool is for use by nursing staff to access the preparedness of carer(s) to administer subcutaneous medication. It is to be used prior to the carer(s) Education Package and is underpinned by Palliative Care Nursing support.

Source: Palliative Care / Carer(s) Education SCMeds. – V4 October 2012

Appendix 8A: Subcutaneous Medication Carer Education Checklist for use by Registered Nurses

Government of **Western Australia**
WA Country Health Service

Care procedure Medication Safety for Palliative Carers at Home. A carer's ability and preparedness to administer medication is to be reviewed with the carer at each home visit.

Name of carer _____ Date: _____

Please tick each item as it is explained to the carer.

EQUIPMENT

Home File:

1.	If possible keep near the telephone	
2.	Emphasise the importance of the palliative care on-call phone number that is in bold print on the front of the file, how to use it and that we can be contacted 24 hours a day.	
3.	Explain if no answer from first call, phone again and explain to switchboard that you did not receive an answer from the first phone call, switchboard will escalate as per policy, to the CNC.	
4.	Go through the home file and explain how pain and symptom forms are used, S4s and S8s on the medication charts will be signed by the RN e.g. write down breakthrough medication on the Medicines-diary (caringathomeproject.com.au) as an accurate record.	
5.	Provide instructions: Preparing and Giving a Subcutaneous Injection and Step by Step Guide Opening and Drawing Up from an Ampoule.	

Carer and Nurses Locked Boxes:

6.	The sharps container and pump box are to be kept in a safe place, e.g. in a cupboard, up high away from children. Strictly only injection equipment is to be kept in all boxes.	
7.	Nurse's locked / coded box is to keep medication for the infusion and any excess PRN stock. Only the Palliative Care nurses are to have a key / code to this box.	
8.	Carer's locked / coded box is to store PRN medication for the carer to administer. Medications from community pharmacy can be kept in a high cupboard until next nurse home visit. Pump medications are not to be stored in carer's locked / coded box.	
9.	Locked / coded boxes, containing drugs, are to be stored at room temperature and not in direct sunlight.	
10.	The S4 and S8 medication chart is to be signed by the RN and the ampoule record sheet is to be kept in nurse's locked box and number of ampoules to be recorded at each infusion change.	

Appendix 8A: continued…

11. A list of colour coded medications and what they are used for can be found in the file for carer, on the Medication & Symptom Chart – Appendix 1 & 2.	
12. Explain the corresponding stickers for labelling of medication. The nurse will home visit depending on client stability to support carer medication draw-ups. An anticipated number of injections to be drawn each 24 hour period. Team discussions and clinical care planning will determine individual case management.	
13. The carer's locked / coded box key is kept in a safe place.	
14. Inform the carer that all unused medication is to be returned to pharmacy promptly if not required as per procedure.	
15. All excess amounts of medication are to be returned promptly to the pharmacy for safe disposal.	

Sharps Container – Shared With Carer(s)

16. The lid of the sharps container is to be kept **closed** to prevent risk of spillage and kept in a safe place away from children.	
17. Explain this container is for sharps such as needles and ampoules only. All empty syringes are to be placed in the rubbish bin.	
18. To close lid, place one hand on each side of the swinging black flap, there is a rounded mould which has to be pushed in, and this allows the lid to close. Then turn lock on front of the box. **Do not touch side locks. Dependent on the type of sharps container.**	

Pump Box - Contains Spare Infusion Pump and S/C Infusion Equipment

19. When not in use keep lid closed and keep in a safe place away from children.	
20. Familiarise carer and patient with equipment in pump box.	
21. Show and explain the spare infusion device.	
22. Ensure spare batteries, for the infusion, are stored on top tray. Batteries in the pump will only last 3-4 days. Reassure carer regarding RN checking battery each home visit. Demonstrate battery check procedure.	
23. Palliative care nurse will check and refill box as required.	

Appendix 8A continued…

How to Give Breakthrough Medication and Drawing Up Medications

24. Ensure carer(s) provision of hand washing with liquid soap, clean towel or paper towel. Discuss the importance of hand washing before commencing the procedure. Introduce visual tools as per equipment list point 5, page 23.	
25. Firstly familiarise patient and/or carer(s) with the drawing up needle (18 gauge with non-bevelled edge), 2mL/ 3mL and 10mL syringes.	
26. Explain aseptic technique infection control and why it is important not to touch ends of syringe and needle where they insert into each other.	
27. Explain how to use ampoule breaker using a safe technique.	
28. Encourage patient/carer to have a quiet place in the house when drawing up medication, this will assist them to concentrate and focus.	
29. Demonstrate how to draw up medication, discarding the drawing up needle into the sharps container and replacing it with a red closing cap.	
30. Demonstrate how to expel air from the syringe prior to placing the red cap on a syringe.	
31. Demonstrate how to clean the smart site with Alcohol swab and allow 30 seconds for it to air dry.	
32. Once carer(s) have been taught and they feel confident, ask them to show you how they would draw up medication and prepare to give the injection.	
33. Allow the carer(s) to practice injecting into a smart site and SAF-T-INTIMA teaching tool.	
34. The normal saline flush is always to be drawn up in a 10ml syringe and labelled normal saline **flush** ½ mL, date and initial, red closing cap on end of syringe - clearly differentiate it from other medications.	
35. Each normal saline flush is to be ½ ml.	
36. One (1ml) or three (3) mL syringes are used for all breakthrough medications	
37. All prepared syringes with medication must be clearly labelled: a) drug and dose b) date syringe prepared c) initialled and colour coded as per chart.	

Appendix 8A continued…

38. Advise carer(s) of drawn up medication patency as per procedure. Appendix 1. The nurse will check for discolouration and/or cloudiness each home visit.	
39. All medication to be stored out of direct sunlight at a temperature below 24 degrees Celsius	
40. Familiarise carer(s) with the PRN medication orders. Explain each medication's indication for use, its effect, and that it has been ordered by the GP	
41. Emphasise the need to write down all medication given to keep an accurate record with date, time, and dose, reason on the Medicines-diary (caringathomeproject.com.au).	
42. Teach carer(s) how to assess for pain (refer to pain scales) or other symptoms.	
43. Reassure carer(s) that the palliative care nurse will check cannula sites during each home visit.	
44. Reassure that the RN will liaise with the GP in regards to the patient's symptoms and condition as deemed appropriate.	
45. Discuss with patient and carer(s) their right to change their mind regarding participation at any time.	
46. Reinforce to phone palliative care when they are giving an injection so a nurse can provide support or information.	
47. Reassure that you will review, monitor, provide ongoing education and support with the carer education.	
48. Carer(s) to phone palliative care when: a) giving a breakthrough injection. b) at any time for information and support.	
49. Inform all unused medication must be returned to pharmacy promptly.	
50. Reassure carer(s) if they have any concerns, to use the afterhours on-call service. *Palliative care is only a phone call away.*	
51. Inform carer(s) they can change their mind at any time, including preferred place of end of life care.	

Appendix 9: Post Education Rating

Patient ID Label

POST EDUCATION RATING:

How is the carer feeling regarding their confidence and ability?

1	2	3	4
Less Confident	Confident	Most Confident	Unwilling/unable

Circle the number to measure how the carer is feeling about their confidence and ability post education. Inform client's GP of any changes to carer confidence as indicated.

Nurse Signature: _____ Date: _____

Review carer confidence weekly or as required, dependent on frequency of visits. Document further comments in the progress notes; plan for education and support.

Variation:

.....

.....

Sign: _____ Date: _____

Variation:

.....

.....

Sign: _____ Date: _____

Variation: .....

.....

Sign: _____ Date: _____

We acknowledge the Brisbane South Palliative Care Collaborative tools:
1. Instructions: Preparing and Giving a Subcutaneous Injection 10 Step Plan
2. Step by Step Guide Opening and Drawing Up from an Ampoule.

Appendix 10: Clinical Audit Tool

Criterion No.	Criterion	Exceptions	Definition of terms and/or general guidance	Data source	Frequency	Position Responsible
1.	The number of patients who choose to die at home.	family unsure		Patient medical record	Annually	CNC
2	Number of patients who received PRN subcutaneous medication at home by the carer.	None		Patient medical record	Annually	CNC
3	The number of carers who declined to administer SC medications.	None		Patient medical record	Annually	CNC
4	Number of incidents or medication errors.	None		Datix CIMS	Annually	CNC
5	Total number of patients with choice who died at home.	None		Patient medical record WebPAS	Annually	CNC
6	Total number of patients who died in hospital despite home choice.	None		WebPAS and patient medical record	Annually	CNC
7	Number of days on the service that patients received SC medication from carer(s) at home.	None		Patient health record	Annually	CNC
8	Number of days in hospital by patients who did not continue care at home.	None		WebPAS and patient medical record	Annually	CNC
9	Percentage of days in hospital to total days at home of patient participants.	None		WebPAS and patient medical record	Annually	CNC