Aurora

Enriching lives, Enriching Communities

Medication Management Policy

Policy Number	Policy Developed by	Date Developed
16 – Schedule 5	Marie Maddock Mary Moylan Mary O'Keeffe Hazel Butler	09.11.2016
Version	**Amendments**	
9	Update to medication training Update to medication errors Addition antibiotic stewardship monitoring form	
Reviewed by		**Review completed**
Hazel Butler, Mirjam Lettner		24.02.2025
CEO signature		**Next Review Date**
		24.02.2028

Mission Statement

Enable people with complex needs to experience the same rights as every other citizen and as equal members of the community.

Table of Contents

1. SECTION 1 4

1.1. Introduction 5

1.2. Purpose and Scope of this Policy 5

1.3. Definitions of Term's used within the Policy 6

2. SECTION 2 9

2.1. Specific Responsibilities – Organisation 10

2.2. Specific Responsibilities – WCI Manager/PIC/Team Leader 10

2.3. Specific Responsibilities – Registered Authorised Person 11

2.4. Specific Responsibilities – Registered Nurse 12

2.5. Specific Responsibilities – Emergency Medication of Adrenaline for Anaphylaxis 14

2.6. Specific Responsibilities – Designated Staff in Emergency Medication for Epilepsy 15

3. SECTION 3 16

3.1. Confidentiality 17

3.2. Medication Training 17

3.3. Training Pathway 18

3.4. Administration of Medication (*Ten Rights*) 19

3.5. Self-administration of medication 20

3.6. Medication for People Supported in Day Service 21

4. SECTION 4 22

4.1. Medication system, Receipt, check and logging medication 23

4.2. Prescribing Practitioner 24

4.3. Prescriptions and Records of Individuals Medications 25

4.4. Altering, crushing, chewing and liquid medications 25

4.5. Emergency Procedure for obtaining prescribed medicines from Medical Practitioners (GPs) over the phone. 27

4.6. Covert Administration of Medication 28

4.7. Medication Monitoring and reviews 29

4.8. Transcribing of Medications 30

5. SECTION 5 31

5.1. Non Prescriptive Medications – OTC (Over the counter medications) 32
5.2. Non- Regular Medication (P.R.N) 32
5.3. Sedative Medications (Pre-Med) Prior to Procedure 33
5.4. Controlled Drugs 33
5.5. Guidelines of the administration of Oxygen (O2) 34
6. SECTION 6 35
6.1. Guidelines of the administration of Oxygen (O2) 36
6.2. Adverse Drug Reaction Reporting 38
6.3. Support a person with their medication while away from the person home: 38
6.4. Complimentary Medications 38
6.5. High Alert Medicines 39
6.6. Medication administration via enteral feeding tubes (PEG) and Nasogastric Tube (NG) 39
6.7. Transdermal Patch Application /Disposal 40
7. SECTION 7 41
7.1. Oral Nutritional Supplements (ONS) 42
7.2. Thickening agents 42
7.3. Medication Reconciliation 44
7.4. Delivery/Collection & Storage of Prescribed Medications 44
7.5. Storage of Medications 44
7.6. Out of date and disposal of medications 45
7.7. Suspected or discovered defective medication 45
7.8. Policy for the disposal of sharps 46
7.9. Needle-stick injury 46
7.10. Antimicrobial stewardship Monitoring Form 47
8. APPENDIX 1 48
9. APPENDIX 2 49

1.3. Definitions of Term's used within the Policy

The following terms are used throughout the document in relation to Medications management and administration procedures.

Term	Definition
Adherence	Adherence to Medications is defined as 'the extent to which the person's action matches the actions recommended'.
Administration	The administration to/by an individual of Medications onto or into their body for therapeutic, diagnostic, prophylactic or research purposes.
Adverse event	A preventable failure at any stage of the Medications management/administration process, which leads to, or has the potential to lead to, harm to the supported individual.
Adverse Reaction	A response to a medicinal product which is harmful and unintended.
Authorised Medications prescribed for an unauthorised indication	Previously referred to "Off-label Prescribing" A Medications which is Prescribed outside the terms of its marketing authorization, and which is not specified in the summary of product characteristics.
Authorised Person	An employee of Aurora (Kilkenny) who has successfully completed the recognized training program for Medication's management/ administration.
Designated Person	An employee of Auroras who has successfully completed the recognised training program for dispensing and administration of emergency rescue medications.
Brand name	The special name given for marketing purposes to any ready prepared Medications placed on the market in a special pack. A brand name maybe a protected trademark.
Complementary and alternative therapies	A group of diverse medical and healthcare systems, practices and products that are not generally considered part of the conventional Medications.
Compliance	The degree or extent of conformity by the individual we support to the recommendations about day-to-day treatment by the prescriber with respect to the timing, dosage and frequency of the prescribed Medications.
Crushing Medications	Involves rendering if from a solid in the form of a tablet or pill to a powder form in order to assist with administration to the person.
Dispensing	The process starting from the receipt of a prescription request, assessment of the request, review of Medications therapy and health information, the preparation of the product, recording the prescription, and delivery of the final product with appropriate counselling (PSI 2008)
Employee	Any individual that is paid to work for the organization. For the purpose of this Policy, employee refers to all people whom work within in the service, hired directly by Aurora or through a third-party agency.
General Practitioner (G.P.)	A person who holds a medical qualification (Medical Practitioners Act, 2007) and is registered with the Medical Council of Ireland.
Guideline	A principle or criteria that guides or directs action. Guideline development emphasizes using clear evidence from the existing literature,

	rather than expert opinion alone, as the basis for advisor materials. (HSE 2011)
Medication administration compliance aids/monitored dosage systems	Different names are used to describe medication administration systems. Administration compliance aids, such as, monitored dosage systems, blister packs, compliance medication systems, unit dose packages, multi-dose packages and aids/monitored dose administration aids.
Medication review	A structured critical examination of the supported individual's Medications with the objective of reaching an agreement with the individual about optimising the impact of Medications and minimising the number of medication-related problems and reducing waste.
Medication (Medications) System	A medication system is an organised system designed to ensure safe and accurate dispensing, packaging and administering of medication.
Must	A command/s the action a person is obliged to take from which no deviation whatsoever is allowed.
Nurse	A person whose name is entered on the register of NMBI (Nurses Act, 1985).
Omission	Failure to do something that a person has a moral or legal obligation to do.
Pharmacist	A registered member of the Pharmaceutical Society of Ireland.
Prescribe	To authorise in writing the dispensing, supply and administration of a named medicinal product (typically a prescription - only Medications, but may include over the counter medications) for a specific person supported.
Prescription	Is issued by a registered medical practitioner for the medical treatment of an individual, by a registered dentist for the dental treatment of an individual, or by a Nurse Prescriber for the medical treatment of an individual subject to Article 3A of the Regulations (Misuse of Drugs (Amendment) Regulations, 2007).
PRN (as required Medications)	Pro Re Nata is a Latin phrase that is commonly used in medication management to mean 'as required' or 'as the situation arises'. It is generally used as the initialism PRN to refer to those prescribed Medications that are not scheduled on a regular basis.
PRN Management Plan / Protocol	An agreed procedure for the administration of PRN medication.
Procedure	A written set of instructions that describe the approved and recommended steps for a particular act or sequence of events. (HSE 2011)
Protocol	A written plan that specifies procedures to be followed in defined situations. It represents a standard of care that describes an intervention or set of interventions. Protocols are more explicit and specific in their detail than guidelines, in that they specify who does what, when and how. (HSE 2012)
The individual's Self administration	The independent/supported use of prescribed Medications by individuals we support in a manner that supports the safe management and administration of their Medications.
Standards	Authoritative statements developed, monitored and enforced by local, national and international independent/governing bodies that describe the responsibilities and conduct expected of nurses and authorised/delegated persons and their involvement with Medications across all healthcare settings.
Transcription	An act by which medicinal products are written from one form of direction to administer to another.
Transportation of Medications Unregulated	A person who is not statutorily regulated and is employed within a healthcare, residential or community setting and whose role includes a component of direct individual care and the performance of delegated care activities, supported by an organisational policy.

Healthcare Worker	
Transdermal	Across the skin, particularly with reference to the absorption of drugs applied topically for systemic effect.
Transdermal patch	A drug-impregnated adhesive patch applied to the skin for controlled release of the active compound.

2. Section 2

2.1. Specific Responsibilities – Organisation
2.2. Specific Responsibilities – WCI Manager/PIC/Team Leader
2.3. Specific Responsibilities – Registered Authorised Person
2.4. Specific Responsibilities – Registered Nurse
2.5. Specific Responsibilities – Emergency Medication of Adrenaline for Anaphylaxis
2.6. Specific Responsibilities – Designated Staff in Emergency Medication for Epilepsy

2.1. Specific Responsibilities – Organisation

2.1.1. Ensure that the Medications management/administration policy and procedure is in line with and adhering to current best practice guidelines. That the review and implementation of guidelines and protocols are promoting and supporting autonomy for the people we support in a holistic person-centred manner.

2.1.2. Maintain overall responsibility for assigning medication management/administration duties to Nurses, authorised and designated staff and assumes overall responsibility for the administration of medication by such staff. This includes Nurses who give guidance to authorized/designated employees on the administration of PRN medications.

2.1.3. It is the responsibility of each employee to familiarize themselves with the Administration of Medication Policy and Procedures.

2.1.4. Aurora (Kilkenny) has a responsibility to provide regular training for employees in the administration of medication. Even when permitted to do so, employees must only undertake those aspects of support in which they have been trained, are competent, and have demonstrated their competence.

2.1.5. Be responsible for selecting employees and assigning responsibility to these employees to manage/administer medication.

2.1.6. Be responsible for providing training to employees, ensuring that all authorised and designated employees have completed an approved training programme.

2.1.7. Maintain a register of authorised employees and ensure that these employees receive certification and renew this certification every two years or earlier if required.

2.1.8. Maintain a register of designated employees for the administration of Emergency Rescue Medications and ensure that these employees receive current and updated training in all aspects of Emergency Administration in specific areas e.g., Epilepsy, Diabetes and Anaphylaxis (as appropriate).

2.1.9. Maintain a register of Registered nurses.

2.1.10. Monitor and investigate near misses, critical incidents and hazards and take appropriate action.

2.2. Specific Responsibilities – WCI Manager/PIC/Team Leader

2.2.1. WCI / PIC / T/L are responsible for ensuring that this policy is made available, in each house/area on the Q drive.

2.2.2. Respond to every employee who seeks clarification on any area within the policy that is not clear to them.

2.2.3. Maintain an up-to-date list of authorised signatures and initials to accompany the Medication Recording Documentation maintained in the Kardex folder.

2.2.4. Perform audits to ensure the Medications Management of their area, ensuring that policies and procedures are safe, appropriate, consistent and effectively monitored.

2.2.5. Monitor any medication errors / discrepancies and near misses, Appropriate action must be taken as necessary and these events to be reported to the Director of Services. It is vital that learning is an outcome from these incidents.

2.2.6. WCI/PIC and T/L are responsible for identifying third part agency staff to complete safe and responsible medication management training. These employees must partake in quality conversations and team meeting with the PIC have direct oversight in the employee to ensure that they follow policy and maintain their training and arrange for their assessments to be carried out by Nursing staff.

2.2.7. Ensure that Nurses, authorised employees and designated employees who require further support or training are facilitated to do so.

2.2.8. Ensure that the policy is upheld in their respective areas.

2.3. Specific Responsibilities – Registered Authorised Person

2.3.1. The Authorised Person is an employee who has completed an approved training programme with current certification and is registered within the Service to conduct medication management. Training shall be provided by a suitably competent healthcare professional with the appropriate clinical and educational training. Training shall be supplemented by competency assessment and refresher training completed at appropriate intervals, in line with peoples' changing needs. (HIQA 2015). Once you have completed all components of the training you can administer medication with in Aurora only. This training does not cover medication management or administration with in another service.

2.3.2. Shall report immediately any concerns when involved in the practice of Medication Management, to their WCI/Team Leaders and registered prescribing Practitioner or pharmacist if appropriate.

2.3.3. Shall know the indications and contraindications for the medication and its desired effect for the individual. Be aware of the main action of the medication, the dose, frequency, route of administration and potential side effects.

2.3.4. If a prescription is unclear, incomplete, inappropriate or difficult to read, the Authorised Person MUST NOT PROCEED. In this instance the Authorised person shall seek advice from senior staff, the registered prescribing Practitioner or the pharmacy staff (as appropriate).

2.3.5. Shall have knowledge of the Kardex folder, including common abbreviations and terms used within Aurora Service.

2.3.6. Shall record their registered name and number in the Authorised Person form at the front of the Kardex of the person supported.

2.4. Specific Responsibilities – Registered Nurse

2.4.1. Ensure that your name is maintained on the live register of N.M.B.I. Failure to do so will be deemed as a breach of contract.

2.4.2. Adhere to the Code of Professional Conduct for each Nurse and Midwife (N.M.B.I.).

2.4.3. Accountable to the people we support, to the Organisation, to N.M.B.I., and Irish laws (Reference 1).

2.4.4. Develop and maintain your competence with regard to all aspects of Medications Management, ensuring that your knowledge, skills and practice are up to date and providing support documentation of Continuous Professional Development (CPD) regarding evidence-based practice in Medication Management.

2.4.5. Be aware of what medicinal products are contraindicated for the people you support.

2.4.6. Follow the procedure outlined in 'The Guidance to Nurses and Midwives on Medication Management (A.B.A. 2007) and all relevant medication management documentation governing local practice.

2.4.7. Not proceeding if the prescription is unclear, incomplete, inappropriate or difficult to read. Registered Nurse should seek verification and amendment from registered prescribing practitioner or pharmacy personnel.

2.4.8. Check all Kardex prescriptions are written up correctly and check them against the main prescription sheet as prescribed by the registered prescribing practitioner.

2.4.9. Have knowledge of Medications management abbreviations and terms used.

2.4.10. Mentor and share knowledge with authorized and designated employees as required.

2.4.11. Assess employees who have undertaken training in medication management / medication administration.

2.4.12. Only registered Nurses who are on the live register are authorized to administer medications intramuscularly (IM), Naso Gastrictly (NG) or by subcutaneous (Sub cut) methods under this current policy. The nursing staff member will be assessed as having the capability (physical and mental capacity) to do so.

2.4.13. There will be an agreement from the multi professional team (minimum General Practitioner (GP) and registered nurse) that it is appropriate course of treatment for the person supported. The Nurse will have completed the necessary training and is considered competent by a healthcare professional and feel confident to administer medication Via the appropriate route.

2.4.14. Nursing staff where and when available should administrate medication. If the nurse is not available then the authorized staff trained should administer medication.

2.4.15. There will be an agreement from the multi professional team (minimum General Practitioner (GP) and registered nurse) that it is appropriate course of treatment for the person supported. The Nurse will have completed the necessary training and is considered competent by a healthcare professional and feel confident to administer medication Via the appropriate route.

2.4.16. Nursing staff where and when available should administrate medication. If the nurse is not available then the authorized staff trained should administer medication.

2.5. Specific Responsibilities – Emergency Medication of Adrenaline for Anaphylaxis

Only Nursing staff that have up to date training in anaphylaxis can administer epinephrine via I.M. injection.

Only nursing staff who have up to date training in anaphylaxis can administer epinephrine as pre Medicine protocol for peer vaccination clinics.

Only employees that have received specific training may administer Adrenaline for anaphylaxis via pre-filled pens

The Team leader/PIC must ensure that a record is kept of all designated employee who have up to date training in kept in the kardex folder of the person with the staff signature and initials.

If prescribed medication for anaphylaxis there must management of anaphylaxis plan that includes:

1. **Name**
2. **DOB**
3. **Known allergies and possible reactions.**
4. **Clear instructions of the use of Adrenaline pen as pre the protocol.**
5. **Instruction on the care of individual following administration**
6. **When to contact the emergency services.**

Each emergency pack contains 2 Adrenaline pens, gloves, medication protocol and a copy of the management plan.

2.6. Specific Responsibilities – Designated Staff in Emergency Medication for Epilepsy

Only nurses and staff with accredited training can administer emergency rescue medication

When accompanying a person outside of their home they must have buccal pack and oxygen if prescribed

Buccal pack must include:

PRESCRIBED MEDICATION X 2

PROTOCOL SIGNED BY GP

O2 ADMINISTRATION PROTOCOL IF PRESCRIBED O2

GLOVES AND TISSUES

OXIMETER

KEYRING WITH PERSON NAME ON PACK.

Designated staff must sign the designated staff register log in each person kardex.

Each person's Epilepsy Support plan should include the following:

NAME

SEIZURE DESCRIPTION/CLASSIFICATION

POSSIBLE WARNING SIGNS

USUAL RECOVERY TIME

WHEN EMERGENCY MEDICATION IS ADMINISTERED AND DOSE

USUAL RECOVERY AND INTERVALS BETWEEN DOSES

Buccal protocol must include:

Name

When emergency medication is given.

Dose

Weather to repeat the dose and after how long.

Maximum dose in 24hrs

When to contact emergency services

Signed by the GP

1. Epilepsy Support plan, buccal protocol and Oxygen protocol are review annual. These plans are reviewed sooner if there is a change in the seizure pattern of in the use or need of Buccal and Oxygen.
2. All seizures are recorded on the yearly record sheet and a seizure incident report.
3. Emergency medication is controlled using the medication stock book with staff checking and recording the medication and daily and completing a weekly stock check

3. Section 3

3.1. Confidentiality
3.2. Medication Training
3.3. Training Pathway
3.4. Administration of Medications (Ten Rights)
3.5. Self-administration of medication
3.6. Medication for People Supported in the Day Service

3.1. Confidentiality

All employees shall ensure they are aware of the importance of keeping information confidential as outlined in Aurora (Kilkenny) Contract of employment, the National Safeguarding Policy 2015 & Trust in Care 2007 and the GDPR National Guidelines set out in 2018.

3.2. Medication Training

3.2.1. Aurora (Kilkenny) has a responsibility to provide regular training for employees in Safe Medication Management and Safe Medication Administration.

3.2.2. Aurora employees only administer medications when they have had the approved training and are assessed as having the skills necessary to carry out this task safely. Training will be provided by a suitably competent healthcare professional with the appropriate clinical and educational training. Training will be supplemented by mentorship and assessment and refresher training completed at appropriate intervals, in line with the changing needs of people supported.

3.2.3. Safe medication management training consists of theory section completed online with a Quiz with an 80% pass rate. This is then followed by a practical thought half day training. Registered Nurses and authorized staff in Aurora will facilitate identified employees to develop their skills in Safe Medication Management, through mentorship and by carrying out the minimum of 3 assessments pertaining to the training provided. An employee must observe medication been administered at least five times before arranging for a medication assessment to be complete post initial training. This training will last for two years and the full training, including three assessments must be repeated every two years.

3.2.4. The training will cover ordering, receipt, storage, administration, recording errors and returning to pharmacy i.e., the medication management cycle. Post this training and after a period of mentorship, employees will be authorized to administer medication when they have been assessed by a nurse as having the skills to do so safely.

3.2.5. Medication Administration via PEG training will be provided to employees who support a person/people who have a PEG in situ. PEG Training will be provided by a suitably competent healthcare professional with the appropriate clinical and educational training. Training should be supplemented by mentorship, assessment and refresher training completed at appropriate intervals, in line with the changing needs of supported people. Employees will only be authorised to administer medications to people via PEG once they have been assessed by a suitably qualified nurse as having the skills to safely do so. Aurora has a detailed eternal feeding policy for staff to refer to.

3.2.6. Team Leads / Nursing staff in each area shall ensure that staff who do not have the necessary skills to administer medications safely, despite completing the required training, do not administer medication to supported people and are encouraged to seek further training.

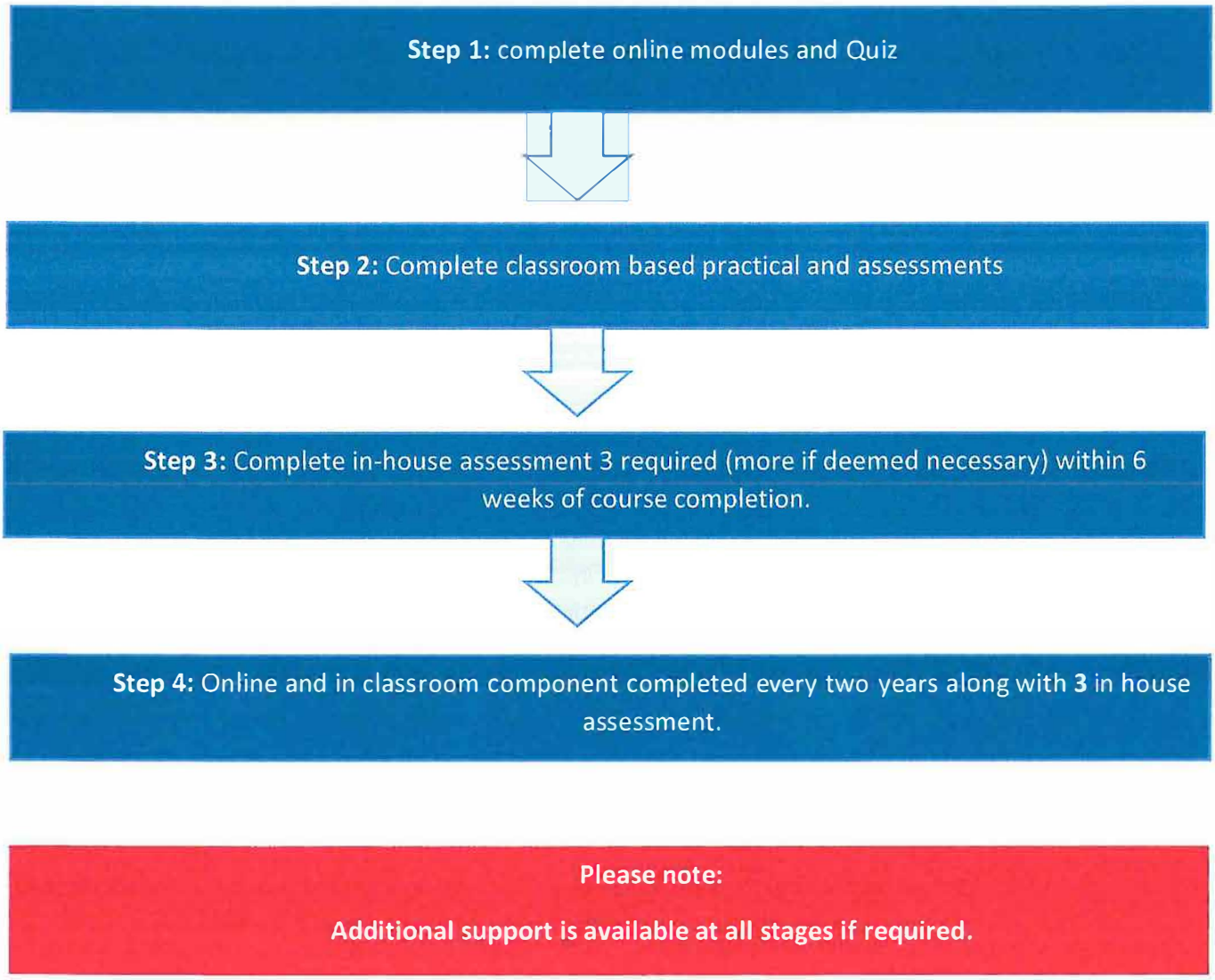
3.2.7. Team leaders shall have accurate and up to date training records of the employees working in the specific houses. Team Leaders shall ensure that all employees have completed training requirements and mentorship prior to being entered onto the service register.

3.2.8. Stock Checks will be carried out on a weekly basis by an authorized staff member who has the skills to carry out the stock checks within the arear they currently work in. An SOP outlining the procedure will be followed by the authorized staff when carrying out the weekly Stock Check. Authorized staff that is proficient in Stock Checking should mentor authorized staff that require upskilling until such time as they have the required skills to carry out the stock check.

3.2.9. Students on work experience programs facilitated within Aurora (Kilkenny) are not permitted to administer medications. Student nurses/midwives may administer medication under the supervision of a registered nurse/midwife and should follow the principles of supervision. The registered nurse/midwife retains accountability for the administration of medical products. N.M.B.I. (2007)

3.2.10. Student nurses who are employed as HCA on fulltime or relief basis in Aurora (Kilkenny) are to follow the Medication Training program as outlined in this section

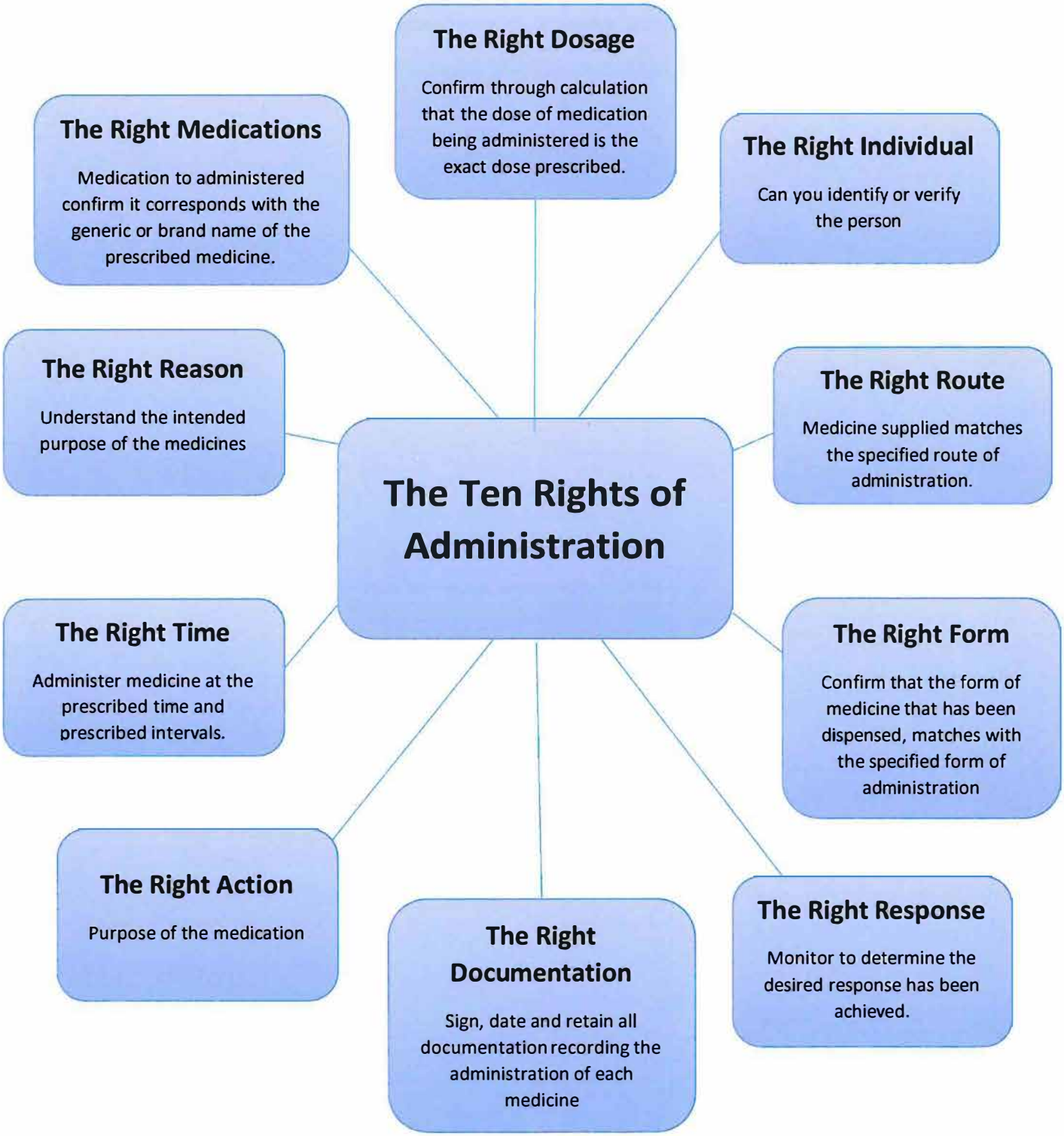
3.3. Training Pathway



3.4. Administration of Medication (*Ten Rights*)

3.4.1. The Ten Rights of Administration (Elliot and Liu 2014); should be applied as the guiding principles for good practice in Medication administration as outlined in the following.

3.4.2. When the person supported **refuses to take their prescribed medication** following reasonable encouragement, this refusal should be noted in the individual's daily notes and in the MAR sheet (Medication Administration Record) (see appendix 8). Where persistent refusals occur, or where administration poses a difficulty, it should be brought to the attention of the registered prescribing practitioner and Team Leader and addressed to seek the best outcome for the person supported.



3.5. Self-administration of medication

3.5.1. Each supported person will have a Self-Medication Assessment, which is agreed by the supported person, Team Leader, and keyworker. This assessment will be incorporated into their Personal Plan.

3.5.2. The Self-Medication Assessment will identify the levels of support required by the person regarding all aspects of administration of their medication up to and including "Self-Administration".

3.5.3. This is a dynamic process and categories of support can change over time and with different medication. The assessment should be reviewed frequently to reflect changes.

3.6. Medication for People Supported in Day Service

Supported people in the Day Services may need their medication administered when attending Day Service, e.g. midday medication.

This medication shall be provided to the day service by the staff of the house or a family member of the supported person.

Receipt of the medication should be recorded by a day service employee in the relevant day service Medication Recording book.

Only authorized employees are permitted to administer medications to supported people in day services.

For individuals who live at home with their family, it is the responsibility of the guardian/family member to ensure that relevant employees are informed of any/all changes to the person's Medication.

In order for authorised staff in Aurora day service to administer regular or short term prescribed medication to people supported, the family must get the GP or prescribing practitioner to complete an Administration of Medication Agreement form and chart the medication on the MARS sheet.

This should be completed in full and provide to the Day Service prior to any administration of medications by day service authorised staff.

In order for authorised Aurora to administer un-prescribed medication the Family/ Guardian needs to complete an Administration of Non-Prescribed Medication Agreement form.

This should be completed in full and provide to the Day Service prior to any administration of medications by day service authorised staff.

All medication needs to be provided in its original packaging. Staff of the day service cannot medication that has been pre dispensed or not in its original packing.

4. Section 4

4.1. Medication system, Receipt, check and logging medication
4.2. Prescribing Practitioner
4.3. Prescriptions and Records of Individual's Medications:
4.4. Altering, crushing chewing and liquid medication
4.5. Emergency Procedure for obtaining prescribed medicines from Medical Practitioners (GPs) over the phone.
4.6. Covert Administration of Medication
4.7. Medication Monitoring and reviews
4.8. Transcribing of Medications

4.1. Medication system, Receipt, check and logging medication

Medication System

4.1.1. The Venalink System - medications are dispensed in unit dosage cards. These are dispensed by the pharmacist on receipt of a prescription by the G.P. or another authorised prescriber e.g., Psychiatrist, Dentist or registered Nurse prescriber.

4.1.2. Whilst the system provides some safety controls, it does not eliminate the possibility of human error. Medication Management is never without some risk - the unit dose system is about minimising the risk in administration, providing a more manageable system for individuals who are supported by authorized and designated employees and/or self-administering; maximising the therapeutic benefit to people supported.

4.1.3. PRN Medication is not suitable to be dispensed in this system.

4.1.4. Newly prescribed Medications will not be dispensed in this System to allow for monitoring of adverse reactions. Medication may need to be discontinued abruptly and would necessitate returning these medications to the pharmacy. When the medication becomes established and well tolerated, then it can be dispensed in this system.

4.1.5. Medication not suitable for the unit dose system will be dispensed and administered using the standard method.

4.1.6. The System will carry the same labelling as required for standard medication dispensing, but also carries information re the identification of each medication in the unit dosage.

4.1.7. Aurora (Kilkenny) will continue to research new and safer methods of Medications Systems to ensure the safest possible system is used.

Receipt, check and logging medication

4.1.8. Receipt of Venalink Packets. On receipt of the Venalink Packets from the pharmacy, check the labels on the top of each pack and then cross reference the labels against the Medication Prescription Recording Documentation in the supported person's Kardex.

4.1.9. If there has been any change made by the registered Prescribing Practitioner check that the change has been made by the pharmacist. If you note any discrepancy at this stage, check with the pharmacy.

4.1.10. Make a visual check of the medications in each blister against the labels attached to the packs.

4.1.11. Record any communication with the pharmacist at this time.

4.1.12. When you are satisfied that the medication is visually correct enter the stock in the Medication Stock Check Book.

4.1.13. Medications received as loose medications and short-term medications shall be entered into the Medication Stock Check Book.

4.1.14. A medication prescription should not have any written amendments. If there are changes in the medication, dosage, frequency, route or method of administration etc. the prescription should be discontinued and re-written by the authorised prescriber.

4.1.15. Use the twenty-four hours clock in all written recordings and documentation of administration of Medications.

4.2. Prescribing Practitioner

4.2.1. Medication is prescribed by a registered Prescribing Practitioner only.

4.2.2. Medication can only be administered with a prescription.

4.2.3. The prescription is the official instruction by the registered Prescribing Practitioner as to how the Medication/s prescribed is to be dispensed and administered.

4.2.4. Medication shall be prescribed by registered Prescribing Practitioner e.g.

- The Individual's G.P./Care Doc/Locum
- Hospital Consultant
- Psychiatrist
- Dentist
- Nurse Prescriber
- Home Care Team

4.2.5. All written prescriptions must be legible. Where a prescription is illegible; the medication must be withheld, the prescribing registered Prescribing Practitioner should be contacted immediately and requested to reissue a legible prescription (if it is a paper prescription).

4.2.6. The prescription shall include all the following information:

- The person supported name
- Date of birth
- Prescription/Recording Sheet in use within the service.
- The date when Medications is to commence
- The generic name of the medication
- The dosage / strength of medication
- Frequency and Time of administration
- Route and method of administration
- Allergies - Known or None Known must be completed
- Prescribing Medical Practitioner's signature (PIN number essential)
- Discontinuation date (if known e.g., short-term medication)
- All recordings on medication documents should be written in black pen and legible handwriting.

4.2.7. The Medication Prescription Recording Documentation should not bear any written amendments. If there are changes in the Medications, dosage, frequency, route or method of administration etc. the prescription should be discontinued and re written.

4.2.8. When prescriptions are discontinued, a line should be drawn diagonally using a black pen through the complete row. The registered Prescribing Practitioner should enter his/her initials and end date in the prescription sheet dispensing history area.

4.3. Prescriptions and Records of Individuals Medications

4.3.1. The prescription will be forwarded to the pharmacy by the GP (Prescriber) physically of by electronic means and will be reviewed by the pharmacist before the medicinal product is dispensed. The pharmacist will keep the original prescription or record of the prescription.

4.3.2. The Pharmacist will transcribe the medication required onto the Kardex.

4.3.3. The GP (Prescriber) will not be required to sign the Kardex.

4.3.4. A **copy** of the original prescription must be printed in the pharmacy and attached to the Kardex to provide evidence of changes or of new prescription.

4.3.5. Prescriptions should be reviewed by the registered Prescribing Practitioner at agreed review times in conjunction with the supported person and support employees where appropriate.

4.3.6. When a Medication Prescription is re written (and signed by the registered Prescribing Practitioner), a new Prescription/MAR Sheet should be started to avoid confusion with numbers and codes.

4.3.7. In the event of a short-term medication specified (e.g., Antibiotics), prescriptions will be clearly indicated for definite period of time i.e., 1/52, 1 by 5 days etc. A MAR sheet must be ordered for this medication from the Pharmacy i.e., copy of the prescription sheet to be brought to the pharmacy.

4.3.8. All known allergies to be clearly highlighted on the prescription.

4.3.9. Only HSE approved abbreviations (frequently used abbreviations within the service, identified in Appendix 1) may be used in the Kardex.

4.3.10. In emergency situations, a registered Prescribing Practitioner can contact the Pharmacy directly via email/" health mail" with the prescription, the name of the medication prescribed, the dosage, the time of administration, the route of administration and the prescriber name/signature.

4.4. Altering, crushing, chewing and liquid medications

4.4.1. Employees should NOT change the presentation of medication prescribed, e.g., splitting tablets, tablet crushing, or opening capsules. Crushing renders medication unlicensed. This action is legal only when it has been authorised in writing by the registered Prescribing Practitioner.

4.4.2. Where swallowing difficulties are present, employees must contact the registered Prescribing Practitioner to explore alternative applications, (e.g., liquid preparations). In the event that there is no alternative and the medication is necessary for the individual, the prescriber must provide written approval that the medication can be safely crushed or opened before an employee can proceed with the crushing or opening of the medication.

4.4.3. Whenever medications are altered, the alteration must be approved by the registered Prescribing Practitioner and recorded on the individual's Medication prescription record/Book/registered Prescribing Practitioner's Prescription.

4.5. Emergency Procedure for obtaining prescribed medicines from Medical Practitioners (GPs) over the phone.

This procedure only relates specifically to emergency situations where availability and access to the GPs is limited to phone contact.

Where the GP is available to do so, he will write the change of medication onto the Kardex, this should be clear and legible and in black pen

Aurora recognises and ensures that safety is the overriding principle in accepting verbal or telephone orders. Verbal and telephone instructions have higher potential for errors as these orders can be misheard, misinterpreted and/or mis-transcribed.

The authorised person (medication trained) /nurse should seek advice from the Emergency governance/ Senior person on duty, fully outlining the emergency and why it is the best course of action for the person supported.

The authorised person/nurse can take instruction on a prescription by way of phone call. There must be a second person to hear and clarify the order with the authorised prescriber (ie GP, Dentist, Nurse prescriber) by repeating back the prescription to the prescriber.

The authorized prescriber identifies themselves and specifies the supported person's name and communicates the order.

When taking details of a prescription over the phone the authorised person/nurse must read back to the authorised prescriber the following prescribing instruction:

- The justification and rationale for accepting a verbal or telephone medication order.
- The supported person's name and DOB
- Drug name and spelling of the drug to avoid an error due to sound alike drugs.
- Dosage, pronouncing it in single digits (e.g. 15mg should be read as one five)
- Frequency (e.g. three times daily, not TID)
- Route of administration
- The indication (why it is required) for the medication to assist in avoiding errors.
- Questions the authorized prescriber if there is any uncertainty regarding the order.
- The authorised person/nurse should keep a written record of this discussion on the 'Over the Phone prescription Record Sheet'**(see Over the Phone Prescription Record Sheet- appendix three)**
- The authorised prescriber should then confirm this information
- **Generic drug names should be used when drug orders are given**
- **Abbreviations should be avoided when an order is given or received**

- The GP must forward the signed prescription to the pharmacy, either physically or by electronic means. (some medications will require the physical prescription only i.e. controlled drugs). This must be agreed with the GP and entered on over the phone record sheet).
- The 'over the Phone Record Sheet' should be kept with the supported persons Kardex.
- A copy of the original prescription should be kept with the supported persons Kardex.
- In addition, where a Doctor orders a change to a supported person's regular medicines, the doctor must also communicate the change to the Pharmacy either by prescription or by other electronic means (fax, healthmail, phone or text).
- The pharmacy will update the Kardex to reflect the change and produce a new Mar sheet, and make changes to medicines as appropriate and reprint labels with new instructions as per the Doctor's new directions.

4.6. Covert Administration of Medication

Crushing Medications and mixing Medications with food or drink to make it more palatable or easier to swallow does not constitute covert administration if the individual has been made aware.

In the absence of consent, covert administration or disguising medication in food or drink may be regarded as deception, as the individual may not be aware that they are getting medication, when in fact they are.

The individual who consumes the food or drink does not always know that medication has been hidden in it. Disguising medication in food or drink should not be a routine practice, whether it is with or without the consent of the individual.

It is recommended that medication will not be given covertly unless clearly agreed by the Multidisciplinary Team.

A **decision to administer medication covertly** should only be taken when the following criteria has been reached:

- Conventional administration methods have been unsuccessful.
- That different form of the medication are offered e.g. Liquid.
- The individual prescribed the medication cannot or will not give consent.
- It is felt that, in the best interest of the individual, covert administration of medication is necessary.

How do you determine in the best interest of the person

A circle of support meeting should be held with the individual and the following people should be invited to attend:

- The person supported along with their family/advocate.
- Appropriate relevant members of the multidisciplinary team,
- Registered Prescribing Practitioner and or GP
- Individual's keyworker, Team leader/PIC and WCI.
- It is essential that, at this meeting, consideration is given to the individual's capacity to give consent to the treatment and to their best interests following MDT input and consideration. * Please refer to the Aurora's ADM Policy.

A clear written record must be kept in the individual's notes, which must also include:
Record of the decision reached
A description of the procedure for the covert administration of the relevant medication.
It is recommended that a review date is noted,
The plan to administer medication covertly is signed by those involved in the decision making process.

The length of time before reviewing this practice will depend on the initial reason for deciding upon the covert administration of medication.

It is recommended that if the individual is acutely unwell and rendered unable to give consent by their current condition, then the review should be done as required to reflect the changing nature of the individual's health.

If the individual is unable to consent by virtue of a permanent condition then the review will be required less regularly and a 3-6 monthly reviews may be adequate. A written record must be kept of the review and the decisions reached.

4.7. Medication Monitoring and reviews

4.7.1. Medication review is an essential component of medication management. It should be undertaken in a proactive and planned manner by the interdisciplinary team. A structured approach to medication review should be implemented and continuously evaluated, decision made to continue, change or discontinue medication.

4.7.2. The medication review should take place in line with the relevant legislation or more frequently where there is a significant change in the individual's care, medication or condition. A full medication review of both regular and PRN should take place every six months and should involve the individual, his or her representative as appropriate, registered Prescribing Practitioner, pharmacist, nursing staff and other relevant members of the health and social care team where possible.

4.7.3. The medication review will involve reviewing all prescribed, over-the-counter and complementary medications used by the person. The person's medication adherence, side-effects, adverse drug events and monitoring test results form part of the review.

4.7.4. The medication review will be documented in the person's medical notes detailing changes that have been made or that no changes have been made. Prescription and administration records should be updated following such reviews to reflect any changes that have been made. All relevant changes to medication following the review are clearly documented and a note is also made if no changes are to be made.

4.7.5. HIQA (2015) recommends that more attentions should be paid to the following:

- Antipsychotic medication
- 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

4.8. Transcribing of Medications

4.8.1. Transcribing is an act by which medicinal products and instructions are written from one form of direction to another. It is recognised that transcribing of any clinical information is a high-risk activity and there are serious risks of inadvertent mistakes in transcription, omissions or duplication of Medications.

4.8.2. Transcribing of medication for people supported living in Aurora is completed by the pharmacist. Only in exceptional circumstances registered staff nurses will transcribe as per NMBI guidance (e.g. during night shifts or at weekends). Once an exceptional transcription has been completed by two staff nurses the person's Kardex has to be amended by the Pharmacist immediately on the next working day.

4.8.3. Medication Management/Community Liaison nurse to be informed by transcribing staff nurses of exceptional transcription completed; this will be logged by the provider to be available for audit purposes.

4.8.4. Best practice indicates that the responsibility for documenting the prescription or Medication's order is with the registered Prescribing Practitioner to prevent the possibility of error by another individual.

4.8.5. The decision to transcribe a prescription should only be made in the best interests of the people. NMBI agus Cnáimhseachais has issued guidance to nurses and midwives in relation to transcription and stated that a nurse or midwife who transcribes is professionally accountable for his or her decision to transcribe and the accuracy of the transcription.

4.8.6. Transcribing may only be carried out by registered nurses with a second person (also a staff nurse) checking the prescription transcribed in order to minimise the risk of error. Social care staff/Health care assistants must not transcribe medication orders. Transcribed orders should be signed and dated by the transcribing nurse, the second nurse must co-sign the signature and a copy of the prescription must be present in the Kardex file within 72 hours.

5. Section 5

5.1. Non-Prescriptive Medications – OTC (Over the counter medications)
5.2. Non- Regular Medication (P.R.N)
5.3. Sedative Medications (Pre-Med) Prior to Procedure
5.4. Controlled Drugs
5.5. Guidelines of the administration of Oxygen (O2)

5.1. Non-Prescriptive Medications – OTC (Over the counter medications)

5.1.1. Aurora (Kilkenny) aims to facilitate a supported person's requests for over-the-counter medication. However, in the interests of the person's safety, all access to over-the-counter medication should be obtained on foot of a written prescription.

5.1.2. All medication supplied or administered to a supported person must be prescribed by a registered Prescribing Practitioner.

5.2. Non- Regular Medication (P.R.N)

5.2.1. The prescription should state: circumstances, interval, and maximum dose in 24 hours, review date. PRN medication is only given for the indicated reason.

5.2.2. PRN medication must be supplied in the original box rather than a monitored dosage system. In the event the pharmacist dispenses medication in alternative packaging, this packaging must be clearly labelled with the pharmacy label. It must also clearly indicate the expiry date.

5.2.3. The decision to administer is taken by the authorized staff member based specifically on the person supported request or on their clinical need as indicated in their PRN Protocol. Authorised staff will contact senior cover personnel, Designated personnel (TL/PIC/WCI/ Emergency governance person) regarding decision to administer PRN medication. Designated personnel do not make the clinic decision to administer medication but are a second person to ensure that the right procedure is followed.

5.2.4. WCIM, PIC and Team leader (of their house only if not a nurse) may also advise on administration of PRN medication if they feel competent to do so or will redirect staff member to a nurse for advice if they feel this is necessary.

5.2.5. PRN medication must only be offered or given at the times listed on the medication administration record. As it is for occasional use, the person should be offered the medication at the times they are experiencing the symptoms, either by them telling their support staff or by staff identifying the person's need as outlined in the PRN protocol. The exact time the medication was given and the amount given must be recorded on the medication administration record.

5.2.6. The PRN Protocol must have the correct information to inform the employee what the medication is for and to enable them to make an assessment on whether the person requires the medication.

5.2.7. Medication with an 'as required' dose (PRN) is usually prescribed to treat short term or intermittent medical conditions i.e.; it is not to be taken regularly. If PRN medication is given regularly, then a referral to the registered Prescribing Practitioner should be considered for a review of the person's medication, as their medical condition may have changed, and the treatment required may need altering. Similarly, if the medication is not having the expected effects the registered Prescribing Practitioner should be contacted. In both cases, the PRN Administration Response Sheet should be clearly completed.

5.2.8. Where medication is prescribed on a PRN basis, the same procedures should be followed as for prescribing, dispensing, supplying, administration and recording all other medication/s.

5.2.9. Restrictive practices include physical, mechanical, environmental or chemical restraint. Chemical restraint which is the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the condition, or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes. An example of chemical restraint which is not acceptable in any designated Centre is: "Administering sedatives to a person who wanders during the night primarily for the convenience of staff" (HIQA 2016) People we support may be prescribed Psychotropic Medications therapeutically by a psychiatrist. When this medication is administered for the intended purpose, it is not deemed chemical restraint.

5.2.10. P.R.N. Medication for these reasons should only be used as indicated by the Prescribing practitioner and it is expected that all possible alternative strategies are to be used to avoid the use of these prescribed medications where possible. All persons prescribed such Medications must have a corresponding Behavioural Support Plan that identifies all alternative strategies to be implemented, prior to the dispensing and administrating of such medications. These strategies must be documented on the individual's PRN Protocol. There may be indication that medication be administered earlier to support the person with known triggers this intended purpose must be detailed in the indications on the Kardex and protocol for the medication.

5.2.11. PRN medication are reviewed at six monthly intervals, in order to maintain the effectiveness of the medications for the person and safe guard their quality of life. Additional supports can be requested from relevant members of the MDT. PRN protocol are reviewed yearly or soon if there is a change in the indications of why it is prescribed.

5.2.12. All PRN documentation is recorded on pink paper to distinguish it from other medications.

5.3. Sedative Medications (Pre-Med) Prior to Procedure

5.3.1. The requirement for a sedative Medication (Pre-Med) for a person, prior to procedure, is assessed by Team Leader and support staff and a Risk Assessment is completed, outlining the justification for same, e.g., in order to support the person and to reduce their anxiety. This information is then discussed with the registered Prescribing Practitioner.

5.3.2. Pre-Med Medications are prescribed by the registered Prescribing Practitioner as a STAT dose (for immediate use) and details are clearly written on the Kardex, including the circumstances in which to administer the Medications. The Nurse / Authorised Person should monitor the individual as appropriate, post sedation, and during and after the procedure.

5.4. Controlled Drugs

5.4.1. Controlled Drugs, as defined in the Misuse of Drugs (Amendment) Regulations 2007. Require additional precautions regarding their storage and administration as follows.

5.4.2. Storage: Upon receipt of Controlled medication, the employee receiving them must immediately count the amount received. This amount received must be recorded then in the individual's Controlled Drugs Recording book (DDA or Dangerous Drugs Act book).

5.4.3. Controlled drugs must be stored in a double-locked press/cabinet. The key to this press must be held by the senior staff on duty or must be securely locked away at all times.

5.4.4. Where a direct handover occurs, from one employee to another, a count of the amounts of controlled drugs will be carried out by both employees who will both agree the amount and co-sign same.

5.4.5. In situations where employees do not handover directly to another employee e.g., low support houses, a local protocol for auditing the amounts of controlled drugs, must be developed to ensure best and safe practice.

5.4.6. Administration: Where possible, two employees must sign for the administration of the drug and for the amount remaining in stock.

5.5. Guidelines of the administration of Oxygen (O2)

5.5.1. Designated employees must complete training in administration of Oxygen. A list of employees trained is maintained by the PIC /Team Leader and Staff Training Department.

5.5.2. Oxygen is regard as a drug and prescribed to maintain target SpO2 level. Specific protocols should be in place including procedures on the management and administration of Oxygen. Recording of Oxygen administration is complete on PRN recording sheets in Kardex folder and on a person DMS notes.

5.5.3. Oxygen delivery systems in Aurora are in two forms: portable oxygen tank and electronic oxygenator. These must adhere to safe storage of oxygen due to increased potential for a fire hazard when combined with heat and it is compressed gas therefore prevention of cylinder been hit or knocked over, weekly checks of cylinders to be completed; on designated recording sheets – signed and dated. Portable oxygen but be secure in transport to the wall or floor of the vehicle or in a hard protective case. Signage is required to notify oxygen is in use/storage/transportation.

6. Section 6

6.1. Medication Errors/Near Misses
6.2. Adverse Drug Reaction Reporting
6.3. Support a person with their medication while away from the person home:
6.4. Complimentary Medications
6.5. High Alert Medicines
6.6. Medication administration via enteral feeding tubes (PEG) and Nasogastric Tube (NG)
6.7. Transdermal Patch Application /Disposal

6.1. Medication Errors

6.1.1. Medication error is the most common type of error affecting the supported person's safety and is the most common single preventable cause of adverse events. Medication errors and near miss events should be viewed as opportunities to assess practices, identify what went wrong, learn from mistakes and institute changes to the medication system.

6.1.2. All medication error or near misses are recorded on NIMS. When reporting a medication error on NIMS it is necessary to provide a severity rating to be allocated to the error to ensure adequate risk management and actions of same. Following is a guide in rating the severity of the error or near miss:

0. **Near Miss (error did not reach the person e.g., medication dropped on floor, documentation error, popping out the wrong medication)**
1. **No injury (error reach the person but on harm caused e.g., not receiving Movicol, multi vitamin)**
2. **Injury not required first aid (error reached the person and necessitated monitoring, antiepileptic medication not administered or wrong dose administered)**
3. **Injury or illness, required first aid (person missing a number of doses of medication that may require support from GP or Doctor as result)**
4. **Injury requiring medical treatment (person receiving the wrong medication or medication that they have allergy or are sensitive too)**
5. **Long term disability/ incapacity (inc. Psychosocial)**
6. **Permanent/ incapacity (inc. psychosocial)**
7. **Death**

6.1.3. It is essential that managers address medication errors to ensure person supported safety and maintaining trust with the employee team and other stakeholders. Here are steps that can be taken for effectively managing and preventing medication errors:

6.1.4. For a medication error / near miss where no harm has reached the person the manger should sit with the staff member and complete an Action Learning Analysis, this can help identify contributing factors that may have led to the Error or near miss and share this learning with the Team to avoid the same issue happing in the future.

6.1.5. For all other medication errors an Immediate Response and Reporting is required:

- **Open Disclosure** with necessary Stakeholders in line with Patient Safety Act is imminent.
- **Assess the persons health**: Inform the person of the error using their preferred form of communication and the steps taken to address the error. This should be documented in the person daily notes. If a medication error occurs, prioritise the person's immediate health. Evaluate for any adverse reactions and provide first aid if needed. Call for GP/ Care Doc for advice or emergency assistance if the situation requires.
- **Notify Manager or Emergency Governance in managers absence**. (For a medication error consult with person and manger to ensure the persons family is advised with honesty and

compassion, providing a clear explanation of the errors and any steps being taken to address it.)

- **Documentation**: Record the details of the incident, including the date, time, medication involved, type of error, and any immediate interventions taken. Accurate documentation ensures transparency and is critical for future reviews.
- **Conduct a thorough Investigation**: Manger or designated staff to examine what led to the error, including factors like staffing, training, environment, and processes (have safe medication practice been followed). Manger may use Action learning Analysis template to help guide this process once complete send ALA on to medication manager community liaison Co-ordinator).
- **Implement Corrective and Preventive Actions:** Where a staff responsible for the error cannot be identified, the manager may introduce a daily loose medication count to monitor the medication on a daily basis.
- **Enhance Staff Training**: Provide ongoing training on safe medication practices, OJM can be provide by a nurse on the Team or Medication manager community liaison Co Ordinator. This should include clear instructions on how to manage medications for individuals if they need special accommodations (like liquid medications for those with swallowing difficulties), safe medication practices and additional guidance and support on aspects of medication management that require additional support.
- **Adjust Environmental Factors**: Ensure that the medication administration environment is organised, quiet, and free of distractions, and that proper storage. Ensure Kardex folder is clean and organised, with the Kardex clear and request pharmacy to reprint if there has been a lot of changes or number of medications discontinued.
- If the same member repeatedly responsible for medication errors, manger may request that staff member to re training in safe and responsible medication management training. Manager also have the option if staff continue to have issue despite support and retraining complete additional practical assessment, completing topic specific quality conversation and requesting that medication be only administered under supervision.
- **Foster a Culture of Safety and Accountability and Encourage Open Communication**: Cultivate an environment where staff members feel comfortable reporting errors without fear of punitive consequences. This encourages learning and transparency.
- **Emphasise Accountability**: While avoiding punitive measures, emphasise the importance of responsibility and adherence to safety protocols.
- **Continuous Monitoring and Quality Improvement:** Regular Audits are scheduled and completed by Medication manager or designated person in each house in line with six monthly provider audits. The actions will be included in the action plan provider audit. If the is dangerous practices observed they will be addressed immediately with staff PIC/ T/L.
- **Review and develop action plan:** Regular Review Meetings can be scheduled meetings with the PIC/ Team Leader and medication manager community liaison co-ordinator for locations that have a number of medication errors.
- These are to review past medication errors develop a plan to support the team, analyse the effectiveness of the changes made. This fosters a continuously improving process.
- Monthly, quarterly and annual reports are developed by the medication manager community liaison Co Ordinator to help identify trends, and develop target support and adjust training if required. These reports are reviewed by the Senior management team, Director of Services and Wellness Culture and Integration manger and discussed with PIC and teams as required.
- **Implement a Quality Improvement (QI) Plan**: Use feedback and error reports to refine procedures continuously and create a safer medication administration system.
- In the case of the day service attendees, the person's family should be contacted and informed of the situation and any action that may be required at home.

6.2. Adverse Drug Reaction Reporting

6.2.1. Although prescription drugs must meet certain safety standards before they are approved for the market, unexpected adverse drug events (ADEs) can occur after a drug is used in a larger population over a longer period of time. Reporting of ADEs in the residential care setting is thus a vital component of drug safety.

6.2.2. Health and Social care professionals should be aware of the indications for the medication's intended use for the person and have knowledge of the desired effect and potential undesirable effects of those Medications.

6.2.3. A serious reaction is defined as one which is fatal, life threatening, results in persistent or significant disability or incapacity, and results in or prolongs hospitalization.

6.2.4. To maximise the value of the adverse drug reactions reporting system in ensuring drug safety, prescriber vigilance is essential. The possibility of adverse reactions must continually be borne in mind.

6.2.5. If suspected, all adverse drug reaction reporting should be reported by the PIC/Team Leader firstly to the person's registered Prescribing Practitioner and the IMB using the Adverse Reactions Form available from Pharmacies or G.P. surgery or the Health Products Regulatory Authority (HPRA) at this website address www.hpra.ie

6.2.6. A copy of the completed form should be held on file and an incident form sent to the WCI.

6.2.7. Adverse drug reactions have been identified as a leading cause of morbidity and mortality. As part of their everyday care of the supported person, Nurses, Authorised employees and the team are in prime positions to observe and report on suspected adverse reactions.

6.3. Support a person with their medication while away from the person home:

6.3.1. Aurora aims to facilitate all the people supported with receiving their medication while away from their home as part of their personal plan partaking in supported employment, social outing or another reason without issue.

6.3.2. A detailed individualized SOP will need to be developed with all the details to ensure the person receives their prescribed medication in a safe and timely manner. A generic SOP on supporting a person with medication while away from the home can be located on the Q drive. This can be individualised to each persons need.

6.4. Complimentary Medications

6.4.1. There is a growing recognition that alternative/complementary medications have a role to play in services for people with intellectual disabilities. It is essential however; that consultation occurs with the relevant registered Prescribing Practitioner prior to commencing any alternative/complementary medication, in case of any contraindications or potential harm.

6.4.2. Advice regarding the use of all complementary/alternative therapies must be gained from the relevant professionally qualified and registered complementary therapy practitioner.

6.4.3. Complementary therapies include but are not limited to, acupressure acupuncture, aromatherapy, herbalism, homeopathy, massage therapy, reflexology and yoga' (N.M.B.I.2015).

6.4.4. Prior to the commencement of any therapy, consultation must take place with the PIC/Team Leader, and the relevant registered Prescribing Practitioner. Minutes or notes form these consultations must be kept on record.

6.5. High Alert Medicines

6.5.1. 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)

6.5.2. HIQA (2015) Service providers will have clear policies and procedures in place for high-alert medicines. They mention insulin, digoxin, and methotrexate and state this is not an exhaustive list

6.6. Medication administration via enteral feeding tubes (PEG) and Nasogastric Tube (NG)

6.6.1. Medications can be administered via the PEG / NG once they have been prescribed by the persons registered Prescribing Practitioner.

6.6.2. Medication can be administered via enteral feeding tubes – PEG and NG - by staff and those who have completed the relevant training to administer medication via enteral feeding tubes (PEG and NG) Training should be provided by a suitably competent healthcare professional with the appropriate clinical and educational training.

6.6.3. Training should be supplemented by competency assessment and refresher training completed at appropriate intervals, in line with peoples' changing needs. (HIQA 2015). A robust Eternal Feeding Policy and Standard Operating Procedure (SOP) is in place to support authorised staff in the administration of medication via PEG. Registered Nurses only administer medication via NG tube.

6.6.4. Any person, who may require enteral feeding is severely compromised, and it is of paramount importance that suitably competent professionals maintain the patency of the enteral feeding tubes, at all times. Where the oral route of drug administration is not feasible, the interdisciplinary team should consider all other methods, i.e., rectal, transdermal, before making the decision to use the enteral feeding tube.

6.6.5. If prescribed Medications are to realise their therapeutic potential, professionals need to focus on the details of drug administration when administering via the enteral feeding tube. A specific registered Prescribing Practitioner's order is required for the administration of any drug via a feeding tube: a specific direction is also required for any tablets that must be crushed.

6.7. Transdermal Patch Application /Disposal

6.7.1. It is always preferable that medication is prescribed for oral use. However, situations may arise where other routes of administration are required. Transdermal patches may be a useful alternative for people, where the clinical condition prohibits the oral route e.g., dysphagia or uncontrolled nausea and vomiting. Patches may also be considered where adverse side-effects have been encountered with oral medication, where there are compliance issues, or where it is more convenient and comfortable for the person.

6.7.2. Due to the delayed onset of action, patches should not be used to treat acute symptoms. Since there are significant physiological skin changes associated with ageing, transdermal patches should only be prescribed for the older person following a comprehensive review and, on a case, -by-case basis.

6.7.3. Please ensure that when applying a new patch that the old patch has been removed and disposed of (This can be done by folding the patch and placing in the clinical waste bin or return to pharmacy box.)

6.7.4. Check the transdermal patch against the prescription sheet of the medication administration record to ascertain the following:

- name of medication
- dose
- date and time of administration
- route and method of administration
- signature of the prescriber

6.7.5. Transdermal patches should not be written (dates put on) this information should be documented in the supported persons MAR sheet as with all other medications. The intervals between reapplication of medication should prescribed and documented by the prescribing doctor.

7. Section 7

7.1. Oral Nutritional Supplements (ONS)
7.2. Thickening Agents
7.3. Medication Reconciliation
7.4. Delivery/Collection & Storage of Prescribed Medications
7.5. Storage of Medications
7.6. Out of Date and disposal of Medications
7.7. Policy for the Disposal of Sharps
7.8. Needle-stick Injury
7.9. Antimicrobial Stewardship Monitoring form

7.1. Oral Nutritional Supplements (ONS)

7.1.1. These are commercially produced products for the purpose of providing extra nutrition to meet the individual's nutritional requirements and/or supplement their present nutritional intake. In some instances, nutritional supplements may be the sole source of nutrition.

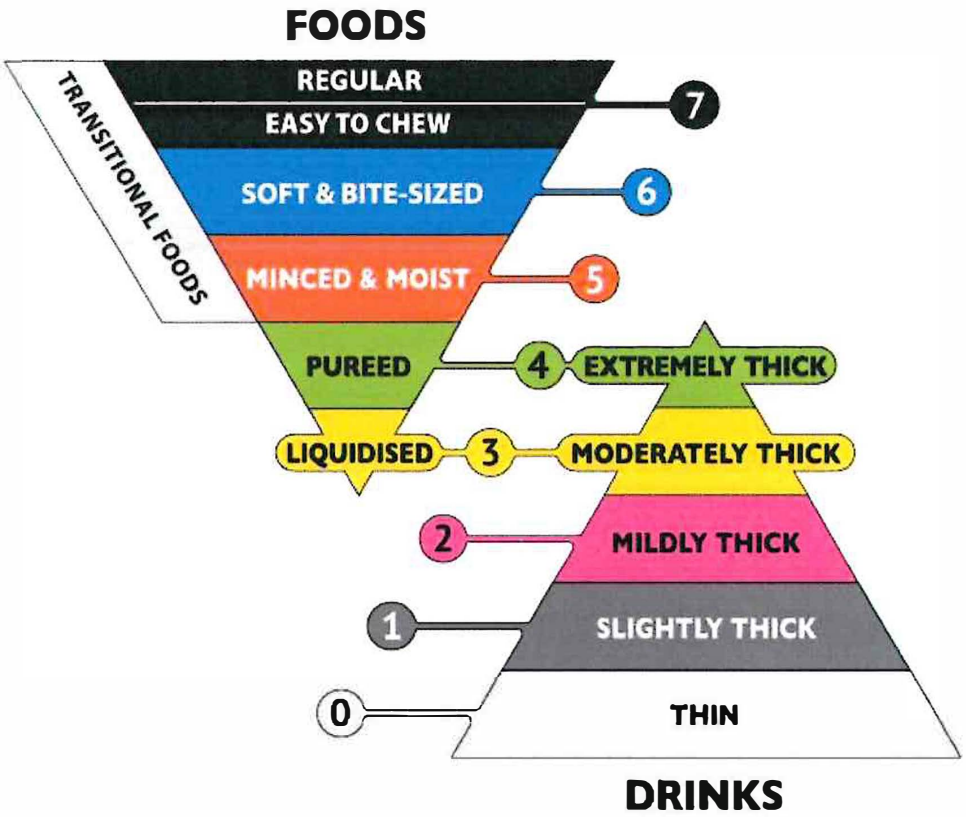
7.1.2. Oral Nutritional Supplements are prescribed by the dietician on an individual basis as a full /part component of the nutrition therapy.

7.1.3. The ONS will be written up in the drug KARDEX/Regime Prescription by the registered Prescribing Practitioner. Staff must ensure that the recommended ONS is given as prescribed.

7.2. Thickening agents

7.2.1. Thickening agents can be used to modify the consistency of thin liquids to IDDSI (International Dysphagia Diet Standardisation Initiative) levels 1-4 (Please see image below to describe the level). A thickening agent are available in tubs with a scoop or sachets of powder to be added to liquid to achieve the desired consistence. Example of thickening agents are Nutilis, Swalloweze, Thick and Easy etc. (This is not a complete list).

(The IDDSI Framework and Descriptors July 2019)



7.2.2. Thickening agents are not licensed as medicines. They are non-medicine items received via GMS intended for the dietary management, under supervision.

7.2.3. Thickening agents are not required to be prescribed on the Kardex and MARS are not required.

7.2.4. **Storage to thickening agents:** Thickening agents are not medicine items and not food items, for this reason they must be stored in a press separate from food items, labelled with an open date and never left unsupervised. As this is not a medicine item but has a risk of asphyxiation if consumed, a risk assessment must be completed in each location. The risk assessment will ascertain if these items require to be stored in a locked press.

7.2.5. If the thickening agent is assessed to require storage in a locked press this must be identified as a restrictive practice. All restrictive practice and associated documentation (Aurora Restrictive Practice policy 2024) are reviewed by the restrictive practice committee annually or as required.

7.2.6. **When may a thickening agent be required?** There are three categories where individuals require thickening agents in the fluids:

- When a person's swallow has been assessed by Speech and Language Therapist (SALT) and identified that they have dysphagia which is a swallowing disorder. This is characterised by difficulty in oral preparation for the swallow, or in moving material from the mouth to the stomach. Consequences of dysphagia can be very serious and include aspiration, choking, malnutrition and can negatively impact on a person quality of life.

- After assessment by SALT a texture modified diet and/or modified fluid consistency is recommended and this recommendation can be found in a person swallow care plan provided by SALT.

- When SALT following extensive reviews and assessments, may deem a person as not safe for oral intake (NPO) and may, in consultation with the person, their support team, family, GP and / or Consultant, discharge the person from their care in relation to oral intake. A decision may be made) to support the person to continue oral intake with the GP and / or Consultant overseeing the supported person's feeding, eating, drinking & swallowing (FEDS) management.

- This scenario constitutes supporting the person to eat/ drink at risk. A Support Plan is put in place outlining the safest constituency, texture, of food / fluid and other environmental controls to best support the individual with their nutritional intake and minimize associated risks.

- When a person's oral fluid intake falls below an outlined amounts the person may be recommended by the GP or prescribing participator to received fluids thickened to aid in hydration. In this instance a person will have the thickening agent on the person PRN Kardex and a PRN protocol outlining the guidance for its use.

7.3. Medication Reconciliation

7.3.1. Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each person's current medication and comparing the list to those in the person's record or Medication's order. It includes names of medications, dosage, frequency and route, in order to identify any discrepancies and to ensure any changes are documented and communicated. This results in a complete and accurate list of medication.

7.3.2. This reconciliation is done to avoid medication incidents such as omissions, duplications, incorrect dosing, or drug interactions. Medication reconciliation aims to provide peoples and professionals with the correct medication at all transitions in care, within and between health and social care services. Transitions in care include changes in setting, service, practitioner, or level of care.

7.3.3. Medication reconciliation is considered complete when each medication that a person is taking has been actively continued, discontinued, held or modified at each point of transfer, and these details have been communicated to the next care provider (HIQA 2014).

7.4. Delivery/Collection & Storage of Prescribed Medications

7.4.1. All medication in Aurora (Kilkenny) services is dispensed by Community Pharmacies.

7.4.2. Procedures must be in place for the ordering of medicinal products from the pharmacy and the immediate reporting and investigating of discrepancies in medication products stocks.

7.4.3. Prescriptions are brought to the pharmacy by an authorised person or emailed by a named person in the Service.

7.4.4. Dispensed medication (Venalink packs) and loose medication bottles and creams and tablets will be collected by an authorised person and should be secured until checked.

7.4.5. All medication is to be signed for on collection and the name of the person collecting must be recorded.

7.5. Storage of Medications

7.5.1. Appropriate safe and secure storage should be provided for all Medications products. The place of storage should not exceed 25 degrees.

7.5.2. Medication is stored in a locked press.

7.5.3. As directed by the pharmacy some medication may need to be stored in a fridge.

7.5.4. In the case of only one medication requiring refrigeration in a home, this medication can be stored in a small locked cash type box in the fridge. The temperature should be kept between 2-8 degrees (HIQA 2015). The keys of this should be attached to the medication keys in the designated medication key safe, with pin lock, in the person's house. The box is clearly labelled and locked at all times.

7.5.5. Temperature of the fridge must be recorded daily and documented on a recording chart.

7.5.6. MDA scheduled controlled drugs will be stored in a separate locked press within the Locked press.

7.5.7. Keys for the press are the responsibility of the authorised person and must be kept secured in a key box and the code only known by authorised staff

7.6. Out of date and disposal of medications

7.6.1. Weekly and Monthly stock of medications should be checked on a weekly basis and a record of this weekly check should be evident in the Aurora Stock Check Book. It is important to check the storage area weekly for expired, damaged, or unused medicines and record the check.

7.6.2. The expired stock, discontinued stock should be kept separate from other medicines, and are disposed of and not further used in accordance with the relevant national legislation or local policies.

7.6.3. Medicines may require to be disposed of when an individual's treatment changes or when treatment is discontinued. The remaining supply should be safely disposed.

7.6.4. Once a medication comes in contact with any bodily fluid it should be disposed of on site. Should a person supported for e.g., spits out, regurgitates a medication these medicines should not be returned to pharmacy as they are contaminated and can be disposed of on-side.

7.6.5. This disposal should be signed by two employees into the disposal of medication on site page in the back of the medication stock book.

7.6.6. Expired stock and medicines no longer prescribed or required will be returned to the supplying pharmacy for disposal.

7.6.7. A complete record for the disposal of medicines should be made.

7.6.8. In the event an expiry date is not detailed on the label contact should be made with the dispensing pharmacist for clarification and a record kept of the clarification received (Email).

7.6.9. In Day Services, if medication has expired, it must be sent home for replacement and a record made of this.

7.6.10. All excess medications and medications for disposal should be returned to pharmacy by an authorized employee. The stock book should be signed and stamped by the pharmacist in the stock check book.

7.7. Suspected or discovered defective medication

7.7.1. When a defect in a medication is discovered or suspected, staff must, as soon as practicable, report the defect to Senior governance and person in charge.

7.7.2. All suspect medicine must be labelled so it can be easily identified and inadvertent use prevented then retained in a safe place separate from the current stock of medication ideally return to pharmacy box.

7.7.3. Return the medication to the pharmacy as soon as possible.

7.7.4. The staff member who discovers or suspects the defect must complete a Medication error/Near Miss Report Form.

7.7.5. The report must fully identify the product, the defect and the person discovering the defect and any other important information.

7.8. Policy for the disposal of sharps

7.8.1. Sharps are defined as needles, ampoules and syringes.

7.8.2. Needles and syringes should be discarded as a single unit, where possible.

7.8.3. All relevant areas should have a sharps box that should be used for the disposal of needles, syringes and ampoules only.

7.8.4. All needles, syringes and ampoules should be placed in this box after use.

7.8.5. No items should be forced into this sharps box, as this may cause an injury.

7.8.6. Any needle stick injuries should be immediately reported as per reporting procedure. Please refer to needle stick injury guidelines.

7.8.7. It is the personal responsibility of the person using a sharp to dispose of it safely.

7.9. Needle-stick injury

7.9.1. In the event of a needle stick injury please refer to the HSE webiste. See also pathway at the end of this document.

7.9.2. Action to be taken following a sharp's injury:

- Encourage the wound to bleed.
- The recipient should not suck the injury site.
- Irrigate the wound thoroughly with running water.
- Dry and cover the wound with a waterproof dressing if necessary.
- Seek medical advice.
- Report incident to Senior Management and complete incident form.

7.10. Antimicrobial stewardship Monitoring Form

7.10.1. Antimicrobial stewardship (AMS) involves coordinated interventions designed to promote the optimal use of antimicrobial agents, including antibiotics, to improve outcomes for all people supported in Aurora, reduce resistance, and ensure the sustainability of effective therapies.

7.10.2. Each person has an antimicrobial stewardship monitoring form in their Kardex. This form is to be completed each time a person is prescribed an antibiotic.

7.10.3. The HSE preferred antibiotic use in community setting table will be filed alongside the antibiotic monitoring form in the Kardex folder.

7.10.4. The aim of the monitoring form is to have the antibiotic history to hand when discussing with the prescribing doctor; such as, if antibiotic therapy is indicated. The preferred first line choices of antibiotics that are likely to be effective, have fewer side effects, and are less likely to lead to resistant infections.

8. Appendix 1

Abbreviation of Common Medications Management Terms

- 1/52 ---------- 1 week
- 2/52 ---------- 2 weeks
- 1/12 ---------- 1 Month
- Daily ---------- Once a day
- Mane ---------- Morning
- Tarde ---------- Evening
- Nocte ---------- Night
- OD ---------- Once Daily
- B.D. / B.I.D. ---------- Twice a day
- T.I.D. / T.D.S. ---------- Three times a day
- Q.I.D. / Q.D.S. ---------- Four times a day
- Alt Days ---------- Alternate days *(would be specified on request by prescribing doctor).*
- STAT ---------- Once only at time specified
- P.R.N. ---------- Pro Re Nata – when required
- 6^0 ---------- Six hourly
- P.O. ---------- Orally by mouth
- S.L. ---------- Sub lingual – under the tongue
- P.R. ---------- Per Rectum
- P.V. ---------- Per vagina
- Top ---------- Topical
- Cap ---------- Capsule
- S.C. ---------- Subcutaneous
- Tab ---------- Tablet
- I.M. ---------- Intra-muscular

9. Appendix 2

References

- An Bord Altranais 2000 Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols. An Bord Altranais, Dublin.
- An Bord Altranais 2007 Medication Management (Guidance to Nurses and Midwives). A Bord Altranais, Dublin.
- Health Information and Quality Authority (H.I.Q.A.) 2014 Guidance for Designated Centres - Restraint Procedures.
- Health Information and Quality Authority (HIQA) 2015 Guidance on Medications Management Procedures
- Health Service Executive (H.S.E.) 2005 Guideline/ Policy/Protocol- Template and user Manual
- H.S.E South East.
- Health Information and Quality Authority (HIQA) 2006 Hygiene Services Assessment Scheme.
- HSE (2013) Medication Management and Administration Policy. HSE
- Joe Wolfe (2013) Safe and Responsible Medication Management Training Programme.
- Nurse Midwifery Board of Ireland (NMBI) 2015 Standards for Medications Management for Nurses and Midwifes, An Bord Altranais, Dublin.
- Appendix 1: Irish Legislation on Medications Management
- Health Act 2007 (Care and Welfare of Peoples in Designated Centres for Older People)
- Regulations 2013.
- Health Act 2007 (Care and Support of Peoples in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
- Irish Medications Board Miscellaneous Provisions Act, 2006 Medicinal Products
- (Prescription and Control of Supply) Regulations, 2003 (S.I.540 of2003).
- Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2003
- (S.I. No. 540 of2003).
- Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007.
- (S.I. No. 201 of2007).
- Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2011. (S.I. No. 525 of201l).
- Irish Medications Board (Miscellaneous Provisions) Act 2006 (Commencement) Order
- 2007 (S.I. No 194 of 2007).
- Irish Medications Board (Miscellaneous Provisions) Act 2006 (Commencement) (No. 2) Order 2007 (S.I. No 543 of2007).
- Nurses and Midwives Act 2011.
- Nurses Rules, 2007 (Made under the Nurses Act 1985, Misuse of Drugs Act 1977 and 1984 Misuse of Drugs (Amendment) Regulations 2007 (S.I. No. 200 Of2007).
- Pharmacy Act 2007.
- Medicinal Products (Prescription and Control of Supply) Regulations 2003, as amended Waste Management Act 199
- HSE (2021) National Framework for Medicines Management in Disability Services. Dublin 8.

Management of Infection Risk from a Blood Borne Virus (BBV) following a needlestick or sharps injury in an Occupational or Community setting

Wound management: Encourage bleeding, wash

Was the exposure significant? - i.e. skin breached and a high risk material?

NO

No risk of HBV/HCV/ HIV transmission. Reassure. Give patient information leaflet and discharge letter. Advise GP/ Occupational health via letter.

YES

Assess BBV risk of source. If source known, test for BBVs OR confirm previous results (with consent). If source unknown OR does not consent, assess risk based on circumstances and risk of BBV

Assess BBV status of recipient (HBV vaccination, previous BBV tests, baseline bloods.) Clinical management of recipient based on risk assessment.

HBV

See HBV PEP table

HIV

HIV PEP is recommended (this includes sharps exposure or sharing of injecting equipment*) if:

- The source is known to be living with HIV and not on antiretroviral therapy OR on antiretroviral therapy with a detectable HIV viral load AND the exposure is within the past 72 hours.
- Where the source is on antiretroviral therapy AND the viral load is unknown PEP could be started whilst awaiting this information. See the EMI Guidelines for further information and indications on use of PEP.

HIV PEP is **generally not recommended (this includes sharps exposures or sharing of injecting equipment*)** but could be considered where all the following criteria are met:

- The source is known to be from a high prevalence country/risk group AND of unknown HIV status AND exposure within the past 72 hours

HIV PEP is **not recommended**

- Following a discarded needlestick/sharps exposure in the community as the risk is extremely low
- If the source is living with HIV with an undetectable HIV viral load
- If HIV status of the source is unknown AND the source is from a low prevalence country/group

*Including the sharing of injecting equipment in the setting of sexualised drug use

HCV

There is currently no PEP available for HCV, but if seroconversion occurs, early treatment is highly effective.

Information and follow-up

Level of risk, precautions, follow-up for further testing, vaccination, PEP, give information leaflets (significant exposure to BBV and HIV PEP information leaflet).