

Guideline for Medication Assistance

RESIDENTIAL SERVICE PROVIDERS
(LEVEL 3 SERVICES)



Queensland
Government



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Purpose

The Department of Communities, Housing and Digital Economy has developed this guideline in consultation with Queensland Health and Crown Law, to ensure the health and safety and basic freedoms of people living in residential services across Queensland who request assistance with their medication. The purpose of the guideline is also to support service providers to develop policies and procedures, implement safe practices and to minimise the risk of harm from inappropriate use of medication.

Regulatory Services regulates privately-owned and operated boarding houses, aged rentals and supported accommodation, which are captured by the provisions of the *Residential Services (Accreditation) Act 2002* (the Act). Residential services typically accommodate some of the most vulnerable Queenslanders, including people with an intellectual and/or psychiatric disability, drug and alcohol problems, brain injury, problems associated with ageing, social and economic disadvantage, and social isolation.

The main objects of the Act are to provide consumer protections to residents, to encourage continual improvement by service providers and support fair trading in the residential service industry. The regulatory system establishes minimum standards for the provision of residential services, compulsory registration of service providers and three levels of accreditation.

A residential service provider must be accredited at level 3 to provide a personal care service in the course of operating a residential service. The Act provides a definition of a ‘personal care service’, which includes regularly providing a resident with assistance in taking medication as noted in schedule 2 of the Act.

Assistance with medication falls under the accreditation matter ‘Assistance with Medication’ as outlined in section 7 of the *Residential Services (Accreditation) Regulation 2018* (the Regulation), which states: “If residents ask for help in taking their medication in accordance with medical directions, help is given in accordance with the guideline for medication assistance in residential services with level 3 accreditation published by the department on the department's website.”

The department received coroners’ reports outlining recommendations in relation to two cases of death in care, where a person was residing in a level 3 accredited residential service. The coroners’ recommendations concern a number of matters including the management of medication by level 3 accredited services. These include appropriate storage of medication, distribution of medication and recording of this process, advising doctors when medication is not taken, documenting procedures, and audits to ensure medication is being received regularly by residents.

This guideline outlines the criteria that the delegate of the Chief Executive considers appropriate to make a decision in relation to the level 3 accreditation standard for Assistance with Medication. During an accreditation assessment for level 3 services, the delegate of the Chief Executive takes into consideration the criteria set out in section 44 of the Act.

These criteria include:

1. the extent to which the service provider provides the personal care service in a way that meets the individual needs of the residents to whom the service is provided, protects their interests and maintains and enhances their quality of life generally, and
2. the suitability of the staff members providing the personal care service.

Compliance with this guideline will be a condition of accreditation as a level 3 residential services provider.



Medication Assistance Compliance Checklist

Topic	Self-assessment questions	Section of this guideline to refer to for information
Written consent	<input type="checkbox"/> Do you have residents who have requested medication assistance? <input type="checkbox"/> Is there written consent on file for each resident who has requested assistance with medication?	1.3, 1.5, Appendix 1
Privacy and confidentiality	<input type="checkbox"/> Does the service maintain privacy and confidentiality of each resident's medication information?	1.4
Documentation	<input type="checkbox"/> Have internal policies and procedures for medication assistance been developed? <input type="checkbox"/> Is medication information documented for each resident? <input type="checkbox"/> Are forms used to record medication doses taken for all regular and 'when required' (PRN) medications? <input type="checkbox"/> Are Medication Distribution Records checked regularly to ensure that doses have not been missed? <input type="checkbox"/> Is the required documentation kept for the period of time specified in the Regulation? (at least three years after the day the resident leaves the service)	1 1.5, Appendix 2, 4, 6 1.5 1.5 1.5
Staff training	<input type="checkbox"/> Is there a written procedure in place for assisting with medication which complies with this Guideline? <input type="checkbox"/> Are all staff who are involved with medication assistance appropriately trained? (e.g. www.myskills.gov.au – Assist clients with medication) <input type="checkbox"/> Is training completed prior to commencing with responsibilities for assisting with medication? <input type="checkbox"/> Are staff trained in first aid and CPR, and do they maintain a current certificate in first aid and CPR? <input type="checkbox"/> Is ongoing education about medication available to staff to update their knowledge? <input type="checkbox"/> Is a record of staff training maintained?	1.5, 1.7, 1.8, 1.11, 1.12 1.6 1.6 1.6 3.1 1.6, Appendix 3

Medication storage, handling and labelling	<input type="checkbox"/> Are medications stored in a secure, lockable location, in original packaging or dispensed medications repackaged in a Dose Administration Aid (DAA) and in accordance with pharmaceutical storage requirements?	1.8, 1.9, 2.1
	<input type="checkbox"/> Are the keys to the storage in the personal possession of staff at all times?	1.8
	<input type="checkbox"/> Are medications that may be needed urgently able to be accessed in a timely manner?	1.8
	<input type="checkbox"/> Are all medications individually labelled by a pharmacist for each resident?	1, 2.1, 2.6, 2.7
	<input type="checkbox"/> Are all non-prescription medications ordered by a medical practitioner?	2.7
	<input type="checkbox"/> Is there a procedure for making medication doses available for a resident to use if they are temporarily off-site?	2.10, Appendix 6
Safe disposal of medications	<input type="checkbox"/> Is there a procedure for disposal of ceased, expired or unwanted medications?	1.10
	<input type="checkbox"/> Are medications for disposal stored separately to medications in use, and returned promptly to the pharmacy?	1.10
Medication incidents	<input type="checkbox"/> Is there a written incident reporting procedure for staff to follow?	1.12, Appendix 4
	<input type="checkbox"/> Are Medication Incident Reports reviewed to identify potential areas that need to be addressed?	1.12
	<input type="checkbox"/> Is there a procedure for managing refusal by a resident and missed doses?	1.7, 1.11
	<input type="checkbox"/> Is there a procedure for managing a suspected adverse reaction to medication?	2.9, Appendix 4
Quality use of medicines activities	<input type="checkbox"/> Have any quality use of medicines activities been implemented? <ul style="list-style-type: none"> • written service agreement with pharmacy • medication review • self-assessment • medication audit 	3.1 3.2 3.3, Appendix 7 3.4

1. Principles of quality use of medicines in level 3 residential services

Quality use of medicines is one of the objectives of Australia's National Medicines Policy. While medications make a significant contribution to preventing and treating disease, increasing life expectancy and improving quality of life, they also have the potential to cause harm.

Quality use of medicines aims to maximise the benefits and minimise the risks of harm from the use of medications. In the residential service sector this means assisting residents to use medications safely and effectively to get the best possible results.

The management of health conditions using medication is an increasingly complex issue. In the residential service sector, residents may progress from low to high needs during their residency, have a greater number of illnesses and take multiple medications. Residents of residential services often require more medications than those living in the community, and may need more than one medication to manage each condition. This can present an increased potential for medication interactions, adverse effects and other medication-related problems.

Achieving quality use of medicines in level 3 residential services

The goal of managing illness with medication is centred on achieving the optimum health outcomes for the resident and must focus on the safe and effective use of medications.

The provision of assistance to a resident with taking medication in level 3 residential services ('Assistance with Medication') is done:

- in response to a request from the resident (or authorised substitute decision-maker); and
- in accordance with medical directions as prescribed, the directions on the dispensed medication label and any additional advice provided by authorised health professionals directly involved with the resident's care (doctor, pharmacist, nurse); and
- in accordance with local policy and procedure manuals developed by service providers to reflect the operational implementation of this guideline.

General principles for medication assistance

1.1 Medical decisions

Service providers and staff of residential services provide assistance with medication to residents in a non-clinical setting, and should not make medical or clinical decisions, or be placed in a position where they make discretionary judgments concerning a resident's health status or medication. For these reasons, there will be times when a service provider and/or staff member needs the assistance of expert health personnel, such as a medical practitioner, pharmacist, community nurse or other health professional.

1.2 Duty of care

Service providers are encouraged to seek their own independent legal advice on their duty of care obligations.

1.3 Written consent

Section 77 of the Act stipulates the service provider for a registered service must make, and keep for at least the time prescribed under a regulation, the records prescribed under a regulation. Failure to do so may result in a penalty.

Under section 11(4) of the Regulation, it is a requirement for the service provider of a residential service providing a personal care service, to make and keep a record of the following:

- (a) the daily living and medical or health supports required by each resident;
- (b) the name and contact details of each resident's doctor;
- (c) the name and contact details of each entity that referred a resident to the service, if known;
- (d) the details of any instruction given by the resident to the service provider, an associate of the service provider or staff of the residential service about the personal care service.



Under section 11(5) a service provider for a residential service must keep a register of the records required to be kept under this section at the registered premises for the service.

Further, under section 11(6) of the Regulation, the records mentioned in this section must be kept for at least three years after:

- (a) the day a resident to whom the record relates leaves the residential service; or
- (b) if the resident dies, while residing at the residential service, the day the resident dies.

Service providers must ensure they obtain an initial request (in writing) from the person requiring assistance with their medication. Alternatively, if a person requiring assistance has impaired decision making capacity, a substitute decision maker as defined under the *Powers of Attorney Act 1998* and *Guardianship and Administration Act 2000* may request assistance in writing on behalf of the resident. Assistance should only be given where a formal, written request has been made.

A 'substitute decision-maker' is a person permitted under the law to make important decisions on behalf of someone who does not have capacity. A person can have more than one substitute decision-maker. The decisions made on behalf of a person by their substitute decision-maker(s) can be about personal matters, which includes health matters, or financial matters.

A substitute decision-maker can be appointed formally through:

- an order of the Queensland Civil and Administrative Tribunal (as a guardian), or
- an Enduring Power of Attorney (as a health attorney and/or financial attorney), or
- an Advance Health Directive (as a health attorney).

A form for documenting written consent is attached (Appendix 1).

1.4 Privacy and confidentiality

Service providers must comply with the privacy and confidentiality requirements of section 6(2) of the Regulation. Privacy and confidentiality of information about each resident's medication must be maintained when assisting each resident, when storing medication and medication records, and when discussing the resident's medication and medical condition(s).

1.5 Record keeping and prescribed records

Service providers are required to keep prescribed records under section 77 of the Act. Section 11 of the Regulation specifies that services must keep a record of the daily living, medical or health supports required by each resident. Regulatory Services interprets this as including the keeping of records of assistance provided to residents in managing their medication. Regulatory Services requires these records to accurately reflect the medication assistance provided to residents.

Accurate and legible records of assistance given with medication should be maintained to avoid any gaps or errors in the medication regimen.

Records must be retained for the period of time specified in Section 11(5) of the Regulation.

It is strongly recommended that service providers establish and maintain medication-related documentation in a confidential file for each resident. Documentation includes:

- the resident's written, informed request and consent for assistance with medication or, where the resident has impaired decision making capacity, written consent from the resident's substitute decision-maker for health matters
- the resident's substitute decision-maker's contact details (if applicable)
- contact details of the resident's treating medical practitioner(s)
- a recent photo of the resident (with written consent). The service provider is responsible for arranging a recent photograph of the resident.
- the resident's medication information:
 - » records of daily medication doses taken (a Medication Distribution Record)

- » records of the resident's refusal to take medication (see section 1.11)
- » documentation of any medication incidents/errors (see section 1.12)
- » information about the resident's allergies and details of any previous adverse reactions (see section 2.9)
- » comments regarding any medication changes and medication-related issues
- » a current medication list provided by the resident's pharmacist or medical practitioner, which is a detailed list of all the medications used by a resident with information on dose, frequency, indication, specific instructions and monitoring requirements. For example, warfarin requires testing of blood clotting (INR) at regular intervals to determine the most appropriate dose, clozapine requires blood tests at prescribed intervals to monitor for side effects.
- A Medication Record, which should be supplemented by any case specific information (Appendix 2).

Medication lists are increasingly being used as a source of information by health care providers and consumers to reduce the opportunity for medication errors, and to ensure that accurate information is available when needed. A medication list may be provided for residents following discharge from hospital, or by the dispensing pharmacist. The list should be kept as part of the resident records and can be checked against dispensed medications to ensure that they match the summaries provided by the pharmacy. Any discrepancy should be reported to the pharmacy. This will also assist in managing the risk that a resident is unintentionally given the wrong medication. Where a doctor has changed or ceased medication, a new medication list must be requested from the pharmacist.

If a resident leaves a residential service, a copy of their medical records should be provided to them, or their substitute decision maker. If the resident moves to another residential service, the new service provider should contact the resident's medical practitioner to advise them that the resident has moved.

A Medication Distribution Record (Appendix 3) should be used for accurate and timely recording of each occasion where medication assistance is provided, and the record should include the following elements:

- the full name of resident (and photo identification if available)
- differentiation between residents of identical or similar surname
- the date and time of day for regular medication doses (e.g. breakfast, lunch, dinner, bedtime)
- the date and time of day when PRN and 'immediate' (STAT) medication is taken
- space for the staff member to initial each time that medication has been given and taken
- a legend for description of specific situations, for example:
 - R** medication refused – notify prescriber
 - A** resident absent (e.g. on leave, at medical appointment)
 - S** resident given medication for self-administration
 - H** resident in hospital
 - U** resident unable to take dose (e.g. due to vomiting)
 - N** medication not available – obtain supply and/or notify medical practitioner (e.g. waiting on delivery from pharmacy)
- a section for staff to document any relevant comments and reasons for refusal of medication.

At the beginning and end of each shift, the service provider or staff member should check all dispensed medication and appropriate records to ensure that medication documentation has been completed, that no medication has been missed, and that accurate records have been kept.

1.6 Staff training

The service provider must ensure that staff are given training in the policies and procedures for assisting with medication, obtaining and storing medication, familiarisation with packaging and labelling, and the completion of medication records.



This training should be provided prior to staff undertaking assistance with medication management at the residential service to ensure that staff have the necessary level of skills, knowledge and competency.

Training should be provided by a Registered Training Organisation using a competency unit aligned to *HLTHPS006 – Assisting clients with medication* (or equivalent). (www.training.gov.au/Training/Details/HLTHPS006).

Staff who have responsibility for assisting residents with medication are also to maintain a current certificate in first aid and CPR from an accredited training provider.

Refresher training at 12 month intervals should be undertaken by staff. If it is identified through incident reporting that staff require further training, this should be given as a matter of urgency.

Training records must be maintained for all staff. A form for documenting staff training is attached (Appendix 4).

1.7 Seven 'rights' for safe medication administration

To reduce the risk of a resident experiencing a medication error, it is recommended that staff assisting with medication follow the principles of the seven 'rights' for safe medication administration that have been developed within the healthcare sector and are widely used:

Right person – check the resident's photo identification to ensure the medication is for the right person. Check that the name on the medication container label matches the resident's name. When the resident is commenced on a new medication, check that they have no previous allergy to the medication.

Right medication – cross check the medication name in the Medication Record with the medication label. Check the medication has been stored correctly, and where an expiry date is visible check the medication has not expired.

Right dosage – for dose administration aids, check the right number of capsules or tablets are contained in the section that is to be used. For other medication packaging, ensure the dose is clearly documented on the pharmacist's label on the medication container.

Right time – ensure medication is taken as close as possible to the prescribed time. Some medications have further instructions that should be adhered to, e.g. 'with food', 'half hour before food' or 'after other medications' (this additional information is provided by the dispensing pharmacist). Confirm the time since the last dose is appropriate, particularly for 'when required' (PRN) medications (prescribed medication that is taken only if needed and is not intended/scheduled for regular continuous use).

Right route – ensure medication is taken or applied via the prescribed route, e.g. oral, topical, inhalation. Instructions for the specific route should be provided in writing by the resident's medical practitioner, which staff are to follow.

Right to refuse – the resident has the right to refuse to take a medication. If a resident refuses to take their medication, this must be recorded on the Medication Distribution Record, and contact should be made with the resident's medical practitioner or pharmacist and their instructions followed (refer to section 1.11).

Right documentation – ensure that the medication is signed for by the staff member on the relevant form and that the correct code for specific circumstances is used when applicable (refer to section 1.5).

When assisting with medications, avoiding interruptions will also help to reduce the risk of error.

1.8 Storage of medication and discrepancy reporting

All medications must be stored out of reach of children, in a cool, dry location or refrigerated if required.

Medication must be stored in original packaging, such as a Dose Administration Aid (DAA) or other dispensed container to minimise the risk of errors. For example, a package marked with days of the week on which individual doses of the medication is to be taken (see Glossary).

All medications must be kept in secure lockable storage that is not able to be accessed by other residents or unauthorised staff. Keys to the storage must be in the personal possession of staff at all times. Storage must also conform to the pharmaceutical or storage instructions given for the particular medication as indicated on the label, to ensure that the medication maintains its stability and potency.

If medication needs to be refrigerated, the refrigeration unit should be lockable, or a lockable container e.g. a lockable first aid container should be used and stored in a refrigerator separately from any food items.

Medications that may be required urgently by the resident need to be readily accessible and able to be used promptly when required (for example an asthma inhaler for relief of acute shortness of breath).

Discrepancy reporting

Any unexplained discrepancy involving medications requires action and investigation by an appropriate authority as described in the next paragraph. If a discrepancy in medication is noted that may indicate theft or misappropriation has occurred, address the matter and any security issues promptly.

This may involve reporting the matter to the police, or seeking advice from the pharmacist or contacting the nearest Queensland Health Public Health Unit (www.health.qld.gov.au/system-governance/contact-us/contact-public-health-units).

Keeping only sufficient stock of medication to meet short-term needs, and avoiding stockpiling, will also assist in reducing the risk of diversion of medication.

1.9 Secure storage of medication by a resident

Where residents retain responsibility for the management and storage of their medication, the service provider (or resident) should make a lockable cabinet available within the resident's room and assist residents to ensure their rooms are locked when unattended. This will minimise the risk of harm to both the resident and other residents at the service through limiting possible intentional or unintentional misuse of the medication.

1.10 Safe disposal of a resident's medication

All medication that is no longer required, or is unwanted, ceased or has expired should be stored in a secure container separate to other medications, and be returned promptly to a pharmacist for safe disposal. Under no circumstances should medication intended for disposal be kept for use by any other resident. It is not legal to provide a resident's medication to another person.

1.11 Refusal to take medication by a resident

At the time of occupancy, written consent should be obtained from the resident stating that if they refuse to take their medication, the service provider or staff will contact their medical practitioner or pharmacist.

If a resident refuses medication, or has missed taking their dose for other reasons:

- observe the resident for any changes to their condition and/or behaviour
- if it is believed that a resident may suffer acute symptoms unless prompt treatment is given, or their safety may be at risk, call an ambulance
- contact the resident's medical practitioner or pharmacist as soon as possible and follow their instructions
- if the medical practitioner or pharmacist are not available, call the Medicines Line on 1300 633 424 or 13HEALTH
- if changes in the resident's condition or behaviour are observed, or it is suspected that a resident is displaying withdrawal effects, contact the resident's medical practitioner for instruction.

The service provider and staff must be aware of the risk of withdrawal effects in instances where a resident has refused to take their medication.

The Consumer Medicines Information (CMI) leaflet that is available for prescription medications and some non-prescription medications may also contain information on what should be done if a dose is missed. (CMI may be found in the medication container or online at www.nps.org.au/consumers/consumer-medicine-information-cmi, or can be requested from the pharmacist or doctor).

Additional information specific to medications associated with the treatment of mental health problems can be found online at www.choiceandmedication.org/queenslandhealth.

The resident's refusal and reason for refusal must be documented on the resident's Medication Distribution Record. The resident has the 'right to refuse' (see section 1.7) and there could be good reason for doing so, e.g. if feeling unwell, or if the resident has identified a potential error in their medication pack.

1.12 Dealing with and recording a medication incident

A medication incident is any preventable event that may lead to inappropriate medication use or result in harm from medications, and may include a mistake with medication, or a problem that could cause a mistake with medication. Examples of medication incidents include:

- medication errors:
 - » medication given to the wrong person
 - » incorrect medication is given
 - » incorrect dose is given
 - » given at an incorrect time or by an incorrect route
 - » incorrect medication has been supplied
- adverse reactions to medication
- missing medication
- out-of-date medication
- resident refuses or requests not to be given medication
- lack of documentation such as consent, clear instructions, Medication Administration Record
- incorrect storage of medications.

In the event of becoming aware of a medication error (which is a type of medication incident), follow the procedure outlined in Appendix 5.

Record all medication incidents on a Medication Incident Report Form (Appendix 5) as soon as possible after the incident, but no later than by the end of the shift. The report should include the following information:

- date that the incident occurred (and date that the incident was identified)
- date that the incident was reported to management/service provider
- name of resident
- description of the incident
- what action was taken at the time of the incident and the outcome
- if any corrective action was taken subsequent to the incident to prevent a recurrence and any follow up action(s) required.

Service providers are responsible for monitoring patterns of medication incidents and errors. This responsibility includes reporting errors to the relevant medical practitioner, ensuring the advice of the medical practitioner is followed in addressing an error, documenting any errors on the resident's medication records and ensuring processes are in place to minimise the risk of continued or future errors.

2. Assistance with medication in level 3 residential services

The service provider/staff should only assist with medication:

- (a) where a pharmacist has dispensed medication into a Dose Administration Aid (DAA) pack;
- or
- (b) from the original container dispensed by a pharmacist and labelled for the individual resident (prescription and non-prescription medications);
- and
- (c) in accordance with any directions on the label attached to the medication container and in the Consumer Medicines Information (CMI) relevant to the specific medication. Where applicable, any warning statements, and safety and first aid directions provided by the manufacturer or supplier of the medication should be adhered to.

The directions on the DAA packaging must indicate dosage, time and days. If this information is not provided, contact either the medical practitioner or pharmacy to verify and request the directions in writing, and request the pharmacist to provide appropriate labelling for the medication.

All changes to, or cessation of, medication should be followed up in accordance with instructions from the medical practitioner. If a medication is to be changed or ceased, the DAA pack or other dispensed medication container must be returned to the pharmacy for the changes to be made by the pharmacist.

If the change is to take place immediately, the medical practitioner can either communicate the required changes directly to the pharmacist or can provide a new prescription to be taken to the pharmacy. Medication changes should be reported to the service provider and documented in the resident's Medication Record by the medical practitioner or pharmacist.

2.1 Handling medication

Service providers/staff members can open a resident's dispensed medication container to take out the required dosage and assist the resident to take this medication in accordance with the label directions.

When assisting residents, ensure that the medication is handled according to the specific recommendations and/or precautions for the medication and that the policies and procedures of the residential service are followed.

If there is uncertainty about how to safely handle medication, contact the medical practitioner or pharmacist for clarification.

Hand washing should be done immediately prior to and at the completion of assisting each resident.

Medication from the dispensed container (or the perforated DAA blister compartment for the correct day and time) should be provided directly into the resident's hand. A clean dry medication cup may be used for an individual resident if required due to the number of medications to be taken or if the resident has a problem with dexterity, or if a liquid medication is being used. The medication cup should be washed immediately after use.

Medication should generally be taken immediately, with the staff member observing that the resident has taken the medication. If the medication is provided to the resident to take or use at a later time, the service provider/staff member cannot verify it was taken and should not record it as taken by the resident.

It should be recorded as provided to the resident to self-administer at a later time. This should only occur as an exception, and with the approval of the resident's medical practitioner.

If the resident refuses to take the medication, record this on the resident's Medication Distribution Record and contact the resident's medical practitioner (see section 1.11).

If a resident has identified they will not be at the residential service when their medication is normally provided by the service provider or their staff, this medication should be handed to them to take prior or later, as long as it is in line with prescribed requirements (e.g. if a resident is going to a movie at 5pm when medication is normally given to all residents, they could be given it at 4pm before leaving).

2.2 Routes of administration for which assistance may be provided

Assistance can be provided for medications that are:

- taken orally (capsule, tablet, wafer, liquid)
- inhaled
- used topically on the skin (medicated creams, ointments, lotions, transdermal patches)
- used topically for eye, ear or nasal conditions.

Appendix 6 provides additional information on the safe use of medication for each of these routes of administration.

Other resources for correct technique and use of specific types of products include:

- Consumer Medicines Information leaflets (available online: www.nps.org.au/consumers/consumer-medicine-information-cmi)
- 'How to use' leaflets available from pharmacies.
- Additional information specific to medications associated with the treatment of mental health problems can be found online at www.business.qld.gov.au/industries/service-industries-professionals/housing-accommodation/residential-service/providing-medication-assistance.

2.3 Routes of administration for which assistance should NOT be provided

- **Suppositories/enemas/pessaries/creams for rectal or vaginal use:** medication that is required to be used rectally or vaginally should be self-administered by the resident according to the specific directions for the product. Where self-administration is not possible, contact the resident's medical practitioner for advice about whether an alternative medication and/or route of administration may be suitable, or whether assistance from community nursing services may be appropriate.

- **Injections:** The service provider/staff must not administer injections unless qualified to do so under the *Health (Drugs and Poisons) Regulation 1996*.

A resident may self-administer their own insulin and this must be recorded on the resident's Medication Distribution Record. If the resident is unable to self-administer insulin, contact the resident's medical practitioner to consider whether community nursing services may need to be engaged to undertake this task.

For residents who require insulin, blood sugar level readings should be recorded, and a hypoglycaemia (low blood glucose) treatment plan endorsed by their medical practitioner should be documented.

2.4 Residents who self-medicate

Residents should be encouraged to maintain their independence as long as possible including managing their own medications in a safe and effective manner. However, service providers and staff should regularly monitor residents who self-medicate to ascertain their capacity to continue to do so. Prompting the resident to ensure that they have taken their medication at the prescribed times can be of help in ensuring they do not miss any doses.

Service providers and staff who are concerned that a resident does not have or no longer has the capacity to self-medicate should raise their concern with the resident's medical practitioners. A formal assessment by a suitably qualified healthcare practitioner may be undertaken if needed.

Residents who self-medicate should also be encouraged to keep records of their medication, including a current medication list.

2.5 'When required' medication (pro re nata, PRN medication)

PRN medication is medication that is to be taken on an as required basis and is not intended for regular, continuous use. PRN medication can only be provided when the resident requests assistance, and is to be prescribed by a doctor to be given under specific circumstances. It is recommended the doctor provide written instructions about the particular circumstances under which the medication is to be given to a resident for relief of symptoms (temporary or intermittent), the interval between doses and the maximum total dose in 24 hours.

PRN medication can include pain relief for intermittent pain, sedatives for insomnia, or medication used for behaviour modification.

PRN medication must be given from a container that has been labelled for the specific resident. When assisting with PRN medication, check the Medication Record to ensure that the medication is given according to the prescribed time interval and that the maximum daily dose has not been exceeded. If advice about the use of PRN medication is needed, contact the resident's medical practitioner or pharmacist.

It is recommended that staff also advise the service provider verbally before assisting with PRN medication or providing PRN medication to the resident for self-administration.

Doses of PRN medication taken by a resident must be recorded by the service provider and staff. It is also the responsibility of the service provider and staff to advise and familiarise the next shift of what PRN medication has been used or self-administered during the shift.

2.6 Non-prescription (over the counter, OTC) medication

'Over the counter' (OTC) medication is medication that is available from a pharmacy without a medical practitioner's prescription for the symptomatic relief of common minor ailments such as coughs, colds, hay fever, tinea, headache (e.g. paracetamol, ibuprofen, antihistamines and decongestants).

OTC medications may be labelled as **PHARMACY MEDICINE** or **PHARMACIST ONLY MEDICINE**, for substances listed in Schedules 2 and 3 respectively of the Australian Government *Poisons Standard (Therapeutic Goods Act 1989)*. Some OTC medications are not listed in the schedules.

If a resident requires OTC medication, it is recommended that the service provider/staff initially contact the resident's medical practitioner to obtain information about any OTC medication that should not be taken (as there is potential for OTC medication to adversely interact with other medications or be inappropriate in some co-existing medical conditions).

For OTC medication that is not part of the resident's regular medication regimen, the duration of use of the medication should be specified by the resident's medical practitioner as OTC medication is generally required only for limited periods of time, often no longer than 24 hours.

The following procedures are recommended for the use of OTC medication:

- OTC medications should be prescribed by the resident's medical practitioner and obtained from the pharmacy that usually dispenses the resident's prescription medication
- OTC medication is to be recorded on the resident's Medication Distribution Record as for prescription medication
- if OTC medication is purchased independently by the resident, the resident should be encouraged to inform staff so that their medication record can be updated. This requirement may be included in the written consent given by the resident
- where a resident is already taking medication(s) or involved in complementary and alternative therapies, the medical practitioner and/or pharmacist should be contacted to determine whether commencing a new OTC treatment will interact adversely with the existing medication(s). If the medical practitioner, pharmacist, or therapist is unavailable, contact the Medicines Line on 1300 633 424, or the Emergency Department of the local hospital. It is important in these circumstances that the service provider/staff are familiar with the resident's usual medication schedule
- if symptoms are not relieved by the OTC medication, contact the resident's medical practitioner for further instructions or assessment.



2.7 Complementary and alternative therapies

Where a resident requires assistance with the use of complementary or alternative treatments, written consent and instructions should be received from the resident's medical practitioner and be documented in the resident's Medication Record as for prescribed medications.

2.8 Adverse reactions to medication

Should service providers or staff identify or suspect that a resident is experiencing an adverse reaction to medication, or the resident reports this to the service provider, the resident's medical practitioner must be contacted, and staff should act in accordance with the medical practitioner's instructions.

- call an ambulance immediately if the resident is in distress or showing signs of requiring hospitalisation, for example difficulty breathing, chest pain, unexpected drowsiness, dizziness, change in consciousness, seizures, or extreme changes in behaviour
- administer first aid as required, if qualified to do so
- if an ambulance is not required, seek advice by phoning the prescribing medical practitioner and continue to observe the resident for changes in behaviour or well-being
- if a medical practitioner is unavailable, seek advice from either:
 - » the resident's pharmacist, or
 - » the Adverse Medicines Events Line on 1300 134 237 (Monday to Friday, 9am to 5pm AEST), or
 - » Health Direct Australia on 1800 022 222 (available 24 hours), or
 - » the Queensland Poisons Information Centre on 13 11 26.

The Consumer Medicines Information (CMI) leaflet that is available for prescription and some non-prescription medications can also be referred to for information about common reactions to medications.

A Medication Incident Report should be completed as soon as possible after the incident, but no later than by the end of the shift (see section 1.12 and Appendix 5).

2.9 When a resident is temporarily off-site

When a resident is temporarily off-site (e.g. social outing, temporary home visit) and will require doses of medication, the resident's originally dispensed medication or a separately dispensed supply sufficient for the period of the absence, and labelled and provided by a pharmacist, should be used.

The *Health (Drugs and Poisons) Regulation 1996* does not permit the service provider or staff member to repack medication (e.g. placed in envelopes or other types of temporary containers).

A form should be used to document each occasion where medication is provided for the resident to use when off-site. The Medication Record (Temporarily Off-site) (Appendix 7) should include the following information:

- medication administered to residents during the time they are temporarily off-site
- all medication returned by the resident at the conclusion of their period off-site
- all refusals to self-administer medication while off-site (if known).

If an incorrect dose of medication has been taken by a resident, or their medication has not been taken at all, inform the prescribing medical practitioner of the error and follow the advice or instructions given. All errors or omissions in self-administering medications must be recorded as a medication incident.

If an ambulance is called and/or the resident goes to hospital, it is important that information about their medication (and/or a copy of their current medication list) is handed to the paramedic, ambulance officer or authorised person in the hospital unless alternate arrangements have been made with the hospital.

3. Quality use of medicines activities

To support safe and effective use of medications, and reduce the risk of medication incidents, additional activities can be undertaken. The following examples are given to assist service providers with achieving quality use of medicines.

3.1 Service agreement for supply of medication and associated professional services

To assist with continuity of care it is recommended that residential services providing medication assistance establish a service agreement with

the pharmacy that supplies medication for the resident(s). Ensure that each resident has freedom of choice in relation to the selection of a pharmacy to provide their medications.

The service agreement would generally cover the following aspects of medication management:

- dispensing and supply of prescription and non-prescription medications, and relevant Consumer Medicines Information leaflets, where available, for individual medications
- agreed delivery arrangements
- arrangements for provision of dose administration aids where required
- procedures for dealing with changes to medication (e.g. changes to dose or frequency, or cessation of medication)
- maintenance and supply of accurate medication lists for individual residents
- a process to ensure continuity of medication supply and timely dispensing of repeat prescriptions
- procedures for after-hours services for supply of urgent medication and advice
- procedures for safe disposal of medication
- procedures for dealing with errors and discrepancies
- provision of education and advice about medication use, medication reviews and audits

- a requirement for regular meetings (at least quarterly) between the pharmacist and the service provider/staff to discuss medication-related issues
- provision of the above services in accordance with Pharmacy Board of Australia Codes, Guidelines and Policies, and other applicable professional practice standards.

3.2 Medication review

It is the responsibility of medical practitioners to ensure that residents on long-term medication have a formal review of their medication conducted at least annually. The review may include the resident/substitute decision-maker, resident's medical practitioner and other stakeholders (e.g. psychologist or mental health worker, pharmacist) directly involved in the health care of the resident. An accredited pharmacist can also perform a medication management review (Home Medicines Review) on a referral from the resident's general practitioner.

Factors that may prompt the need for a medication review include:

- a discharge from hospital (frequently a source of medication changes)
- an observed change in response to the effects of medication
- a suspected adverse drug reaction
- continued refusal or suspected non-compliance with medication.

3.3 Self-assessment

To assist service providers in implementing these guidelines and meeting the requirements of level 3 services in assisting residents with medication, a self-assessment checklist (page 6-7) can be used to identify areas needing attention or development.



4. Resources

3.4 Medication audits

Audits of medication stored at the residential service may be undertaken at regular intervals, to minimise risks associated with the usage, storage and disposal of medication. Medication Incident Reports may indicate to service providers that more frequent medication audits are required. The audits may be carried out by the pharmacist who is contracted to provide the dispensing service for the residential service, or by an independently contracted pharmacist or other authorised health professional.

Medication audits may take into consideration:

- any medications on hand at the commencement of the period being audited
- any medications received from pharmacists during the period being audited
- medications used during the audit period
- medication signed-in by a resident returning from off-site
- medication returned to a pharmacist, medical practitioner or hospital
- any medication returned to a pharmacy for disposal.

After considering the results of a medication audit, service providers should contact the relevant medical practitioner and/or pharmacist to obtain advice on managing any issues identified. For example, differences in the reconciliation of actual medication stock on hand with expected stock on hand. The service provider would be responsible for ensuring appropriate steps are implemented to rectify emerging or ongoing issues.

The following resources are available to assist service providers and staff, and can be contacted if appropriate/necessary:

- ❑ **Adverse Medicines Events Line** on 1300 134 237 for information about suspected adverse effects of medications. Available Monday to Friday, 9am to 5pm.
- ❑ **Medicines Line** on 1300 633 424 for general information on prescription, over-the-counter and complementary (herbal, 'natural', vitamin and mineral) medications. This service is not for emergencies, medical advice or a second opinion. Available Monday to Friday, 9am to 5pm.
- ❑ **Health Direct Australia** on 1800 022 222 for hour advice and information from a registered nurse.
- ❑ **13HEALTH** on 1343 25 84 (24-hour service) for general health and well-being information (www.health.qld.gov.au/13health).
- ❑ **Queensland Poisons Information Centre** on 13 11 26 for information and advice to assist in the management of poisonings and suspected poisonings (including concerns about medications arising from an overdose or suspected poisoning, but not for information about missed doses or refusal to take medication).

Online medication-related information can be found at www.nps.org.au.

APPENDICES

Appendix 1: Written request/consent for assistance with medication

Appendix 2: Medication Record

Appendix 3: Medication Distribution Record

Appendix 4: Staff Training Record

Appendix 5: Medication Incident Report Form and Flowchart for responding to a medication error

Appendix 6: Routes of administration for which assistance can be given

Appendix 7: Medication Record (Temporarily Off-site)

The forms are available online at www.business.qld.gov.au/industries/service-industries-professionals/housing-accommodation/residential-service/providing-medication-assistance.

Written request for assistance/ consent for medication assistance



I, _____ [insert resident's name] _____ hereby request management and/or staff of
_____ [insert name/or address of the service] _____ to assist me with medication as prescribed
by my medical practitioner.

- I understand that this means assisting me at the correct times to access my prescribed medication from its container which has been dispensed by a registered pharmacist.
- I understand that this means assisting me to access appropriate non-prescription medication in accordance with the directions provided by the manufacturer.
- I understand that this means assisting me with alternate medications recommended by my medical practitioner and/or pharmacist.
- I authorise the safe storage of such medication in a locked area within the facility.
- I authorise that my prescriptions are given to the pharmacist as required.
- I acknowledge that should I refuse to take the prescribed medication, I do so at my own risk, and that staff will notify my medical practitioner.

Signature of resident

Date

Signature of authorised person (e.g. statutory attorney,
guardian, substitute decision maker)

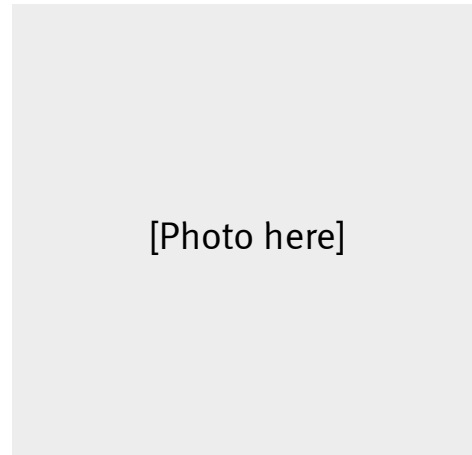
Date

Print name of authorised person	
Relationship to resident	



Medication Record

Name	
Date of birth	
Written request for assistance with medication signed and on file <i>(tick box if request on file)</i>	<input type="checkbox"/>
Doctors name	
Day time phone	
After hours phone	
Pharmacy name	
Pharmacy phone	



Current medication list provided by resident's doctor or pharmacist <i>(tick box if on file)</i>	<input type="checkbox"/>
Does the resident have any known allergies or previous adverse reactions to medications?	<input type="checkbox"/>
Location where these are documented:	

Notes/comments relevant to resident's medication				
Date	Medication name	Notes	Medical practitioner notified	Staff signature



Medication Distribution Record

Name of resident: _____

<p>Legend:</p> <ul style="list-style-type: none"> Staff initial – medication given and taken R – medication refused – notify prescriber A – absent (on leave, at medical appointment) S – resident given medication for self-administration H – resident in hospital U – resident unable to take dose (e.g. due to vomiting) N – medication not available – obtain supply and or notify medical practitioner (e.g. waiting on delivery from pharmacy) 	<ul style="list-style-type: none"> B – Breakfast L – Lunch D – Dinner BT – Bed Time
---	---

Week beginning ↓	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday			
	B	L	D	B	L	D	B	L	D	B	L	D	B	L	D	B	L	D	B	L	D	

Record of PRN medication

Date	Medication	Dose and time	Staff signature

Record of refusal of medication

Date	Medication	Details of refusal	Comments	Medical practitioner notified	Staff signature



**Queensland
Government**

Medication Incident Report Form

Name of resident/s:

Date incident identified:

Date and time incident occurred:

Describe the incident and what happened:

Describe how the incident was managed:

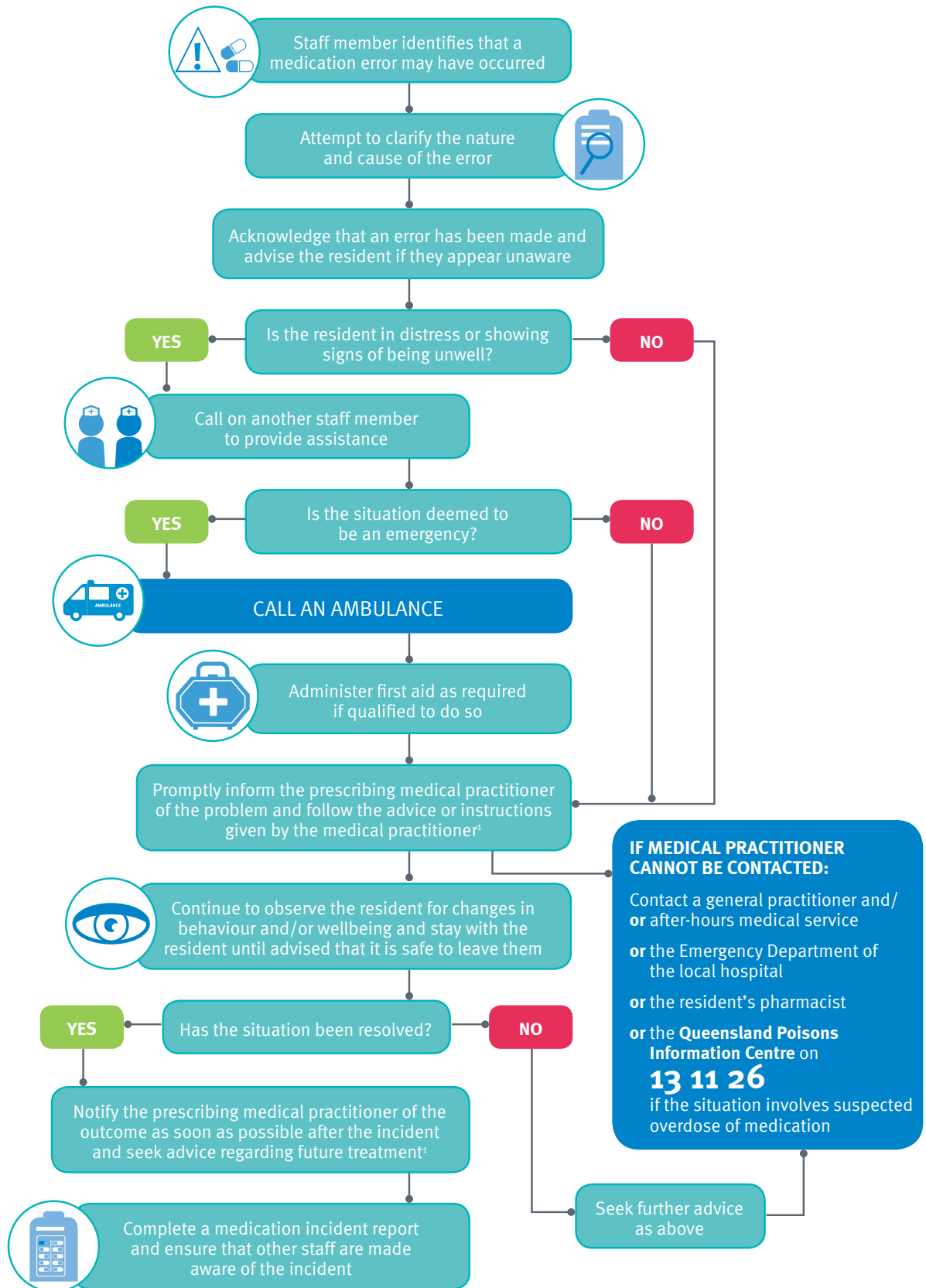
Date reported to management/service provider:

Describe any corrective actions planned or taken to prevent a recurrence:

Signature of staff reporting issue

Date:

Appendix 5: Flowchart for responding to a medication error



¹ Where the medical practitioner's advice or instruction involves a change to the original medication schedule, the advice or instruction is expected to be in writing. Where it cannot be provided in writing, it should be verbally confirmed by the medical practitioner with either the service provider or staff member. A second service provider or staff member should repeat the instruction back to the medical practitioner for confirmation of accuracy, and request confirmation from the medical practitioner in writing as soon as possible thereafter. A written record of the verbal advice from the medical practitioner should be made as soon as possible by staff members in the resident's medication record and in staff communication notes used within the service. If a new prescription is required, the medical practitioner's oral instruction must be to the pharmacist who will be dispensing the medication.

Appendix 6: Routes of administration for which assistance can be given

Route of administration	Guidance notes to assist with correct use of medication products	Additional resources
<p>Oral medication</p>	<p>Capsule, tablet or wafer Medication in capsule or tablet form should not be split or crushed unless stated on the label or with specific instructions provided by the medical practitioner or pharmacist. Serious adverse effects can result from the inappropriate splitting/ crushing of capsules and tablets that are formulated to be swallowed whole. If a resident is having difficulty with swallowing tablets or capsules, contact the medical practitioner or pharmacist for advice. In some circumstances an alternative formulation or different medication may be needed.</p> <p>Any concerns about a resident’s ability to swallow medication should be referred to the medical practitioner or pharmacist.</p> <p>Staff should ensure they follow any policy in place relating to the engagement of a speech pathologist to review the residents’ ability to swallow, particularly their ability to swallow medications.</p> <p>Staff should follow recommendations developed by health professionals e.g. speech pathologists which support the resident to be able to swallow their medication safely.</p> <p>Liquid medication Use a medication measure that is designed and marked specifically for liquid medication, and follow the specific directions for the product, for example regarding storage, shaking the bottle prior to use.</p>	<p>Medicines Line on 1300 633 424 for information on how to take medications</p>
<p>Topical medication</p>	<p>Medicated creams, ointments, lotions: If applying topical medication, wear protective gloves. If additional medication is required from the container, do not use the same glove.</p> <p>Unless directions state otherwise, topical medications are applied thinly.</p> <p>Skin patch medications (transdermal patches): A transdermal patch is a medicated adhesive pad placed on the skin to deliver a time-released dose of medication through the skin.</p> <p>The patch is to be applied strictly according to directions on the label and packaging. Ensure that the previous patch is removed prior to applying the new patch, and observe the required patch-free period if applicable.</p> <p>Skin irritations or skin tears caused by the removal of a patch must be reported to the resident’s medical practitioner for appropriate treatment.</p>	<p>Information on the right way to use eye, ear, and nose drops; eye ointments; inhalers; and suppositories: www.safemedication.com/how-to-use-medication</p>

	<p>Document the location of the patch and write the date of application on the outer surface of the patch.</p> <p>Recommendations for the safe and appropriate disposal of the used patch must be followed. The removed patch should be folded with the adhesive side inwards, wrapped or replaced in the original packaging and disposed of securely.</p>	
Inhalation medication	<p>Medications for respiratory and some nasal conditions are inhaled using a device called a Metered Dose Inhaler, or MDI.</p> <p>There are many different types of device available (e.g. standard MDI, accuhaler, turbohaler, autohaler, breezhaler, spacer), each with a specific method for correct use. The resident's medical practitioner or pharmacist will decide which device is most appropriate, and can provide education on the correct technique for the use and cleaning of the device.</p>	<p>Resources developed by the National Asthma Council Australia demonstrating the correct use of inhalers can be found at: www.nationalasthma.org.au/living-with-asthma/how-to-videos</p> <p>Videos of correct inhaler use: www.nps.org.au/consumers/inhaler-devices-for-respiratory-medicines</p>
Nasal drops and sprays	<p>Read the directions carefully before assisting with nasal drops or sprays and follow the specific method for use of nasal products.</p>	<p>Consumer Medicines Information leaflets</p>
Eye drops/ ointment	<p>Read the directions carefully before assisting with eye drops/ ointment and follow the specific method for use.</p> <p>If more than one kind of eye drop is required, wait at least five minutes between each different drop.</p> <p>Observe the recommended storage conditions and expiry date after opening (commonly 30 days).</p>	
Ear drops	<p>Read the directions carefully before assisting with ear drops and follow the specific method for use.</p> <p>If after using the medication, the resident's ear lobes become red, swollen or itchy, report this to the resident's medical practitioner promptly.</p> <p>Observe the recommended storage conditions and expiry date after opening.</p>	<p>Information on the right way to use eye, ear, and nose drops; eye ointments; inhalers; and suppositories: www.safemedication.com/how-to-use-medication</p>

Other resources for correct technique and use of specific types of products include:

- Consumer Medicines Information leaflets (available online: www.nps.org.au/consumers/consumer-medicine-information-cmi)
- 'How to use' leaflets available from pharmacies.



Medication Record – Temporarily Off-site

Name of resident	
Date/s temporarily off-site	

Name and signature of service provider or authorised staff:

Print name

Signature

List of medication released to resident

Drug name	Dose	Route	Frequency

List of medication returned

Drug name	Dose

Confirmation of medication returned

Print name of service provider or authorised staff

Signature

Glossary

Adverse drug reaction	A response to a drug or medication which is noxious and unintended, and which occurs at doses normally used in humans for the prophylaxis (prevention), diagnosis, or therapy of disease, or for the modification of physiological function
Complementary and alternative medications (CAMs)	CAMs include herbal, vitamin and mineral products, nutritional supplements, homeopathic medications, traditional Chinese medications, Ayurvedic medications (holistic (whole-body) healing systems), Australian Indigenous medications, and some aromatherapy products regulated under the <i>Therapeutic Goods Act 1989</i> . Other terms sometimes used to describe CAMs include ‘natural medications’ and ‘holistic medications’
Consumer Medicines Information (CMI)	Brand-specific leaflets produced by a pharmaceutical company in accordance with the Therapeutic Goods Regulations to inform consumers about prescription and pharmacist-only medications. Available from a variety of sources, e.g. enclosed with the medication package, supplied by a pharmacist as a leaflet or computer printout, provided by a doctor, nurse or hospital, or available from the pharmaceutical manufacturer.
Dose administration aid (DAA)	A device or packaging system such as blister packs, bubble packs or sachets for organising doses of medications according to the time of administration
Formulation	The form in which a medication is presented e.g. tablet, capsule, lozenge, syrup, mixture.
Medication errors	A type of medication incident, defined as: Preventable events that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health professional, patient or consumer. This can include any discrepancy between the prescriber’s interpretable medication order and what was given to and/or taken by a patient.
Medication incident	Any event where the expected course of events in the process of assisting with medications is not followed, including events that could have or did cause the resident harm, and where the medication is likely to have been a contributing or causal factor.
Medication review	A structured, critical examination of a consumer’s medications with the objective of reaching an agreement with the consumer about treatment, optimising the impact of medications, minimising the number of medication-related problems and reducing waste.
Non-prescription medication (Over the counter/OTC medication)	Medications available without prescription. Examples are cough mixtures, simple analgesics and antacids. Some can be sold only by pharmacists (‘Pharmacist Only’) or in a pharmacy (‘Pharmacy Only’); others can be sold through non-pharmacy outlets such as supermarkets.
PRN medication	Medication that is to be taken on an as required basis for the defined treatment of intermittent symptoms or a short-term condition, and is not intended for regular, continuous use.
Quality use of medicines (QUM)	Quality use of medicines means: <ul style="list-style-type: none">• selecting management options wisely• choosing suitable medicines if a medicine is considered necessary, and• using medicines safely and effectively. (Consumers Health Forum of Australia – Understanding quality use of medicines)

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