National Framework for Medicines Management in Disability Services

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Glossary of terms

Administration
The process of giving a dose of medicine to an individual or an individual taking a medicine.

Advocate or Representative
A person nominated by an individual adult or by the family of an individual child to speak or take action on their behalf, ensure the wished of the individual is communicated.

Represent the preferences of the individual, involved in promoting the health, welfare or wellbeing of the resident.

Consent
The process of giving permission to a medical treatment or service based on sufficient information given to an individual.

Dispensing
The process starting from the receipt of prescription from prescriber, to the collection of the medicine. It is carried out by the pharmacist, who selects and supplies the correct medicine, labels and records medicines, and provides advice or information.

Healthcare professionals
Healthcare professionals are clinical staff at the point of support including but not limited to medical, nursing, and pharmacy professionals (adapted from HIQA, 2017).

Individuals
Term used to describe person who uses a service or support in a disability service. It is used instead of consumer, client, or service user.

Medicine Administration Record (MAR)
The MAR is an accurate record and instructions for use of all medicines prescribed and used by individuals. It is an instruction to administer and a record of administration. The MAR is used to support safe prescribing and administering, between different staff, family members, and service settings.

Medicine or Medicinal Product
Any substance or combination of substances used for treating or preventing disease in human beings. It is also any substance or combination of substances which may be administered to human beings either to restore, correct or modify physiological functions by exerting a pharmacological, immunological or metabolic action, or to make a medical diagnosis.

Prescription
A document meeting all legal and regulatory requirements to instruct a pharmacist to dispense one or more medicinal products for use by a specified individual.

Prescription-only medicine may only be dispensed on foot of a valid prescription. These medicines are listed in Schedule 1A or 1B of the Medicinal Products Regulations (Prescription and Control of Supply) 2003 and amendments, medicines for parental administration (an injection or infusion) or which is or contains a new chemical molecule.

Pro re nata or PRN medicines
“Pro re nata” is a Latin phrase used to describe medicines that are administered as required or as the situation arises. PRN are temporary medicines prescribed for a short term/irregular condition. For example, periodically taking paracetamol for a headache if required.

Self-administration
The action of an individual who has a central and active role in administering the medicines to themselves.

Service Provider
A service or organisation providing supports to individuals with disabilities.

Staff
Staff includes those defined in the Health and Social Care Professionals Act 2005 such as social care workers. Staff also includes those who work in social care including but not limited to healthcare assistants and Care Assistants (ID) (adapted from HIQA, 2017 and HCA independent report 2018).

1. Introduction

1.1 Purpose

Development of the framework was guided by the HSE Disability Services Community Operations: Medicines Management Steering Group. The group comprises representatives of key stakeholders including individuals with disabilities, relevant health, social care and education sector professionals, regulators, and voluntary organisations.

The purpose of this framework is to provide guidance on medicines management for staff working in disability services and is intended to be used by service providers when developing or revising their own local medicines management policies. This framework is in line with existing legislation and Health Information and Quality Authority (HIQA) regulations. This document references and uses terminology from the document "*Disability Services: Medication Management Framework*" by the Tasmanian Government (Department of Health and Human Services, 2017) with their permission.

1.2 Methodology

The following framework is supported by a literature review on medicines management in intellectual disabilities which was commissioned by the steering group and conducted by Trinity College Dublin. The "*Guidance on Policy and Guideline Development of Person-centred Medication Management*" which was written by National Federation was also reviewed in detail (NFVB, 2009). Sub-groups within the HSE Disability Service Community Operations: Medicines Management Steering Group also conducted three literature reviews; firstly, for the assessment tool, secondly for the educational guidance, and thirdly for medicines management for physical/sensory disability services. The literature was compiled with assistance from a HSE librarian. All literature reviews are available upon request.

An initial meeting was held in April 2017 to identify stakeholders and the first meeting of the steering group was held in July 2017. The steering group comprised of representatives from the regulators, older persons services; representatives from GPs, nurses, pharmacists, social care workers; representatives from both the HSE and voluntary bodies; national disability services; and the confidential recipient.

It was identified that there were four streams of work which would each require a working group. Working groups comprised of specialists in each area and were formed to develop the sections on: governance, prescribing, assessment, and education and training. The governance group developed Appendix 1 which identifies the necessary structures, processes, standards, and oversights that need to be in place to ensure that safe, person centred and effective services are delivered (HSE, 2016). The prescribing group developed guidance for pharmacists dispensing medicines to individuals. A sample Medicine Administration Record

template is provided in Appendix 2. A working group developed an assessment tool to assess the types of support required and identified areas for capacity building to enable individuals to self-administer medicines where possible. The assessment tool can be found in Appendix 4. The education and training group developed national guidance of core (evidence-based) learning for safe medicines management by staff based on this document. Providers of this training must be accredited by the QQI and the training must be delivered by staff that have studied pharmacology in their primary degree. The component module must be accredited by QQI at a level 5.

Legal advice was sought to identify if there were any legal barriers based on Irish and European law that would prevent the "service provider" being the entity responsible for assigning medicines management to any staff. The legal advice confirmed that there are no references in the legislation and regulations to prevent this course of action.

In July 2019, a draft version of the framework was sent to a number of service providers, organisations, and regulators as part of the initial consultation process. A total of 14 responses were recorded and their feedback is reflected in draft 15, the first version of the document. Furthermore, advice was sought from key regulators to include the Nursing and Midwifery Board of Ireland (NMBI), Mental Health Commission (MHC), Health Information and Quality Authority (HIQA), and the Pharmaceutical Society of Ireland (PSI).

1.3 Scope

The framework applies to all services providing supports to individuals with a disability that are directly provided or funded by the HSE. This includes children and adults in residential services, day services, respite services, and home-based services. Approved centres regulated by the Mental Health Commission are not included in this guidance and should adhere to the Mental Health Act 2001, Section 4.

The information outlined in this document applies to children supported by disability services. While specific considerations are required to administer medicines to children, they should be encouraged to develop their capacity to manage their own medicines under appropriate supervision.

For the purpose of this document, the following definitions apply:

- **Individual** refers to a person who uses a service or support within disability services. Individual is used instead of terms such as consumer, client, or service user (Department of Health and Human Services, 2017).
- **Staff** includes those defined in the Health and Social Care Professionals Act 2005 such as social care workers. The role of healthcare assistants (Care Assistant – ID) is an evolving one as recommended in the *Review of the Role and Function of Healthcare Assistants (2018)*, and medicines management is considered to be an element of career development for this grade.
- **Healthcare professionals** are the clinical staff at the point of support including but not limited to medical, nursing, dieticians, speech and language therapist, and pharmacy professionals (adapted from HIQA, 2017).

1.4 Defining medicines management and administration

Medicines management covers a number of tasks including prescribing, ordering, dispensing, receiving/transporting, storing, assessing, preparing, assisting, administering, disposing, and reviewing individuals with their medicines (HIQA, 2015). It also includes medicines reconciliation. Medicines administration can involve preparing the medicines, giving it to the individual/ and or the individual takes it themselves; placing the medicine into their mouth, placing drops into the individual's eye/ear or applying a medicinal cream or ointment. Administration is the process of taking or giving a medicine either by staff or individuals themselves.

1.5 Medicinal products

A medicinal product is any substance or combination of substances which have the properties to treat or prevent disease in human beings. It is also any substance or combinations of substances which can restore, correct, or modify physiological functions by exerting a pharmacological, immunological or metabolic action, or to making a medical diagnosis (HPRA, 2017).

From this point forward, the term "medicines" will be used in this document instead of drugs and medication when referring to medicinal products. Medicines can come in many different forms: tablets, patches, capsules, creams, liquids, lotions, ointments, gels, suppositories, pessaries etc.

Medicines may include prescription medicines, over-the-counter medicines, medicinal products used for skin care and personal hygiene, vitamins, and supplements. Oral nutritional supplements and enteral feeding products are included in the context of this framework, and are treated in the same way as medicines.

2. Governance structure for medicines management

2.1 Organisational governance

The service provider (HSE directly provided or funded) is responsible for medicines management and ensuring that all staff and healthcare professionals involved in the management of medicines in its service are provided and supported with:

- A robust governance system,
- local policies and procedures that are aligned to this document,
- accredited training appropriate to their role,
- supervision.

In addition, the service provider must ensure:

- Concordance (willingness to participate rather than forced to comply or do) with legislation and licensing requirements
- Availability of timely, accessible, and appropriate medicines advice and information.

The ultimate accountability for medicines management lies with the service provider. See Appendix 1 for guidance on a robust governance framework.

2.2 Key principles in medicines management

Person-centredness

Medicines management should place the individual at the centre of planning in order to maximise their capacity to control and live the lives of their choosing. Individuals should be empowered and actively encouraged to exercise their right to decide on supports which includes medicines management (United Nations, 2006). Person-centred services involve multidisciplinary partnership between all those engaged in care and support.

Knowledge and skills

The service provider should ensure that staff and healthcare professionals have the knowledge, competencies, and skills to fulfil their role in driving quality care. In medicines management, it also involves educating and providing access to information to individuals being supported. Resources should be made available to individuals, staff, and healthcare professionals regarding medicines management that is accessible and appropriate.

Leadership and accountability

Leadership is about motivating people to a common goal and driving change to ensure safe, high quality delivery of health and social care. The management team should be clear about leadership, accountability, governance structures and their role for medicines management. The ultimate accountability for the designation of roles in medicines management lies with the organisation.

Information

Careful and intelligent uses of information to measure, monitor, and oversee the quality and safety of medicines management.

Culture

A culture of learning, person-centredness, and focus on the quality of supports is promoted throughout the organisation. A supportive culture that respects the dignity and autonomy of all individuals is in place.

Relationships

Organisations should promote strong relationships that partner staff and healthcare professionals with individuals to facilitate alignment of the entire organisation around quality of supports.

Quality improvement

There should be a quality improvement plan in place, developed in line with the Framework for Improving Quality and with national and organisational priorities.

In addition, a key principle in medicines management:

Safety

The identification, control, and mitigation of risks to achieve effective, efficient, and positive outcomes for individuals and staff is integral to safe medicines management. A positive safety culture is essential for improving medicine safety.

2.3 Risk and incident management

Good governance in healthcare and social care settings require established risk management processes to facilitate a strong risk awareness and innovative culture for medicine safety as well as ensuring the service provider meets legal, regulatory, and governance obligations.

Proactive risk management can identify insidious medicine safety risks that could harm an individual as the complexity of some social care systems can often mask underlying medicine safety issues. Though a medicine error may not have yet occurred it is important to proactively assess isolated risks as well as identify system vulnerabilities across the service.

Effective leadership and building a positive safety culture are essential for improving medicine safety. This means promoting an environment where staff and individuals want to report risks and medicine incidents in order to learn from them, and where incidents are seen as caused largely by system failures rather than by individuals (WHO, 2016).

Guidance on risk and incident management is available from the HSE Incident Management Framework 2018 and the HSE Integrated Risk Management Policy 2017 (HSE, 2018; 2017).

2.3.1 Medicine incidents

Although most medicine incidents do not cause harm, some have caused serious harm and even death. Oftentimes, mistakes with medicines are caused by underlying problems with the system. Problems such as look-alike labels, confusing equipment and poor handwriting can lead to mistakes. When an incident is first identified, there are a range of factors to consider and steps that should be taken to minimise risk to individuals:

1. Assess the individual: Has the medicine reached an individual? If so, have they come to any harm? Where there is concern that an individual has or could experience any harm, they should be reviewed by a doctor or nurse as appropriate and their treatment monitored to minimise any adverse effects.

2. Inform the individual: explain to the individual that they have been involved in a medicine incident. Guidance for staff is available in the HSE Open Disclosure Policy (HSE, 2019).

3. Take action: take action to prevent the incident recurring. When a medicine incident has been identified it is often apparent that something needs to change urgently. For example, if a standard operating procedure is incorrect and has contributed to an incident then it must be changed immediately. Temporary measures put in place initially may be revised once a full investigation and implementation of lessons has taken place.

4. Report the incident: medicine incidents should be recorded as soon as possible after the event so that all relevant information can be obtained. Reporting systems should be available to staff and they should be familiar with their use, so that lessons will be learned across the system.

5. Inform staff: inform any staff involved as soon as possible. They will be able to recall the events leading up to the incident with greater clarity if they do so soon after the event. It also offers the opportunity to reassure staff members that they did not intentionally make a mistake and that it is probable that a colleague, if presented with the same set of circumstances, could make the same error. People who have been involved with medicine incidents may suffer a drop in confidence in their work and should be encouraged to discuss the incident with a line manager, mentor or senior colleague.

2.3.2 Incident reporting

All HSE and HSE funded services and most pharmacies and general practitioners have their own systems for recording and managing patient safety incidents. Incidents that occur in HSE and HSE funded services will be reported on the National Incident Management System (NIMS) and or to the Health Products Regulatory Authority (HPRA).

A key component of safe care is to have a strong reporting culture, in which members of staff have an active awareness of the potential for things to go wrong and where reporting incidents is openly encouraged. A review of medicine incidents reported in Irish hospitals by the Clinical Scheme in the State Claims Agency (2016) found that there was a significant under reporting of medicine incidents onto NIMS.

The reporting and review of medicine incidents highlight where systems or standard operating procedures need to improve or when written information or training should be refined.

Thematic analysis of pooled medicine incident reports can be used to identify patterns in the occurrence of incidents. This can be then used to generate individual safety alerts and/or changes in practice, to prevent similar events occurring elsewhere in the service.

3. Roles and responsibilities in medicines management

3.1 All parties

- Adhere to the key principles as listed in "2.2 Key Principles in Medicines Management" of this document
- Co-operate to ensure safe and responsible management and use of medicines
- Reflect on practices and recognise problems when they arise and initiate interventions to improve practice
- Comply with legislation and local policies of the service provider.

3.2 Individuals with disability

- Collaborate with staff and healthcare professionals to enhance knowledge about their own medicines where possible
- Seek support if problems arise
- Understand where possible, the scope of support provided by staff and do not request them to act outside of their scope of responsibility
- Ask for information, resources, and services to make informed decisions that will enable safe and effective medicines management.

3.3 Advocate or representative

- A person nominated by an individual adult or by the family of an individual child to represent or take action on their behalf to ensure the wishes of the individual are communicated (Government of Ireland, 2015)
- Represent the will and preferences of the individual
- Promote the health, welfare, and wellbeing of the individual.

3.4 Service provider

- Develop and implement local policy and structures to effectively support good medicines management which includes organisation-designated responsibilities for medicines administration, or support of individuals to self-administer medicines. This

includes ongoing education and training in medicines management for staff who are administering medicines.

- Comply with existing legislation and regulations (HIQA, 2013)
- Ensure that each service area prepares individualised assessments and person centred care plans
- Maintain training records
- Support a positive safety culture that encourages reporting and learning from incidents and near misses
- Provide clear information for employees about contacting more senior staff for assistance in case of unexpected events or if uncertainty arises
- Create a supportive culture in the workplace to enable staff to feel confident, assured, and supported
- Regularly review and evaluate policy and practices, reforming where required
- Ensuring relevant staff undertake the Quality and Qualifications Ireland (QQI) accredited, Level 5 training in medicines management.

3.5 Social care workers, healthcare assistants and healthcare professionals working within the service

- Understand the local policy, procedures, and support systems of their service provider in relation to medicines management
- Participate in assessment and reassessment of own competence in accordance with organisational policy
- Where appropriate, support individuals and administer medicines according to the directions on the packaging or the dispensing label provided by the pharmacist
- Use the medicine administration record to reduce risk of error
- Reflect on personal skills, knowledge, and limitations. This includes understanding the scope of their roles and responsibilities
- Inform their employers if they are uncertain or do not feel confident in performing certain tasks
- Understand and operate within the scope of their role, code of conduct and legislative framework as relevant to their role
- Practice safely and effectively

3.6 Healthcare professionals working in the community (e.g. nurses, doctors, pharmacists)

- Liaise with the individual and those supporting the individual as appropriate, in order to ensure safe medicines management and use

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- Communicate with staff in the service, where relevant, in order to understand the relevant systems of the service provider in relation to medicines management
- Prescribe (doctors, nurses) and dispense (pharmacists) in accordance with legislation, regulation and relevant quality standards and provide documentation e.g. MAR as agreed with the service
- Work with individuals to provide information to maximise their ability to understand and manage their medicines
- Review medicines to ensure appropriate use at regular intervals, as appropriate for the situation and as agreed with the individual and/or service

4. Medicines management

4.1 Prescribing

A prescription is a document meeting all legal and regulatory requirements to instruct a pharmacist to dispense one or more medicinal products for use by a specified individual. Prescription-only medicine may only be dispensed on foot of a valid prescription.

Each prescription must be in ink (typed or handwritten), dated and signed by the prescriber in their usual signature. Prescribers need to use clear and legible writing as this is often an issue where staff cannot decipher the writing on the prescription on the chart. Prescriptions must state the individual's:

- name
- address
- age and weight of child if under 12 years old
- a list of the medicines with instructions for use
- name of prescriber
- job title of prescriber
- medical council number of prescriber (doctor)

Temporary legislation for Covid-19 allows for prescriptions to be sent from a prescriber to pharmacy via Healthmail. In this situation a signature is not a requirement as Healthmail is a closed system. All other prescription requirements are still required.

Prescriptions may also need to fulfil requirements for reimbursement purposes under a number of government schemes e.g.: General Medical Scheme, Long Term Illness Scheme, High-Tech Scheme, Drug Payment, Health Amendment Act. For some specified medicines, an individual will require reimbursement approval before receiving medicine under the community drug schemes. Details of reimbursement items are available on the HSE Primary Care Reimbursement Service website.

Where changes to an individual's medicines are made while a prescription is still valid, these changes should be made to an updated prescription(s).

Prescriptions must be issued by a registered medical practitioner, dentist, or registered nurse prescriber and must fulfil all legal and professional requirements for prescriptions (Government of Ireland, 2003).

The prescriber should assess with the individual their need for a medicine, the risk and benefit of medicine options and the individual's preferences and previous experiences with medicines (e.g. allergies, adverse reactions, inability to use a device). This includes assessing

the condition, the evidence base governing appropriate treatment, the presence of contraindications or cautions to the medicine, interactions or duplications with existing medicines and the safety profile of the medicine.

The individual's other medicines must always be considered if a new medicine is being added. De-prescribing and changes to other medicines should always be considered when a new medicine is being added.

4.1.1 Prescribing controlled drugs

Prescriptions for controlled drugs have specific legal requirements. Refer to legislation and regulation, e.g. Medical Council and Pharmaceutical Society of Ireland Joint Guidance:

https://www.medicalcouncil.ie/News-and-Publications/News/2017/Items/Cafe-Prescribing-and-Dispensing-of-Controlled-Drugs.pdf

Temporary legislation for Covid-19 allows prescriptions for controlled drugs to be sent to pharmacies via Healthmail.

4.1.2 Prescribing as required (PRN) medicines

PRN medicines are prescribed to treat short term or intermittent symptoms or conditions, and are not to be taken regularly. However, if PRN medicine is given regularly then a referral to the prescriber should be considered in order for a review of the individual's medicines be clinically assessed against their medical condition as it may have changed and a clinical decision may be required as the treatment may need to be altered. The PRN prescription should clearly state:

- The exact reason for medicine to be administered
- Initial dosage
- Timing of respective doses
- Maximum dosage in a 24-hour period (HIQA, 2015)

4.2 Ordering, collecting, and receiving medicines

Individuals have freedom of choice in relation to their pharmacist and where their medicines are dispensed (HIQA, 2015). Orders should in all cases be supported by a prescription and also a document of supply and receipt. A physical hard copy of a prescription must accompany any orders for prescription only medicines to avoid any doubt. *Temporary legislation for Covid-19 allows for prescriptions to be conveyed via Healthmail to the pharmacy. A local procedure should be introduced to manage safe supply if a physical hard copy is not used in this context.* Documentation can include ordering by paper or electronic means. All orders placed must comply with General Data Protection Regulation (GDPR) and respect the need

for confidentiality of individuals' medicines needs. Individuals should be encouraged to collect and receive their medicines themselves where possible and with the support of staff.

Orders should identify who has placed the order, their status, their location, and their contact details in addition to the item of medicine to be ordered and any other information required by local policy.

Medicine receipt and storage may be subject to legislative and professional regulation, depending on the setting the individual is living in. There must be a clear hand-over process to the staff or healthcare professional, when the medicine is received and may vary depending on the service. This includes day services, respite, holiday breaks etc. This must be included in local policy and procedure for medicines management. The policy should include a process for checking medicines when received from the pharmacy, signing for the medicine if applicable, and record-keeping of receipt of medicines. Safe, secure tamper proof containers should be utilised to transport medicines where the individual has been assessed as not having the capacity to safely transport their medicines. This is regardless of the route by which medicine arrives at the facility, usually via pharmacy supply chain. In some services such as respite services, it may be via the individual, or individual's family or directly from wholesalers.

4.3 Dispensing medicines

Dispensing involves the complete process which occurs from the receipt of the prescription or request at the pharmacy, to the collection of the prescribed item or medicine by the individual or their representative. In some settings, there may be a stock order from a pharmacy, e.g. from a pharmacy (in-house or community pharmacy) for supplies for residential care areas. Where this is applicable, a local policy should be in place.

Before dispensing medicine, and before the supply of any medicinal product that has been prescribed, it is a statutory requirement that a registered pharmacist must review the prescription having regard to the pharmaceutical and therapeutic appropriateness of the particular medicine therapy for the individual, including the use by the individual of any other medicines etc. that the pharmacist is, or ought to be reasonably aware of. The pharmacist must also ensure that the medicines dispensed are suitable for use for the duration of expected use (e.g. expiry date is beyond the period dispensed for).

Following completion of the above mandatory review, the registered pharmacist must ensure that the individual or the staff has sufficient information and advice for the proper use and storage of their prescribed medicines. In doing so, the pharmacist must offer to provide individual counselling to each individual or to their carer on the occasion of each supply of the medicines concerned. The pharmacist must also offer to discuss with each individual, or with the staff, all such matters as the pharmacist, in the exercise of his or her professional judgement, deems significant.

The original prescription must be physically present in the pharmacy and be reviewed by a pharmacist before the medicinal product is dispensed. The pharmacist keeps the original prescription. Where a Medicines Administration Record (MAR) is in use for an individual, a clear copy of the prescription should be given to the person collecting the medicines, and this copy should be attached to or stored with the individual's MAR for reference.

To maximise safety in medicines management, the pharmacist should provide advice, consultation, and information leaflets where appropriate to ensure that staff and the individual have sufficient information for the proper use and storage of their prescribed medicinal products.

Dispensing labels provided by the pharmacist must indicate:

- The name of the individual
- Product name
- Directions for use
- Precautions
- Date of dispensing
- Address where product is dispensed
- Keep out of reach of children
- If relevant: for external use only

Schedule 1A medicinal products may usually be dispensed on one occasion only. If repeats are specified, the product may be dispensed up to a maximum of six months.

Schedule 1B medicinal products may be dispensed for a maximum of six months unless the prescription indicates otherwise (S.I. No. 540/2003 - Medicinal Products (Prescription and Control of Supply) Regulations 2003).

Schedule 2 and 3 controlled drug prescriptions must be dispensed within 14 days of the date of the prescription. If dispensed in instalments, the first dispensing must be within 14 days of the date on the prescription and the last instalment is no later than two months from the date of the prescription.

Schedule 4 part one, controlled drugs (e.g. benzodiazepines and z-drugs) prescriptions may be repeated and the prescription is valid for a maximum of six months. There is no requirement to dispense within 14 days for these medicines.

4.3.1 Dispensing emergency medicines without prescription

Pharmacists are permitted to supply certain prescription only medicines without a prescription in emergency circumstances. This can be carried out at the request of the individual or the prescriber (Regulation 8 of the Medicinal Products [Prescription and Control of Supply] Regulations 2003 as amended).

Where the request for the emergency supply of medicine is made by the individual or on behalf of the individual by a member of staff or healthcare professional, the pharmacist must interview the individual and ensure that:

- There is an immediate need for the medicine
- It is not possible to obtain the prescription without undue delay
- The medicine has been prescribed for the individual on a previous occasion

The pharmacist then can safely specify the dose of the medicine for the individual. The medicines should be dispensed with the label including the words “Emergency Supply”. The reason for the emergency supply should be documented in the MAR and individual medicines record.

No more than a 5-day supply of medicines may be made, with the exception of:

- Aerosols for the relief of asthma, creams, or ointments, where the smallest available size may be supplied
- The oral contraceptive pill, where a full cycle may be supplied
- Liquid antibiotics, where the smallest quantity to complete a course may be supplied.

4.4 Record-keeping

All medicines that are administered to individuals with the support of staff or healthcare professionals should be recorded on the Medication Administration Record (MAR). The MAR is a document which contains the instructions for administration from the prescription(s) and a record of administration. The MAR must be kept up to date at all times.

If an individual administers their own medicines, a MAR may not be required. This includes individuals who self-administer but may require some physical assistance.

The MAR should contain (HIQA, 2015):

- ✓ Medicines listed on prescription
- ✓ Times of administration (must match the prescription)
- ✓ Signature of staff administering the medicine
- ✓ Space to record comments such as withholding or refusal of medicines

It should be an up to date list of all medicines an individual is prescribed. A copy of the active prescription(s) should always be attached to or stored with the MAR to reduce risk of error and allow cross checking and verification. **The MAR cannot be used as a prescription to order or dispense medicine. It contains a record of and instructions of administration, but it is not a prescription.**

There are three ways the instructions can be accurately filled on to the MAR:

The prescriber fills in the medicines information and instructions on the MAR, separately and in addition to the issuing of a legally valid prescription

The pharmacist dispenses the medicine and generates duplicate dispensing labels, attaching one label to the product and one to the MAR

The pharmacist dispenses the medicine and generates a MAR from a software package

A local procedure, developed in collaboration with prescibers and pharamacists, is required to standardise:

- Responsibilities and processes for generation of the MAR (using one or more of the above options)
- Responsibilities for and processes for updating the MAR when changes are made to the individual's prescription, or when the individual's reponse to medicines or other conditions make changes to medicines necessary. This will involve a new prescription, with the person responsible for generation the MAR instructions, generating the revised instructions.
- The processes to ensure there is one MAR in use at a time, that there is no duplication, and that arrangements are made to ensure the individal can receive medicine while their next medicine supply is being ordered or dispensed.

This must include local procedures to ensure the MAR is updated when changes are made. It must specify responsibilities for documenting new items and in particular, it must specify responsibilities for discontinuing medicines temporarily or permanently on the MAR.

Particular care is required to ensure that if a dose of a medicine is increasing or reducing gradually, the prescription, the label on the dispensed item, and the MAR must all correspond. For a pharmacist supported MAR, the service may need to ensure an alternative approach can be taken if medicine is supplied from a different pharmacy (i.e. out of hours). The service must ensure there is a procedure to manage copies of prescriptions which are no longer valid to reduce confusion (e.g. after a change in prescription).

Transcription of medicines instructions or adjustments by staff other than those responsible for preparing the MAR (prescriber or pharmacist) should be minimised and may only happen under the direction of a local policy. Where transcription takes place, the details should be checked, any queries raised and dealt with and co-signed by a second staff or healthcare professional. Refer to An Bord Altranais (2007).

4.5 Storage of medicines

Service providers must provide secure storage arrangements for medicines appropriate to the assessed needs of the individuals living in their home. In situations where individuals have been assessed as having the capacity to self-administer, their medicines do not need to be in a locked container. This is to encourage a home like environment.

However, in some cases, service providers will need to provide safe storage that is only accessible to the appropriate individual(s), staff and healthcare professionals. The storage of medicines must be secure and safe from unauthorised access. These areas should have enough space to allow for regular cleaning, date checking, and stock control. Such areas must be of a stable temperature and protected from light or dampness. The place of storage should not exceed 25°C. Staff who administer medicines should have a key to the storage cupboard or fridge. Access to keys should be addressed in the local policy. If Picture Identification Sheets are used, they should be issued by the pharmacist at the time of dispensing to ensure they are up-to-date and accurate.

It is good practice to store medicines in the original packs or containers in which they were dispensed. Medicines may also be stored in blister packs. Ensure the label remains legible and clearly dated, and should never be re-labelled. A nebuliser can be kept for individual use and stored in a labelled container; however, it must be let drip dry after washing in a safe place.

4.6 Storage of refrigerated items

Medicines that require refrigeration according to the packaging, labelling, or the pharmacist, should be stored in a refrigerator between 2°C to 8°C (HIQA, 2015). As stated previously, service providers must provide secure storage arrangements for medicines appropriate to the assessed needs of the individuals living in their home. This may include the need for a separate and locked fridge in some cases.

4.7 Storage of controlled drugs

Medicines should always be stored in a safe and secure manner. This applies to controlled drugs, or other drugs where there is potential for abuse, for example Tramadol, which should be kept in a secure storage cupboard or room where it will not be interfered with by any unintended persons or at the incorrect times. The safe storage and transport of controlled drugs should be in line with other drugs. All medicinal products should be recorded clearly to allow for transparency and accountability.

5. Supporting self-administration of medicines (assessing and assisting)

5.1 Assessing

The active involvement of the individual, including those who self-administer medicines and those who may require varying levels of supports should be promoted. The service provider's medicine management policy and individual's care plan should describe the education and capacity building of the individual and enabling strategies to help them to move on the continuum of self-management, for example communications tools, demonstration, visual prompts, phone reminders for those using phones etc.

5.1.1 Autonomy and informed consent in supporting medicines administration

Personal autonomy is the understanding that human beings should be respected, especially in relation to the individual's dignity, privacy, and choice (HIQA, 2016). The ability of an individual for self-determination according to their own values, morals, beliefs, and preferences should be considered when creating a person-centred plan for care and support.

Refusal of medicines occurs for various reasons and service providers should include robust guidelines for staff on how to manage such situations. Guidelines should include actions to be taken, who to contact, and the documentation to be completed (HIQA, 2015).

If an individual refuses to take their medicines it is important to recognise that right. In this event, the following must be implemented and documented:

- Monitor the individual's safety
- Ensure that information appropriate to the needs of the individual is given by a suitably qualified healthcare professional, explaining the risks and benefits of the medicine
- Explore the reasons for refusal including possible side effects endured, e.g. nausea, change in taste, mood change, loss of energy, unsuitable time of administration, difficulty in swallowing, etc.
- Explore possible alternatives and seek solutions based on reason for refusal
- Ensure refusal is documented in the individuals care plan
- Inform the prescriber and the General Practitioner
- Seek assistance of relevant healthcare professionals and external advocates

If the individual is assessed as not having capacity to understand or make informed decisions then the assistance of other healthcare professionals must be sought. It may be also necessary to seek legal opinion. The practice of covert administration of medicines is inappropriate except as a last resort in the case of individuals who actively refuse medicine but who are assessed not to have the capacity to understand the consequences of their refusal. This assessment must be carried out and documented by a multidisciplinary team and referred to the rights committee.

Informed consent is an important principle within respecting individual autonomy. Individuals can give consent, which means giving permission to a medical treatment or service. The individual must have sufficient information about the treatment, care, or support to give informed consent. The individual should understand the potential benefits or risks (National Consent Advisory Group, 2013).

5.1.2 Decision making

The 2015 Assisted Decision-Making (Capacity) Act (ADMA) provides a statutory framework for an individual to make legally binding agreements to be supported in making decisions about their welfare. This allows an individual to appoint someone to assist, co-decide, or to represent them to make a decision.

Each individual is presumed to have the capacity to make all decisions unless shown otherwise. Individuals can choose and register assistants and co-decision makers, while a representative must apply to court. Owners, registered providers, or employees of the individual's service provider cannot be named as assistants, co-decision makers, or decision making representatives.

Capacity is defined by the ADMA (2015) as "decision-making capacity" which is the ability to understand the nature and consequences of a decision. It should be underpinned by the context, time and awareness of choices that are available.

An individual may lack capacity to make a decision at a certain time but it can change over time, for a different decision or for a different medicine. Where possible and as long as it is safe, individuals should be encouraged to develop the knowledge, ability, and capacity to self-administer their medicine.

5.2 Assessment tool for self-administration of medicines

Appendix 4 Assessment Tool for Self-Administration of Medicines can be used to assess the supports required for an individual to facilitate the safe-administration of medicines. In the case where a person with a disability has capacity, they may complete the assessment tool themselves and discuss and agree supports with their staff. The assessment tool should be completed by the individual or the staff or healthcare professional who knows the individual best. Where an assessment is carried out by staff or a healthcare professional, the service provider is responsible to ensure appropriate training has been given to staff.

The assessment tool is used to assess the knowledge, ability, and capacity of individuals with regards to their medicines. The assessment will determine if the individual can self-administer

without support, self-administer with supports, or cannot self-administer medicines (Ohio Department of Developmental Disabilities, 2015). This is a dynamic process and categories of support can change over time and with different medicines, and the assessment should be reviewed frequently to reflect that change. Outcomes from the assessment tool will inform the "Individual Medication Management Plan" component of the individual's Personal Care Plan.

5.3 Assisting and administering medicines

Medicines can be administered by the individuals, healthcare professionals or staff depending on the self-assessment outcomes, which can vary with capacity training and other external factors. Administration is the process of giving a dose of medicine to an individual or an individual taking a medicine. In cases where healthcare professionals or staff support an individual with medicines administration, they must administer and assist individuals in line within their regulatory framework where it applies, and according to the individual's care plan, including the risk assessment, and will and preference(HIQA, 2015). The service provider must put supports and training in place to support staff to safely manage and administer medicines. Where there is a nurse available at the time of medicine administration, the nurse is the most appropriate person to administer medicines.

Types of support:

1. Prompting

The dictionary definition of 'prompting' is: 'the action of saying something to persuade, encourage or remind someone to do or say something'. In medicines management, prompting is encouraging or reminding the individual to administer their medicines.

2. Assisting

An individual may be able to retain control of their medicines but need assistance with mechanical tasks.

Assisting with medicines can include:

- ordering repeat prescriptions from the GP's surgery
- picking up prescriptions from the GP's surgery
- collecting dispensed medicines from the pharmacy
- bringing medicines to an individual at their request so that the individual can take the medicines.

Staff preparation:

- Wash and dry hands before commencing any administration of medicines
- Ensure all utensils to be used are clean and dry
- Establish the individual's identity
- Have water ready for the individual if it is needed
- Check individual's preferences relating to medicines administration

- Check the MAR (where used) that the previous dose was administered correctly, raise any discrepancies with line manager or person in charge and document this error.
- Check the label on the package for:
  - > Name of medicine
  - > Name of individual
  - > Dose to be administered
  - > Time and frequency of administration
  - > The expiry date
- Record the administration of medicine on the MAR (Department of Health and Human Services, 2017).

5.3.1 The ten rights of medicine administration

(NMBI, 2020)

1. Right patient
2. Right reason
3. Right medication
4. Right route
5. Right time
6. Right dose
7. Right form
8. Right action
9. Right documentation
10. Right response

See Appendix 3 for full description of each "Right"

5.3.2 Administering emergency medicines

Service providers are encouraged to consider potential emergency needs of individuals in their care and staff working with them.

It is recommended that an emergency prescription or protocol is developed by the prescriber for certain individuals as instructed by their care plan and that staff are trained in its use.

Where potential emergency needs of individuals receiving care from a service are possible, the service may wish to ensure that emergency medicine is available for administration by trained persons should the emergency arise. For example, the Pre-Hospital Emergency Care Council provides approved training courses for cardiac first responders and guidance for use of medicines which may be administered by trained persons. Where staff or healthcare professionals have been trained under such a programme, it is recommended that service providers outline arrangements for the procurement, storage, and administration of such medicine, without an individual prescription, to individuals in the event of an emergency.

5.4 Infection, prevention, and control (IPC) measures when administering medicines

Infection, prevention and control has always been an integral part of medicines management, but as a result of COVID-19 has become even more increasingly important. This section discusses the basic measures required to prevent the spread of any infection.

5.4.1 Hand hygiene

Standard precautions include hand hygiene before and after every episode of service user contact. WHO 5 moments:

https://www.who.int/infectionprevention/campaigns/clean-hands/5moments/en/

Clean hands using alcohol hand gel or soap and water, and dry with a disposable paper towel when you arrive at each house/room and before you leave each house/room and after any contact with the individual as per WHO 5 moments in Hand Hygiene.

Hand hygiene refers to any action of hand cleansing, such as hand washing with soap and water or hand rubbing with an alcohol based hand rub. Alcohol based hand rubs are the gold standard for hand hygiene practice in healthcare settings when hands are not visibly soiled. However, if hands are visibly soiled or have had direct contact with body fluids they should be washed with liquid soap for at least 20 seconds and running water then dried thoroughly with disposable paper towel (HSE, 2020).

5.4.2 Respiratory hygiene and cough etiquette

Cough and sneeze etiquette relates to precautions taken to reduce the spread of virus via droplets produced during coughing and sneezing. Individuals, staff and visitors should be encouraged to practice good cough and sneeze etiquette, which includes coughing or sneezing into the elbow or a tissue, and disposing of the tissue, then cleansing the hands.

5.4.3 Personal protective equipment (PPE)

Surgical masks should be worn by staff when providing care to individuals within 2 metres of them, regardless of the COVID-19 status of the individual.

Staff should wear surgical masks for all encounters, of 15 minutes or more, with other staff in the workplace where a distance of 2 metres cannot be maintained.

For more information on the use of PPE and IPC measures in disability services:

https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources/guidance-on-the-use-of-ppe-in-disability-services.pdf

https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources/right-based-guidance-on-the-management-of-ipc-risks-in-disability-services.pdf

5.5 Compliance aids

Medicines in compliance aids such as blister packs must be used in chronological date and time order. The pharmacy will advise if medicines are not suitable for use in a compliance aid.

5.6 Crushing or altering medicines

If an individual has difficulties swallowing medicines or is using a feeding tube, an assessment is needed to consider how each of their medicines should be given. Giving a medicine in an alternative form such as a liquid formulation, soluble tablet or suppositories is preferred where available. The pharmacist will be able to advise on alternative forms available, and the assessment may include other professionals such as doctors, speech and language therapists and dieticians, depending on the needs of the individual. Each medicine will need to be assessed and an appropriate form prescribed and dispensed, with instructions for how to prepare and administer the medicine to ensure safety and efficacy.

Each medicine will need to be prescribed in the appropriate form, and where medicines are suitable for crushing, this should be indicated by the prescriber and in the dispensing label instructions.

The individual's care plan, medical notes, and MAR should reflect the decision to change form of medicine and specify indications for administration, monitoring, and review.

A crushed tablet may be easier for an individual to take if they have trouble swallowing or use a feeding tube.

Risks with crushing medicines:

- may increase adverse effects and toxicity
- may be difficult to quantify dose of medicine
- may affect the efficacy of medicine

To crush a tablet, only use a crushing device designed for this purpose and follows the device instructions. Crushed medicine may be added to a small amount of foodstuff such as yoghurt or jelly, or a small amount of cool liquid. Some medicines are not compatible with dairy products, and the instructions for use should highlight this.

If the individual prefers to have crushed medicines in their food or a beverage, care should be taken to ensure the full dose is consumed.

As with other medicines, the individual's care plan, medical notes, and medicine administration record (MAR) should reflect the decision to change the form of medicine and specify indications for monitoring and review.

5.7 High-alert medicines

High-alert medicines are medicines that contain a heightened risk of causing significant harm to an individual when used in error. Although mistakes may or may not be more common with these medicines, the consequences of an error are more devastating to individuals (ISMP, 2017).

Harm can occur if high-risk or high-alert medicines are administered incorrectly, or if a dose of medicine is not administered. Harm may also occur with appropriate use of medicines classed as high-alert or high-risk as they may have more side effects than other medicines.

Individuals needing high-alert medicines often require more intensive management and monitoring than other individuals. Service providers should ensure that individuals receiving these medicines and others with a high risk of harm are supported by staff and healthcare professionals with the appropriate processes, information, monitoring, and review to support their safe and effective use.

HIQA (2015) requires that "service providers should have clear policies and procedures in place for the use of high-alert medicines". They mention insulin, warfarin, digoxin, and methotrexate and state, "this is not an exhaustive list".

Service providers should determine which medicines require special safeguards to reduce the risk of errors and minimise harm. These should include:

- Anticoagulants (e.g. Warfarin, heparin)
- Insulins
- Opiods (e.g. Codeine, tramadol, morphine, oxycodone, fentanyl)
- Methotrexate (for autoimmune conditions including arthritis) and oral chemotherapy which may be long-term.
- High Tech medicines
- Valproate (Epilim) must not be used in girls and women who may be able to have children unless the terms of the pregnancy prevention programme, known as 'prevent', are followed. This programme includes measures to ensure patients taking valproate (Epilim) are fully aware of the risks and the need to avoid becoming pregnant while taking it. Details of the pregnancy prevention programme are included in section 4.4 of the Summary of Product Characteristics (SmPC) which is part of the product information. It is important that women and girls who have been prescribed valproate should not stop taking their medicine without consulting their doctor.

The toolkit includes:

An annual risk acknowledgement form, which should be used at time of treatment initiation and during each annual review of valproate treatment by the specialist. There are also educational materials for healthcare professionals and also for individuals.

- Generic substitution is a specific and important concern in some conditions. Prescribers, dispensers and all health and care staff need to be aware of the particular issues involved in switching of certain medicines and to actively monitor to prevent it. The medicines reconciliation process and medicines administration record needs to detect if generic substitution has occurred at the prescribing, dispensing or administration stages. Prescribers in disability services and across the health service should always hand-write "do not substitute" on those medicines.

A more comprehensive list is available from ISMP.

Strategies may include:

- Standardising the ordering, storage, preparation, and administration of these products
- Improving access to information about these medicines for individuals and staff working with them
- Limiting access to high-alert medicines, particularly with controlled drugs
- Using extra labels or warnings and, if technology is available, automated alerts.
- Putting in extra steps in the process e.g. independent verification is advised for high-alert medicines as outlined in NMBI's Guidance for Registered Nurses and Midwives in Medication Administration (2020).
- Where a registered nurse is on duty, they should administer these medicines.

5.8 Alternative and complementary medicines

Any treatment for an individual should be discussed with the multidisciplinary care team and the individual. If a prescription is needed, then the practitioner may proceed to prescribe the medicine. Any medicine administered to an individual should be recorded on the MAR, including supplements, alternative, or complementary medicine. Complementary alternative medicines can also interact with existing prescribed medicines of the individual, and the advice of the pharmacist should be sought in these instances.

Usually the prescriber will instruct the pharmacist to dispense the product. For over the counter items, it may not require a prescription but it should still be recorded onto the MAR where applicable. The scope of what staff or healthcare professional can acquire on behalf of the individual should be clearly stated in local policies or in the individual care plan.

5.9 Minor ailments – over the counter medicines

Treatment for minor ailments is not always prescribed. Medicines, such as cold remedies, some hay fever treatments, mild pain-killers, topical creams for bites and stings, indigestion remedies can be bought over the counter in pharmacies, convenience stores and supermarkets.

If Over the Counter (OTC) medicine is purchased by an individual or relative for their own use, it should be discussed with to the individual's pharmacist and/or doctor, to ensure that there are no interactions with the individual's prescribed medicines.

If staff should decide to administer an OTC treatment to an individual that has not been prescribed, they should:

1. Ensure that the individual is suffering from a minor ailment for example, but not limited to the following examples toothache, headache, cold, sting etc.

2. Obtain advice from the individual's pharmacist, healthcare professional for example: nurse, dentist, doctor, podiatrist etc.

3. Include the advice given in a written protocol for administration of the medicinal product

4. Ensure that the individual is supported to attend a doctor if the symptoms persist, as advised on the product's information

5. Purchase the item from a pharmacist, and ask the pharmacist to apply a label.

6. Ensure that the medicine is suitable for the age range of the individual (child / adult etc).

5.10 Disposal of medicine

If medicines are dispensed monthly, it is important to check the storage area monthly for expired, damaged, or unused medicines and record the check. Expired stock and overstock should be kept separate from other medicines, and are disposed of and not further used in accordance with any relevant national legislation or guidance or local policies.

Medicines may need to be disposed of when an individual's treatment changes or when a treatment is discontinued. The remaining supply should be safely disposed of with the individual's consent. Medicines may be disposed of on-site if facilities are available. Most often expired stock and unused medicines are returned to the supplying pharmacy for disposal. A complete record for the disposal of medicines should be made (HIQA, 2015).

6. Reviewing medicines

6.1 Medicines review

A medicines review is a process whereby an individual's medicines' risks and benefits are considered and discussed, taking into account the individual's health needs, experience with medicines and their wishes as well as evidence based medicine. Decisions are made to continue, change, or discontinue medicines based on this review.

A multidisciplinary team consisting of (as appropriate) staff, a healthcare professional, the prescriber, the individual and/or their representative, should make themselves available to participate in interdisciplinary reviews of each individual and their medicines every six months. This should be documented in the individual's file or person centred plan. Evidence of pharmacists' participation in reviews should be retained in the pharmacy (Pharmaceutical Society of Ireland, 2018).

Pharmacists should also make themselves available to actively participate in the development of medicines management policies in residential homes, and to advise prescribers and care team on the safe use of medicines. Participation in any of these activities does not replace their obligation to conduct the mandatory reviews required. If an individual is assessed as suitable for self-administering, medicine review arrangements should be made between the individual, and the multidisciplinary team which includes the GP, nurse and pharmacist.

HIQA (2015) recommends that more attention should be paid to the following:

- Antipsychotic medicines
- Sedative medicines
- Medicines for the management of depression
- Antiepileptic medicines
- Analgesia or pain medicines
- Laxatives and treatments for constipation
- Anticoagulant and anti-platelet medicines
- Antimicrobial medicines
- Diuretic medicines
- Influenza and pneumococcal vaccines
- Non-steroidal anti-inflammatory drugs
- Drugs with drug-nutrient interactions

6.2 Medicines reconciliation

Medicine reconciliation aims to provide individuals with the correct medicines at all points of transfer, and upon admittance, within and between health and social care services. For example, it could include a review at an out-patient clinic, transfer to a hospital or a different residential service, admission or re-admission to a residential service (HIQA, 2014).

Medicines reconciliation is the formal process in which staff and healthcare professionals partner with individuals to ensure accurate and complete medicine information transfer across different services. The varying roles of the multi-disciplinary team participants in the reconciliation process must be clearly defined. Medicines reconciliation consists of the following:

- Building the best possible medicine history by getting a record from the individual and or their representative and verifying with at least one reliable source of information
- Determining the complete and correct list of the individual's actual medicine use at the time of transfer
- Reconciling the history with the prescribed medicine, identifying and resolving any discrepancies
- Documenting changes and updating the MAR
- Communicating accurate, up to date medicine information on the MAR, and the r easons for any changes to the individual and care providers across further transfers.

Services should have systems and resources in place to reliably ensure safe medicine use, (including an accurate medicines list) across admissions, transfers, and discharges. Individual medicine lists should be maintained with assistance from staff and healthcare professionals working with the individual including the prescriber(s) and the pharmacist(s).

6.2.1 Respite reconciliation

The Respite Manager/Person In Charge/Nurse Manager shall ensure that contact is made with the individual or the family prior to their arrival for respite care to inform them to bring all the medicines they need for the duration of their stay and to bring these in their original containers.

- The Respite Manager/Person In Charge/Nurse Manager shall ensure that the individual and their carer are reminded to inform the service if there have been any changes to their medicines regime since their last admission to respite services. This should be captured/recorded in the 'Respite Confirmation Agreement'. A personal health record that is integrated and easily transferable between sites of care would facilitate successful medicine reconciliation. The manager will ensure that the necessary arrangements are made to update the MAR.
- The Respite Manager/Person In Charge/Nurse Manager will ensure that the individual and family are informed that medicines can only be administered in respite care if they are prescribed by a registered prescriber (An Bord Altranais 2007). This includes over the counter medications such as paracetamol or aspirin, creams and ointments which are prescribed on a pro re nata (PRN) basis.

- All relevant information about a newly admitted individual's medicines, including allergies and sensitivities should be sought from the appropriate source i.e. the individual, family or General Practitioner and recorded on the MAR.
- In exceptional circumstances, if an individual arrives without their prescribed medicine, the staff or healthcare professional must contact the individual's family to obtain the medicine and/or contact the General Practitioner to obtain an up to date signed prescription which can be forwarded to a local Pharmacy for dispensing. The individual's medical card number will be required to obtain the medicine from the Pharmacy.
- Record all actions taken in the individual's notes.
- If the individual is unable to provide the information or there is any concern about accuracy of the information about their medicine, the General Practitioner or Consultant must be contacted to verify the accuracy of this information. It could be helpful to contact the local pharmacy the individual uses as they have records of previously dispensed medicines with the accurate dosage if necessary. The staff or healthcare professional must ensure that all the information and documentation is in order before administering the medicines.
- Document all medicines received in a MAR. The staff or healthcare professional must record medicines in and out and include admission and discharge date.

6.2.2 Medicine supply

Arrangements regarding the pharmacy location and pharmaceutical requirements must ensure that the service provided is both efficient and accountable. This arrangement must be detailed in the initial agreement between the individual/ service and the Pharmacist and reviewed on an annual basis, and must include emergency procedures. The agreement must clearly state the process for obtaining medicines normally and should include:

- Method of delivery/collection of repeat prescriptions
- Actions to be taken if supplies run out before the normal repeat time.
- Procedure for inclusion of prescribed medicines outside of normal repeat prescription cycle (this should take account of individuals who come into the location with insufficient medicine to last until the normal repeat prescription cycle).
- Separate provision for day service and/or holidays.
- The agreement should include details of the recording mechanism being used.
- It must also make clear how medicines would be obtained when the supplying Pharmacy is closed.
- The minimum service available includes an initial visit with subsequent visits at intervals agreed with the pharmacist and the centre manager. The manager must retain a record of the advice given on these visits for future reference.

7. Education and training for staff

Care and service provision for individuals should be based on their will and preferences. This requires an understanding of their existing medicine needs and capabilities. Staff and health-care professionals should be facilitated to understand the types of support, assessment tools, and values attached to managing the medicinal support needs of the individual (HIQA, 2013).

Appendix 5 "**Guidance for education and training programmes in medicines management in disability services**" is for staff who do not have pharmacology in their previous education or training, but who do currently hold a minimum of a major award at QQI level 5. This identifies core skills and knowledge which will provide the basis for the development of programmes on the safe management of medicines in disability services. The minimum education requirement will be a component module at a QQI level 5. This guidance will apply to all service providers developing education programmes, including the Centres for Nurse and Midwifery Education (CNMEs) and private education companies. The component module will be delivered only by professionals who have had pharmacology in their primary degree or training. Assessment of participants will be performed by the education provider. Following completion, the programme will be evaluated by the education provider.

If the individual has full capacity and only requires assistance with prompting or mechanical assistance, the person giving support does not need QQI level 5 component module. However, if the person providing support is administering medicines to the individual, that person must have the QQI Level 5 component module.

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9. Medicines management group membership

9.1 Steering group

NAME	ROLE	ORGANISATION
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Aileen Keane	Regional Manager, Regulatory Practice Development	HIQA
Carmel O'Donnell	Professional Officer	NMBI
Caroline Wall	Clinical Nurse Manager II, Person in Charge	Cheeverstown House
Christine Barretto	Social Care Workers Representative, Special Interest Group Chair	Social Care Ireland
Ciara Kirke	Clinical Lead Medication Safety, Quality Improvement Division	HSE
Dr. David Hanlon	NCAGL Primary Care	HSE
Helena Butler	Lead for Policy and Compliance, National Older Persons Services	HSE
Joan Donegan	Interim Director, Nursing and Midwifery Planning and Development	HSE
Leigh Gath	Confidential Recipient	HSE
Marie Kehoe O'Sullivan	National Disability Specialist, Quality Improvement Disability Operations	HSE
Maureen Parsons	Service Compliance Auditor, Quality and Governance Directorate	Rehab Group
Muriel Pate	Medication Safety Specialist Pharmacist, National Quality Improvement	HSE
Nicole Lam	Research Officer, Quality Improvement Disability Operations	HSE
Paddy Byrne	Community Pharmacist	NA
PJ Wynne	Quality Standards and Compliance Officer, Social Care Division	HSE
Shirley Guerin	Chief Pharmacist II, Phoenix Pharmacy Department	HSE
Teresa O'Malley	Nursing Practice Development Co-ordinator, Intellectual Disability Services, Donegal, Sligo, Leitrim, West Cavan.	HSE

PREVIOUS MEMBERS OF THE STEERING GROUP	DATES
Anne Farrelly, ADON, RNID	10/2017 to 10/2018
Bernadette Flood, Pharmacist, Daughters of Charity (resigned)	04/2017 to 10/2017
Caralyn Horne, Quality Standards and Compliance Officer, Social Care Division	04/2017 to 10/2017
Dr. Siobhan Kennelly, NCAGL Social Care	04/2017 to 06/2018
Ann Sheehan Operations Team, Disability Services, Social Care Division	04/2017 to 08/2018

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Maureen Parsons	Service Compliance Auditor, Quality and Governance Directorate	Rehab Group
Muriel Pate	Medication Safety Specialist Pharmacist, National Quality Improvement	HSE
Paddy Byrne	Community Pharmacist	NA
Shirley Guerin	Chief II Pharmacist, Phoenix Pharmacy Department	HSE
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Theresa Anderson	Head of Clinical Services & Deputy Chief Executive Officer	Cheshire Ireland

9.4 Education subgroup

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Christine Barretto	Social Workers Representative, Special Interest Group Chair	Social Care Ireland
Joan Donegan	Interim Director, Nursing and Midwifery Planning and Development	HSE
Marie Kehoe O'Sullivan	National Disability Specialist, Quality Improvement Disability Operations	HSE

9.5 Governance subgroup

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Dr. David Hanlon	National Clinical Advisor and Group Lead Primary Care	HSE
Gerry Clerkin	Head of Quality and Safety Social Care Division	HSE
Gillian Whyte	Nursing and Midwifery Planning and Development Officer	HSE
Jude O'Neill	Head of Social Care, Midlands Louth Meath CHO	HSE
Judy Ryan	Director Nursing and Midwifery Planning & Development, South East	HSE
Lorraine Egan	Manager of Disability Services Laois/Offaly	HSE
Marie Kehoe O'Sullivan	National Disability Specialist, Quality Improvement Disability Services	HSE
Mary Keogh Prunty	Director of Nursing Donegal Disability Services	HSE
Tim O'Sullivan	Director of Nursing Sligo/Leitrim Disability Services	HSE
Una Tomany	Area Director Disability Nursing CHO 1	HSE

Appendix 1:

Governance framework for medicines management in Disability Services for adults and children

Governance Framework for medicines management in Disability Services

Good governance in medicines management requires that the service is clear about what it does, how it does it, and how it is accountable to its stakeholders.

- It clearly states who has overall executive accountability for the quality and safety of medicines management so that individual staff members, team and senior management are aware of their role, responsibilities and who and what they are accountable for.
- Processes and arrangements must be in place to plan and manage medicines effectively and safely to ensure that the users of the service receive a quality service (HIQA 2012).
- Monitoring and auditing should be conducted to assure adherence to associated regulations, legislation, national policy, standards and recommendations.

Governance for quality requires that the necessary structures, processes, standards and oversight are in place to ensure that safe, person centred and effective services are delivered (HSE 2016). The National Office for Community Operations – Disability Operations, recognises the divergence of services and the complex needs of individuals who require support with their medicines in each CHO area. The structure contained within this document is the core governance framework recommended which will ensure the service is providing good governance and leadership in medicines management which will support individuals to live meaningful lives in accordance with their will and preference.

Key Principles to supporting Medicines Management

In developing a governance framework for medicine management in Disability Services, six key principles with associated indicators were identified (HSE 2016). These are closely aligned with the Health Information and Quality Authority (HIQA) National Standards for Residential Services for Children and Adults with Disabilities (2013) and HIQA Medicines Management Guidance (2015).

- **Knowledge and Skills**
  > Management teams have the knowledge and skills to achieve their role in driving quality care
- **Leadership and Accountability**
  > Management team are clear about leadership and accountability for quality and safety
- **Information**
  > Intelligent use of information to measure, monitor and oversee quality and safety of care
- **Culture**
  > A culture of learning focused on quality of care is promoted throughout the service provider
- **Relationships**
  > The service provider promotes strong relationships that partner with individuals and staff to facilitate the alignment of the entire service provider around the quality of care
- **Quality Improvement**
  > There is a quality improvement plan in place which has been developed in line with the Framework for Improving Quality (HSE, 2016) and aligned with national and service provider priorities
- **Safety**

  The identification, control, and mitigation of risks to achieve effective, efficient, and positive outcomes for individuals and staff is integral to safe medicines management. A positive safety culture is essential for improving medicine safety.

Implementing a robust governance framework supports services to meet the assessed needs of the individual and will support the service in adhering to regulations as set out in the Health Act 2007 (Regulations S.I 367, 2013).

For the purposes of this framework, the following assumptions have been made:

- Disability services includes residential and non-residential, community, and people living in their own homes (for both adults and children)
- A Designated Centre will be supporting no more than 20 people across a variety of settings.
- There will be a Full Time Person in Charge per Designated Centre.
- A number of Designated Centres can be managed through one Medicines Management Governance Structure. This is called an “Allocated Service”.
- There will be a Director of Services managing an Allocated Service who will be responsible for all the Designated Centres within the Allocated Service.
- There will be a Medicines Management Governance Structure in place for each Allocated Service that reports to the Drugs and Therapeutics Committee within each CHO Area in the case of HSE Provided Agencies or the Organisation’s Drugs and Therapeutics Committee in the case of HSE Funded Services.

Knowledge and Skills

				Legislative Alignment	
Indicator	**Evidence**	**Responsibility**	**Accountability**	**National Standards***	**Health Act 2007 Regulations 2013****
Management teams have the knowledge and skills to achieve their role in driving quality and maintaining safety of medication management	• Corrective and Preventative actions are identified, implemented and monitored	CEO/Designee Head of Social Care	Senior Accountable Officer	5.1, 5.2	14, 23, 29
Medicine management education requirements are satisfied as outlined in the guidance document	• Staff Training Records • Audits of training	Providers of Education Programmes in Medicines Management Director of Services Person in Charge	Senior Accountable Officer	4.3	16
All staff with responsibility for any element of supporting a person with a disability in taking their medicines will have access and receive the training, knowledge and skills appropriate to their role and based on the individual medicine assessment plan. This includes: • Prescribing (doctor or nurse prescriber) • Reviewing (doctor or nurse prescriber or pharmacist) • Dispensing (pharmacist) • Ordering (individual or person supporting the individual) • Transporting (individual or person supporting the individual) • Storing (individual or person supporting the individual) • Disposing (individual or person supporting the individual) • Administering (individual or person supporting the individual) • Reporting (where appropriate) • Recording (where appropriate)	• Audits • Medicine Records • Care Plans • Verification from the person with a disability	Disability General Manager Director of Services Person-In-Charge	Senior Accountable Officer	7.2, 7.3, 7.4	16, 29

*National Standards for Residential Services for Children and Adults with Disabilities **Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

Leadership and Accountability

Indicator	Evidence	Responsibility	Accountability	National Standards*	Health Act 2007 Regulations 2013**
All service providers will develop a medicines management policy which will be aligned to the HSE National Medicines Management Guidance Framework. The service provider sets out within their policy aims, objectives and expected outcomes for medication management	• Records of committee meetings • A local medicines management policy signed off by staff and local management	Head of Social Care Director of Services Disability General Manager	Senior Accountable Officer	4.3	4
Clear lines of accountability exist within the service provider in relation to medication management	• Organisational Chart • Procedures which outline the roles and responsibilities of individual roles in the management of medicines • Record of Committee Meetings: Quality and Safety or Drugs and Therapeutics	CEO/Designee Head of Social Care	Senior Accountable Officer	5.1, 5.2, 5.4	23
A clear structure / diagram is available which outlines the lines of accountability and reporting relationships.	• Organisational Chart	CEO/ Designee Head of Social Care	Senior Accountable Officer	5.1, 5.2, 5.4	23
The service provider has a quality and safety and Drugs and Therapeutics committees in place with terms of reference, to provide necessary oversight	• Agenda and minutes of meetings • Incident monitoring and root cause analysis	Chair of Committees CEO /Designee Head of Social Care	Senior Accountable Officer	5.2	23
At the outset medicine safety will be an agenda item on the quality and safety committee meetings.	• Records of meetings and actions • Appointment of designated QA person – Medicine Safety Officer	CEO / Designee Head of Social Care	Senior Accountable Officer	5.2	23
The leadership team commit resources to support sustainable improvements in medication management	• Records of quality improvement action plans • Audits • Evidence of oversight of corrective and preventative actions • Staff Training	CEO / Designee Head of Social Care	Senior Accountable Officer	6.7	23, 29

*National Standards for Residential Services for Children and Adults with Disabilities **Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

Information

Indicator	Evidence	Responsibility	Accountability	National Standards*	Health Act 2007 Regulations 2013**
Intelligent use of information to measure, monitor and oversee quality and safety of medication management.	• Audits, • Records of Quality and Safety Committee Meetings, • Follow up on Incidence Reporting • Staff Verification	CEO / Designee Head of Social Care Director of Services	Senior Accountable Officer	8.1, 8.2	21, 23
Policies, procedures, protocols and/or guidelines are implemented to support evidence based practice in medication management.	• Implementation of PPPG's on Medicines Management	Director of Services Person in Charge	Senior Accountable Officer	4.3	4
Clinical audit processes are established and quality improvement plans are developed.	• Clinical Audits and Quality Improvement Plans	Director of Services Person in Charge	Senior Accountable Officer	5.2	23, 26
An incident reporting process is in place and incident management systems are established including root cause analysis for serious adverse incidents and serious reportable events.	• Incident Reports and implementation and monitoring of corrective and preventative measures • Records of Drugs and Therapeutics Committee and Quality and Risk Committee meetings	Drugs and Therapeutics Committee Disability General Manager Director of Services	Senior Accountable Officer	3.4, 4.3	23, 31
Processes are in place for identifying, reporting, reviewing and learning from medicines-related problems	• Medicine Management Plan • Audits • Incident Reports and evidence of corrective and preventative measures • Care plans • Staff Verification • Care Plans	Director of Services Disability General Manager Medicine Safety Officer	Senior Accountable Officer	3.4, 4.3	23, 26, 31
Service user feedback is actively sought and information is used to improve medication management processes	• Feedback appropriate to service user communication ability is collated • Records of quality improvement action plans based on service user feedback	Director of Services Person In Charge	Senior Accountable Officer	1.7	5, 6, 9

*National Standards for Residential Services for Children and Adults with Disabilities **Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

Governance Framework for Medicines Management in Disability Services for Adults and Children

Indicator	Evidence	Responsibility	Accountability	National Standards*	Health Act 2007 Regulations 2013**
Culture					
A culture of learning based on the following principles will be promoted throughout the service: • Person centeredness • The safety of the person within a framework of positive risk taking • Supporting people to live a life of their choosing • Supporting the persons will and preference	• Care planning • Team Meetings • Mission Statements • Service User verification	Director of Services Person In Charge General Manager Head of Social Care	Senior Accountable Officer	1.1, 1.3, 1.6, 2.1, 2.4, 4.2, 4.3	5, 6, 9, 10, 11 ,13, 23
All medicine plans will reference how individuals will have their medicines administered and will be supported to self-administer upon completion of an assessment regarding the supports an individual may require with their medicine administration	• Assessment of supports to self-administer • Medicines Plan	Director of Services Person In Charge	Senior Accountable Officer	2.1. 4.3	5, 6, 9, 10, 13
A culture of open disclosure is established which includes recognising, reporting and learning from medication safety errors.	• Incident Reports • Records of Quality and Risk Meetings • Feedback on incidents • Actions Plans • Staff verification	Director of Services Quality and Risk Advisor	Senior Accountable Officer	3.4, 4.3, 5.1, 5.2	23, 26, 31
Relationships					
The organisation promotes strong relationships that partner with individual individuals, family members and staff	• Records of individuals and family forums. • Person centred Plans	Disability General manager Director of Services Person In Charge	Senior Accountable Officer	1.1, 1.2, 1.3, 1.5, 1.6, 2.1	5, 6, 9, 10, 13
Quality Improvement					
There is a quality improvement plan in place which has been developed in line with the Framework for Improving Quality and aligned with national and organisational priorities	• Quality Improvement Plan	Head of Social Care Person In Charge	Senior Accountable Officer	3.4, 4.3, 5.2	23

*National Standards for Residential Services for Children and Adults with Disabilities **Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

Table (a) Proposed Management and Governance Structure for HSE-provided services

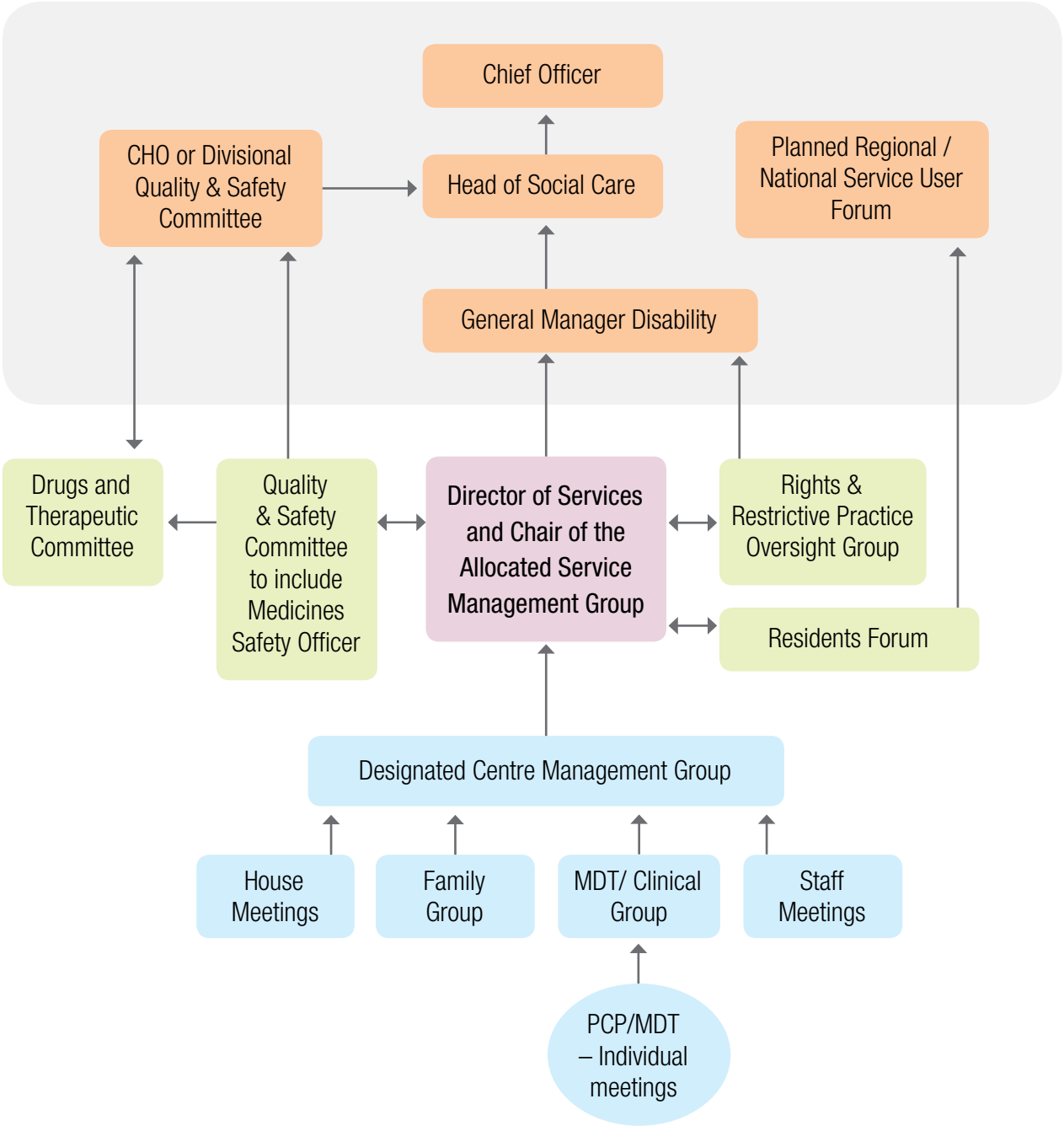
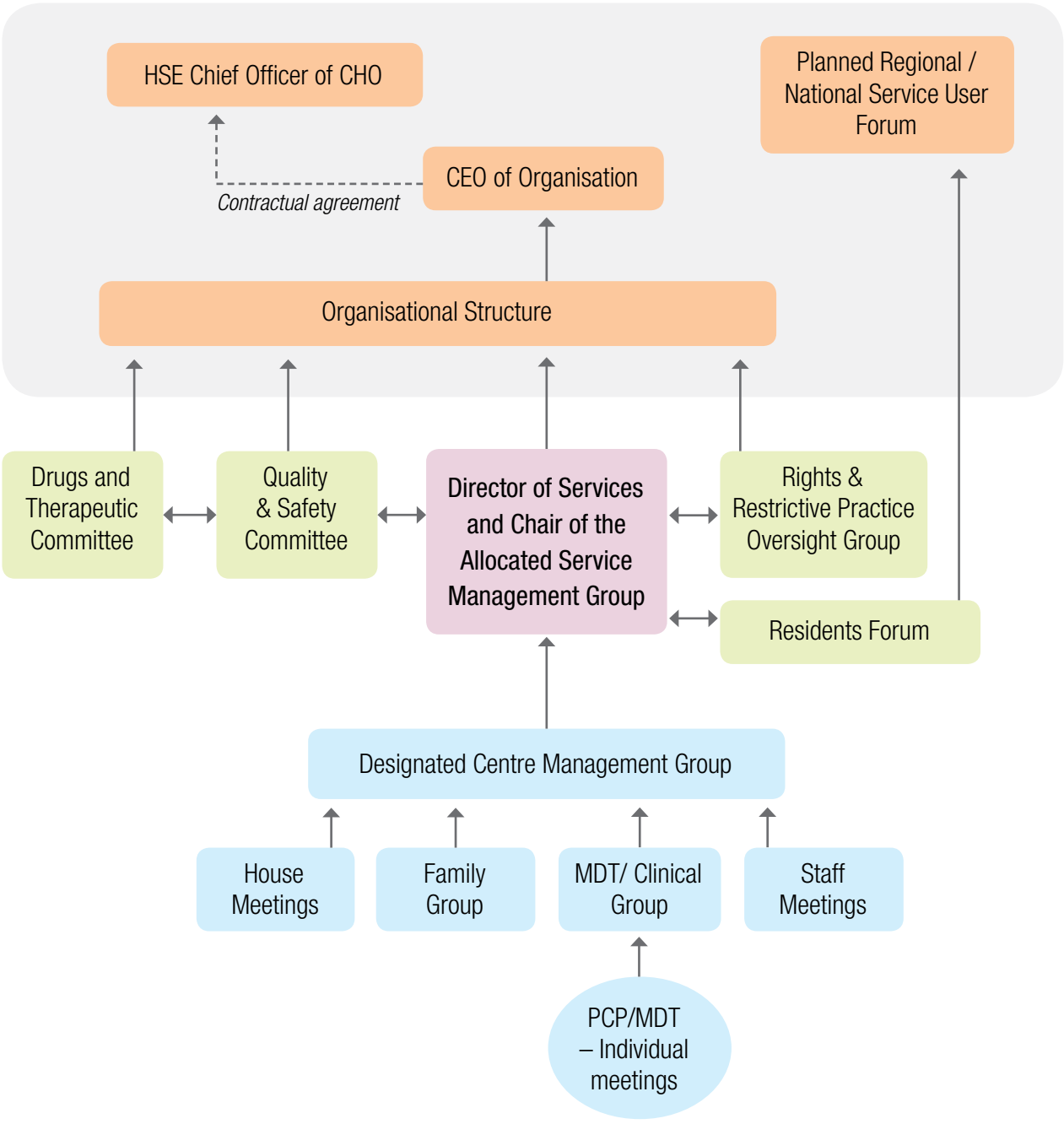


Table (b) Proposed Management and Governance Structure option for HSE-funded services



References

Health Service Executive (2016) Overview Governance for Quality and Safety, Dublin: Quality Improvement Division,

Health Service Executive (Accessed February 2019) at *https://www.hse.ie/eng/about/who/qid/governancequality/governance-for-quality-and-safety-overview.pdf*

Health Information and Quality Authority (2013) National Standards for Residential Services for Children and Adults with Disabilities

Health Information and Quality Authority (2015) Medicines Management Guidance

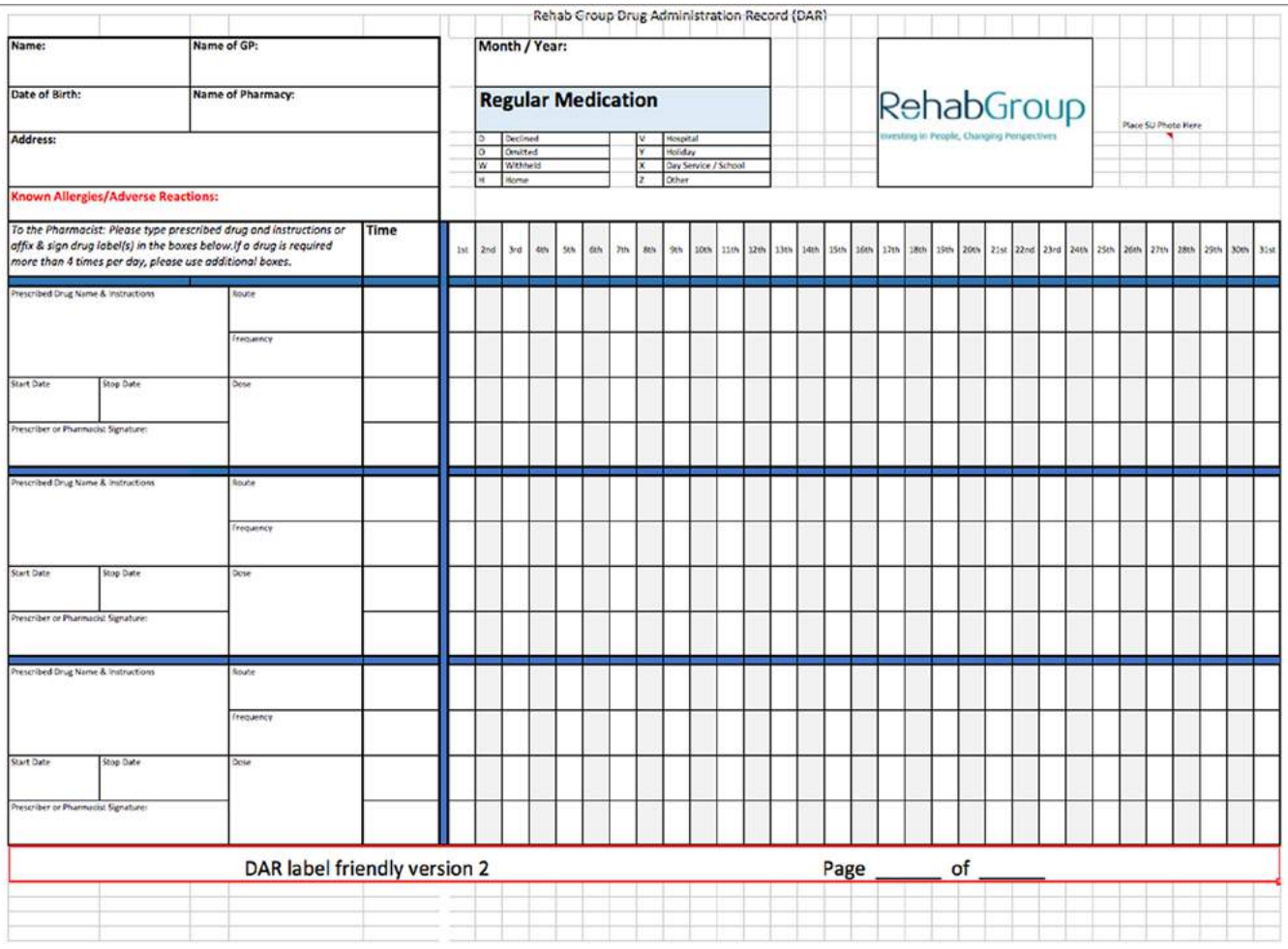
Government of Ireland (2013) S.I. No.367 of 2013: Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Health Service Executive (2017) Social Care Division: Intellectual Disability Residential Services: Governance Structure Framework

Health Service Executive (2016) Framework for Improving Quality

Appendix 2:

SAMPLE Medicines Administration Record Template



Rehab Group Drug Administration Record (DAR)

Name:	Name of GP:
Date of Birth:	Name of Pharmacy:
Address:	
Known Allergies/Adverse Reactions:	

Month / Year:

Regular Medication

D	Declined	V	Hospital
O	Omitted	Y	Holiday
W	Withheld	X	Day Service / School
H	Home	Z	Other

RehabGroup

Investing in People, Changing Perspectives

Place SU Photo Here

To the Pharmacist: Please type prescribed drug and instructions or affix & sign drug label(s) in the boxes below.If a drug is required more than 4 times per day, please use additional boxes.

Time

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th 13th 14th 15th 16th 17th 18th 19th 20th 21st 22nd 23rd 24th 25th 26th 27th 28th 29th 30th 31st

Prescribed Drug Name & Instructions | Route | Frequency | Start Date | Stop Date | Dose | Prescriber or Pharmacist Signature:

Prescribed Drug Name & Instructions | Route | Frequency | Start Date | Stop Date | Dose | Prescriber or Pharmacist Signature:

Prescribed Drug Name & Instructions | Route | Frequency | Start Date | Stop Date | Dose | Prescriber or Pharmacist Signature:

DAR label friendly version 2 Page _____ of _____

v2 for labels

Appendix 3:

Ten rights of medicines administration (NMBI, 2020)

1. Right patient
When administering medicines, be certain of the individual's identity by verifying the wristband, photograph, name, and the date of birth on the medicine administration record

2. Right reason
Understand the intended purpose of the medicines being administered

3. Right medication
Confirm the name of the medication to be administered. Confirm it corresponds with the generic or brand name of the prescribed medicine. It should be properly packaged and within its expiry date. Check the medicine administration record or ask individual if they have a known or recorded allergy to prescribed medicine or known allergies

4. Right route
Administer medicine at the prescribed anatomical route and site

5. Right time
Administer medicine at the prescribed time and prescribed intervals

6. Right dose
Confirm through calculation that the dose of medicine being administered is the exact dose prescribed. High risk medicines must be identified in local PPPGs. Prescribed dose must be independently verified by another person before administration

7. Right form
Confirm the medicine supplied matches the specified route of administration

8. Right action
Explain the purpose of the medicine to the individual and why it is prescribed

9. Right documentation
Sign, date and retain all documentation recording the administration of each medicine in the medicine administration record. The record should only be signed when the medicine administration has been witnessed

10. Right responses
Monitor the individual for an adverse reaction, assess the individual to determine that the desired effect of the medicine has been achieved, in consultation with the medical practitioner and/or prescriber.

Appendix 4:

Assessment tool for self-administration of medicines

(Adapted with permission from the Ohio Department of Developmental Disabilities, 2015)

My name is: _____

Date of birth: _____

Setting of assessment (home/work/recreational): _____

The assessment is to be completed by me or a person who knows me well and, if possible, a second observer present. Assess my knowledge and skills in the environment where I take my medicine(s) and identify areas where I can build capacity to self-administer. Outcomes from the assessment will be included in their individual care plan.

Person(s) conducting this assessment will need to have ALL necessary information regarding my current medicines including medicine names, doses, routes, times, reason for medicines, and basic side effects. Complete this form in its entirety regardless of answer.

_____ _____

Name and title of person performing assessment Date

_____ _____

Name and title of second observer Date

Assessment

1. I can recognise my medicine by colour, size, shape, and/or reading the label. I will not take my medicine if it looks different. (i.e can read label, has memorised, will ask for help or will confirm with someone else).

Yes ☐ Continue to 2.

No ☐ Unable to self-administer with or without assistance. Continue to 2.

2. I can tell you what my medicine is for (pain, nerves, breathing, itch etc).

Yes ☐ Continue to 3.

No ☐ Unable to self-administer with or without assistance. Continue to 3.

3. I know and recognize how much medicine I am to take or apply (1/2 pill, the cup filled to this line etc). I will not take my medicine if it is the wrong amount.

Yes ☐ Continue to 4.

No ☐ Unable to self-administer with or without assistance. Continue to 4.

4. I will recognise and know who to tell if I don't feel good (pain, nausea, dizziness) as it may be a side effect.

Yes ☐ Continue to 5.

No ☐ Unable to self-administer with or without assistance. Continue to 5.

5. I know who to tell when I have 4-7 days of medicine left so I never run out. I will get a refill or seek assistance if needed for refill.

Yes ☐ Continue to 5.

No ☐ Unable to self-administer with or without assistance. Continue to 6.

6. I know whom to call if my medicine is wrong and will tell them straight away. (i.e doesn't look right, dose incorrect, spilled medicine).

Yes ☐ Continue to 7.

No ☐ Unable to self-administer with or without assistance. Continue to 7.

If questions 1 through 6 are all YES, I am able to self-administer. Continue to next questions for possible assistance needed with self-administration.

7. I take my medicine at the right time every day by using the clock or my routine (before bed, after lunch etc).

Yes ☐ Continue to 8.

No ☐ If self-administering, the individual's personal care plan will include time reminder prompting. Continue to 8.

8. I can get medicines to and from storage, out of the container, and to my mouth without spills

Yes ☐ Continue to 9.

No ☐ If self-administering, personal care plan will include physical assistance regarding storage or packaging or consuming/applying.

9. I can swallow my medicines (capsules, tablets, liquids) with no difficulty.

Yes ☐ If YES to all 9 questions, self-administer without assistance

No ☐ If self-administering, personal care plan can include crushing or altering medicines as instructed on the individual's Swallowing Plan.

Assessment outcomes:

After all questions are completed, choose one of the following assessment outcomes. The personal care plan will then specify how their medicines will be administered.

1. Question 1 through 9 all = YES

☐ **I can self-administer medicines <u>without</u> assistance**

2. Question 1 through 6 = YES, 7 through 9 = NO)

☐ **I can self-administer medicines <u>with</u> assistance.** Select as many that apply:

☐ I need reminders to take my medicines on time and/or confirm I'm following the directions on the container.

☐ Assist me by taking the medicine in its container from storage area, handing the container with the medicine to me, and where necessary, open the container for me.

☐ With my consent and as requested by me, and with my direction, remove my oral or topical medicine from the container and help me take or apply the medicine. Where necessary, physically assist me to place a dose of the medicine in my mouth or topically on my skin.

☐ With my consent and as requested by me, and with my direction, crush or alter my medicines that is consistent and as directed by my Swallowing Plan.

3. Question 1 through 6, any = NO

☐ **I am not able to self-administer medicines with or without assistance. A trained and authorized person must administer my medicine.** (check below if applicable):

☐ I am able to do some steps of my medicines administration and a trained or authorized person completes the other steps of my medicines administration. Details are listed in my care plan.

Other considerations - Indicate if any of the following are applicable:

☐ I am able to self-administer some of my medicines/dosages (i.e inhaler, nebulizer etc) those are listed in my plan. A trained and authorized person needs to administer other medicines. The medicines administration and tasks I do myself are:

_____

_____

☐ I have demonstrated unsafe behaviours and I am unable to safely self-administer medicines with or without assistance. This is addressed in my plan as a rights restriction:

_____

_____

☐ I have a enteral feeding device or modified texture diet, medicines are given via tube, or the prescriber and multidisciplinary team have confirmed the safe administration of any medicines given orally (or modified the administration to assure safety).

Annual review

Confirmations of no changes or the dated edits were noted by:

First review: _____

Signature and title Date

Second review: _____

Signature and title Date

NOTE: The assessment must be re-evaluated as needed and at least annually. Reasons to re-evaluate this assessment include but are not limited to:

- Individual moves to a new home
- Medicine packaging changes
- New medicines
- Significant changes in the number or dosages of medicines
- Change in the individual's health status
- Following capacity building training
- Individual exhibits changes in behaviours
- Any changes that could potentially effect safe self-administration of medicines

Appendix 5:

Guidance for education and training programmes in medicines management in Disability Services

Introduction

The Medicines Management Steering Group has developed this national, standardised, evidence based guidance of core learning for safe management of medicine by staff, based on the Framework for Medicines Management in Disability Services (2019).

The core skills and knowledge described in this document highlights components which are common and transferable across different types of service provision. Specialist skills and knowledge are outside the scope of the framework. Additional learning outcomes may be locally determined to meet education and training needs in specific settings e.g. according to local context, risk assessment or policy. It should be noted that individual supports vary and assessments will demonstrate the differing types of supports needed.

Development of the Component Module

Development of the component module was guided by a steering group comprising representatives of key stakeholders, including individuals with disabilities, relevant health, social care and education sector professionals, regulators, voluntary organisations.

Aim

The aim of this guidance document is to ensure that staff supporting the individual with their medicines management and administration, can access appropriate education, training and assessment, enabling them to perform this role safely and successfully for people with Intellectual Disability and/or physical and sensory Disability.

Objectives

The objectives are as follows:

1. Provide a standardised approach towards education, training, and competence validation of staff in medicines management. All education programmes must be aligned with this framework in order to ensure a national standardised approach.

2. Provide the essential evidence based knowledge, skills, and attitude to enable staff to safely support the management and administration of medicines for individuals.

Component module philosophy

The component module philosophy is based on the key principles that are described in the Framework for Medicines Management in Disability Services (HSE, 2019)

Principles of adult education will underpin the delivery of this component module, with an emphasis on facilitating participants to critically evaluate their own learning needs and take responsibility for their professional development. Ongoing competence to practice can only be achieved by a commitment to lifelong learning on the part of the staff.

Learners who complete this course will be equipped to recognise and support the varying and changing support needs of individuals.

Component module validation

Education providers who are registered with QQI which include HSE and Voluntary Centres of Nursing and Midwifery (CNME's Centres of Learning and Development (CLD), and Centres of Education Training and Development (CETD)) and Centres of Children's Nurse Education and private education providers will be responsible for developing the component award in medicines management in disability services. They will ensure that it is evidenced based and adheres to all the components of this guidance document. All trainers must have had pharmacology in their primary degree or training.

1. The component will be developed by staff who have the knowledge skills and competence and will be validated by QQI at level 5.

2. Medicines management skills assessor will document the assessments as evidence of skill acquisition in practice.

3. A certificate will be awarded on successful completion of the component

4. Local, procedures and guidelines must be ratified through local governance structures.

5. Local procedural guideline should be reviewed as per local requirements.

Learning resources

While undertaking the component module, learners will have access to library resources and teaching accommodation to support their learning.

Criteria to undertake the programme

Learners must:

- Be employed by the HSE/HSE Funded agencies
- Apply to their local approved educational provider using the appropriate application form
- In advance of applying for this component module on medicines management, have successfully completed at a minimum, and hold certification in a QQI Level 5 major award or higher, which includes a component module on caring.

- Be approved and nominated by their Service Manager as an appropriate person to undertake this role.
- Be employed in an area where medicines management is required to enhance the individual's quality of life and service provision.
- Accept personal responsibility and accountability for medicines management in accordance with local PPPG's.
- Completed basic numeracy skills and English language assessment prior to commencing the course.
- Have certified evidence of having at a minimum completed a Basic Life Support (BLS) course as per guidelines of the training provider.

Core Requirements for course provision

All HSE/HSE funded agencies/Education and Training providers who facilitate safe administration of medicine education and training programmes shall incorporate the following core requirements:

- Explicit learner competence assessment process in accordance with QQI education
- Quality assurance, guidelines to include skill demonstration of each of the five rights of administration of medicines
- A current Quality Assurance agreement with QQI
- Locally agreed shared mechanisms for recording and reporting attendance and absences while undertaking the component module.

Aim and learning outcomes for each unit of learning:

AIM	**The individual will be supported to ensure they have optimal levels of involvement in their medicines management to their fullest capacity.**
OUTCOME **the learner will:**	**ASSESSMENT** **the learner must:**
Explain the legislation that underpin the promotion and development of a person's capacity	• Identify legislation relating to decision making and capacity in a health or social care work setting • Describe what is meant by assisted decision making as detailed in the Assisted Decision Making (Capacity) Act 2015 • Explain what is meant by the terms "capacity" and "will and preference". • Explain why it is important to assume that someone has capacity unless there is evidence that they do not. • Describe situations where it would be necessary to seek additional expertise for example where individual choice would contravene legal and work setting requirements, or go beyond agreed boundaries for the staff role. • Explain what is meant by "consent", and how it can change according to what decisions may need to be taken. • Describe what is meant by capacity building • Describe how to support the individual to be as independent as they can be with regard to their medication management through > Environmental adaptation > Assistive Communication techniques > Provision of accessible information > Collaborating on developmental goals in the individual's person centred plan
Describe the assessment of capacity and capability	• Take into account the assumption of capacity. • Describe situations where an assessment of capacity might need to be undertaken regarding medicines • Identify the variety of methods used to gather information from/with the individual during the assessment process. • Outline the main steps/process in the ongoing assessment of the ability of the individual to manage their own medicines. • List the documents used in the assessment of the individual • Explain why it is important to recognise changing needs of the individual • Explain how any concern about changing needs of an individual would be recorded and reported • List possible actions to be taken to respond to these changes.
Privacy and dignity	• Describe what is meant by privacy and dignity • Identify ways to promote dignity in their day-to-day work supporting individuals with their medicine • List situations where an individual's privacy and dignity could be compromised in regard to management of medicines • Describe how to maintain privacy in regard to the management of medicines

Aim and learning outcomes for each unit of learning:

AIM	**Staff will understand their responsibility and accountability with regard to safe medicines management.**
OUTCOME **the learner will:**	**ASSESSMENT** **the learner must:**
Understand their own responsibility and accountability with regard to medicines management	• Describe own duties and responsibility in relation to medicines management • identify their line management structure in relation to medicines management • List the regulations, standards, and codes of conduct and practice (if applicable) that relate to their role in medicines management • Explain how they will work in accordance their services' policy • Know the importance of accounting for all actions and omissions relating to their role in medicines management.
Demonstrate their role in relation to safe medicines administration	• Identify common classes of medicines • List classes of medicines commonly used for example to treat pain or infections • List the ten rights of medicine administration. • Demonstrate methods of correctly identifying the right individual in different environments • Demonstrate how to identify the right: 1. Patient 2. Reason 3. Medication 4. Route 5. Time 6. Dose 7. Form 8. Action 9. Documentation 10. Response • Conditions when PRN medicines can be administered • Describe symptoms of side effects of commonly used medicines • List the classes of medicines that they are authorised to administer or to support a person to self-administer • List the routes of administration of medicines they are authorised to administer or to support a person to self-administer (oral, aural, dermal, rectal, vaginal – additional education is required for injectables and enteral tube feeding) • Describe the conditions under which the form of the medicine could be changed (e.g crushing tablet), and who is authorised to make that decision • Support individuals to use medicines in a way that promotes hygiene. • Define polypharmacy and the risks associated • Support the individual to identify any risks associate with aspects of their medicine management • Explain their responsibilities in relation to over the counter medicines and supplements

continued

Understand their role in relation to documentation and record keeping	• Document and communicate care encompassing medicines management in a clear, objective, accurate and manner within the Framework for Medicines Management in Disability Services and HIQA regulations. • Explain the approved abbreviations used in the recording of the administration of medicines • Explain the importance of keeping full and accurate records and the consequences if this is not done. • Describe how to complete: > Medicine management support/care plan > Administration of medicines record > Receipt of medicines record > Record of discrepancies > Return to pharmacy/ disposal of medicines record > Medicine incident report > Error report
Be able to ensure that individuals receive the maximum benefit from their medicines.	• List the desired effects, short-term and long-term side effects of commonly used medicines • Explain how medicines are only withheld /delayed based on a specific rationale following communication with line manager or prescriber • Describe how a person should be monitored after administration of medicine(s) • Describe the role of different professionals that individuals may need to access for support on medicines management. • Explain how, when, and to whom to escalate any concerns they might have including whistle-blowing and safeguarding

Aim and learning outcomes for each unit of learning:

AIM	**The individual is involved in the identification of their support needs in medicines management in a person centred way.**
OUTCOME the learner will:	**ASSESSMENT the learner must:**
Understand person centred values	• Describe how to put person-centred values into practice in their day-to-day work • Explain the importance of The United Nations Convention on the Rights of Persons with Disabilities in relation to medicines management. • Explain why it is important to find out the history, preferences, wishes and needs of the individual
Provide support within the agreed, person centred medicines management support/ care plan	• List the elements of a person centred medicines management support/care plan • Describe the steps in the implementation of a person centred medicines management support/care plan • Explain how risk management including assessment, planning, and review apply to medicines management. • Describe the steps in the process of review and adaptation of the person centred medication management support plan in response to the individual's assessed changing needs • Explain why the changing needs of an individual must be reflected in their care and/or support plan
Provide and explain Information to the individual in a way that they understand.	• Describe ways of helping individuals to make informed decisions about their medicines • Name reliable sources of information on medicines (BNF or Medicines.ie, HPRA.ie Irish drug formulary) • Describe how to communicate information to the individual about their medicine in a way that meets their communication needs • Describe how to obtain suitable Information sheets which should use the name of the medicines that the individual is familiar with.

Aim and learning outcomes for each unit of learning:

AIM	**The purpose of the prescription or medicines order will be understood by staff and they will seek further information, advice and guidance if necessary before supporting an individual with their medicine.**
OUTCOME **the learner will:** Be clear as to directions of a prescription	**ASSESSMENT** **the learner must:** • Describe the elements of a valid prescription • Relate how to follow directions on a prescription • Administer medicine only to the individual for whom it is prescribed and dispensed • Know generic names of medicines as well as brand names
Seek further information, advice and guidance from appropriate sources if necessary before supporting an individual with their medicine.	• Explain the use of ISBAR or other communication tool when contacting prescriber, pharmacist, or nurse for clarification on prescription

Aim and learning outcomes for each unit of learning:

AIM	**Medicines should be received and handled according to legislation and local policies and procedures.**
OUTCOME **the learner will:**	**ASSESSMENT** **the learner must:**
Understand the procedures for ordering medicines	• Describe the procedure for ordering and receipt of medicines if applicable • List personnel who are authorised to order medicine as per organisational policy and procedure
Receive, collect, and transport medicines safely	• Locate the local/organisation's policy for ordering receipt, collection, transportation, storage and disposal of medicines • Outline staff actions to be taken, and who should be notified when dealing with discrepancies in medicine orders received • Outline how to obtain pharmacy top-up if an individual's medicines run out or is changed. • Outline how to obtain medicines from other settings, if required • Outline the procedure for the safe supply of medicines for people going on holiday or home. • Outline procedures for the ordering and handling of medicines for people on admission, transfer and discharge, eg going into hospital.
Check in and store medicines safely	• Outline medicine security and safety measures, including key-holder access • List the different places and environmental conditions required for the storage of medication, including why some medications require special storage conditions and others do not. • List examples of medicines which require refrigeration
Safe disposal of unused/ out of date medicines	• Describe how to follow procedures for the safe segregated storage of out of date or partly-used medications until they can be returned to the individual's pharmacist. • Describe the procedures for the disposal of out of date, damaged or part used medicines

Aim and learning outcomes for each unit of learning:

AIM	**Every medicines-related error will be reported appropriately, whether harm occurred or not and remedial action will be implemented in accordance with local policies.**
OUTCOME **the learner will:**	**ASSESSMENT** **the learner must:**
Know what constitutes a medicine error	• List types of medicine errors • State the appropriate action to take if a medicine error occurs • Explain how to contact the GP and the use of ISBAR communication tool when an error occurs • Explain how learning from errors can improve care and support of people with disabilities
Report every medicine error	• Describe the procedure for reporting errors • Describe the open disclosure procedure/ informing the individual/family

AIM	**Following the administration of a medicine, the individual's response to that medicine will be monitored and take appropriate action to record and report to the appropriate individual (GP, Line Manager) as per local policy**
OUTCOME **the learner will:**	**ASSESSMENT** **the learner must:**
Know how to monitor the individual for desired effects, side effects and adverse effects of the prescribed medicine	• List potential for interactions between: > the prescribed medicines > the prescribed medicines and dietary products > the prescribed medicine and any other additional over the counter and supplementary. • Recall how to observe the individual and have sufficient knowledge of the individual to know when they are not reacting normally, even if the individual cannot self-report. • Ensure that the individual is aware of the intended purpose of the medicine being administered as well as the potential adverse events/reactions • Describe how to monitor the individual following the administration of the medicine for effectiveness and /or any side effect/adverse reaction • Apply "Stop and Watch" for observing for efficacy of drug administration • State the steps to be taken If staff observe an adverse reaction or suspected adverse reaction • Describe the recording and reporting procedures for any adverse events or reactions in the individual's care plan; this includes the individuals physical condition • Monitor for side effects and record them correctly • Know how and when to contact the National Poisons Advice Centre • Describe how to report an incident and the Incident Management Framework 2018 using NIMS report • List the principles of > HSE Open Disclosure Policy > Protected Disclosures Policy (2009)

Aim and learning outcomes for each unit of learning:

AIM	The right of the individual to refuse their medicines with reference to the individual's person centred medicine support plan.
OUTCOME the learner will:	**ASSESSMENT the learner must:**
Recognise the implications of a decision by the individual to omit/decline taking a medicine	• State the knowledge staff must have with regard to the individual's medicine management support plan. • Explain the policy on refusal of medicines by an individual being supported and how it is documented • List the potential consequences of omission of common medicines • List the policies and procedures for managing a situation where an individual refuses their medicine/decides to omit a medicine • List the principles of Safeguarding of adults Vulnerable to Abuse Policy (2014) • Explain the importance of updating the individual's personal support/care plan following new agreements with the individual and their prescriber

OBJECTIVE	Medicines will be reconciled at each transition/transfer/change
OUTCOME the learner will:	**ASSESSMENT the learner must:**
Work with the individual and, where appropriate, their families and carers, GP and pharmacist in medicine reconciliation	• Define medicines reconciliation • List and describe the three steps in medicines reconciliation Reference -- Accuracy at Every Step: The Challenge of Medication Reconciliation *www.ihi.org/resources/Pages/ImprovementStories/AccuracyatEveryStep.aspx* • List the requirements of an accurate medicine history with /for an individual and compare it with most recent prescription

Component module accessibility

The component module will be facilitated through the Centres of Nursing/Midwifery Education, Nurse Practice Development Units or other approved educational providers registered with QQI for the delivery of this component module. The component module should be responsive to the needs of service providers and should be open to change as required by legislation or regulatory changes.

Service providers have an obligation to ensure that there is sufficient co-ordination, supervision, and support for staff to access this component module.

Component module duration

The duration of the theoretical component will be agreed by the education provider to meet QQI level 5 requirements.

The supervised assessment by service providers must be completed within twelve weeks after the completion of the theoretical component.

Component module assessment

The Assessment Process is the process of judging learner achievement in relation to the standards of knowledge, skill, and competence so that the successful learner may receive an award (QQI 2018).

The education provider as part of their Quality Assurance Agreement with QQI will develop an assessment instrument which is in keeping with the six principles set out by QQI; validity, reliability, fair, quality, transparency and complementarity. There are six broad categories of assessment techniques and it is recommended that the education provider selects a minimum of two. One of these is to be a skills demonstration where at minimum the tenrights of medicine administration will be demonstrated under supervision. Indicators of performance will be developed by the provider to ensure consistency of assessment. The staff will receive a Component Certification for Medicines Management in Disability Services QQI Level 5 on successful completion of the assessments.

Component module evaluation

The component module is evaluated by the educational provider, the learners, and the service providers. A component module review schedule should be clear and specific, based on the component module duration and service provider's own policy for review. The component module must satisfy the Quality and Qualification Ireland (QQI)'s guidelines for further education and training programme.

Learners and service providers should be facilitated to give feedback and evaluation to the educational providers. This ensures that the component module meets not only legislation and regulatory requirements but the needs of everyday practice.

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