University Hospitals Bristol
NHS Foundation Trust

# Chapter M9: Policy for the Administration of Medicines

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|---|---|
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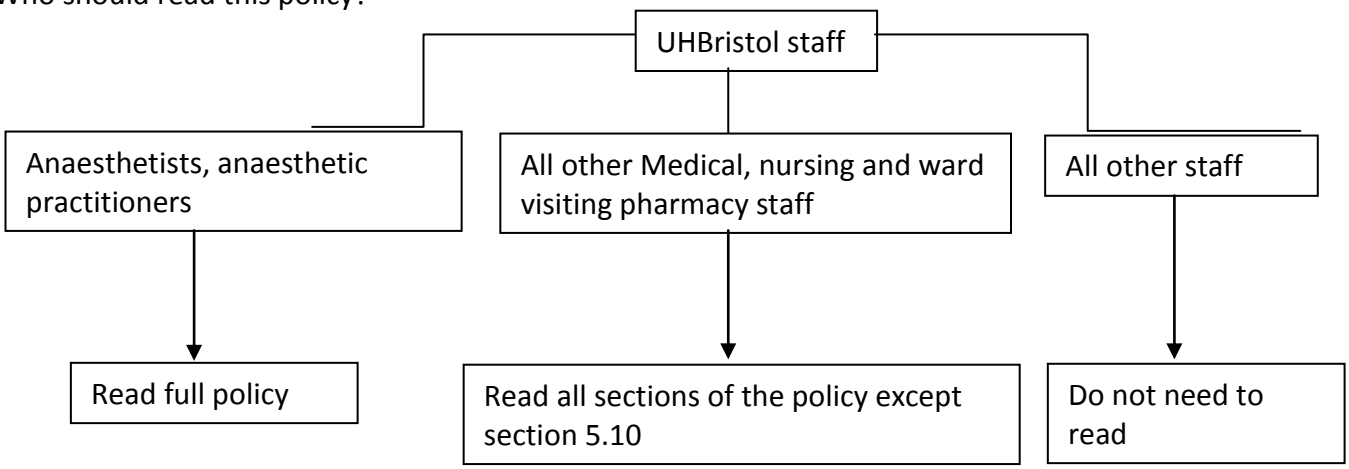
| Document Abstract |
|---|
| This policy outlines the responsibilities for the safe administration of medicines. It defines who can administer medicines and is the parent policy that should be read in conjunction with the administration of medicines standard operating procedure. |


Who should read this policy?



| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of Version** | **Version Number** | **Lead for Revisions** | **Type of Revision** | **Description of Revision** |
| February 2005 | 1.0 | Director of Pharmacy | Review | Revised guidance |
| June 2007 | 2.0 | Director of Pharmacy | Review | Revised guidance |
| September 2010 | 3.0 | Director of Pharmacy | Review | Revised guidance |
| September 2012 | 4.0 | Director of Pharmacy | Review | Updated to current trust policy format and to further develop local application of national guidance.<br>Incorporation of existing policy M09a1 - Administration of medicines by student and qualified non-registered anaesthetic practitioners<br>Incorporation of paediatrics administration |
| August 2014 | 5.0 | Director of pharmacy | Minor | Updated following NHS Protect, medicines security self-assessment checklist http://www.nhsbsa.nhs.uk/4430.aspx included information regarding expiry of liquid medications once opened. Information on syringes being removed from an electronic pump. |
| March 2015 | 6 | Director of Pharmacy | Minor | Include comprehensive detail in verbal orders section of the policy.<br>Define practitioner/ authorised practitioner roles to include perfusionists and physician's assistants. |
| May 2015 | 7 | Director of Pharmacy | Minor | Include detail of non-registered practitioners/ technicians administration of medicines |
| January 2016 | 8 | Director of Pharmacy | Minor | Include oral/ enteral syringe detail. Include ATMP.<br>Review, update and adopt EPMA administration procedures |
| October 2016 | 9 | Director of Pharmacy | Minor | Verbal order update<br>Transport of medicines to community |
| May 2017 | 10 | Director of Pharmacy | Minor | Additional staff groups to section 3.3 |

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# 1. Introduction

*1.1* This chapter outlines the policy to be followed by all staff when administering medicines, and is to be used in conjunction with the current 'Code of Ethics' or published professional guidelines for each clinical profession.

*1.2* The procedures that should be followed when administering a medicine are found in the Administration of medicines standard operating procedure

# 2. Purpose and Scope

*2.1* To ensure that prescribed medicines are administered to patients in the correct manner, that is:

The correct medicine is given in the correct dose via the correct route to the patient for whom it is intended at the time at which it is prescribed.

# 3. Definitions

## *3.1 Medicine*

A medicine is a medicinal product as defined by article 1 of the directive 2001/83/EC as detailed here:

(a) Any substance or combination of substances presented as having properties for treating or preventing diseases in human beings.

(b) Any substance or combination of substances which may be used in or administered to human beings either with a view to restoring correcting or modifying physiological function by exerting a pharmacological immunological or metabolic action, or to making a medical diagnosis.

(c) An inert substance added to some other substance or solution so that the volume of the latter substance is increased and its concentration per unit volume is decreased

## *3.2 Medical Staff*

The term medical staff includes dentists, and where nurses are specifically mentioned this includes midwives.

## *3.3 Practitioner or Authorised Practitioner*

(a) Registered medical staff (including dentists) and foundation doctors

(b) A registered nurse or midwife

(c) A pre-registration student nurse or pre-registration student midwife (who is not a registered nurse)

Who as part of their training has successfully undertaken the university maths test, but only as a second checker with a registered nurse (who accepts full responsibility for the correct administration and recording of the medicine prescribed).

(d) Medical students

Under the direct supervision of a registered medical practitioner, as second checker with the registered medical practitioner (who accepts full responsibility for the correct administration and recording of the medicine prescribed).

(e) Other healthcare professionals who are acting in accordance with a Patient Group Direction or under agreed protocols, including:

(i) Operating Department Practitioner who is registered with the Health Care Professions Council (HCPC).

(ii) Clinical Perfusion Scientists (Perfusionists). Perfusionists are specialist autonomous practitioners involved in the management of patients undergoing cardiac surgical procedures.

Qualified Perfusionists employed by UHBristol NHS Foundation Trust must be registered with the College of Clinical Perfusion Scientists of Great Britain and Ireland.

The Perfusionists at UHBristol work under delegated authority from the Clinical Director/ Trust. They follow detailed guidance and work to competencies as outlined in the Department of Clinical Perfusion Science Standard Operating Procedure (2015). The Department of Clinical Perfusion Science Standard Operating Procedure Annexes (2015) stipulates the range of medicines, which may be administered, and in what circumstances.

(iii) Physicians' Assistant (Anaesthesia) (PA(A))

PA(A)s are practitioners trained to care for patients undergoing surgery and/or anaesthesia under the supervision of a Consultant Anaesthetist.

Each PA(A) has gained a Postgraduate Diploma in Anaesthetic Practice and is affiliated to the Royal College of Anaesthetists.

PA(A)s working practices are governed by a document produced by the Royal College of Anaesthetists as regards to supervision and limitations of scope of practice (2011) http://www.rcoa.ac.uk/node/1927

(iv) Student anaesthetic practitioners are required to administer anaesthetic medications as part of their curriculum programme, and will undertake theoretical and practical training throughout the first year of the programme whilst working under the direct supervision of an anaesthetist. On successful progression to year two students may work within the full scope of local policy practice under the individual supervision of an anaesthetist. Qualified and student anaesthetic practitioners are able to administer medication against a patient specific written or computer generated anaesthetic prescription record or anaesthetic drug plan.

(f) Second Level Nurses

Who have undertaken some form of additional instruction regarding medicines administration following their original registration and training. This additional instruction may have been in UHBristol or in another NHS organisation as per the scope of professional practice policy. Newly employed second level nurses should be asked to provide evidence of this additional instruction. Divisions should specifically ask for verification of this when they seek references for second level nurse applicants.

(g) Nurse Assistants and Assistant Practitioners

Who have undertaken some additional training through the QCF qualification, may assist the patient with taking oral medicines/ nebulised drugs/ approved topical products. Any medicines left with NAs to give to patients must be under the direct supervision of a registered nurse.

(h) Assistant Practitioners

Who have completed the Trust competency on intravenous fluid management may act as the second checker for intravenous fluids with no additives via a peripheral cannula.

(i) Assistant Practitioners

Who have completed the Trust competency on naso-gastric feeding management may act as the second checker for enteral feeds.

(j) Non-registered Eye Hospital Technicians

This staff group may administer specific eye drops strictly in conjunction with the clinical protocol applicable to the clinic in which they are working.

(k) Cardiac Physiologists

(l) Advanced practitioner MSK Sonographers

### *3.4 Individuals not employed by UHBristol*

(a) On children's wards parents or carers may be involved in medicines administration, particularly if they have been assessed under the self-administration scheme.

(b) Patients or their carers may be involved as part of a trust-approved self-administration of medicines scheme, providing that they have been assessed as suitable to administer medicines.

## 4. Duties, Roles and Responsibilities

### *4.1 Responsibility*

(a) The Director of Pharmacy, in consultation with the Chief Nurse and the Medical Director, is responsible for establishing a safe and secure system for the handling of medicinal products within UHBristol.

(b) The Sister/Charge Nurse is responsible for the system operating on a ward or clinical area, and the 'Nurse in Charge' for a shift is responsible for ensuring that the system is followed. Some of the duties maybe delegated, but the responsibility always remains with the appointed nurse in charge. A registered ODP is given the same responsibilities as a registered nurse regarding the management of medicines in theatre. This includes the ordering of Controlled Drugs and 'holding the keys'.

(c) The authorised practitioner administering a medicine will be responsible for their actions in doing so.

## 5. Policy Provisions

### *5.1 Principles for the administration of medicines*

Detailed procedures for the administration of medicines to all patients are found in the Administration of Medicines Standard Operating Procedure.

The practitioner administering the medicine must:

(i) Know the therapeutic uses of the medicine to be administered, its normal dose, side effects, precautions and contra-indications.

(ii) Be certain of the identity of the patient to whom the medicine is to be administered

(iii) Be aware of the patient's plan of care

(iv) Check that the prescription is complete, clear, unambiguous, in-date and signed, saved or authorised by the prescriber in the electronic prescribing programme.

(v) Check that the medicine to be administered is labelled and clearly identified.

(vi) Have considered the dosage, method of administration, route timing of the administration in the context of the condition of the patient and co-existing therapies.

(vii) Be competent in calculating paediatric drug doses when a medicine is being given to a child. When administering an intravenous medicine to a child, the Medusa or BRHC IV guide should be checked prior to administration of the medicine.

(viii) Check the expiry date of the medication to be administered.

(ix) Check that the patient is not allergic to the medication before administering it

(x) Contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medication are discovered, where the patient develops a reaction to the medication, or where assessment of the patient indicates that the medication is no longer suitable

(xi) Make a clear, accurate and immediate record of all medication administered, intentionally withheld or refused by the patient, ensuring that written entries and the signature are clear and legible. EPMA entries should be made in full at the time of administration and not in advance of the patient actually receiving the medicine. It is also the practitioner's responsibility to ensure that a record is made when delegating the task of administering medication.

(xii) Where supervising the administration of medicines, clearly countersign the signature of the student.

(xiii) Enteral syringes must be used in the administration of enteral drugs (this includes nasogastric, gastrostomy, PEG's and other enteral feeding tubes).

(xiv) If a medicine is not administered within 90 minutes of the prescribed time then the Trust's policy on delayed and omitted medicines is to be followed. An omitted medicine is to be recorded in the EPMA system or on the prescription chart in accordance with the trust approved non-administration codes. Drug rounds must be commenced in a timely fashion to ensure that all patients on the ward receive all of their medicines within the 60 minute window permitted for critical medicines and 90 minute window for all other medicines. For example, if the drug round normally takes 90 minutes, an 8am round should commence at 7.30am to ensure that all patients have received all of their medicines by 9am.

(xv) Liquid medications, once opened, may have a shorter expiry. Therefore practitioners must also record the date the liquid was first opened and the expiry date clearly on the bottle to ensure the medication can be checked for fitness for use at a later time. Information regarding expiry dates may be found on the bottle or product literature. Pharmacy may also be contacted to establish expiry information.

(xvi) For medications being administered from a syringe, using an electronic controlled programmable pump to control the flow rate of the medication, the syringe should not be removed from the pump, whilst still connected to the patient unless absolutely necessary. If the syringe needs to be removed from the pump, the line from the syringe should be clamped.

## *5.2 Administration of medicines to children*

a) Complicating factors for administration of medicines in paediatrics include lack of readily available information on doses of some medicines, the frequent use of off label and unlicensed medicines, non-availability of convenient dosage forms requiring calculations, part use of dosage forms intended for adults, and administration difficulties that can vary with the age and co-operation of the child.

In addition to all points detailed in section 5.1, the following must be applied when administering medicines to children:

(i) All medicines administered to children by nurses must have an independent check, with the exception of the medicines which are included in the paediatric administration of medicine single checking SOP.

(ii) Where the dose has to be calculated it must be double checked with particular attention being paid to the use of decimal places.

(iii) The dose of the medicine should always be checked against a reference. All clinical areas should have the latest edition of BNF for Children available as a primary reference source. When administering an intravenous medicine to a child, the Medusa or BRHC IV guide should be checked prior to administration of the medicine.

(iv) In the event that qualified medical staff undertake solo administration of a medicine, they are responsible for their actions in doing so.

(v) The parent may administer the medicine under the supervision of a qualified nurse. Where the parent is administering the medicine, nurses must**:**

(A) check the medicine as outlined in administration of medicines standard operating procedure

(B) observe the administration of the medicine

(C) record the administration in the appropriate records

b) Role of student nurses in the administration of medicines to children

Student nurses (child branch or otherwise) are not permitted to check any medications for children. They may under the direct supervision of a Registered practitioner administer oral medicines to infants and children and observe practice to develop skills in the administration of medication to children.

c) The Role of Registered Physiotherapists in the Administration of Medicines to Children

Registered paediatric physiotherapists may act as a checker for the administration of mucolytics, bronchodilators and antibiotics when they are specifically administered to improve physiotherapy efficacy at the start of the respiratory physiotherapy session.

## *5.3 Controlled Drugs*

Administration of controlled drugs must be in line with the controlled drugs policy and standard operating procedures. See Section 13 of the Administration of medicines standard operating procedure and the Controlled drugs chapter of the medicines code.

### *5.4 Advanced Therapy Medicinal Products*

Advanced therapy medicinal products (ATMPs) are new medicinal products based on genes (gene therapy), cells (cell therapy) and tissues (tissue engineering). A number of advanced therapy medicinal products combine biological materials, such as tissues or cells, and chemical structures such as metal implants or polymer scaffolds. Since these products are a combination of medical device and medicine, they need adapted requirements for administration. All ATMPs must therefore be administered strictly in line with the product specific administration information, clinical trial protocol or local protocol for use as agreed by MAG, with all necessary independent checks carried out throughout the administration process in line with UHBristol policy on medicines administration.

### *5.5 Administration of Medicines to Patients with Impaired Mental Capacity*

Trust Guidance on Covert Administration of Medicines and the principles of the Code of Practice for the Mental Capacity Act should be followed with the use of the covert medication care plan and the covert medication administration decision checklist, mental capacity assessment tool and mental capacity best interest assessment.

### *5.6 Administration of medicines following verbal orders*

(a) Trust policy is that verbal orders for medicines are not permitted except in a medical emergency where the doctor is not available to attend as described below

(b) There has been an incident reported within the trust where a patient in status epilepticus who required rectal diazepam did not receive it in a timely fashion as the incident occurred out of hours and the on call doctor was involved in another emergency (an arrest situation). The doctor gave a verbal order for the diazepam which the nurses would not accept.

(c) In an emergency situation, it is acceptable for a doctor to give a verbal order providing two nurses independently take the order and repeat the intended medicine and dose back to the doctor. The name and dose of the required medicine, along with the full name of the prescriber issuing the verbal order must be written down in the medical notes by the nurses receiving the verbal order. Both nurses must countersign the entry in the medical notes to confirm that the name and dose of medicine written down is what the prescriber has ordered.

(d) All occurrences of administration of a medicine on the basis of a verbal order must be reported as a clinical incident, clearly stating that it was a medical emergency and why the doctor could not attend to prescribe the medicine in writing before administration.

The doctor must attend to write the prescription as soon as the situation with which they are dealing with is resolved. There is the facility to write an EPMA prescription remotely but best practise is that the prescriber attends the patient in person to write the prescription for the medicine. If a nurse has given a medicine in an emergency on a verbal order, this must be recorded in the nursing notes and then transcribed onto either the paper drug chart or the EPMA system as soon as a valid prescription is written.

(e) The human medicines regulations 2012 list the following medicines as exempt from regulation 214(2), meaning that they can be administered in an emergency situation without a prescription.

Adrenaline 1:1000 up to 1mg for intramuscular use in anaphylaxis
Atropine sulphate and obidoxime chloride injection
Atropine sulphate and pralidoxime chloride injection
Atropine sulphate injection
Atropine sulphate, pralidoxime mesilate and avizafone injection
Chlorphenamine injection
Dicobalt edetate injection
Glucagon injection
Glucose injection

Hydrocortisone injection
Naloxone hydrochloride
Pralidoxime chloride injection
Pralidoxime mesilate injection
Promethazine hydrochloride injection
Snake venom antiserum
Sodium nitrite injection
Sodium thiosulphate injection
Sterile pralidoxime

### *5.7 Administration of Unlicensed Medicines and Medicines Used Outside the Scope of a Product Licence*

See separate policy on use of unlicensed medicines

### *5.8 Mixing medicines for administration*

Mixing medicines in the clinical environment may occur where two or more enteral medicines are mixed, or where injectable medicines are combined in a container (e.g. a syringe) or intravenous line (e.g. at a 'Y site' or through a 3-way tap).

If the prescriber intends two or more medicines to be mixed before entry into the circulation, i.e. prior to or during administration then it is the prescriber's responsibility to ensure that it is safe to do so.

Prescribers must give a written direction to the nurse as to how they should mix (or not) all drugs:

i. In situations where the mixing is in a container, (for example an infusion bag or syringe) the prescription must specify the detail for the admixture.

ii. Where medicines are to be mixed in lines, administration should only be undertaken if specific stability information is available. If the stability of any admixture is in question, the advice of Pharmacy should be sought.

### *5.9 Administration of medicines in the community*

Medicines that are required to be administered by UHBristol staff in the community will be administered in line with the standard operating procedure for the administration of medicines as far possible. In the event that only one practitioner or authorised practitioner is present, solo administration of a medicine will occur.

Medicines that are administered by other providers in the community to patients of UHBristol (e.g. via a recovery at home programme) will be administered in line with the providers standard operating procedures.

If UHBristol members of staff are administering medicines in the community and are transporting medicines to and from patient's homes, the member of staff must ensure safe and secure transport of the medicines at all times. The patient must consent to the removal of any medicines from their home.

### *5.10 Preparation of medicines for administration in theatres*

Medicines for administration to patients in theatres must be individually prepared for each patient. The practice of 'batch' preparing medicines when several patients on one theatre list all require the same medicines must not occur.

### *5.11 Administration of medicines by student and qualified non-registered anaesthetic practitioners*

1. Qualified and student anaesthetic practitioners are able to administer medication against a patient specific written or computer generated anaesthetic prescription record or anaesthetic drug plan. They will work under the supervision of a suitably qualified anaesthetist.

2. All administration of medications, anaesthetic gases and inhalational agents will be restricted to clinical practice in anaesthesia. This will include both intravenous and controlled drug administration as outlined in this policy.

(a) Qualified anaesthetic practitioners

(i) Anaesthetists providing supervision to qualified anaesthetic practitioners may supervise two anaesthetic practitioners simultaneously. The supervising anaesthetist will be present in the operating theatre for induction of and during the emergence from general anaesthesia.

(ii) The accountability remains with the supervising anaesthetist to ensure responsibility is appropriately delegated within the remit of the prescribing and administration policy and this supporting addendum.

(b) Student Anaesthetic Practitioners

(i) Student anaesthetic practitioners will work one-to-one with an anaesthetist throughout their training. They will be required to administer anaesthetic medications as part of their curriculum programme, and will undertake theoretical and practical training throughout the first year of the programme whilst working under the direct supervision of an anaesthetist. As part of the curriculum a student must demonstrate theoretical knowledge which is formally assessed at month eight and provide evidence of clinical competency by the end of year one, in order to progress to the second year of the programme. (This is in compliance with their contractual terms of employment relating to training and duty of care).

(ii) On successful progression to year two students may work within the full scope of local policy practice under the individual supervision of an anaesthetist.

(iii) For the purpose of this policy, the supervising anaesthetist remains accountable for all delegated clinical practice relating to administration of medications throughout the trainee programme.

3. Administration of Medications, Anaesthetic Gases and Inhalation agents.

a) The supervising anaesthetist will complete and sign an individual patient anaesthetic medication plan enabling the qualified or student anaesthetic practitioner to administer drugs in line with anaesthetic practice.

b) Students will second check and draw up a range of agreed drugs with the supervising anaesthetist. This will include diluted preparations and pre-filled syringes.

c) All medications required during the anaesthetic that have not already been checked and drawn up must be checked with the supervising anaesthetist.

d) The student may only give medication checked by the supervising anaesthetist

*e)* Students will check vaporisers with the supervising anaesthetist and administer in line with the patient specific anaesthetic medication plan.

f) All intravenous medications for a specific patient will be clearly labelled in a designated tray that will stay with the patient throughout anaesthesia.

g) All drug administration will be recorded on the anaesthetic record and signed by the qualified or student anaesthetic practitioner and the supervising anaesthetist.

A. Intravenous administration

(i) Qualified anaesthetic practitioners may administer intravenous medication on evidence of appropriate intravenous training and competency based clinical practice and in line with local policy.

(ii) All student anaesthetic practitioners will undertake recognised training in intravenous additives and other appropriately related skills, (such as IV cannulation and IV equipment training) as part of the curriculum, as do other registered professionals in order to undertake the administration of intravenous drugs to the equivalent standard. Training will take place as part of module three of the national curriculum. It will include theoretical and practical skills training and a calculation test delivered locally, and must be successfully completed by all students. Students will be required to demonstrate evidence of successful assessment within the workplace as part of the curriculum by the end of the first year of training.

(iii) On progression to year two, students may work within the scope of practice set out in section 2.2 of this policy.

B. Controlled Drug Handling and Administration

(i) In line with current theatre practice, controlled drugs will be issued only to the supervising anaesthetist.

(ii) Supervising anaesthetists may delegate the administration of controlled drugs to a qualified or appropriately trained student anaesthetic practitioner against a patient specific anaesthetic medication plan.

(iii) Both qualified and student anaesthetic practitioners may have possession of a controlled drug (schedule 2, 3, 4 & 5) for the purpose of administration in accordance with the directions of an anaesthetic medication plan.

(iv) Disposal of all unused controlled drugs will be carried out with the supervising anaesthetist.

C. Exclusions

(a) Anaesthetic practitioners will not administer medications using patient group directions (PGD).

(b) Anaesthetic practitioners cannot prescribe drugs.

(c) Anaesthetic practitioners will not administer drugs to children under 15 but may work as an assistant to an anaesthetist.

### *5.12 Oral / Enteral syringes*

There is a risk that oral liquid medications can be incorrectly administered into the intravenous system if intravenous syringes are used to measure and administer oral liquid medication, either orally or via enteral feeding tubes. Intravenous syringes must not be used to measure any form of liquid medication, feed or fluid, intended for oral or enteral administration

a) Oral Medicines

i. Oral syringes or a measuring spoon must be used to administer all liquid medication via the oral route.

ii. All oral syringes are single use only and should be disposed of following one use. Single use means the use of one syringe during one uninterrupted process with one patient and a process that does not involve the syringe being washed. Under no circumstances should syringes be washed and reused.

iii. An appropriately sized syringe or measuring spoon should be selected to measure liquid medication for oral or enteral feeding tube delivery. A 60 ml catheter tip syringe is not sufficiently accurate to measure small volumes of oral liquid medication.

iv. The administration of oral liquid medication should be one uninterrupted process from measurement to administration. If this is not possible, the syringe should be labelled with the name and strength of medicine, the patient's name and the date and time that it was prepared.

b) Enteral Medicines

i. Enteral syringes must be used to administer all liquid medication, feeds and fluid via an enteral feeding tube.

ii. The use of three-way taps in enteral systems should be avoided due to the additional ports that enable wrong route errors, additional risks of infection and creating a more complex system where multiple lines may be attached.

iii. Care should be taken when administering medication via an enteral feeding tube. Small syringe sizes are able to generate large pressures within the enteral feeding tube.

iv. Blocked enteral feeding tubes should not be attempted to be unblocked using a syringe size of less than 20 ml due to the risk of generating pressures that could cause the tube to burst.

v. Enteral feeding administration sets must be labelled with the words 'ENTERAL'. If this is not an integral part of the tubing then a label should be applied with the word 'ENTERAL' clearly written and visible.

# 6. Standards and Key Performance Indicators

## *6.1 Applicable Standards*

(a) Administration of all medicines in the trust will be in accordance with the policy provisions detailed in section 5.

(b) Administration of all medicines in the trust will be in accordance with the procedure detailed in the medicines administration SOP.

## *6.2 Measurement and Key Performance Indicators*

(a) Administration of medicines will be audited on a regular basis, at least once every two years.

(b) Ward managers are responsible for ensuring that all administrations of medicine on their ward are according to the medicines administration standard operating procedure.

# 7. References

(a) Royal Pharmaceutical Society. The Safe and Secure Handling of Medicines: A Team Approach. (A Revision of the Duthie Report 1988). March 2005.

(b) Department of Health Modernisation Agency. Medicine Matters. March 2005.

(c) Department of Health Modernisation Agency. Anaesthesia Practitioner Curriculum Framework. June 2005.

(d) www.modern.nhs.uk/workforce

(e) Appelbe G.E. & Wingfield J. - Dale and Appelbe's Pharmacy Law and Ethics, 7th Ed. Pharmaceutical Press

(f) Toft B. Independent review of the circumstances surrounding four serious adverse incidents that occurred in the Oncology Day Beds Unit, Bristol Royal Hospital for Children on Wednesday, 3 January 2007

# 8. Appendix A – Monitoring Table for this Policy

| Activity | Action by | Responsible manager | Frequency | Reported to |
|---|---|---|---|---|
| Audit practice against policy and SOP | Nursing or Pharmacy staff | Senior nurse, quality and practice development.<br>Director of Pharmacy | 2 yearly | Medicines governance group |

# 9. Appendix B – Dissemination, Implementation and Training Plan

*9.1* The following table sets out the dissemination, implementation and training provisions associated with this Policy.

| Plan Elements | Plan Details |
|---|---|
| **The Dissemination Lead is:** | Director of Pharmacy |
| **This document replaces existing documentation:** | Yes |
| **Existing documentation will be replace by:** | Rescinding of superseding documents. |
| **This document is to be disseminated to:** | All staff administering medicines including; Doctors, Nurses, Pharmacy Staff, Health Care Assistants etcetera. |
| **Training is required:** | Yes |
| **The Training Lead is:** | Director of Pharmacy |

| Additional Comments |
|---|
| Requires summary of place in Medicines Code of 21 Chapters |

# 10. Appendix C – Document Checklist

*10.1* The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

| Checklist Subject | Checklist Requirement | Document Owner's Confirmation |
|---|---|---|
| **Title** | The title is clear and unambiguous: | Yes |
| | The document type is correct (i.e. Strategy, Policy, Protocol, Procedure, etc.): | Yes |
| **Content** | The document uses the approved template: | Yes |
| | The document contains data protected by any legislation (e.g. 'Personal Data' as defined in the Data Protection Act 2000): | Not Applicable |
| | All terms used are explained in the 'Definitions' section: | Yes |
| | Acronyms are kept to the minimum possible: | Yes |
| | The 'target group' is clear and unambiguous: | No |
| | The 'purpose and scope' of the document is clear: | Yes |
| **Document Owner** | The 'Document Owner' is identified: | Yes |
| **Consultation** | Consultation with stakeholders (including Staff-side) can be evidenced where appropriate: | Yes |
| | The following were consulted: | Medicines Governance Group<br>Heads of nursing / midwifery<br>Modern matrons |
| | Suitable 'expert advice' has been sought where necessary: | Yes |
| **Evidence Base** | References are cited: | Yes |
| **Trust Objectives** | The document relates to the following Strategic or Corporate Objectives: | Adherence to NHSLA Medicines Management Standards and Care Quality Commission Outcome 9 |
| **Equality** | The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document: | Yes |

| Checklist Subject | Checklist Requirement | Document Owner's Confirmation |
|---|---|---|
| **Monitoring** | Monitoring provisions are defined: | No |
| | There is an audit plan to assess compliance with the provisions set out in this procedural document: | No |
| | The frequency of reviews, and the next review date are appropriate for this procedural document: | Yes |
| **Approval** | The correct 'Approval Authority' has been selected for this procedural document: | Yes |

| Additional Comments |
|---|
| Not Applicable |

Clinical Procedure for the

# SELF-ADMINISTRATION OF MEDICINES

**SETTING** Trust wide

**FOR STAFF** Medical, nursing & AHP staff administering medication, pharmacy staff

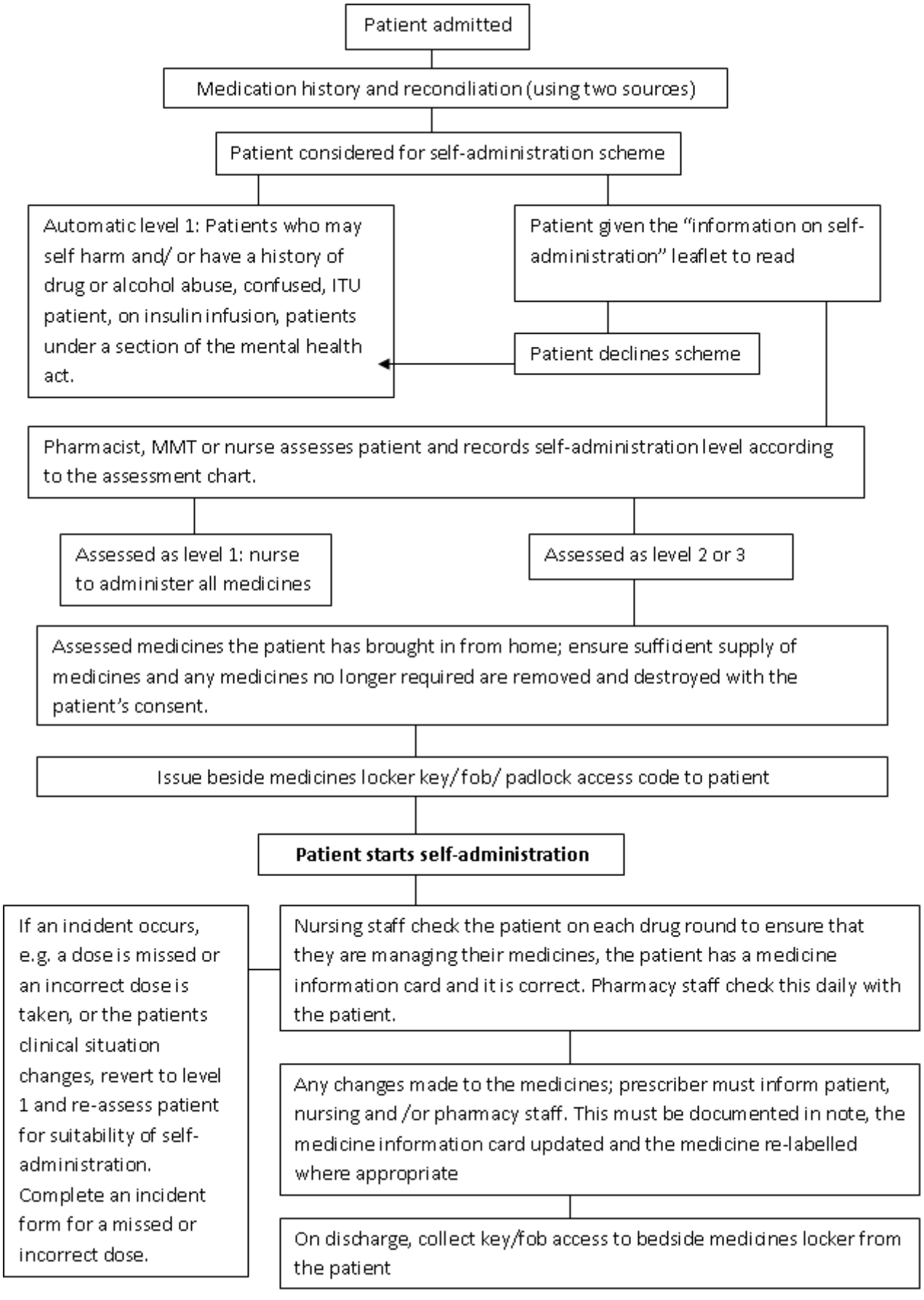
**PATIENTS** All adult and paediatric patients

**Contents**

1. **Summary**
2. **Prior to assessment for self-administration**
3. **Assessment for self-administration of medicines**
4. **Patient consent**
5. **Reassessment for suitability for**
6. **Recording administration of medications**
7. **Changes to medication**
8. **Variable dose medication**
9. **Medicine information card**
10. **Missed doses**
11. **Storage of patients own drug locker key**
12. **Controlled drugs**
13. **Medicines Compliance Aid**
14. **Nursing assessment**

## 1. Summary

**For paediatric patients, patients with Parkinson's disease and patients with learning difficulties, the parents/carer may be assessed to administer the medication if the patient is not suitable for self-administration themselves.**



Medicine information is card offered to patients who are assessed as L3, if appropriate

## 2. Prior to assessment for self-administration

The patient must have a full drug history completed, using a minimum of two record sources. This should be documented on the front of the drug chart before the patient can be assessed for self-administration:

Adults

**Medicine Communication**

**Medication history** from (circle): GP fax, Patient, Patients own drugs or other source
(state) _____ Sign: _____ Date: _____
Verification of drug history Sign: _____ Date: _____

Paediatrics

***MEDICINES COMMUNICATION***
***Medication history from (circle): GP fax, Patient, Patients own drugs, or other source .....***
*Signature ..... Name ..... Date / /*

The nursing staff, MMT (Pharmacy Medicines Management Technician) or pharmacist may consider every patient for self-administration. It is the responsibility of the assessor to ensure that, if delegating administration of medicines to the patient, the patient is competent to undertake this. The assessor is accountable for the appropriateness of this delegation.

Those patients who could be suitable for level 2 or 3 administration should be given the patient information form on self-administration of medicines whilst in hospital to read prior to the assessment.

## 3. Assessment for self-administration of medicines

The health professional (nurse, MMT or pharmacist) should complete the assessment with the patient. If this is with a parent/carer, each parent/carer should complete the assessment before administrating medicines.

**Side one**

Self administration of medicines
Patient assessment and consent
University Hospitals Bristol NHS

This assessment should only be started once a drug history has been completed.

This assessment is to be filled in by a medicines management technician, nurse or pharmacist with the patient, medical notes, nursing notes or after discussion with other members of the healthcare team.

PATIENT

Stick patient identification label here

**Start Here** SECTION A

Do you think your patient could manage their medications in hospital?

Please tick any statement that applies:

- Patient declines to take part in scheme
- Patient lacks capacity
- Patient is thought to be at risk of self-harm
- Patient is confused
- Patient is in ITU or is acutely unwell
- Patient is under a section of the Mental Health Act
- Patient is on an insulin infusion
- Medication administered by carer in community
- Thought to be inappropriate by the medical team
- Other (please state reason in box below)

If you **have** ticked any of the statements above the patient is suitable for level one administration only. **Please complete SECTION D only.**

If **none** of the statements above apply, please continue to **SECTION B** assessment with patient. Patients on insulin must also complete **SECTION C overleaf.**

**Vision and Dexterity Assessment** SECTION B

Assess the patient - are they able to perform the following confidently?

Please tick each box if patient is observed to undertake that task appropriately:

- Read the labels on their medication appropriately
- Open the packaging to access their medication
- Get their medication out of the strips, bottles of tubes
- Replace lids and additional medication into its original containers
- Access and close the patients medication locker
- Confirm patient understands action required if they miss or take an incorrect dose

Assessment Score (number of boxes ticked)

/ 6

Action Required (circle appropriate level below)

| 0 – 2 | 3 – 5 | 6 |
|---|---|---|
| **Level 1** Nurse to administer all medication | **Level 2** Nurse to observe patient administering medication | **Level 3** Patient to administer own medication |

If patient also takes insulin complete SECTION C for total

**Side two**

Self administration of medicines
Patient assessment and consent
University Hospitals Bristol NHS

**Insulin Assessment** SECTION C

Additional assessment for patients wishing to administer their insulin.

Please tick each box if patient is observed to undertake that task appropriately:

- Hold their injection device appropriately
- Place a needle on the end of the device
- Dial up the prescribed dose of insulin
- Place the needle into the skin and administer injection
- Dispose safely of a used needle and store insulin
- Confirm patient understands action required if they miss or take an incorrect dose

Assessment C Score

/ 6

Total Assessment Score (SECTION B & C)

/ 12

Action Required (circle appropriate level below)

| 0 – 4 | 5 – 11 | 12 |
|---|---|---|
| **Level 1** Nurse to administer all medication | **Level 2** Nurse to observe patient administering medication | **Level 3** Patient to administer own medication |

**Post Assessment** SECTION D

1. DECLARATION OF CONSENT
(Patient to read and sign)

I have read and understood the patient information leaflet entitled "Self-Administration of Medicines" and am willing to take part in the self administration scheme. I understand that I may withdraw my consent at any time by informing the nurse looking after me. I am also aware I may be asked to stop or be reassessed regarding my ability to self administer my medicine at any time. I agree to keep my medicines secure and access key safe at all times.

Patient Signature

2. ASSESSOR NEXT STEPS

Once assessment is carried out, please tick to confirm each of the following steps have been completed:

- Annotate assessment outcome on drug chart
- Inform nursing team of assessment outcome
- Inform medical team of assessment outcome
- If Level 2 or 3; Complete assessment of medication and labels
- If Level 3 complete patient medicines information leaflet
- Order further medication supplies as required
- File assessment sheet in medical notes

Print name:

Role:

Date:

D D M M Y Y Y Y

**a) Section A:** Patients who have any of the following at assessment automatically default to Level 1 of the self-administration scheme:

- Confused
- At risk of alcohol or drug abuse
- ITU patients
- Acutely unwell
- Under a section of the Mental Health Act
- On a hospital insulin infusion
- Have their medication administered by a carer in community, for example in a nursing home. The ward team and/or patient may feel that the carer should be suitable to be assessed to administer medicines to the patient, for example carers of patients with Parkinson's disease or carers of people with learning difficulties. If a carer is to be assessed, the 'Self Administration Of Medicines Paediatric Patient Assessment And Consent' form should be used as this form is specifically designed for carers. A separate assessment form should be used for each carer.
- Lack capacity
- Child protection concerns
- Known concerns regarding compliance and concordance (unless a trial at L2 was concluded as important)

**b) Section B:** All patients must be assessed for each different medicine that they take. Only if the patient can undertake the tasks in section B with all of their medicines can the box be ticked. The total number of ticks must be added together to get an assessment score. This resulting score indicates the self-administration level as documented on the assessment sheet, e.g. a score of 4 would indicate a level 2 self-administration.

**c) Section C**: Any patients taking insulin must be assessed against the criteria in section C in addition to section B. The patient must be directly observed undertaking the six tasks in section C with *all of* their insulin(s). Only if the patient can undertake the task with all their insulin(s) can the box be ticked. The total number of ticks must be added together to get an assessment score. This score is then added to the score achieved in section B to get a 'total assessment score' out of a possible 12. This resulting score indicates the self-administration level as documented on the assessment sheet, e.g. a score of 10 would indicate a level 2 self-administration for all the patients medications (i.e. insulin, inhalers, oral medication, eye drops etc.)

**Patients may only have one self-administration level for all medications**.

**d) Section D**: Post assessment. The patient must read and sign the declaration of consent. 'Next steps' for the assessor section: This includes where to record the outcome of the assessment (front of the drug chart, see below example). For paediatrics record this information on the side of the front page of the drug chart (see example below)

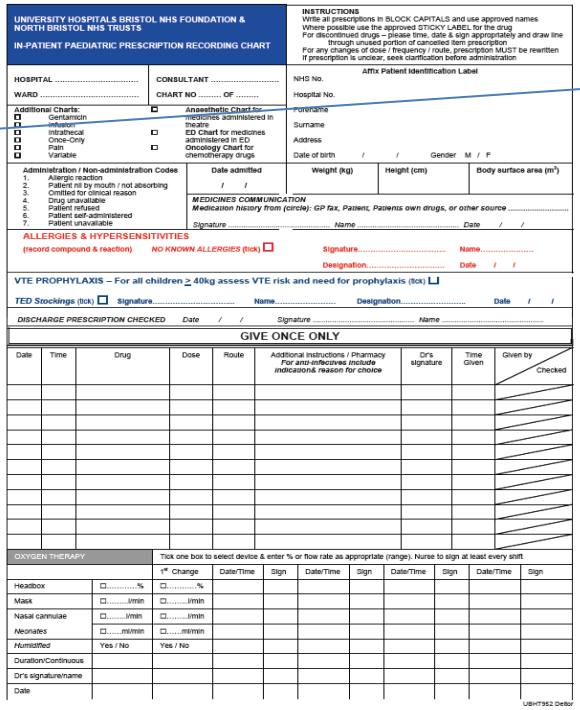
Each of the 'next steps' must be ticked on the assessment form once completed. The patient assessment form must be filed in the patients notes when it is complete.

## Patient self administration of medicines

| Level (circle) | Date | Assessed by (print name) | Reassess date |
|---|---|---|---|
| L1 L2 L3 | | | |
| L1 L2 L3 | | | |

Administration codes for drug card

L1 Level 1 L2 Level 2 L3 Level 3



UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION & NORTH BRISTOL NHS TRUSTS

IN-PATIENT PAEDIATRIC PRESCRIPTION RECORDING CHART

INSTRUCTIONS
Write all prescriptions in BLOCK CAPITALS and use approved names
Where possible use the approved STICKY LABEL for the drug
For discontinued drugs – please time, date & sign appropriately and draw line through unused portion of cancelled item prescription
For any changes of dose / frequency / route, prescription MUST be rewritten
If prescription is unclear, seek clarification before administration

Affix Patient Identification Label

HOSPITAL ..... CONSULTANT .....
WARD ..... CHART NO ..... OF .....

NHS No.
Hospital No.
Forename
Surname
Address
Date of birth / / Gender M / F

Additional Charts:
Gentamicin
Infusion
Intrathecal
Once-Only
Pain
Variable
Anaesthetic Chart for medicines administered in theatre
ED Chart for medicines administered in ED
Oncology Chart for chemotherapy drugs

Administration / Non-administration Codes
1. Allergic reaction
2. Patient nil by mouth / not absorbing
3. Omitted for clinical reason
4. Drug unavailable
5. Patient refused
6. Patient self-administered
7. Patient unavailable

Date admitted / /
Weight (kg)
Height (cm)
Body surface area ($m^2$)

MEDICINES COMMUNICATION
Medication history from (circle): GP fax, Patient, Patients own drugs, or other source .....
Signature ..... Name ..... Date / /

ALLERGIES & HYPERSENSITIVITIES
(record compound & reaction) NO KNOWN ALLERGIES (tick)
Signature..... Name.....
Designation..... Date / /

VTE PROPHYLAXIS – For all children ≥ 40kg assess VTE risk and need for prophylaxis (tick)
TED Stockings (tick) Signature..... Name..... Designation..... Date / /

DISCHARGE PRESCRIPTION CHECKED Date / / Signature ..... Name .....

GIVE ONCE ONLY

| Date | Time | Drug | Dose | Route | Additional Instructions / Pharmacy For anti-infectives include indication& reason for choice | Dr's signature | Time Given | Given by / Checked |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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OXYGEN THERAPY — Tick one box to select device & enter % or flow rate as appropriate (range). Nurse to sign at least every shift

| | | 1st Change | Date/Time | Sign | Date/Time | Sign | Date/Time | Sign | Date/Time | Sign |
|---|---|---|---|---|---|---|---|---|---|---|
| Headbox | □.....% | □.....% | | | | | | | | |
| Mask | □.....l/min | □.....l/min | | | | | | | | |
| Nasal cannulae | □.....l/min | □.....l/min | | | | | | | | |
| Neonates | □.....ml/min | □.....ml/min | | | | | | | | |
| Humidified | Yes / No | Yes / No | | | | | | | | |
| Duration/Continuous | | | | | | | | | | |
| Dr's signature/name | | | | | | | | | | |
| Date | | | | | | | | | | |

UBHT952 Dec08

Patient self-administration. L3/ 5-11-14 .A.Nurse. Reassess: 19-11-14

Patient self-administration. Level (eg.L3)/date/assessed by/reassessment date

### 4. Patient consent

Patients who are assessed at Level 1 do not need to be consented. Patients who are assessed as suitable for level 2 or 3 must sign a consent form. Consent recording for level 2 and 3 self-administrations should be documented in section D of the assessment form.

### 5. Reassessment for suitability for self-administration

Registered nurses on each shift should decide if the level is still appropriate for the patient self-administration. If it is felt a reassessment is appropriate, for example if the patient condition changes, this should be undertaken and the outcome recorded on the front of the drug chart and dated. If the self-administration level does change, for example from level 3 to 2, access to the medicines locker must be removed from the patient. All patients should be formally reassessed for self-administration every 14 days.

### 6. Recording administration of medications

The level of administration should be endorsed for each prescription in the additional instructions box.

**On each drug round:**

**Level 1:** Nurse will sign on the prescription chart with their initials when administration of medicine complete

**Level 2:** Nurse should write "L2" on prescription chart and sign each administration box when administration of medicine complete
For paediatric patients nurse should write "L2/6" on the prescription chart and sign each administration box when administration of medicine complete.

**Level 3:**
The nurse must check with the patient that they have taken their medications. If there is any doubt of the patient's administration a tablet count could be done. For liquids, it is accepted that it may be hard to notice missed doses unless multiple missed doses are made. Therefore extra vigilance must be taken by the healthcare team to ensure liquids are being taken by the patient. Nurse should write L3 (L3/6 for paediatric patients) on prescription chart along the column for that date. This confirms the nurse has checked verbally with the patient and the medicine information card that the medication has been taken
The nurse must **not** sign for the administration unless they are confident the patient has taken their medication as prescribed

## 7. Changes to medication

If a patient is commenced on new medicines or any changes are made to existing medicines, the following must be undertaken:

a) The prescriber must give full instructions to the patient and the nurses and/or pharmacy staff regarding the change as soon as possible after making the change. It is recommended that the prescriber who alters the medication documents this communication with the patient in the medical notes.

b) **Change to dose, frequency or other directions of a medication currently prescribed**: The medication must be relabelled with full instructions for discharge. If the pharmacist/MMT has left the ward the chart must go to pharmacy as soon as possible. At BRHC contact your ward pharmacist. The medicine information card must be updated.

c) **New medication:** The new medicine must be ordered by the pharmacist /MMT. If they have left the ward, the medicine must be ordered from pharmacy as soon as possible. At BRHC contact your ward pharmacist. If a new medicine has not yet been dispensed/out of hours a stock pack can be used, however, the patient **must not self-administer from a stock pack.** The nurse should administer the dose and store the medicine in the ward drug cupboard until a supply can be obtained from pharmacy with full directions. The medicine information card must be updated with information for the new medicine.

d) **Discontinued medication**: Where medicines have been stopped the medicine **MUST** be removed from the locker. The medicine information card must be updated to record discontinuation.

## 8. Variable dose medication

If the patient is prescribed a variable dose of a medication (for example, amiodarone, prednisolone, warfarin), the patient must be informed to check the dose to take with the nurse every day. The patient should not take any medication until the dose is confirmed with the nurse. The medication must be appropriately labelled to reflect the variable dose.

**Insulin**
Variable units of insulin may be prescribed for a patient. This is typically carried out on specialist diabetes wards. In this setting the ward may provide an additional insulin dosing form stating the units to take. If the patient is self-administering at level 3, the additional insulin dosing sheet should be used alongside the medicines information card. The insulin dosing sheet must be clearly explained to the

patient prior to commencing self-administration. For insulin only, it is accepted that no dose is stated on the medicines information card.

### 9. Medicine information card

A medicine information card will be offered to all patients self-administering if thought appropriate at **level 2 and 3.** The medicine information card will be completed by the assessor and will contain dosing information for all the medicines the patient will self-administer.

A second check, or transcription check, of the medicine information card is required. This can be completed by a pharmacist, MMT or nurse. The second checker must sign on the medicine information card.
The medicine card should remain with the patient and must be available for presentation to any health professional.
The medication card must be updated for all prescription changes, for example when a new medicine is prescribed, a medicine is stopped, there is a change in dose or a change in frequency. Pharmacy, nursing or the medical team may undertake this function. Out of hours or at the weekend, it would be acceptable for a doctor, nurse or two nurses to change and check the medicines information card.

### 10. Missed doses

If a level 3 patient forgets to take a dose of their medicine, the patient should be informed to contact the nurse looking after them immediately and await instruction.

The nurse should then undertake the following

a) The medical team should be informed of the missed dose and asked what action to take, i.e. whether to take the dose immediately or to miss the dose completely.
b) Record an entry in the patient's medical notes to the effect that the patient forgot to take a dose, the medication name, strength and dosage and that the medical team have been informed of the omission.
c) Complete online trust incident form
d) Record the missed dose and actions taken in the nursing notes
e) Consider self-administration reassessment if necessary

### 11. Medication supply, storage and destruction

#### A. Supply

Patients who arrive on the ward with their own medicines should have them assessed to determine if they are fit for use (ward MMT, nurse or pharmacist to assess medicines as soon as possible on/after admission). Patients own drugs should be assessed according to: Pharmacy Department, BRI: Medicines Management Services Standard Operating Procedure MM – 006

Quantities of the patients own medicines or supplies of medicines from pharmacy must be recorded on the drug chart in the pharmacy supply box and dated. This will ensure that the quantity of medicines could be checked if concerns regarding self-administration are raised.

Patients should have at least 2 weeks supply (or as appropriate, for example an original pack) of their oral medicines. On some occasions it may be appropriate to supply less than two weeks' worth of medicines, for example if a patient takes many liquids and there is limited space in the patient's own drug locker to safely store and access the medications. In all situations, quantities of medications should be monitored daily by nursing and pharmacy teams. If supply of a medicine is short, top up using pre-packs or obtain further supplies through your ward

MMT/Pharmacist Monday-Friday. If ward pre-packs are to be used these must be checked by another nurse to ensure the dosing matches the drug chart. The supply of the pre-pack must be endorsed on the drug chart:

Pre-packs are expensive to produce. The smallest pre-pack unit available should be used until pharmacy is open. Pre-packs should be used in preference for discharge medication over a patient self-administering their medication as an inpatient.

If the pre-pack does not match the drug chart, ward stock must be used until pharmacy supplies a labelled pack with full directions.

Out of pharmacy opening hours, ward stock should be used where possible until further supplies can be obtained from pharmacy.

Unlabelled ward stock must not be given to level 2 or 3 patients to self-administer as **all medicines used for self-administration must be labelled with a pharmacy label that contains the patient names and correct directions**.

If the prescribed medicine is not a stock item, the item must be ordered from pharmacy. Out of hours, medicines should be obtained according to the procedure for the prevention of delayed or missed doses.

If a patient's own drugs are not suitable for use or none has been brought in then a pre- packed supply ('TTA pack') can be used if available on the ward.

Where medication is supplied from the pharmacy, two weeks supply (or the nearest original pack as appropriate) will be dispensed unless otherwise clinically indicated. Medicines that are not routinely supplied for two weeks include:

- Antibiotics 5 –7 days
- Calcium folinate
- Analgesics
- Oral electrolyte supplementation, calcium and magnesium
- When required (PRN) medicines

**B. Storage of medication** Any medicines that are fit for use will be kept in the patient's bedside medicines locker and will be kept secure with a key, fob or padlock. However there are exceptions:

a) Schedule 2 Controlled drugs and fridge items should not be stored in the patient's own drug locker. All other medication may be placed in the locker for administration.

b) If a level 3 self-administration patient does not wish to administer a medication, for example a chemotherapy agent, this medication should be stored safely elsewhere than the patient own drug locker.

If the patient's own drug locker is found to be unlocked, the medicines must be checked again and secure storage arrangements implemented immediately. The ward sister must be informed and an incident form completed. If the patient is self-administering at level 3, the patient must be re-assessed for suitability for level 3 self-administration.

**C. Destruction of Medicines**

Any medicines that are not fit for use can be destroyed with the patients' consent. These should be

returned to the ward pharmacist for destruction. If the patient does not give consent, the medicines should be bagged up, sealed and labelled with patient details & the directions 'unsuitable for use'.

### 12. Storage of patients own drug locker key

For level 1 and 2 self-administration, the patient must not have access to their medicines locker. For level 3 self-administration the patient should look after a key, fob, or code that accesses only their medicines locker. It is the patients' responsibility to keep the key or fob safe. If a key or fob is lost an incident form must be filled in completed and the ward sister informed. The medicines must be moved to a secure location and the lock replaced ASAP. The patient must also be re-assessed for suitability for level 3 self-administration.

### 13. Controlled drugs

Patients may self-administer their own controlled drugs if a decision is made that they are suitable to do so and the patient is self-administering their other medication at level 3. The procedure for self-administration of controlled drugs is as detailed in the Controlled drugs procedures, section 18. For paediatrics patients if a patient own drug locker is not available and the patient has been reviewed by the pain team one drug locker is kept on ward 35 that can be used in this situation.

### 14. Medicines Compliance Aid

If the patient is to use medicine compliance aid (MCA – trade name of one aid often used is Dosette®) then teaching must also include how to use and access the device chosen. MCA's must not be used for routine administration of medication. Teaching patients to use of an MCA is resource-intensive and can only be undertaken after discussion with the ward manager, the ward pharmacist and, if necessary, the pharmacy dispensary manager.

Patients will be provided with a filled MCA from pharmacy for a period of one week only for the express purposes of this teaching and assessment. Once an assessment is complete then supply will revert to medicines in standard containers until discharge.
Medicines may be taken by a patient from a MCA that the patient has brought in from home into hospital if it:

a) Has not been tampered with
b) Is fully labelled with directions
c) Was recently dispensed, for example in last month
d) Matches the medication prescribed on the drug chart

Patients cannot use a compliance aid that they have filled themselves which is not fully labelled with directions.

### 15. Nursing Assessment

If felt appropriate by the ward manager training for assessors can be completed and each nurse should be signed off as competent (see Appendix 1) prior to assessing patients for self-administration.

**RELATED DOCUMENTS**

Medicines Code. Chapter M18: Patient Self-administration of Medicines
http://nww.avon.nhs.uk/dms/download.aspx?did=6974
Training for Assessors : Appendix 1
Capacity policy / guidance……

**SAFETY**

The agreement for a patient to self-administer must always be reassessed if their

capacity alters

**QUERIES** [redacted]

## APPENIDX 1

### Training for Assessors

Each nurse who will be assessing patient/parent suitability for self-administration must be able to demonstrate the following skills.

1. Be familiar with and understand the clinical procedure for the self-administration of medicines.
2. Feel confident in assessing the suitability and competence of the patient/parent to self-administer their medication.
3. Feel confident to decline/withdraw self-administration to any patient/parent not meeting safe practice.
4. Be familiar with the patient's medication (indication, dosage, administration, side effects).
5. Be able to counsel and inform the patient/parent in a manner that is easily understood.
6. Follow the clinical procedure, ensuing full documentation and liaison with medical, nursing and pharmacy staff, in particular highlighting any changes.

The ward manager will assess staff competency and keep a list of names and signatures of those nurses who meet the above criteria and are deemed competent.

Name of nurse:……. Is competent to assess patients/parents for suitability and safe practice to perform self-administration of medication.

Signature of nurse:……. Date:…….

Signature of ward manager:……. Date:……..

University Hospitals Bristol
NHS Foundation Trust

Patient information service
Trustwide

# Carer information

## Do you look after someone who is in hospital who couldn't cope without you?


Respecting everyone
Embracing change
Recognising success
Working together
**Our hospitals.**

Above & Beyond
Fundraising for Bristol city centre hospitals

## Do you look after someone who is in hospital?

If the person you care for is now in one of our hospitals, or is going to be admitted soon, you may have concerns about how staff will include you in decisions regarding their care and discharge home again. This leaflet provides information for you and also the person you care for.

## Am I a carer?

- A carer is someone who provides unpaid help and support to a partner, child, relative or neighbour, who could not manage without their help.

- A carer often does not realise they are a carer and can struggle to tell someone that they are finding it difficult to cope.

- A carer is not necessarily the closest relative of a patient, or next of kin.

- A carer can be any age, including a child.

You may already have been a carer for the patient, but the changes in their health as a result of the current admission to hospital may now place new demands on you when they return home.

## Are you trying to juggle caring with work and family commitments?

The hospital staff need to know the valuable part you play in a person's life to support recovery, both in hospital and when they go home.

It could be that choosing to be or having to become a carer is new to you. If this is the case, you will probably have a whole range of questions on what caring might mean for you, such as:

- What will caring involve?
- Will I receive any help?
- Where can I get help and support from?
- How will being a carer affect me, my family and my job?
- Can I cope with the physical and emotional demands of caring?

## On admission

**It is important to talk to staff as early as possible if you are or might become a carer.**

## Emergency admission

If the admission is unplanned, the patient may be cared for in the emergency department, acute medical unit or the surgical and trauma assessment unit in the first instance. Please let staff know you are the carer and whether you are also the next of kin. This is a good time to clarify 'Consent to Share', whereby the patient can advise the team exactly what information we are able to share with you as the carer.

## Planned admission

If the patient's admission to hospital is planned, the patient is likely to have a pre-assessment appointment at which they will meet with a doctor or nurse who will explain what will happen when they go into hospital.

During the pre-assessment appointment, please let the staff know that you are the patient's carer and, in consultation with the patient, what information can be shared with you. This will enable the staff to know what information they can provide to you, without breaking confidentiality.

## Patient information and consent

As a carer of someone who is in hospital, you may need information about the person you care for and staff may want to speak to you to gather information about the person for whom you care. As Social Services and healthcare authorities have a duty to protect an individual's confidentiality, they will seek the patient's consent before discussing any information with you. If the person is unable to consent, then the Mental Capacity Act (2005) will be implemented.

## Mental Capacity Act (2005)

The Mental Capacity Act (2005) sets out the process to be followed when someone over the age of 16 lacks capacity to make decisions. No one can give consent for another adult, even if they are a family member. If you care for someone who does not have capacity, there is a legal obligation that you are consulted about any decision that needs to be made, and that you are part of any best interest meeting that is held. Your opinion will be valued and taken into account when considering what action to take. For more information please visit: **www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act**

## Carers of patients with dementia

If you are a carer of someone with dementia, please ask our staff for a copy of the **'All about me'** leaflet. It is a simple and practical tool for people going into hospital and their carers. It provides a 'snapshot' of the person with dementia and gives hospital staff information about them as an individual, including the patient's likes, dislikes and interests.

## Carers of people with learning difficulties

If you care for someone with a learning disability, the learning disabilities nurses can offer you and the patient support and advice whilst the patient is in hospital. You can also download a copy of the **Hospital Passport** (easy read version) before the patient comes into hospital through the following web link (**www.uhbristol.nhs.uk/patients-and-visitors/information-for-patients/hospital-passport/**) which you or the patient can bring in when they are admitted to the hospital.

The learning disabilities nurse (adult) can be contacted on **0117 342 1707** and the disabilities nurse (children's) on **0117 342 8653**.

## Young carers

A young carer is anyone under the age of 18 who is providing care for someone. Please let the staff know if you are a young carer when the patient is admitted and we will listen to you and help support you. You can also obtain support externally from The Carers' Support Centre Young Carers Team, whose details are shown on page 10 of this booklet.

## Parent carers

You may be a parent carer if you are looking after a child with a disability and providing substantial and regular care, beyond what is usually expected for a similarly aged child. The Carers' Support Centre, Bristol Parent Carers and South Gloucestershire Parents & Carers organisations can provide you with help and support. Their contact details are shown in the Support Organisations section at the back of this booklet.

The paediatric hospital passport will help us care for your child and ensure we meet their needs. If you do not have a copy please visit **www.uhbristol.nhs.uk/hospital-passport/**.

# During the patient's stay

Planning for a patient's discharge should take place at the earliest opportunity. You and the patient should be involved at all stages of planning for discharge. Hospital and social care staff should work together to manage all parts of the discharge process. This is to ensure that the patient is suitably cared for after they have left hospital and is not at risk of being unable to cope.

You should also be given an opportunity to talk about your needs as a carer and what help you may need to look after the patient. It is your legal right to have your needs addressed and this is achieved by having a carers assessment.

Our trust has a carers liaison service who are available to support the carers of any patient from Bristol and South Gloucestershire. They are able to offer advice to carers of patients from other localities and can signpost to other services that can help. For more information, please visit **www.uhbristol.nhs.uk/patients-and-visitors/carers/support-in-hospital/**.

The carers liaison and development worker can be contacted on:

**0775 744 1613** (Monday to Thursday)

**0791 788 0375** (Thursday, Friday and every other Wednesday)

Other departments across the Trust who can support carers are:

## Spiritual and pastoral care team

Tel: **0117 342 0607**

Email: **the.chaplaincy@uhbristol.nhs.uk**

## Patient support and complaints team

Tel: **0117 342 3604**

Email: **pals@uhbristol.nhs.uk**

### LIAISE (Bristol Royal Hospital for Children *only*)

Tel: **0117 342 8065**

Email: **bchinfo@UHBristol.nhs.uk**

### Cancer Information and Support Centre

Tel: **0117 342 3369**

Email: **cancerinfoandsupport@uhbristol.nhs.uk**

## What can I do if I am worried about my treatment or the treatment of a relative?

In the first instance, please raise this with a member of staff in the hospital who is providing care to the patient. They should be able to resolve this directly with you or find someone to help you. If you feel you need to raise the issue further, please contact the patient support and complaints team.

## Carer governors

We have several carer governors in the Trust who represent carers' views. For more information please contact the Foundation Trust Office between 9am and 5pm, Monday to Friday.

Tel: **0117 342 3763** or **0117 342 3764**

Email: **foundationtrust@uhbristol.nhs.uk**

## Visiting hours

If carers wish to be present on any of our **adult** wards at protected meal times, as well as out of normal visiting hours to support the needs of the patient, please speak to a member of the nursing team to let them know.

You may be asked to leave if you or your family members are unwell with symptoms of a sudden fever, cough, sore throat, headache, muscle aches or diarrhoea and vomiting.

## Your carer's assessment

Once a decision has been agreed that the person you're looking after no longer requires hospital care, the hospital should inform social services. Social services then have three days in which to carry out a community care assessment for the person you are looking after, as well as a carer's assessment of your own if you're going to provide that person with regular and substantial care.

It is possible that your carer's assessment will be done over a period of time. It may begin before the person you're looking after is discharged from hospital and it may continue once they are back home.

## Help and support when you get home

### Medication

If you are worried or confused about any of the medication for the person for whom you care, please call the number on the medication packet. Alternatively, if you have any concerns immediately after the patient has been discharged home, please contact the ward who will be able to offer some assistance to you.

## Other medical worries

If you are concerned about the person you care for once they are discharged, you can phone your GP who will be able to help you with any ongoing concerns.

In case of an emergency, please dial **999**.

# Support organisations

Below are the contact details of national and local organisations that provide support and help to carers.

**Alzheimers Society**

Supporting carers and people with dementia.

Tel: **0117 961 0693**

Web: **www.alzheimers.org.uk**

**Bristol City Council Health and Social Care** (Care Direct)

Tel: **0117 922 2700**

Web: **www.bristol.gov.uk**

**Bristol and Avon Chinese Women's Group**

Provides support to carers from Bristol's Chinese communities.

Tel: **0117 935 1462**

Web: www.bacwg.org.uk

**Bristol Black Carers**

Provides information, advice and services supporting carers from black and minority ethnic communities.

Tel: **0117 379 0084**

Web: **www.bristolblackcarers.org.uk**

**Bristol Parent Carers**

Provides information, advice and support to parent carers in the Bristol area.

Tel: **0117 939 6645** ext. **204**

Web: **www.bristolparentcarers.org.uk**

Email: **info@bristolparentcarers.org.uk**

**Carers Direct**

This is a national helpline that you can call at any time and will give you free information, advice and support for carers.

Tel: **0300 123 1053**

**Carers' Support Centre**

Provides information, advice and services focused on supporting carers in Bristol and South Gloucestershire.

Tel: **0117 965 2200**

Web: **www.carerssupportcentre.org.uk/**

**Carers' Support Centre Young Carers**

Tel: **0117 939 2562**

Web: **www.carerssupportcentre.org.uk/**

**Dhek Bhal**

Provides support to carers principally from Bristol's South Asian communities.

Tel: **0117 9146 671 / 0117 914 6672 / 0117 954 8885**

Web: **www.dhekbhal.org.uk**

Email: **dhekbhal@yahoo.co.uk**

**Rethink Carers Service**

Provides support services for carers of people with mental health issues.

Tel: **0300 5000 927**

Web: **www.rethink.org**

**Hawkspring**

Provides support to family members and carers of those affected by drug and alcohol problems.

Tel: **0117 964 2859**

Web: **www.hawkspring.org.uk**

Email: **info@hawkspring.org.uk**

**South Gloucestershire Parents & Carers**

Provides information, advice and support to parent carers in the South Gloucestershire area.

Tel: **07827 322 358**

Web: **sglosparentsandcarers.org.uk**

Email: **parents@sglosparentsandcarers.org.uk**

This booklet has been created with Carers Support Centre.

Carers Support Centre provides services for carers of all ages in Bristol and South Gloucestershire.

This includes a confidential telephone support line, carers emergency card, one-to-one support and carers' groups, activities for carers to take some time out, short breaks and training.

CarersLine: **0117 965 2200**

Email: **carersline@carerssupportcentre.org.uk**

If you care, we care.
Carers Support Centre
Bristol & South Gloucestershire

carerstrust
a Network Partner

For access to other patient leaflets and information please go to the following address:

**www.uhbristol.nhs.uk/patients-and-visitors/information-for-patients/**

**Hospital switchboard: 0117 923 0000**

**Minicom: 0117 934 9869**

**www.uhbristol.nhs.uk**

For an interpreter or signer please contact the telephone number on your appointment letter.

For this leaflet in large print, audio or PDF format, please email patientleaflets@uhbristol.nhs.uk.


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