

Palliative Care Drug Administration Procedure by Carers (Adult Palliative Care)

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1 INTRODUCTION

This document relates to patients who are receiving palliative care and/or their informal carers giving medication for symptom control through buccal or subcutaneous routes.

The document has been written for health care professionals working in the community.

The need to implement this procedure should be patient/carer led and should not be imposed on the patient/carer by health care professionals.

This procedure has been developed to give health care professionals a safe framework to work within when patients or carers wish to and are trained and assessed as competent to give as required medications. If a patient or carer wishes to also set up continuous subcutaneous infusions (CSCI), these will be discussed with the Specialist Palliative Care Team on an individual basis to ensure safe practice.

Aim

To provide a safe framework for informal carers and/or patients to administer agreed medications via buccal and subcutaneous routes.

2 SCOPE

- This guidance will facilitate effective symptom control, patient choice, carer involvement and effective palliative care. This will be delivered within a safe and supportive environment.
- The registered nurse responsible for assessing and overseeing the patient's care is responsible for ensuring this procedure is followed safely and is continually reviewed and monitored.
- The registered nurse should ensure that the patient/carer administering the medication has been deemed competent and confident to do so using the step by step assessment procedure and documentation.

3 GUIDANCE FOR PATIENTS/CARERS TO ADMINISTER ANTICIPATORY MEDICATION

Bradford District Care NHS Foundation Trust fully recognises that the obligation to implement guidance should not override any individual clinician to practice in a particular way if that variation can be fully justified in accordance with Bolam Principles. Such variation in clinical practice might be both reasonable and justified at an individual patient level in line with best professional judgement. In this context, clinical guidelines do not have the force of law. However, the Trust will expect clear documentation of the reasons for such a decision and for this variation. In addition, any decision by an individual patient to refuse treatment in line with best practice must be respected, escalated to the consultant and fully documented in the appropriate records of care/treatment.

3.1 Management

This procedure will only be utilized when a patient or carer expresses their wish to administer prescribed medication to assist with symptom control. It is not envisaged that this procedure will be used frequently.

3.1.1 Criteria for Suitability

Patients who may require a stat dose of a medication in an anticipated emergency, for example, seizure or catastrophic bleed.

Patients who are self-caring and do not want to be dependent on a health care professional to administer injections.

Patients who choose not to have a syringe driver, but prefer their medication to be controlled by as required (PRN) subcutaneous administration.

Patients with a syringe driver in place who require PRN medication for symptom control.

The willingness and capability of the patient/carer to undertake the procedure has been ascertained, and both the patient and/or carer have consented to undertake the procedure and are deemed competent and safe to do so.

The patient would like the carer to undertake the procedure.

The patient/carer and their environment are risk assessed and found to be suitable.

3.1.2 Criteria that might Prevent Suitability

There is concern that the patient/carer will not be able to cope either physically or emotionally with undertaking the procedure.

Concerns regarding safety of medications left in the home.

Safeguarding concerns.

The clinical situation is complex and professional assessment will always be required at the time medication is needed.

3.2 Implementing the Procedure

The decision for carers or patients to administer PRN medication within palliative care should be made by the multidisciplinary team (MDT) consisting of the specialist palliative care nurse, a senior member of the nursing team and a representative from the medical team, either the GP or Consultant in Palliative Medicine.

The patient/carer and their home environment should be considered to be safe and suitable for undertaking this procedure and an informal risk assessment undertaken. If there are concerns about the safe use of this procedure it should not be used.

Specialist Palliative Care professionals should be consulted and included in the discussions before implementing this procedure.

It is important that the patient/carer contribute to discussions and decision making.

Discussions must include how the patient and carer feel about undertaking such a task in order to relieve symptoms (see appendices).

It must be made clear to the patient and carer that they are able to discontinue this procedure at any point.

The MDT should identify the person responsible for teaching the procedure and the person responsible for monitoring and supporting the carer through the implementation of the procedure. This will usually be a registered nurse in the community setting within a District Nurse Team or the Palliative Care Support Team.

Once the patient/carer has been assessed as competent to administer subcutaneous / buccal medication, the relevant care plan on System1 will be completed.

A high priority reminder will be added to the patient record and Gold Line tasked to alert them to the arrangements in place.

Please notify out of Hours Nursing Team so they are aware of procedure in place.

When the patient or carer feel that symptoms arise and medication is needed, they should call Gold Line who will assess the situation and support them with the decision and administration process.

If the carer/patient self-administers PRN medications on more than 2 occasions in 24 hours a health care professional should be consulted and the patient reviewed.

Subcutaneous medications should be given through, a subcutaneous port that will have been placed by a nurse. There may be an occasion where we teach patient/carer to give a sub cutaneous injection without a port in place.

3.3 Consultation

3.3.1 Peer Review

This guideline has been discussed and agreed at the Bradford, Airedale, Wharfedale and Craven End of Life Operational group and the Procedural documents ratification group.

The patient information leaflet has been reviewed by the Airedale Hospital Readers Panel.

4 DEFINITIONS

4.1 Anticipatory Medication

This would be injectable medication for uncontrolled symptoms in the patient's last weeks of life.

5 REFERENCES TO EXTERNAL DOCUMENTS

- NMC Standards for Medicine Management (2007)

6 ASSOCIATED INTERNAL DOCUMENTATION

In respect of this policy, specific related Procedural Documents / Trust documents are:

- BDCFT Syringe Driver Guidelines (2015)

7 APPENDIX A: PRACTICAL PROCEDURE

Equipment

- Patient information leaflet (Appendix 1 & 2)
- Community prescription sheet and administration record
- Saf T intima/other sc port
- Sterile film dressing
- Supply of 1ml / 2ml luerlock syringes
- Supply of blue needles
- Ampoule of water for injection
- Prescribed drug for PRN use
- Sharps box
- Hand gel

Action	Rationale
<p>Although this procedure will be used in the community setting, the decision that this procedure may be required could take place in the primary, secondary or hospice setting</p> <p>If the patient is being discharged from hospital or hospice, liaison between the acute setting and community is essential.</p>	<p>To ensure safe transfer of care</p>
<p>Once the MDT has agreed to support this procedure, it is the responsibility of the registered nurse to:</p> <ul style="list-style-type: none"> • Confirm the suitability of patient/carer and environment to safely undertake this procedure • Explain the procedure to the patient/carer, including the support available, the indications for, actions and possible side effects of the prescribed drugs • Discuss the issue of the “last injection” with the carer and what to do if they feel they are no longer able to carry on with the procedure. The team member must feel confident in discussing this with the carer • Demonstrate how to give the injection/buccal medicine including: <ul style="list-style-type: none"> ○ Hand washing/ use of hand gel ○ Drawing up the prescribed medication as indicated on the prescription sheet ○ Administering the medication via the injection line ○ Flushing the injection line with 0.3ml of water/saline for injection ○ Correct disposal of sharps 	<p>To fully inform the carer/patient to enable them to make a safe and informed choice</p> <p>To ascertain their willingness to undertake the procedure. How to cope/who to call in an emergency</p> <p>To demonstrate a safe procedure</p> <p>To ensure the patient is given the correct drug at the prescribed dose and by the correct route</p> <p>To flush any remaining solution (irritating solution away from the line) and ensure that the patient receives the full dose of the medication</p> <p>To minimise infection To protect the patient from harm</p> <p>To comply with NMC Standards for Medicine Management (2007)</p>

<ul style="list-style-type: none"> • Explain how to record the details of administration on the medication chart • Provide the patient/carer with the information leaflet 	
<p>After the patient/carer are assessed as competent to give the medications, the nurse will:</p> <ul style="list-style-type: none"> • Complete the assessment sheet with them to confirm their competence • Complete the relevant care plan • Add a high priority reminder to System1 • Contact Gold Line to make them aware of the plans in place 	<p>To ensure the carer feels competent and is deemed competent to undertake the procedure</p> <p>To provide documentation of correct process</p> <p>To inform Gold Line so they can support patient/carer</p>
<p>When the carer feels that a PRN medication may be required, they should: Contact Gold Line</p> <ul style="list-style-type: none"> • Explain symptoms • Agree drug & dose to be given • Record date, time and route of administration on the medication chart • If symptoms are not resolved by the medication, patient/carer to contact Gold Line again who will advise next steps (in discussion with pall care specialist nurse or consultant if required) • If PRN drugs are required and given by patient/carer on 2 occasions, a review by a health care professional should be undertaken before the patient/carer administer further doses 	<p>To ensure the patient is given the correct drug at the prescribed dose and by the correct route</p> <p>To provide an overview of medicines administration</p> <p>To protect the patient from harm</p> <p>To support the patient/carer</p> <p>To comply with NMC Standards for Medicine Management (2007)</p>
<p>The nurse will visit frequently to support the patient/carer, check the documentation and check the balance of ampoules is correct. Any new stock will be added to the total</p>	<p>To ensure good communication is maintained between carer and health care professional</p>

8 APPENDIX B: ASSESSMENT OF THE ADMINISTRATION OF A SUBCUTANEOUS INJECTION VIA AN INJECTION LINE BY A PATIENT OR INFORMAL CARER

To be completed by the Registered Nurse in discussion with the patient/carer

Patient's Name.....Patient's NHS Number.....

Carer's Name (if applicable).....

Name of Assessor.....Designation of Assessor.....

Base.....Telephone Contact Number.....Date.....

This assessment form should be completed by the carer and assessor together for each episode of supervised practice. Each stage will be initiated when both the carer and assessing nurse agree competence has been achieved.

	Initial	
	Carer	Nurse
Section A		
Is able to name and identify specific drug being used and main potential side effects	Y/N	
Is aware of how and who to contact in the case of queries or untoward events	Y/N	
Is able to identify potential problems with injection site and their likely causes	Y/N	
Has Gold Line number and is aware to contact them prior to giving medication	Y/N	
Section B (OBSERVATION)	Y/N	
Washes hands before preparing drugs and equipment required for the injection	Y/N	
Before giving the medication, check the port site for redness, swelling or leakage	Y/N	
Drug preparation and dosage checked against patient's prescription	Y/N	
Expiry date on drug preparation checked (if expired – discard)	Y/N	
Drug is stored at room temperature away from sun light	Y/N	
Correct drug dosage is drawn up	Y/N	
Air expelled correctly from syringe	Y/N	
The needle is removed from the syringe and disposed of safely (if not needed)	Y/N	
The syringe is connected to the port correctly and the drug is given slowly	Y/N	
After the injection, the site is re - checked for redness or leakage	Y/N	
The syringe and needle are disposed of safely	Y/N	
The line is flushed with 0.3ml sterile water for injection	Y/N	
Document that the injection has been given, recording the time, drug, dosage, signature and number of ampoules remaining	Y/N	
Knows when to seek help/advice and how to obtain this. For example, symptoms are not controlled and they feel unable to give the injection	Y/N	

~All stages need to be met to meet competence~

The carer/patient is competent to undertake a subcutaneous injection via an injection line

Signature.....Designation.....

Date.....Date Reassessment Due.....

I, the carer/patient, have undertaken the above assessment and feel safe and confident in giving a subcutaneous injection via an injection line

Signature.....Designation.....

Date.....Date Reassessment Due.....

Comments

9 APPENDIX C: PATIENT / CARER LEAFLET

Information to Support Patients and/or Relatives/friends to give Injections or Buccal Medicines at Home

(Buccal means medicine placed between the cheek and gums rather than swallowed)

- You have been given this leaflet because you have asked if you can give injectable or buccal medication at home to help with comfort.
- It is important that you feel confident and comfortable to do this.
- The health care team will support you in this task and teach you how it's done.
- You do not have to give these injections unless you want to and feel comfortable to do so.
- If at any time you feel you can no longer give them, please let your healthcare team know.

What you will be taught / need to know

1. The nurses will put in an injection line. When you give the injection, you will only give the injection into the line, not into the patient's skin.
2. You will be asked to check the injection site before each injection for signs of redness, swelling or leakage. If concerned you must contact the Gold Line or your District Nursing team.
3. You will be taught what the injection is for and when to give it.
4. You will be taught how to draw up the required amount of the medicine, as written on the prescription chart, into a syringe and how to give it using the line.
5. You will be taught how to flush the line after giving the medicine with 0.3ml of sterile water for injection, to ensure that all of the medicine is given to the patient.

6. You will be taught how to safely dispose of any needles and syringes used.
7. You will need to write and sign your name, giving details of date, time and amount of drug given and how many ampoules are left.
8. You will be advised to only give 2 injections in any 24 hour period before seeking further advice and help. **If you feel the medication is not being effective, please contact Gold Line or your GP or palliative care nurse.**
9. The patient's regular medication will be reviewed regularly to minimise the need for any extra injections.
10. There is a step by step guide included in this leaflet (see next page).

Important points to remember

Please contact the **Gold Line 01535 292768 (24 hours per day) before giving any medications so they can support you in deciding which medicine to give.**

Step by Step Guide for Injections

1. Call Gold Line to discuss what is needed and let them know is happening (01535 292768)
2. Check the prescription administration sheet
3. Check the port is in place and is free from redness
4. Wash hands
5. Draw up medication
6. Give injection via port
7. Flush with 0.3 ml sterile water
8. Re-check site for redness or leakage
9. Record the injection given in patient notes.

Using Buccal Midazolam

- Remove the syringe from its protective plastic tube. Remove the syringe cap before use to avoid risk of choking
- DO NOT attach a needle to the syringe
- The full amount of solution should be inserted slowly into the space between the gum and the cheek (as shown below)



- If necessary, approximately half the dose should be given slowly into one side of the mouth, then the remainder given slowly into the other side
- The dose must not be administered below the tongue since the teeth may clamp shut and break the syringe in the mouth
- Ideally the patient should remain lying down for at least an hour after administration
- You can also read the Patient Information Leaflet supplied in the pack

Name of Medicine	Why needed? (e.g. pain, anxiety, seizure)	Drug and dose to give (after discussing with Gold Line)

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