Guidance for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)

Inclusion Criteria

- The patient is an adult with a palliative diagnosis and is experiencing symptoms that may require subcutaneous medication administration. This may be regular or as required medication.
- The patient and/or carer have consented to administer subcutaneous medication and have been assessed as having the capability (physical and mental capacity) to do so.
- There is agreement from the multi professional team (minimum General Practitioner (GP) and Case Manager) that it is appropriate for the patient and/or carer to administer subcutaneous medication.
- The patient and/or carer have successfully completed the necessary training and is considered competent by a healthcare professional and feels confident to administer subcutaneous medication.
- It is suitable for an LCH staff member, if acting as a carer and not an employee, to administer injectable CDs provided they meet all of the other criteria that would apply to any carer.
- Both patient and carer are aged 18 years or over.

Exclusion Criteria

- The patient or carer who would like to administer the medication is under the age of 18 years.
- The patient or carer willing to give the subcutaneous medication has been assessed and lacks the capability (physical or mental capacity) to do so.
- The patient or carer who would like to administer the medication has a known history of substance misuse. There are concerns relating to substance abuse involving the patient or carer or persons who may have access to the home environment.
- There are safeguarding concerns in relation to the patient or relevant carers who may be willing to administer medication.
- Failure to adhere to the protocol and agreed plan of management.

The decision for any exclusion must be made following discussion within the multidisciplinary team and the reason(s) for exclusion clearly recorded in both the medical and nursing record.

Risk Management

- The prescriber will need to consider the appropriateness and number of injections available for the patient or carer to give. It may be that not all of the prescribed subcutaneous medications are appropriate to be given by the patient or carer.
- Patients/carers must be provided with written information for each medication including the name, dose, indication, common undesirable effects, interval before a repeat dose is permitted and maximum number of doses in 24/hrs as part of the information leaflet: 'A Guide to Patient and Carer Administration of Subcutaneous Medication (Palliative Care)'.
- Patients/carers must keep a record of all injections given, including date, time, medication strength, formulation and dose, and name of person giving the injection. In practice this will be on the LCH Medication Administration Record (MAR) Chart (PM1) used by healthcare professionals.
- Patients/carers must be provided with contact telephone numbers for the Neighbourhood Team both in and out of hours and encouraged to contact Neighbourhood Team for support.
- The patient/carer can administer an agreed maximum number of prescribed injections for each injection in any 24-hr period. This will be documented on the Consent Form. They will be required to consult the GP/Out of Hours Doctor or Neighbourhood Team once the agreed number of doses of each medication is reached This is to allow a healthcare professional to review their effectiveness and to ensure any background medication e.g. in a syringe driver is reviewed and the doses of the subcutaneous medication are appropriate. It will also ensure that adequate supplies of the injections are available.
- Sensitive discussion with any carers involved in the administration of subcutaneous medication should explore how the carer may feel about undertaking the task and the giving of medication to relieve symptoms when the patient is close to death.
- In the case of any individual who is approaching the end of their life, there is a possibility that they might die soon after appropriately receiving a subcutaneous injection for symptom control. Death may be perceived by the carer to be attributable to this 'last injection'. To reduce the risk of resulting carer distress nurses should consider discussing this possible eventuality during the training period and consider revisiting this as circumstances change e.g. as death approaches and becomes more of a reality carers might feel differently.
- Patients and carers will be provided with a sharps bin and taught the correct technique for sharps disposal.
- Patients/carers will be informed of the correct steps to be taken in case of needle stick injury: make it bleed, wash it, cover it and report it to the GP and registered nurse immediately to report according to Incident Reporting Policy.
- Should any medication errors or incidents occur, as a result of patient/carer administration, this must be communicated to the patient's care team immediately and reported and investigated in accordance with LCH Incident Reporting Policy. The incident should be investigated as soon as possible and where necessary the administration of subcutaneous medication by the

patient or carer will cease and any further injections will be given by healthcare professionals.

Consent

- A 'Consent Form for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)' must be completed for all patients and carers who wish to administer subcutaneous medication. The completed form should be filed in the patient's notes and the electronic record updated.
- Where the patient has the capacity to consent to the carer administering subcutaneous medication, this will be sought. It is however recognised that a number of patients will not have the capacity to agree to this and so the procedure will be undertaken in the patient's best interest, again this reasoning must be clearly documented within the patient's record.

Procedure

1. A patient with a palliative illness or their carer expresses a wish to undertake the administration of subcutaneous medication to facilitate the management of symptoms.

2. A description of the procedure is discussed in detail with the patient or carer so that they may better understand what is required of them.

3. If they wish to proceed there must be a discussion with the healthcare team caring for the patient (minimum GP and registered nurse) who must be familiar with the procedure to ensure that the patient/carer meets the inclusion criteria and agree to support the process.

4. Where the use of a range of a dose of medication is prescribed, the GP (or Independent Nurse Prescriber) must advise the patient/carer to administer a set dose within the range and to seek advice if this requires adjustment. This aims to reduce the burden on the patient/carer in decision making. They must agree the medication and indications which the patient/carer may administer by subcutaneous injection which may not necessarily be all prescribed subcutaneous medication. Patients and carers can only administer subcutaneous injections via a Saf-T-Intima s/c cannula.

5. The name of the medication the patient or carer may administer must be recorded on the 'Consent Form for Patient or Carer Administration of Subcutaneous Medication'.

6. Training of the patient/carer is undertaken by a registered nurse according to the information leaflet 'A Guide to Patient and Carer Administration of Subcutaneous Medication (Palliative Care)'. Training must include an understanding of the indications for the medication to be administered and any common side effects.

7. The registered nurse must either supervise the patient/carer administering a named medication, if any medication is required at the time of the training, or if not possible then observe them flushing the line with 0.3ml water for injection.

8. Training must ensure that the patient/carer is familiar with recording of medication administered (dose, time, date) on the Medication Administration Chart (PM1) and that they are able to update the stock record (PM4) so that further supplies can be ordered in a timely manner if required.

9. Patients/carers must be trained in the safe disposal of sharps and understand the management of needle stick injuries.

10. Patients/carers must be aware of the process to follow in the event of a medication error or incident. All incidents must be reported and investigated in accordance with Incident Reporting Policy.

11. The registered nurse must ensure that the patient/carer has 24hr contact details for the Neighbourhood Team.

12. The 'Consent Form for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)' must be completed when the registered nurse and patient/carer feel they are confident and competent to undertake the procedure without supervision. This must be retained in the home of the patient with any other LCH documents (e.g. MAR Chart). It must be recorded on SystmOne® that the consent form has been completed. The SystmOne® record should be updated to record that the patient/carer is able to administer subcutaneous medication. It is recommended that this information is included as a 'high priority reminder'.

13. The frequency of contact by neighbourhood team teams must be agreed with the patient/carer and recorded within the SystmOne record.

Further support must be to the patient/carer after any change of dose. Any additional training or supervision must be recorded on the 'Consent Form for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)'.