Home & Community Health Association

Draft Medication Guidelines for the Home and Community Support Sector: Consultation April 2018

Comment from the Home and Community Health Association

General Comments

1. HCHA supports the principle of medication guidelines because we think they are necessary to support safe and effective services and to support people to live independent lives at home.

2. Congratulations to those who have developed this draft, especially the providers and individual staff who have so much energy into it. Also to the Waitemata DHB staff who have helped pull it together. This is a collaborative initiative with the aim to support safe services. The draft enables further discussion across the broader community health sector. We strongly urge a broad integrative approach, led by the sector.

3. **HCHA Literature review.** To support quality improvement, HCHA commissioned a literature review in 2016[1]. This identified and critiqued literature relating to current policy, guidelines, and practice of non-regulated caregivers in relation to medication while they are working with clients in their own homes. The review drew on relevant New Zealand (NZ) statutes, standards and practice guidelines related to medication support and administration, District Health Board (DHB) policies, and education and training recommended and/or available to Home Support Workers (HSWs). Relevant published research and international guidelines were also included. The HCHA is pleased to see a range of the conclusions of that report reflected in the guidelines, however we think there could be closer alignment between the two.

4. **Findings of the HCHA Literature Review support the content of the draft Medication Guidelines**

   The review authors concluded that:

   a. there is a dearth of literature relating specifically to medication support and administration by HSWs in the home care environment, however, guidelines (NZ and international) are available that can inform the development of policies and processes to provide safe and effective services to support home-based clients in taking medications.
   b. In NZ, there is legislative freedom for HSWs to administer prescribed medication, however, existing policies, guidelines and research signal a more cautious and

[1] Roy, D.E. and McKechnie, R.C. (2017). Non-regulated Home Support Worker role in medication support and administration: A scoping review of the literature prepared for the Home & Community Health Association. Unitec ePress Metro Report Series (2017/2). ISSN: 2537-8678 Retrieved from http://www.unitec.ac.nz/epress/

restrictive approach that is based safety for both the client and the HSW. There is little evidence that shows negative outcomes of HSWs supporting and administering a wide range of medications to clients in their homes providing they have the right education and training and supervision (in some cases under direction and delegation of a health professional).

c. Common criteria for provision by HSWs of safe effective medication support and administration services include:
    - Clients and/or their representatives retain responsibility for medications. HSWs provide support and assistance for them to self-manage these, which follows a documented care plan developed in conjunction with the client and/or their representative and based on client's informed consent.
    - Organisational protocols should include provision of a regular medication review by a pharmacist and assessment of client medication practices by suitably qualified staff.
    - Medication support and medication administration require different levels of knowledge and competency, which must be reflected in education/ training provided. Minimum requirements as appropriate to the level of medication support and administration required.
    - Competency based training that is most probably work-based and focused on the necessary knowledge and skills required to ensure safe medication support and administration for clients.
    - Literacy and numeracy levels to be considered/assessed as part of education and training. We would suggest this be extended to include health literacy
    - Competency assessment should be completed by accredited assessors and renewed/reviewed annually/biannually or when the HSW moves to a new position.

d. Employer and HSW responsibilities were recommended.

5. **We suggest a broad approach, promoting medication standards or principles for community-based organisations.**
   Whilst we support the home care sector developing a guideline for its use, we raise a strategic consideration about a broader collaborative community based approach with the aim of supporting independence and self-care, and preventing medication errors and problems, addressing all aspects of medication management and support. This could cross both community and aged residential care, including consumers, carers, primary, pharmacy and NGOs in the process. There is some precedent for this[2] although we think this is an opportunity for more consumer engagement and more outcomes focus.[3]

6. **The focus of the guidelines needs to broaden.**
   The guidelines focus very much on compliance along lines of responsibility. Whilst that is reality the focus primarily on a clinical view restricts views towards service user agency, choice and independence. We recommend that other relevant international guidelines specifically developed for community based and homecare services are more closely considered. It needs to be an actively supportive and enabling document.

[2] Accreditation Canada's Medication Management Standards for Community-Based Organizations
[3] Accreditation Canada's Medication Management Standards for Community-Based Organizations

7. **Not considering the complexity of community clients**. The view in the guidelines may be too broad to address the multiplicity of complexities of community clients. Provider organisations need to respond to the needs of their client group, and this may require a range of competency training and assessment, rather than single 'standards'. We think this is reflected in the literature review. We suggest that the working group consider documents such as 'Guiding Principles for medication management in the Community' (Australia). Another document to consider is 'Medication Policy and procedures' from the Australian Department of Human Services, NSW.

8. **Consumer/carer consultation essential.** There does not appear to have been specific consumer or carer consultation up to this point in the development of the guidelines. The success of the guidelines would rely on close understanding of the different roles, responsibilities and perspectives. Considering the intent of the current health strategies including positive ageing and the disability strategy, and the move towards greater self-care, targeted consumer input should at least be part of any 'next steps'.

9. **More emphasis is needed on supporting the independence of the** person.
   Similar to our comments above, we consider that there needs to be more emphasis on the independence of the person receiving support. We note the UKHCA Medication Policy Guidance[4], which states that:

   > Many service users are capable of self-administration of medication. Homecare organisations should not assume that service users need assistance. Self-administration should be the preferred option for all service users who are able to do so. Often, by discussing their needs during the assessment process, ways can be found to maintain the service user's independence in respect of self-medication.

   We also suggest inclusion in the guideline relating to maintaining the service user's rights to privacy, dignity, confidentiality, independence and their choice not to take medication.

10. **Understanding of governance arrangements.**
    The guidelines do not consider linked responsibilities. For example no responsibilities are included for home care commissioners or other types of health providers (NASCs, pharmacists, GPs) in terms of jointly reviewing responsibilities to ensure it is clear who is accountable and responsible and for what. We refer the working group to 'Managing medicines for adults receiving social care in the community'[5]

11. **Responsibility varies across the sector.** As an example of the above, not all providers carry out assessments or are required to have health professionals on team. There is also considerable variation across the sector in relation to the regulated professionals employed by providers. Under some contracts (eg restorative, rehabilitative) the health professional is more likely to be an occupational therapist or physiotherapist. Some providers employ other therapists such as behavioural and cognitive therapists, disability support experts and in some cases social workers. We do not think that the guidelines as currently written recognise the breadth of lines of responsibility that exist.

12. **Intent on use of guide.** As a general comment on the development of the draft guidelines (rather than their content). HCHA considers there has been insufficient clarity in terms of the intent of the guide to service application: i.e. whether it should be voluntary; required in

[4] UKHCA Policy Guidance, Medication Policy Guidance, October 2012
[5] https://www.nice.org.uk/guidance/ng67/chapter/Recommendations

all audits to NZS 8158; required in contracts where appropriate; required in new contracts; required in all contracts. Each of the options has considerable policy, resource and quality management implications. We acknowledge that the working group developed the guide without what they perceived would be constraints of funding and resource considerations, and with a focus on 'best practice'. HCHA has consistently recommended that prior to any consideration of national application there should be a piloting process followed by national consultation that also includes funding and contracting intent and resourcing implications. The latter deeply informed consultation on NZS 8158, and that was a successful approach.

13. **Contractual and Funding Implications of any application of the guidelines**
Should these guidelines be applied to all current contracts, then they would have to be preceded by contract negotiation (another supporting reason for national consultation). The addition of RN oversight, and competency assessments for RNs and HSW, without adequate resourcing, could make service provision financially unviable for many providers and in several areas of NZ. On an initial consideration of this:
    a. Whilst providers are likely to have medicines policies as per NZS 8158: 2012, it is probable that not all operate competency processes for HSW on medication.
    b. Most current FFS contracts do not include and do not fund the employment of registered nurses.
    c. Many smaller providers do not have the client volume to financially manage the employment of a registered nurse.
    d. Trying to manage health professional oversight through a 'collaborative' arrangement with another organisation is highly problematic in terms of the line of professional responsibility.

14. **A Pilot should be first step.** The draft guideline has been developed by a regional group of providers and DHB representatives. We proposed initially that the guidelines should be piloted, learnings, gathered, followed by a national consultation that includes in its project brief the range of implications and applicability.

15. **No presumed move to national implementation.** It would be entirely inappropriate for the document to move immediately towards a national status or to be incorporated into contracts. Where the guideline is to be incorporated into contracts it would require negotiation with providers, and a transitional process to ensure alignment with systems, training and staff.

16. **We strongly query whether this is the best use of the limited and decreasing supply of registered nurses.**
The guide if implemented in its current form would require much more Registered Nurse input than currently exists in the sector, and possibly more than is available now and in the future in terms of workforce supply. There is also simply not the funding capacity available for this to occur.

17. Further to our point above, the guideline as written places unreasonable demands on the registered nurse role. Health professionals in the community sector are increasingly involved with case management and problem solving directly for clients, eg monitoring issues around palliative or pain care management and monitoring changes in the status of clients living with complex multiple health conditions or serious injuries, and connecting the person to the appropriate supports. This is a priority, especially as the acuity of clients increases and

the number of acute clients increase. The workload on a community nurse is already substantial, and we need them to work at the top of their scope. We need to be careful, therefore, not to busy them up with compliance tasks that can be achieved in some other way or on an 'as needed' basis.

18. **Unrealistic expectations**
The guidelines place responsibility on providers that belong elsewhere, and which would result in substantial resource allocation compared to the risk. One example is the expectation for providers to chase up medication orders. The practical implications of some requirements in the guideline needs to be much more carefully thought through. This is also where a broader community based guideline or consideration of goveranance responsibilities may assist.

19. **Employee Safety**
Not included in this guide is training and procedures where a support worker is injured or at personal risk in relation to medication support (eg is exposed to blood or medication that affects them, or infection, or is injured in some other way). There is (limited) research to show this does occur, and it is certainly relevant under Health and Safety legislation.

20. **Consent, Refusal and Covert assistance.**
There is little emphasis on consideration of the consent of the person being assisted. Should consent be sought each time that they are given medication support? There is no recognition that clients may refuse medication and the procedures and responses that should be followed when that occurs. There is no consideration about what the response should be when a person lacks capacity to be able to consent, and covert medication needs to be considered and how that will be managed with the person and their carers or responsible people. Consent in relation to children is a specific area that needs consideration.

21. **Consideration of client factors**
Should there be more guidance in terms of competency development around dosage levels administration and reactions, eg dosages and administration for children, or to people who may have low weight or have different reactions to medications due to such things as frailty, malnourishment, current medical conditions and pain. There is good research showing the dangers of common drug combinations in terms of falls and other illnesses.

22. **Support requested for Over the Counter Medications and complementary therapies**
The guidelines do not cover where a person or their informal carers may ask for support relating to OTC Medications that are not covered in the care plan, and the policies and procedures that should apply. Similarly procedures in relation to service users choosing to use complementary therapies and seeking support, should be developed.

Specific Comments

23. **Definitions.**
Suggestion that the definition notes that in NZS 8158, provider is defined as the person directly providing support, and provide organisation as the contracted organisation, however for the purposes of this document, provider is the provider organisation. An alternative would be to use the term 'provider organisation' throughout the guideline.

24. **Introduction**

Under 'Introduction, the term 'safe practice summary' is used in paragraph 2. We query whether this term is commonly used in the sector.

25. **Introduction reference to NZS 8158.** In that same paragraph, the sentence reads:

> The Guidelines reflect the standard and the criterion from the Home and Community Support Sector Standards (Ministry of Health, 2012) and are based on current evidence of best practice and relevant legislation. They serve as a reference tool for HCSS Providers to support safe medication practice policies and processes.

The reference to MoH after the sector standard is incorrect. The relevant document is NZS 8158 and it is a Standards NZ document. ACC was the primary funder, MoH and NZHHA gave support and funding. It was not an MoH document.

26. **Roles and Responsibilities: HCSS provider.**

Responsibility	**HCHA Comment**
To have Medication Practice Policies and Processes in place that reflect current legislation, regulations, standards and the Medication Guidelines for the HCSS sector	Agree
Ensure the Medication policies and processes are aligned to tikanga and other specific cultural customs and values according to client preference	Agree, though suggest adding caveat about balancing with risk. For example if a client refused to take medicine due to a custom or value, should the provider be responsible for aligning its policies and processes to that position?
To have systems in place to monitor all people who receive medication support from the provider.	Monitor is too broad a term which will confuse, especially auditors and funders. There are likely to be cross-over responsibilities. Suggest reconsideration of the wording to reflect level of risk, interrelating responsibilities and competencies.
To have an incident reporting process and an internal auditing system in place to monitor and support the correction of all identified medication errors	Agree
To ensure employee's responsibilities and obligations are clearly outlined at each stage of the medication category (i.e. Independent, Prompt and Staff Administration)	Agree
Ensure training is in place and employees are verified as competent to perform the medication support functions they are allocated to carry out	Agree
Ensure accurate education, training and competency records are maintained	Agree

Ensure, where appropriate, that employees have access to an RN, either onsite or by telephone	Disagree. Not all employees need access to an RN, eg those providing only household management or disability support not requiring medication support. Also, text and other forms of electronic connection are increasingly used. We suggest this is amended to read 'Ensure that, where appropriate, employees have access to an RN, either onsite, by telephone or electronically.
(Not yet included): liaison with primary care and relevant pharmacists and prescribers	We suggest that a further responsibility should be considered, that is to develop active working liaison with relevant primary care and relevant pharmacists and prescribers.
(Not yet included): keeping up to date with medication requirements.	We suggest that a further responsibility should be considered, i.e. that the organisation keeps up-to-date with new medication requirements from regulators or patient safety alerts and that any changes are planned, implemented and communicated
(Not yet included): Risk Assessment in relation to medication administration	We suggest that a further responsibility should be considered, i.e. that a risk assessment is carried out for all service users who require assistance with medication. This should include any medication allergies, storage and use of controlled drugs.

27. Roles and Responsibilities: RN.

Responsibility	**HCHA Comment**
To pass an annual medication competency	Disagree. This is too broad a compliance requirement. We suggest this needs focused consultation with sector quality staff and their managers.
To work within their scope of practice and understand their responsibilities regarding direction and delegation.	Agree
To comply with the Nursing Council of New Zealand which states "a RN may be held responsible where an unsafe system is in place if the nurse ignores or complies with such a system leading to harm or potential harm to health consumers".	Agree in principle, the wording seems awkward, suggest it refers to a specific document of the NC rather than just the NC.

To provide education/support to persons' and family members in relation to medication to support them to be independent as long as they are safe to do so	This is a very broad requirement, which we query in terms of practical applicability. In what circumstances do RNs meet with clients and how often? How far realistically would it be expected that education and support would extend? Education and support could be appropriate to need. But we think this needs more specific consultation with a range of sector quality staff and managers.
To delegate responsibility of medication administration to enrolled nurses and HSWs, provided it is within the HCSS Provider's guiding policies and procedures and the staff member's verified competency.	Agree
To ensure any persons receiving support with medication have an up to date/signed Medication Order (prescription) and a medication administration record (MAR).	Disagree. See our comment under Medication orders. This requirement needs a great deal more consultation and consideration.
To ensure that any person receiving support with medication has an Individual Support Plan that clearly identifies the category of medication support they require.	Agree
To ensure that any instructions regarding medications are accurately communicated to the main caregiver. This is particularly important in cultures where translation is required as the family translator may not be the main caregiver.	Agree, other than Last Line: Suggest the word 'family' is deleted, as 'family translator' it is too limiting for the situation that may apply.

28. Roles and Responsibilities: Enrolled Nurse

Responsibility	**HCHA Comment**
To pass an annual medication competency	We query whether an annual competency is necessary
To work within their scope of practice (this includes administering oral, topical, rectal, vaginal medicines and intramuscular/ subcutaneous injections)	Agree
To escalate any issues or adverse events to the RN responsible for their practice To work under the direction/delegation of an RN at all times ***Note:*** *An enrolled nurse cannot direct or delegate non-regulated staff to administer medications*	Agree

29. Roles and Responsibilities: HSW

Responsibility	HCHA Comment
To pass an annual medication competency,	Disagree. Providers have commented that biannual competency is generally sufficient, but that some HSW may also need specific competency sign off in relation to specific tasks. Providers also comment that medication updates tend to be part of an information session rather than a competency assessment. Anyone doing IV medication needs to show competency, but again it may not need to be each year. Suggest amendment to add "… where medication competency is required as part of their role"
To adhere to the Individual's Support Plan regarding medication	Agree
To work under the direction/delegation of a RN at all times	There are many situations in the sector where RNs are not required under the contract. Possible clarification could be 'In every instance where a support worker is providing medication support they will work under the direction/delegation of an RN.'
To escalate any issues or adverse events to the responsible RN.	Should be 'responsible person'.
(Not yet included) – to seek support	Suggest that there should be responsibility on the HSW to seek training and support when they think they need it. There is a range of other HSW responsibilities in the UKHCA policy guidelines which should also be considered.

30. Medication Support Categories

Under 'prompt'. Some persons in this category may eventually become 'Independent' following support from an HCSS staff member. Suggest deletion of 'following support from an HCSS staff member because the source of support is irrelevant.

We also suggest that there be a similar comment regarding people who need manual assisting, who may later become independent, or only need prompt support.

31. Medication Competency Assessment

Best practice indicates each HCSS Provider must evidence that all staff involved in supporting clients with medication support are verified as competent to do so. Knowledge and skills will be assessed by a RN who has demonstrated competency. Competency sign off for staff must include the core competency minimum requirements. These are divided into 1) Theory and 2) Practical components as seen below.

- Providers have commented that it is not necessary for an RN to sign off the competency in cases where there are blister packed medications.
- Some medication assistance activities (eg peg feeds) would require the higher levels of training, competency assessment and oversight identified in the guidelines, whilst others (eg eye drops, topical creams) may not need that level of oversight.
- For some providers the education team manage the competency sign off. None of them are RNs and the agency uses Careerforce training. A similar comment is made in relation to practical skills not needing to be signed off by an RN.
- Our key points here can be summarised to say that:
    a. competency assessments should be applied according to risk;
    b. competency assessments should be applied according to the circumstance of the medication support (eg not necessary in blister pack situations);
    c. alternative forms of competency assessment to that from an RN should be included in the guidelines.

32. **Documentation, Medication Orders**

It is the prescriber's responsibility to ensure that the Medication Orders are in a format that all staff can easily read to prevent medication prompting or administration errors. The RN who is responsible for the safe administration of medication to the person, is responsible for ensuring that the Medication Order is signed, current and includes clear instructions for staff.

We disagree with this inclusion and consider it needs much greater though. Providers have commented that:

- support workers administer from blister packs which are not signed by the prescriber.
- The medication order is only relevant to medications that are not pre-packaged and which would be given by a nurse.
- It is unreasonable to 'ensure' that persons receiving support have an up to date medication order and a MAR. This would be a substantial requirement for providers to chase these up from multiple sources. It is very different to the situation in residential care where there are only one or two GPs and probably only one pharmacist. This requirement needs a great deal more consultation and consideration.

33. Obtaining medication orders. Section 4

Again, we think this needs to be more carefully thought through taking a problem solving approach with sector quality staff and managers. As currently written it is not achievable.

Our comment in 27 above applies. It is not clear how HCSS providers are to obtain medication orders in the case of blister packs, or if they are responsible for managing Medication Orders.

34. Medication Administration Record (MAR) – Section 4

Prior to administration the MAR should be checked against the Medication Order to ensure it is correct. After administration, the MAR must be signed immediately by the staff member who administered the medication. If the medication was not administered as per the Medication Order, this must be documented on the MAR (ie, the person refused).

Further clarity is needed here around the MAR, noting that some providers have commented that "The medication administration record is generated by the provider. The prescriber documents the medication order on this and then the provider documents that the medication has been administered." There appears to be confusion between a MAR (as in the Definitions' generated by the prescriber and a MAR generated by the provider. Again this is an area for further consideration, consultation and solution finding.

35. Medication Errors

There is not a great deal in the guidelines about policies and procedures for the HSW to practically respond at the time when there has been a medication error (apart from reporting it). Eg what happens if the service user becomes quite unwell as a result. Also that known medication errors by the client, informal carers or the support worker should be reported without delay.

36. Controlled Drugs (Section 6)

A provider has commented that in relation to the 'note' regarding a syringe driver, this should be a point on its own, not a note.

37. High Risk and non pre-packaged medications (Section 7)

Providers have commented to HCHA that they think the list on page 11 is a mix of high and not. For example ear drops and eye drops would not fall into a high risk, but may require specific competency. Pre-packaged medications may have high risk, but may require a lower level of specific competency.

38. Medication Check and Reconciliation (Section 8)

This section places a requirement on HCSS Providers to check that people who have had a change in their medication, and are in the 'Prompting' or 'Administration' category have had a medication reconciliation undertaken by their last prescriber. Providers have commented to us that this will be resource intensive activity. They also query what happens if a person has district or community nursing support separate to home support?

39. Storage, and disposal Section 9.3

Medications must be stored safely in a suitable location under appropriate conditions according to the person's social and environmental situation and pharmacy instructions. Prescribed medication must be stored in their original pharmacy dispensed packaging.

- Comment: The use of 'must' is confusing here, since it does not ascribe that legal requirement to an person. Providers cannot be held responsible if a client decides to keep their meds on their bedroom cabinet.

- We suggest in relation to HCSS provider responsibility there could be a statement that providers should make best efforts to support the safe storage of medications. This could include advising individuals where there is potential risk to the safety of the medication or the safety of the person, the HSW, or others in the house.

- Medication should not be disposed of in household waste or down the sewage system via sinks or toilet.

- There should be a record in the care plan or provider MAR where medications have been disposed, including where possible the agreement of the service user.

40. **References.** We suggest that the references also include reference to the sector standard NZS 8158.

41. **Practical information would be useful** (how to implement the guideline), such as training that would improve knowledge (eg what is prompting).