Palliative Care

GUIDELINE TITLE: Palliative Care Drug Administration Procedure by Patients or their Informal Carers (Adult Palliative Care)

DOCUMENT REFERENCE	**(Generated by SharePoint)**
VERSION No	1
LEAD AUTHOR'S NAME	Dr Linda Wilson / Rachel Binks
LEAD AUTHOR'S ROLE & DEPARTMENT	Consultant in Palliative Medicine(Community) Nurse Consultant, Digital and Acute Care
APPROVAL BODY 1	
DATE APPROVED: APPROVAL BODY 1	
APPROVAL BODY 2	PDRG
DATE APPROVED: APPROVAL BODY 2	
REVIEW DATE	
LOCATION OF COPIES **Named person is responsible for ensuring only current copy is in use. Department managers are responsible for their own areas for ensuring only current copies are in use**	

DOCUMENT REVIEW HISTORY

REVIEW DATE	**REVIEWED BY**
May 2019	

DOCUMENT CHECKED FOR Yes/No

CORPORATE ISSUES	
CLINCAL GOVERNANCE ISSUES INCLUDING RISK	
INCLUSION OF COMMUNITY SERVICES	
PEOPLE GOVERNANCE ISSUES	

If printed, this becomes an uncontrolled document. Only AireShare version or numbered copies in stated locations are valid for operational use

Contents

1. Introduction 3
1.1. Aim 3
1.2. Scope 3
1.3. Statement of intent 3
2. Management 4
2.1. Criteria for Suitability 4
2.2. Criteria that might prevent suitability 4
3. Implementing the procedure 4
4. Consultation 5
4.1. Peer review 5
6. References 5
7. Appendices 5
7.1. Appendix 1 - Practical procedure 6
7.2. Appendix 2 - Assessment Of The Administration Of A Subcutaneous Injection Via An Injection Line By A Patient Or Informal Carer. 8
7.3. Appendix 3 – Patient/Carer leaflet 10
7.4. Appendix 4 – Procedural Document Development Checklist 11

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 sc infusions (csci), these will be discussed with the specialist palliative care team on an individual basis to ensure safe practice.

1.1. Aim

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

1.2. 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.

1.3. Statement of intent

Airedale 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

2. 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.

2.1. 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

2.2. 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. 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 have been assessed as competent to administer sc / buccal medication, the relevant care plan on Systm1 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.

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.

4. Consultation

4.1. 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.

5. References

NMC Standards for Medicine Management (2007)

BDCFT Syringe Driver Guidelines (2015)

6. Appendices

6.1. Appendix 1 - 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 2ml luerlock syringes
- Supply of blue needles
- Ampoule of water for injection
- Prescribed drug for PRN use
- Sharps box
- Hand gel

Action	Rationale
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 If the patient is being discharged from hospital or hospice, liaison between the acute setting and community is essential.	To ensure safe transfer of care

Once the MDT has agreed to support this procedure, it is the responsibility of the registered nurse to:
 	
• 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:
  ○ Hand washing/ use of hand gel
  ○ Drawing up the prescribed medication as indicated on the
	
	To fully inform the carer/patient to enable them to make a safe and informed choice
	
	To ascertain their willingness to undertake the procedure. How to cope/who to call in an emergency
	
	To demonstrate a safe procedure
	
	To ensure the patient is given the correct drug at the prescribed dose and by the correct route

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 • Explain how to record the details of administration on the medication chart • Provide the patient/carer with the information leaflet	To flush any remaining solution (irritating solution away from the line) and ensure that the patient receives the full dose of the medication To minimise infection To protect the patient from harm To comply with NMC Standards for Medicine Management (2007)
After the patient/carer are assessed as competent to give the medications, the nurse will: • Complete the assessment sheet with them to confirm their competence • Complete the relevant care plan • Add a high priority reminder to Systm1 • Contact Gold Line to make them aware of the plans in place	To ensure the carer feels competent and is deemed competent to undertake the procedure To provide documentation of correct process To inform Gold Line so they can support patient/carer
When the carer feels that a PRN medication may be required, they should: Contact Gold Line • 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	To ensure the patient is given the correct drug at the prescribed dose and by the correct route To provide an overview of medicines administration To protect the patient from harm To support the patient/carer To comply with NMC Standards for Medicine Management (2007)
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	To ensure good communication is maintained between carer and health care professional

6.2. Appendix 2 - 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……

Carers 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	
Section A		Carer	Nurse
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

6.3. Appendix 3 – Patient/Carer leaflet

FINAL Information for patients and carers to

6.4. Appendix 4 – Procedural Document Development Checklist

Prior to submitting any document for initial ratification or following a review, the following checklist must be completed and appended by the author to the document. Please remember when writing a procedural document you need to be as specific as possible and not leave any area open for misinterpretation.

TITLE OF DOCUMENT:	√ or X	Comments
Front page – title, document reference table		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, or SOP?	Y	
Has the correct document template been used?	Y	
Is the document reference table completed?	Y	
Is the review date identified?	Y	
Is the frequency of review identified? If so, is it acceptable?	Y	
Contents page and associated trust documents		
Are the contents page and page numbers accurate?	y	
Are all associated trust documents hyperlinked?	NA	
Introduction		
Are the intention, purpose and scope of the document made clear?	y	
Are all relevant, supporting policies, local and national guidelines and SOPs listed?	y	
Has an equality impact assessment been completed?	N/A	
Have the Trust's EcoAwaire ideals been considered?	N/A	
Definitions		
Are all terms clearly defined?	y	
Duties		
Are all roles and responsibilities made clear?	N/A	
Developing a new procedural document		
Have any training needs been identified?	n	
If so, have Education & Training / practice development been consulted?	N/A	
Consultation, approval and ratification process		
Is the consultation / peer review process explicit?		
Has the patient and carer panel been consulted?	N/A	
Does the document identify which committee/group has approved it?	y	
Are there any fraud implications with this policy? If yes has the Local Counter Fraud Specialist been consulted?	N/A	
Is this document used to evidence CQC or NHSLA standards (if yes has the Assistant Director Healthcare Governance been consulted)	N/A	
Dissemination & Implementation		
Is there an outline/plan to identify how this will be done?	y	
Does the plan include the necessary training/support to ensure compliance?	y	
Have resources implications (including financial) been considered and documented?	y	
References		
Are all references properly listed?	y	
Is there a clear evidence base?	y	
Version control		
Does the document have a clear version number?	y	
Are minor amendments clearly documented on the version control page?	na	
Process for Monitoring compliance		
Are there measurable standards, KPIs or a defined audit tool to support monitoring compliance of the document?	N/A	
Is it clear which committee or group is responsible for monitoring compliance with the policy?	y	
Overall Responsibility for the Document		
Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	y	
Are there any other issues to be considered?	n	