



**Addressing self-medication safety in a
rehabilitation facility – a multi-disciplinary
approach to minimising risk and improving
patient outcomes across the continuum**

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“Place under your tongue and swallow.
Then spit it out when no one’s looking.”

Self Medication History at HRC

- Protocol and compliance checklist developed in late 80's
- Contract between client, pharmacy and medical staff – nurses as supervisors only
- A revised document signed by the pharmacist in 1993 states:
“The self-administration program forms part of the on-going rehabilitation process at Hampstead Centre.”
Nursing role unchanged. Nominal mention of Multi-D team

Self Medication History at HRC

- Vague criteria for participation in the program
- Each unit interprets criteria and develops own compliance monitoring processes

Self Medication History at HRC

- Nurses become instigators, educators and evaluators of self medication
- In 1997, a Medication Incident Working Party was established by the Nursing Department after concerns of increased medication errors which also included self medication
- Interdisciplinary Working Party recommended by MIWP and convened.

Medication Management/Safety Committee

- Formed in 2006 (at urging of nursing staff), 7 years after recommendations of Interdisciplinary WP had been made to management!



Committee Objectives

- Quality Activities related to medication management
- Improve medication safety
- Reduce risk associated with medications

HRC Self-Medication Sub-Committee

- Clinical Service Coordinators x2
- Pharmacist
- Medical Officer



Self-Medication Issues at HRC

- Multiple medication charts in use (pre-NIMC).
- Change of Medical Officers and lack of orientation concerning self medication.
- Potential of “double dosing”

Self-Medication Issues at HRC

- Potential for omission of medication.
- Potential of client forgetting medication – lack of supervision
- Decision on medications to be included or not in dosettes.

What had to change?

- Self Medication storage – individual supply.
- Investigation of other forms of dispensing other than dosette.
- “Progress” clients onto bottles and boxes instead of using dosettes.
- Appropriate selection of clients for self administration.
- Establish appropriate policies, e.g. RAH Drug Formulary is acute-specific

What had to change?

- A need for common documentation
- A need for common assessment sheet for suitability to self medicate that can be included in medical records.
- Need to safely meet rehabilitation goal of independence.

By the way, we also changed:

- Cold chain storage and monitoring
- Nurse-initiated medication orders (response to lack of after-hours MO coverage)

Nurstoons

by Carl Elbing



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Sub-Committee's Objectives

- Developed a self-medication policy, processes and documents based on Best Practice and rehabilitation principles
- Encouraged further Allied Health involvement (unit-specific)
- Oversee introduction of new medication trolleys/IPS
- Investigate dispensing systems
- Evaluate trials and revise policies as necessary

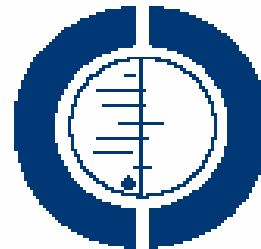
Best Practice

- Computerised physician ordering
- IPS
- Pharmacists to double check and consult
- Dedicated nurse for administration
- Double checking by nurses may reduce errors
- Medication Safety Committees can reduce errors



Reminder packaging for improving adherence to self-administered long-term medications (Review)

Hwangbo CJ, Glasziou P, Peiris R.



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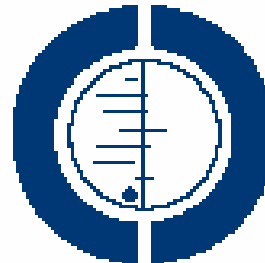
Reminder packaging for improving adherence to self-administered long-term medications (Review)
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There is evidence that the use of “multi-compartment medication compliance aids” may represent a simple method of improving medication adherence.

Interventions for enhancing medication adherence (Review)

Hayan RB, Shi Z, Deyou A, Kipkui S, Song A, McDonald HP



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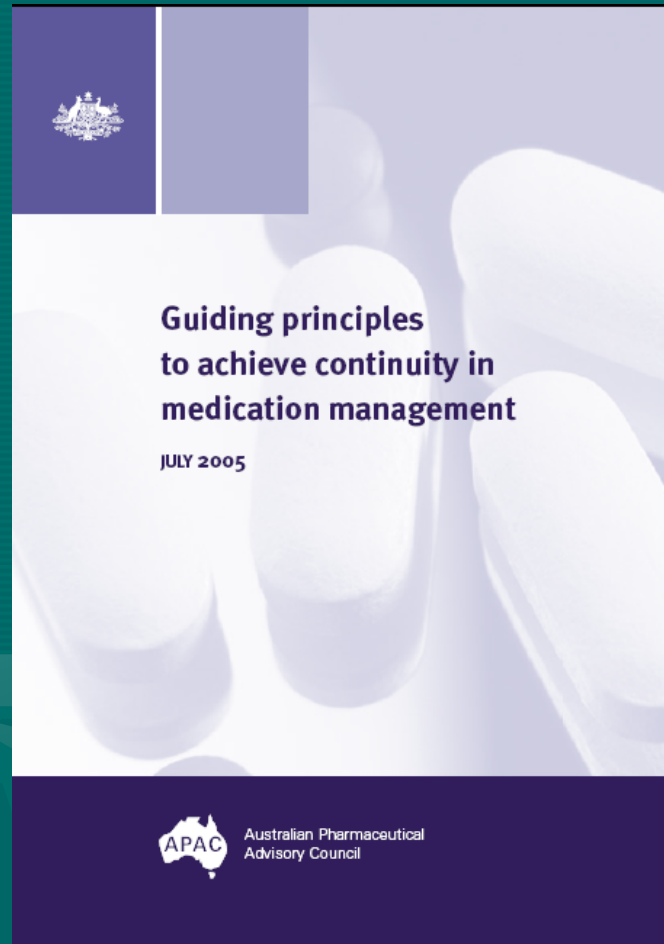
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Interventions for enhancing medication adherence (Review)
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The common thread to interventions at improving adherence with medications is increased frequency of interaction with patients

Guiding Principles



Guiding Principles

PRACTICE STANDARDS

SHPA Guidelines for Self-Administration of Medication in Hospitals and Residential Care Facilities

The Society of Hospital Pharmacists of Australia
Committee of Specialty Practice in Rehabilitation and Aged Care*

These are standards of professional practice and not standards prepared or endorsed by Standards Australia. They are not legally binding.

INTRODUCTION
Self-administration of medication is part of the discharge planning process in rehabilitation wards. While it occurs predominantly in rehabilitation wards, medication self-administration is a strategy that can be undertaken on selected patients in other types of ward environments.

Assessment of self-medication competency or successful completion of the training program will determine the need for support after discharge. By identifying and addressing problems as part of the discharge planning process, the risk of problems arising in the future is minimised.

Capable residents of residential care facilities maintain a degree of independence when they accept responsibility for their medication management.

OBJECTIVES
These guidelines are intended for use in hospitals where self-administration of medication is part of a patient education and assessment program. Self-administration of medication is used in residential care facilities to encourage residents to maintain independence. The guidelines cover:

- Selection of suitable people;
- Choice and provision of medication; and
- Legal and procedural documentation.

Protocols and procedural documents should be developed by individual facilities to suit their specific requirements (Appendix 1).

The term "self-medication" is used as an abbreviated form of "self-administration of medication" for the purposes of these guidelines. It in no way suggests that the medical officer is not the sole prescriber.

EXTENT AND OPERATION OF THE SERVICE
Suitable people for a self-administration program are those who are medically stable and whose medications are reasonably constant. Individual need for particular dose forms should be assessed. Prior to commencement of self-medication, a formal assessment is conducted to

determine the patient's competence to manage the tasks involved. The person must be able to read and understand the directions on the label, to open and close containers, or administer topical preparations such as eye drops.

Ideally, medical, nursing, pharmacy and occupational therapy personnel should be involved in this process. Physical or mental disabilities should be taken into account. The acutely ill patient who is having frequent changes in medication is unsuitable.

Prior to initiation of self-medication, the number of daily doses required should be minimised. Appropriate times for the administration of medication with regard to food and other drugs should be taken into account.

Special consideration should be given to the management of controlled drugs, variable dosage drugs (e.g. warfarin, insulin), clinical trial drugs and "as required" medication.

The patient must be involved in the decision to self-medicate and give informed consent before taking responsibility for managing their medication. How this is done should be determined by the facility. It may take the form of a signed agreement that will be part of the patient's medical history.

POLICIES AND PROCEDURES¹
Storage of medication in the ward must comply with hospital and state regulations. Medication must be secure from access by other patients in the ward. Suggestions are a lockable bedside drawer or cash box. The patient is responsible for one key, nursing staff holds a second key and a third key is held by the pharmacist servicing that ward. Another method is to have the patient request medication from the drug trolley when it is required.

The doctor must record in the patient's medical record that approval has been granted for the patient to enter the self-administration program. The medication chart should be endorsed that the patient is self-administering their medication. Legal responsibility remains with the hospital for the correct administration of medication.

A pharmacist must counsel the patient about the medication, including indication, dosage, and storage requirements. Medication must be dispensed in containers labelled with full directions and advisory labels. A written medication list should be provided. The system of assessment and supervision must be explained. A dose administration aid (DAA) should be used when it is judged to be the only method of supply appropriate for

- Selection of suitable people
- Choice and provision of medication
- Medication storage
- Legal and procedural documentation
- Resources

Reasons for Self-Medication

- Client lives alone and will be solely responsible for medications
- Client has social support but who are unwilling to assist
- Uncertainty regarding discharge destination
- Discharge to low level residential care
- Client takes frequent leave
- Client/family requests self medications
- Client needs to direct carers to administer
- Any other reasons determined by clinical team

Potential barriers

- Client has significant deficits, e.g. visual, dexterity, memory, communication
- Concerns re adherence
- Client unable to demonstrate understanding of condition/s and medications
- Unstable medication regime
- Client does not understand responsibilities
- Unable to open containers or direct carers
- Client does not consent

Problem solving strategies provided

Documentation

ROYAL ADELAIDE HOSPITAL		PATIENT LABEL	
INPATIENT PROGRESS NOTES		Unit Record No.:	
		Surname:	
		Given Names:	
		Date of Birth:	Sex:
DATE & TIME	PROGRESS NOTES – SIGN & RECORD DESIGNATION FOR ALL ENTRIES		
	~ Assessment of the Client for Suitability to Self-medicate ~		
	PART ONE – Client is suitable to trial self medications: Document the reason for commencing trial: <i>e.g. Client will be independently living on discharge and medication safety must be assessed prior to discharge: there is a need to assess the client's ability to direct carer's to administer medications.</i> <i>If client is not suitable for self medication trial, write "Not applicable" and proceed to Part Two.</i>		
	Trial is to be conducted as per HRC guidelines.		
	PART TWO – Client is unsuitable/unwilling to self-medicate: Document the reason for not proceeding with trial below (Refer to problem solving section of HRC Self-Medication Guidelines for alternative strategies): <i>e.g. Client will not be responsible for medication administration on discharge; client is not able to safely administer or direct administration of medications.</i> <i>If client is suitable for trial, write "not applicable".</i>		
	Mode of medication management (circle): Dosette Bottles / Boxes		
	Assessment completed and discussed with patient by:		
	(Sign) _____		(Name / Designation)
	(Sign) _____		(Name / Designation)
	Next Review (if applicable):		
	Date of assessment: _____		
	Fax copy of completed form to Pharmacy with initial self-medication order.		
	Date / /		

JANUARY
2002

INPATIENT PROGRESS NOTES

MR 40.0

Trial Process

- Four stages, accompanied by team evaluation, in consultation with client, documentation and further education as required. Each stage is a minimum of one week (if appropriate to length of stay)
- Education by Pharmacist a key component
- Record of adherence

Guidelines implemented March 2008 following education in all clinical units (and trial in 2 units)

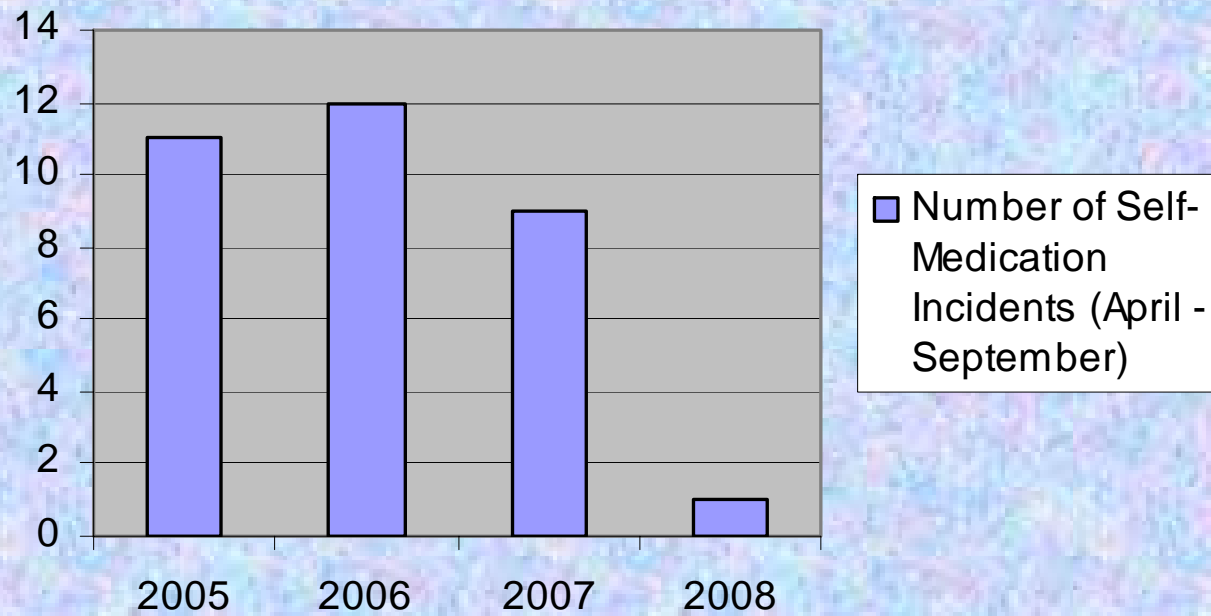


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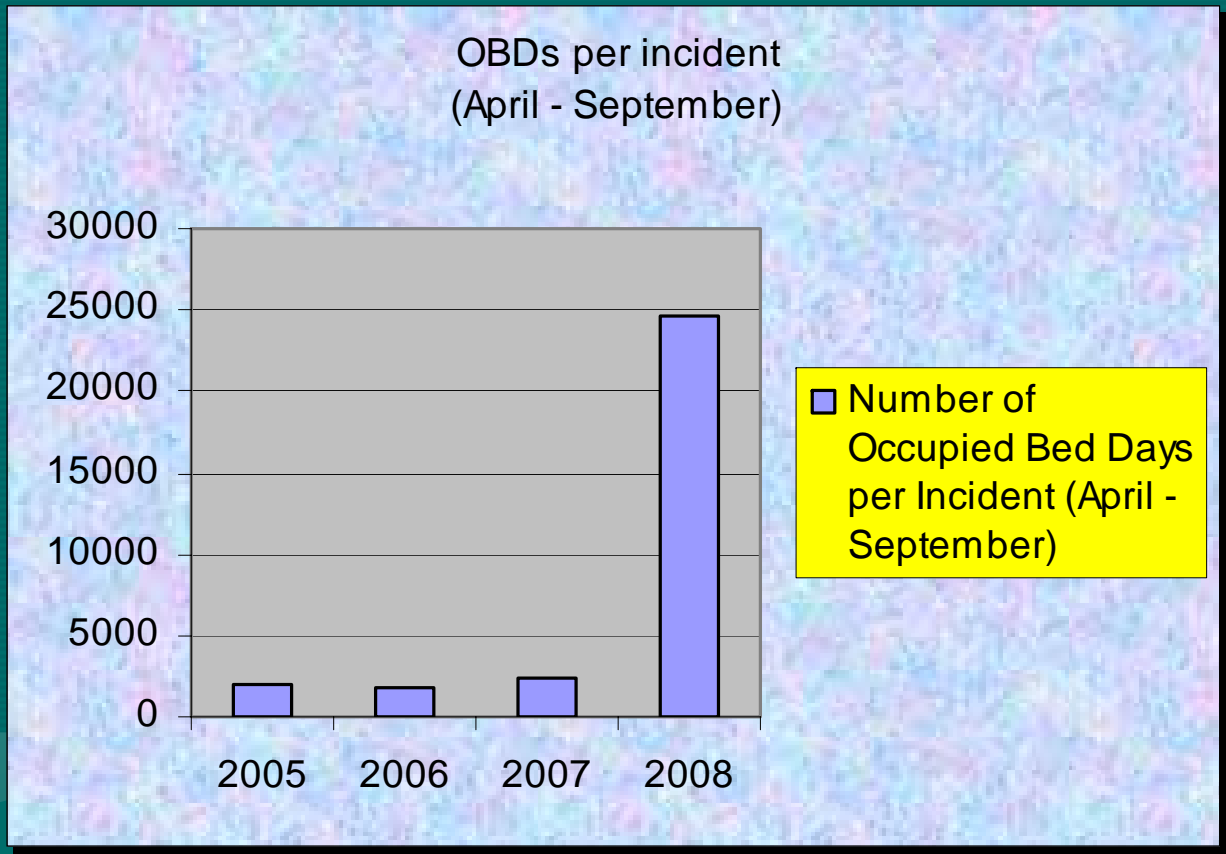
Audit 6 months post-implementation

- 84% of clients who are self medicating have documented assessment
- 89% have mode of administration pre-assessed
- 89% have adherence documentation implemented

Number of Self-Medication Incidents
(April - September)



OBDs per incident
(April - September)



Problems

- Still a Nurse/Pharmacist responsibility
- Need for further education re guidelines
- Poor documentation of compliance after initial stage
- Strange decision-making re client independence

Learning from mistakes



- Keep
- It
- Simple
- Stupid



THANK YOU

Any questions?