Best Practice Procedures
FOR PHARMACY AND RESIDENTIAL AGED CARE FACILITIES
Portion-pak®
Best Practice Procedures

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Introduction
Portion-pak® has the advantages of Multi Dose, the safety of Unit Dose 7® colour coding, and the convenience of Flexi-pak® detachable doses.

How does it work?
Portion-pak comes in strips of seven for each dosage time. Prior to each medication round, nursing staff remove each dose and place it in an administration tray to take on the medication round. At the point of administration, the foil lid is peeled back, but remains on the blister. This means the residents photo and all their medication information stays attached to the blister right up until it’s administered. This reduces the risk of giving medication to the wrong person.

Multi-use packaging
Portion-pak has the largest blister capacity in the Webstercare® range. This allows nursing staff to use the blister as a medication cup, crush the tablet in the blister and add puree to it if required.

Webstercare Aims
Webstercare aims to:

- Encourage a safe and responsible attitude towards use of medication
- Minimise the likelihood of under-use and over-use of medication
- Optimise the possible health outcomes through appropriate use of medication
- Allow for easy monitoring of medication use by nursing staff

Supply of Portion-pak is consistent with the concept of quality use of medicines for residential care and supports facilities in safe and effective medication management as required in the accreditation outcome 2.7. See Appendix 1 for an outline of the standards.
Essential Components for Portion-pak

To supply and use Portion-pak you will require the following materials;

1. Portion-pak Blisters

The Portion-pak blister consists of seven medication compartments, one for each day of the week. A blister strip is required for each dosage time e.g. Breakfast, Lunch, Dinner and Bedtime. Each blister strip is separated by a perforation that allows the individual doses to be detached.

There are two size blisters available, small and large.

2. Portion-pak Cold Seal Foil

The Portion-pak Foils are printed using a laser printer via the Webstercare Medication Management Software (MMS). Each sheet of foil consists of three Portion-pak blister labels.

The Webstercare MMS prints the following features onto the foil;

- A barcode
- Dosage time (also represented by a coloured band)
- Day and date the medication is to be administered
- Patient’s name and photograph (client photo)
- Drug name, strength and dose
- Room number
- Pharmacy name and contact details
- Doctor
- Expiry Date

Printed Portion-pak Foil
3. Portion-pak Blu-Lok® Platen

The Portion-pak Blu-Lok Platen accommodates one Portion-pak blister strip. The interlocking design allows the user to join multiple platens together when packing. A minimum of four platens is recommended.

4. Portion-pak Storage Tray

The storage tray holds the Portion-pak blisters once prepared by the pharmacy, so they can be securely transported to the facility. Storage trays are also stored at the facility in the medication room before each dose is removed and placed in the administration tray ready each medication round.

The storage trays are designed to stack on top of each other and can be stored in Portion-pak trolleys. An I.D insert which is printable using Webstercare’s MMS, can be placed in the storage tray which allows you to distinguish one dosage time from the next.
5. Portion-pak Administration Tray

The blisters are placed into the Administration Tray prior to each medication round. The administration trays are stored in the medication trolley for the duration of each round. The blisters are held at a 30 degree angle to allow for easy identification.

6. Portion-pak Trolley

The Portion-pak Trolley is used to store the administration and storage trays and any other items needed during the medication round. The trolley has three small drawers that fit three administration trays in each. One large drawer can store non packed and other items. The Portion-pak trolley also comes with a waste bucket and a holder for easy waste disposal.
7. Webstercare Medication Management Software

The Professional and Professional Plus versions of the Medication Management Software (MMS) have the ability to print the Portion-pak foils.

Special Medication Categories

All PRN, Antibiotic and accountable medications should be packed be into either Webster-pak or Unit Dose 7 Webstercard.

PRN (‘When Necessary’) Medication

PRN medication is administered as required up to the prescribed limit and documented on the medication chart or signing sheet.

A full pack is prepared (all blister compartments) with one PRN medication. Multiple folders may be required until all medication is packed. For example: Panamax 500mg 100 tabs, 2 four times a day PRN, would require 2 packs; one pack of 28 and one of 22.

PRN medications are identified by a white folder or ‘PRN’ labelling on the pack.
**Antibiotics**

Antibiotic medications are identified by a green folder or coloured band. Full quantities of antibiotics or short term medications are packed into one or more packs with the dosage times set out by times of the day and days of the week. Long-Term Antibiotic medication is packed with regular medications.

Accountable Medications e.g. S8’s

Depending on the policies and procedures of an individual aged care facility, accountable medications may be packed with regular medications or separately.

If packed separately, accountable drugs may be recorded and stored according to State regulations (if required). Accountable medications are identified by a purple folder or coloured band.

Accountable medication that is prescribed as a PRN will be dispensed in the full quantity into one or more packs. Purple folders with numbering from 28 (top-left) to 1 (bottom-right) are available. This assists with accounting for the number of doses remaining.
**Warfarin Medication**

If required, Warfarin medication can be packed separately. Warfarin is identified by a mustard folder or coloured band. The different coloured folder alerts staff this medication requires additional attention. You may choose to store all Warfarin medication together at a particular dose time.

![Warfarin Medication](image)

**Medication ‘Not Suitable for Packing’**

Medication unsuitable for repackaging can be dispensed in their original containers. The medication chart and signing sheet serve as reminders for when non-packed medication should be administered. Alert cards should also be used in the medication chart folder as an extra reminder for nursing staff.

Examples of medicines unsuitable for packing include effervescent tablets, dispersible tablets, buccal tablets, hygroscopic preparations and some solid dose cytotoxic preparations.

Webstercare can provide guidelines on medications not suitable for packing; however individual circumstances and environmental issues will be taken into consideration by the servicing pharmacy.
Pharmacy Section

Getting Started

It’s very important to have complete and accurate resident profile information before you start to package medication into Portion-pak. To record this, use the Doctor Order/Patient Medication Profile Form.

Exact dosage times and complete profiles of all medication must be recorded and maintained.

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**Multi Dose Checking Sheet**

It is essential to check this information with the doctor or carer against written documentation supplied by the doctor. You must then cross check this information against the prescriptions. You may find discrepancies that will need to be discussed and resolved before commencing. At this time it is opportune to check for any potential drug/drug or drug/disease allergies, interactions or dosage discrepancies and take appropriate action.

The Multi Dose Checking Sheet can be printed through the reports section of the Webstercare MMS (Medication Management Software). For further information refer to the MMS Quickstart Guide or contact Software Support on 1300 132 466.
**Patient Profiles**

The pharmacist must prepare accurate information on all medication and dosages. Doctor Order/Patient Medication Profile Forms are completed from prescriptions or the medication chart. If these details are different from other medication records, the pharmacist must verify this information with the doctor, unless the doctor completed information.

The Doctor Order/Patient Medication Profile Form should be retained and used at all times as your master copy record for each patient's individual medication profile. This is kept up to date at all times and used for your final check against each finished pack. These profiles are best kept in a ring binder or similar, preferably protected in a plastic sleeve.

All medication are to be listed on the Doctor Order/Patient Medication Profile Form, not only items which are packed into the Portion-pak, but also any other items, such as: liquids, eye drops, ointments, patches, sprays and 'when necessary' medication e.g. Analgesics or Sedatives.

**Complying With PBS Requirements**

Medications are dispensed via the dispensing software in the usual way. Once the dispensing is complete, a record of the dispensed medication for each patient must be maintained. This can be done through the use of the MedsPro® using the Virtual Pill Count (VPC)™ system. A record of your patient’s medications is retained in the software. If at any time a patient requests their medications, you have a record of their balance held on their behalf and you can supply at short notice. Alternatively, Integrity bags can be used to store each patient’s medications which are individually labelled.

Non-packed medication will be dispensed, labelled and supplied as normal e.g. Liquids, eye drops, ointments, PRNs.

**Complying with Guidelines**

Pharmacists should also refer to the “guidelines for medication management in residential aged care facilities” released by the Australian Pharmaceutical Advisory Council (APAC). Other professional guidelines such as QCPP and PSA should also be taken into consideration.
Packing and Sealing the Portion-pak

The Portion-pak system is quick and simple to prepare. Refer to Appendix 2: Portion-pak Packing Procedures for a guide.

Preparation
The Packing Technician:

- Thoroughly washes hands prior to packing and uses gloves or Pil-Kots™
- Collects the first resident’s medication
- Ensures there are plenty of supplies for packing
- Places the medication for the first resident on their right. Once they have used the medication, it is placed on their left hand side until packing is complete, speeding up the workflow.

Workstation Set-Up for Portion-pak

Packing from Foil. Supplies within reach. Medication placed on one side prior to packing.
Step 1
Using the Webstercare MMS print the Portion-pak foils through a laser printer. You can print per individual resident or for a group of residents e.g. facility or section.

Step 2
Using the interlocking feature, lock four Portion-pak Blu-Lok platens into place. Select the appropriate size blister for each meal time and place an empty blister sheet into each platen.

Step 3
Load medications into the blisters as per the medication profile printed on the Portion-pak Cold Seal Foil. Check for packing accuracy before sealing the blisters.
Step 4
Peel off one Portion-pak Cold Seal Foil strip from the top right hand corner of each column. Align the perforations on the foil with the perforations on the corresponding blister strip and carefully adhere the foil to the blisters.

*Sealing blister with Portion-pak Foil*

Step 5
Complete the sealing process by rubbing the palm of your hand across the blisters to maximise contact between the foil and blister. The Pressure Roller can also be used to ensure a consistent, secure seal.

*Portion-pak sealing*
Step 6
Sign the ‘tech box’ on the last blister of each strip to verify you have packed accurately.

QA Sig Box signed by Packing Technician

Step 7
Place the Portion-pak strips into the Portion-pak Storage Trays ready for checking by a Pharmacist. A separate tray is used for each dosage time.

Placing Portion-pak Strips into the breakfast storage tray ready for checking by a pharmacist
The Final Check

The minimum checking process recommended is a double cross check. Once the pack has been prepared and checked by the packing technician, it must be cross-checked and audited by a Pharmacist.

**Step 8**
The Pharmacist checks the strips against the Multi Dose checking sheet with the original packs on hand if required. It is best practice to check a resident’s entire profile at once. This way you get a complete overview of the patient’s medication profile. Keep medication profiles well organised and up to date in a folder. Always make sure there is enough information so that another Pharmacist can easily prepare/check packs if the regular Pharmacist is not available. Changes can be communicated directly by the Doctor and/or by means of a written prescription or by another written authorisation such as evidence of a medication chart. Keeping this documentation on record ensures there is always an audit trail of the communication process.

*Checking Portion-pak against the Multi Dose Checking Sheet (hard copy record)*
Step 9

The Pharmacist signs the ‘Pharm box’ to confirm a final audit has taken place and that they confirm the packs to be correct.

Step 10

Place a ‘Facility ID Insert’ at the front of each storage tray or meal time ready for delivery to the Aged Care Facility. Storage trays stack on top of each other to assist with transportation to the home. Facility ID Labels can be reused from week to week. They should be replaced when details change or they become worn.

Having the Prescriptions When Needed

To comply with the PBS regulations you must ensure that prescriptions are available at the time of dispensing. It is unacceptable and illegal for there to be any owing prescriptions unless in the case of an emergency order from the doctor. When packing with the MedsPro system, you know exactly how much medication is on hand at any time and when to request new prescriptions. Contact Webstercare for further information.
Re-Ordering Medication
The MedsPro system alerts you when it’s time to re-order medication. Alternatively, re-ordering medication can be done using the blue Pharmacy Order and Thermal Re-Order Labels. During the packing process, if less than one-week’s supply of a medication remains, remove the label’s lift-off tab and apply to the Order Sheet. Alternatively, orders can be handwritten onto the Order Sheet.

Thermal Re-order Label applied to original box.

Re-order section removed and placed on order sheet for dispensing.

The Pharmacy Order Sheet can then be actioned by either dispensing medication from an existing prescription or contacting the doctor informing them of the need for a new prescription.

Medication Changes
Medication changes are common in an Aged Care Facility. There are a few scenarios in which a medication change may occur:

1. New Medication: the new medication is supplied in a separate pack(s) containing enough medication to last the remainder of the current weekly cycle. This means a blister strip may contain empty blisters.

2. Dosage Increase: if possible the additional dose of medication is supplied in a separate pack/s containing enough medication to last the remainder of the current weekly cycle. This means a blister strip may contain empty blisters. You may choose to re-supply the entire pack if appropriate.

3. Dosage Decrease: the previous pack(s) must be returned to the pharmacy and a new pack supplied with enough medication to last the remainder of the current weekly cycle. This means a blister strip may contain empty blisters.
4. Ceased Medication: the previous pack(s) must be returned to the pharmacy and a new pack supplied with enough medication to last the remainder of the current weekly cycle. This means a blister strip may contain empty blisters.

**Pharmacy Support**

Your success with Portion-pak depends on your understanding of the procedures involved. Please contact us if you need further assistance or advice on Free Call 1800 244 358.
Residential Aged Care Facility Section

Storage

Prior to administration, Portion-pak can be stored at the aged care facility in two ways depending on the size of the facility/section.

1. In a locked medication room
2. In the locked Portion-pak Trolley

In the medication room, the storage trays are stacked on top of each other. The trays slide in and out like a drawer so you can easily access all Portion-pak strips.

Storage trays can be placed in the drawers of the Portion-pak trolley. Two storage trays will fit side by side in each trolley drawer.

During the medication round, the Portion-pak in the administration tray and other non-packed medications, are stored in the medication trolley drawers. Due to the compact nature of Portion-pak, limited storage is required in the medication room.
Medication Round

Preparing for the Medication Round

Nursing staff:

- Remove the appropriate doses for the medication round from the Portion-pak storage tray and place them in the administration tray

- Place other required items such as medication cups, jam etc. in the trolley
- Select the Medication Charts for administration as well as the signing sheet or touchscreen computer for signing
- Check for non-packed, accountable medication or antibiotics to be administered during the round

![Non-packed and other items can be stored in the bottom drawer of the trolley](image)

- Take the trolley on the medication round

**Administering Medication**

The Portion-pak system supports facilities in safe and effective medication management as required in the accreditation outcome 2.7. Refer to Appendix 3: Portion-pak Administration Guidelines for a summary of the following procedures.

**Step 1**
Place administration tray on the top of the trolley for the medication round.

![Portion-pak and Medication Charts/Signing Sheets](image)
Step 2
Identify the resident by name and photograph on the Portion-pak dose, medication chart and/or signing sheet or touchscreen PC.

Step 3
Peel back the Portion-pak lid leaving the resident photo attached to the blister.
Step 4
If required, crush the medication in the Portion-pak blister. To avoid cross contamination, place a medication cup within the Portion-pak blister. Once crushed you can add appropriate mixer to the blister.

Crushing using the Rhino Crush. Medication cup on top of medication avoids contamination.

Mixer can be added into the Portion-pak blister

Step 5
Give the Portion-pak to the resident with a glass of water. Provide assistance where required. If the medication has been crushed, remove the contents from the Portion-pak with a spoon and administer to the resident. Witness the resident swallowing the medication.

Step 6
Record administration on the medication chart, signing sheet or MedSig electronic signing program.

Step 7
Monitor the resident for any adverse reactions to the medication.
**Resident not Present at Medication Round**  
**Nursing staff:**

- Leave the Portion-pak blister in the administration tray
- Continue with the medication round until all residents are completed
- Return to administer the medication to the resident

If the resident is still not present, nursing staff note the reason code on the medication chart or signing sheet and add any information to progress notes if required. Refer to *Appendix 4: Exceptional Circumstances Standard Operating Procedures* for further information.

**Resident Refusing Medications**  
**Nursing staff:**

- Temporarily reseal Portion-pak or place removed medications into a Day Out Clamshell-pak labelled with the residents name and room number
- Place the Day out Clamshell-pak in the trolley drawer
- Continue with the medication round as normal
- Return to the resident and administer from the Day Out Clamshell-pak
- If they again refuse, mark the resident’s medication chart/signing sheet with the appropriate reason code

Refer to *Appendix 4: Exceptional Circumstances Standard Operating Procedures* for further information.

**PRN (‘When Necessary’) Medication**  
**Nursing staff:**

- Locate the PRN medication folders
- Select the required resident’s PRN medication folder
- Identify the resident by name and photograph on the pack and chart/signing sheet/touchscreen PC
- Sign the PRN medication chart/signing sheet/touchscreen PC with date, time, quantity and signature
- Document details and outcomes in the residents progress notes as per facility policy and procedures
Residents off Site/Social Leave

To provide safe and effective medication management for residents who are off site, either on social leave or on a day excursion/outing refer to the facility policy and procedures manual. For a guide to handling off site medication administration refer to Appendix 5: Off Site Medication Administration Standard Operating Procedure.
Communication

It is important that good communication is maintained between the aged care facility and the servicing pharmacy.

Re-ordering Medication
The facility will not need to re-order regular packed medication as this is part of the weekly packing cycle. The pharmacy organises for the regular weekly medication to be delivered at an agreed time each week.

For Non-Packed or PRN Medication, it is important to have a process in place that all staff follow. Staff members at the facility will either:

- Order medication that is running low from the pharmacy through the MedsComm electronic ordering system
- Peel off the double ply re-order label and place it on the green Pharmacy Order Sheet for daily ordering through the pharmacy
- Hand write an order on the Pharmacy order sheet

Medication Changes
Medication changes are common in an Aged Care Facility. Medication changes must be communicated to the pharmacy immediately to ensure pharmacy records can be kept up to date and replacement/additional packs can be organised in a timely fashion. There are a few scenarios in which a medication change may occur.

New Medication
The new medication is supplied in a separate pack(s) containing enough medication to last the remainder of the current weekly cycle. In this scenario there may only be enough packs for the remainder of the week. For example, a weekly cycle starting Monday, a new medication is started Wednesday, only packs from Wednesday to Sunday are supplied i.e. 5 days’ worth.

The Pharmacy will update their information to include the new medication with the next full week’s medication.

This new medication can be labelled “additional” medication or similar to alert nursing staff if required.

When the new order is written on the medication chart by the Doctor, nursing staff will:

1. Communicate the new order to the pharmacy using MedsComm or the Pharmacy Order Sheet
2. Fax/scan to the pharmacy with a copy of the relevant medication chart and prescriptions if required

When the new order is completed via telephone, nursing staff will:

1. Write the medication order onto the medication chart in the Telephone Orders section, recording doctor, medication, dosage and date following facility policies and procedures
2. Communicate the new order to the pharmacy using MedsComm or the Pharmacy Order Sheet
3. Fax/scan to the pharmacy with a copy of the relevant medication chart and prescriptions if required
4. Pharmacist needs to clarify order with Doctor

When the new order is a faxed order, the staff at the aged care facility will:

1. Communicate the new order to the pharmacy using MedsComm or the Pharmacy Order Sheet
2. Fax/scan to the pharmacy with a copy of the faxed medication chart and prescription
3. Attach the signed faxed copies to the medication chart for recording administration

**Dose Changes**

- Dosage Increase: where possible the additional dose of medication is supplied in a separate pack(s) containing enough medication to last until the end of the current weekly cycle.

- Dosage Decrease: the previous pack(s) must be returned to the pharmacy and a new pack supplied with enough medication to last until the end of the current weekly cycle

Nursing staff will communicate dosage changes by:

1. Communicating the new order to the pharmacy using MedsComm or the Pharmacy Order Sheet
2. Fax/scan the pharmacy a copy of the relevant medication chart and prescriptions if required

**Ceased Medication and Dosage Changes**

*When a medication is ceased by the Doctor, the pack(s) must be returned to the pharmacy and a new pack supplied with enough medication to last until the end of the current weekly cycle.*

Nursing staff will communicate ceased medications by:

1. Communicating the ceased medication to the pharmacy using MedsComm or the Pharmacy Order Sheet
2. Faxing to the pharmacy a copy of the relevant medication chart
**Dropped or ‘Lost’ Medication**

Any medication that is accidentally lost or dropped can be replaced by administering last day of the weekly cycle. This allows time for a replacement dose to be provided by the pharmacy in a labelled vial or blister pack. This may be labelled “replacement” medication or similar.

1. Administer the last dose from the pack checking that medication and dosages are correct

2. Notify the pharmacy immediately

3. Pharmacy will supply an additional dose to ensure this later dose will not be missed

Nursing staff should communicate dropped or lost medications to the pharmacy. The pharmacy will always send new medication supplies at least 24 hours before the current supply runs out.
Quality Processes

Quality Assurance
Quality Assurance (QA) audits are carried out regularly and a written report provided for review and action. In particular QA audits address adherence to State and Commonwealth regulations, storage and labelling of drugs, medication administration practices, adherence to these Best Practice guidelines and any other matters specified by the drug committee.

Packaging Material
Packaging material such as blisters and foil are disposable and must not be re-used. Packaging material with resident details must be discarded appropriately in a confidential waste bin.

Medication Advisory Committee (MAC)
The purpose of a MAC is to determine policies and procedures to ensure optimal medication usage. It is important that the supply pharmacist and medication review pharmacist are involved in the Medication Advisory Committee (MAC).

Incident Reports
Incident forms are used to aid the continuous improvement process. This form is ideal for reporting medication incidents, causes and suggested short and long-term corrective action. A quality assurance checklist can be provided by Webstercare, to verify suggested processes are in place, identifying room for improvement. This checklist has an incident report column where the need for corrective action can be identified.

Involvement and response from the servicing pharmacy is an important part in continuous improvement.

Equipment
Both the aged care facility and the servicing pharmacy are responsible for ensuring all equipment and consumables used in the medication administration process are fit for the purpose as supplied by Webstercare.
**Disposal of Drugs**

Any unused, discontinued or out of date medication is removed and disposed of in accordance with State and Commonwealth regulations and in an environmentally safe manner. Medication discontinued for a resident is kept for a short period of time in case it is recommenced (for example, one week) and then disposed of. Medication prescribed and supplied for one resident is NOT to be used for another.

**Deliveries and After Hours Service**

The majority of routine orders are delivered on a weekly basis at a time agreed or at a frequency decided by both parties. Depending on the contract between the pharmacy and the aged care facility, the pharmacy may provide a daily service for urgent items, new items and new residents as well as general stock. Typically an emergency number is available for after hour’s emergencies.

**Emergency Supply**

As Doctors may initiate treatment when the pharmacist is unavailable, a list of emergency items is determined by the prescribing preferences of the visiting doctors in accordance with State and Commonwealth Regulations, and through the Medication Advisory Committee (MAC) of the Aged Care Facility.

A supply of emergency medication is kept, where allowable, in an emergency supply box or similar. Emergency supply medication is to be kept in original manufacturer’s bottles and packs and administered only on the authorisation of a medical practitioner.

Procedures for STAT Medication at the aged care facility:

1. Identify the medication that you require
2. Remove from STAT box
3. Determine what you need to do with the medication (e.g. liquids)
4. If needing only one or two doses of an emergency supply medication (tabs / caps), administer only the doses required until the resident’s pack arrives
5. Return balance of medication to the emergency supply box

When emergency stock is used, the pharmacy must be informed so that it can be replaced. The emergency stock packs carry the re-order label and are labelled ‘emergency supply’ or as stock.
**Education**

In-service education should be provided to all staff on implementation of the system. The pharmacist accompanies the nursing staff on the initial medication rounds to support staff becoming familiar with the systems and procedures. Regular in-service is provided to staff on the policies and procedures involved in the smooth operation of the system.

General pharmaceutical education is provided on a regular basis and the Webstercare Continuing Education Newsletter is provided monthly to all nursing staff. The Webstercare website ([www.webstercare.com.au](http://www.webstercare.com.au)) holds a library of past continuing education documents distributed over several years.
Appendices

Appendix 1: Aged Care Standards and Accreditation Agency - Expected Outcome 2.7 Medication Management

2.7 Medication management concerns the way homes ensure that the medication needs of residents are managed safely and correctly. Residential aged care homes need to be able to demonstrate that their medication management system is safe, according to relevant legislation, regulatory requirements and professional standards and guidelines.

A key process most often identified as deficient in this expected outcome is the monitoring of staff practices to ensure they comply with established procedures. General Manager Accreditation Victoria Crawford said, “The strong relationship identified between the monitoring of staff practices and deficiencies in medication management suggests that adequate monitoring of staff practices and providing adequate training may prevent or minimise deficiencies in this area.

“In addition to errors in the administration of medication by staff, these deficiencies include incorrect storage of medication, and the reporting and documentation of medication errors.”

Medication administration by staff was another area of significant concern highlighted as part of the review.

“Administration of medication involves ensuring residents receive the correct medication, in the correct dose through the correct route and at the correct time,” said Victoria. “Homes need to ensure that the staff administering the medication have the required qualifications, skills and knowledge to undertake this role in a safe and correct manner.”

The ordering and recording of medications was also a key process found to be deficient where homes were found to be non-compliant. Problems in this area include out-of-date orders, orders that are not legible, signed and dated or orders that do not clearly stipulate dosage and time of administration.

“Regular evaluation and review of residents’ medication needs and preferences and of the homes’ overall medication management system should assist homes to identify and rectify these deficiencies,” said Victoria.

Factors which homes can consider to improve their medication practices include:

- How are staff practices developed and monitored to ensure understanding and compliance with processes and procedures? For example,

are quality assurance audits conducted and reviewed, and does supervision of staff occur including in relation to the use of assessment tools, equipment, and methods of managing medication?

- How does the home ensure regular evaluation and review of residents' medication needs and preferences as undertaken by a pharmacist or medical officer? For example, does this include consideration of:

  • allergies
  • each resident’s cognitive ability
  • each resident’s pain management needs
  • each resident’s swallowing and other physical abilities
  • medication side effects including polypharmacy effects
  • monitoring of doses which may need to be regularly adjusted (for example, psychotropic medications, warfarin and insulin)?

- Are medication side effects reported to the resident’s medical officer? For example, are staff aware of follow-up actions and protocols as a result of adverse drug reactions and adverse pathology results?

- Do nurse-initiated medications and PRN medications include indications of:

  • reason for administration
  • maximum dosages
  • route of administration and any other administration instructions
  • authorisations by each resident’s doctor?

- Does the home respond to actual or potential adverse drug events; significant adverse drug reactions, and medication errors? For example, how does the home ensure medication incidents are documented, reported and appropriately addressed?

These processes and the others that comprise medication management mainly involve the home ensuring that appropriate procedures are followed and that if ‘things go wrong’ the causes are identified and corrected, and the information used to eliminate or minimise the likelihood of any future malfunctions. Information management and continuous process improvement are thus critical to ensuring that quality in medication management is maintained.
Appendix 2: Portion-pak Pharmacy Packing Procedures

Packing Procedures

1. Using the Medication Management Software (MMS), print the Portion-pak Cold Seal Foils through a laser printer.

2. Lock four Portion-pak platen into place. Select appropriate blister size for each meal time and place empty blister strip into each platen.

3. Load medications into the blisters as per the medication profile printed on the Portion-pak Cold Seal Foils.

4. Peel off the Portion-pak Cold Seal foil strip from the top right hand corner of each column. Align the perforations on the foil with the perforations on the corresponding blister strip and carefully adhere the foil to the blisters.

5. Complete the sealing process by rubbing the palm of your hand across the blisters to maximise contact between the foil and blister. Sign the "tech box" on the last blister of each strip to verify it is packed correctly.

6. Place the Portion-pak strips into the Portion-pak Storage Trays.

7. The Pharmacist checks the strips against the original medication profile/checking sheet with the original packs at hand. The Pharmacist signs the "pharm box" above the "tech box" to confirm the final audit.

8. Place a "Facility ID Insert" at the front of each Storage Tray or meal time ready to be delivered to the Aged Care Facility.
Appendix 3: Portion-pak Administration Guide

Steps for Safe Medication Administration

1. From the storage tray remove the appropriate dose for the medication round for each resident and place it in the administration tray.

2. Place administration tray on the top of the trolley in preparation for the medication round.

3. Identify resident by name and photograph on the Portion-pak dose, medication chart and/or signing sheet.

4. Peel back the Portion-pak lid leaving the resident photo attached to the blister.

5. If required, you can directly crush in the Portion-pak. Once crushed mix with soft food or liquid.

6. Give the Portion-pak to the resident as well as a glass of water. Provide assistance where required. If the medications have been crushed remove the contents from the Portion-pak with a spoon and administer to the resident. Witness the resident swallowing the medication.

7. Record administration on the medication chart, signing sheet or electronic signing program.

8. Monitor the resident for any adverse reactions to the medication.
Appendix 4: Exceptional Circumstances Standard Operating Procedures

Please see over page.
**Purpose**

The aim of this procedure is to provide directions to ensure safe and effective management of medications when exceptional circumstances occur during a routine medication round, such as:

- Resident is temporarily absent during a medication round
- Medication cannot be administered due to unsuitable environment
- Resident chooses not to take the medication
- There are discrepancies between the medication, the medication chart and/or signing sheet
- Medication is withheld as per Doctors instructions

**Policy Statement**

It may not be possible initially to administer all medications during a routine medication round and exceptions will occur; for example, a resident may choose to refuse medications or may be temporarily absent. The aim of this policy is to ensure that when exceptional circumstances occur, resident’s medications are managed safely and effectively.

**Definitions**

- **RACF** - Residential aged care facility
- **DAA** - Dose administration aid
- **PMC** – Primary Medication Chart
- **DOCP** – Day Out Clamshell-Pak
- **Packed medications** – Medications that have been dispensed by a pharmacist, packed into a Webster-pak DAA and labelled for an individual resident
- **Staff member** - RACF staff member who meets the scope guidelines for medication administration.

**Scope**

The provision of safe and effective medication administration for residents during routine medication rounds is undertaken by a Registered Nurse, Endorsed Enrolled Nurse, or Care Worker who has the knowledge, skills and competence to administer medications and is authorised by the facility to undertake such a role.

**Procedure**

It is intended that this policy is customised and used in conjunction with the facilities medication policies and procedures and that administration staff are familiar with relevant policies.

1. Select the pack(s) for the medication round time and place on trolley. The visual colour cue on the Webster-pak should correspond to the correct dose administration time e.g. pink = breakfast. If unsure check against a Folder Colour Code card. Select the Primary Medication Chart (PMC) and signing sheets if not using MedSig electronic signing. Check you have everything you need for administration before starting medication round.
2. Identify the right resident by using resident’s name and colour photograph on the Webster-pak, primary medication chart and signing sheet / electronic signing option. Check the Webster-pak and non-packed medications against the primary medication chart and signing sheet.

If you find any discrepancies, do not administer the medications. Advise your supervisor and they will clarify the medication order. If needed, they will contact the pharmacy or GP for more information. Administer medications only after discrepancies have been clarified.

3. Check the environment is suitable for the type of medication that is to be administered. Factors to consider are:
   - resident’s right to privacy
   - infection control
   - Specific equipment needed for medication administration

If the environment is not suitable then do not administer the medications. Place a plastic alert card (see below) either next to the Webster-pak or next to the signing sheet. If using MedSig electronic signing use the exception code E (end of round). Continue to the next resident.

4. Check to see if the resident is available and ready to take their medications

If the resident is temporarily unavailable, place a plastic alert card (see above) next to the Webster-pak or next to the medication signing sheet in the medication chart folder. Do not remove medications from the blister at this stage.

If using MedSig electronic signing use the exception code E (administer at end of medication round). Continue to the next resident.

5. After locating resident, verbally confirm their ID and ask if they are ready to take their medications. If the resident chooses not to take their medications at this time, place a plastic alert card (see above) next to the Webster-pak or next to the medication signing sheet in the medication chart folder. Do not remove medications from the blister at this stage.

If using MedSig electronic signing use the exception code E (administer at end of medication round). Continue to the next resident.

6. After confirming the resident is ready to take their medications remove the contents of the Webster-pak using a Pill-Bob or medication cup. Check all tablets / capsules have been removed for
that dosage time and check against the number of tablets in the cup. Check for other medication packs such as antibiotics and non-packed medications.

Administer medications to resident with a glass of water and offer assistance as needed. Witness the resident swallowing the medication. Sign in the right date and dose box on the signing sheets or MedSig electronic signing after administration is complete.

If the resident chooses not to take one or all of their medications after they have been removed from the blister, place the loose medications into the appropriate dose time blister of a Day Out Clamshell-pak (DOCP). The DOCP is colour coded to identify Breakfast, lunch, dinner and bedtime doses. Label the DOCP with the resident’s name and leave on the trolley until the end of the medication round.

7. After administration to each resident, locate each resident with missed medication by using the plastic alert cards. Administer the medications following facility procedure for medication administration. Sign in the right date and dosage box on the signing sheet.

Reapproach residents who have previously chosen not to take their medications. If the resident chooses not to take these medications at the end of the medication round, dispose of the medication/s appropriately following facility policies. Use the appropriate exception code as needed e.g. R for refused, in the right date and dosage time box on the signing sheet and document in progress notes according to facility policies.

Related Documents
- Medication administration policy
- Disposal of medication policy
- High risk medication policy
- Off site medication administration policy

Legislation
- Aged Care Act 1997
- Quality of Care Principles 1997, Schedule 2: Accreditation Standards
- User Rights Principles: Schedule 1 Charter of residents’ rights and responsibilities

References
- APAC Guidelines for Medication Management in Residential Aged Care Facilities
- Webstercare Best Practice Policies and Procedures
Appendix 5: Off Site Medication Administration Standard Operating Procedure

Please see over page.
Standard Operating Policy and Procedure:  
**Off Site Medication Administration**

**Purpose**

To provide direction for the provision of safe and effective management of medication for residents who are off site, either on social leave or on a day excursion/outing.

**Policy Statement**

All residents who are off site for a medication dosage time/s are provided with their medication/s to support ongoing optimal drug therapy.

**Definitions**

- RACF - Residential Aged Care Facility
- DAA – Dose Administration Aid
- DOCP - Day Out Clamshell-Pak
- Packed medications – medications that have been dispensed by a pharmacist into a Webster-pak DAA and labelled for an individual resident.

**Scope**

The provision of safe and effective medication administration for residents that are off site is undertaken by a Registered Nurse, Enrolled Nurse or Care Worker who has the knowledge, skills and competence to administer medications and authorised by the facility to undertake such a role.

**Procedure**

1. Determine who the medications will be provided to e.g. resident or their representative. Factors to consider include:
   - Resident’s rights
   - Resident’s cognitive ability
   - Resident’s physical ability
   - Resident currently self administering

   If the resident is not currently self administering confirm the willingness of their representative to take responsibility for medication administration.

2. Determine the number of medication dosage times that the resident will be off site.

3. Confirm the right resident is selected
   - Select the right medication chart
   - Cross check the resident medication chart with the Webster-pak
     - Confirm resident identity using the photo and demographic details on both the medication chart and the Webster-pak

4. Determine the types of medications that the resident will need during their absence from the RACF e.g. packed, unpacked medications such as eye drops, ointments, creams, inhalants, insulin, patches, injection etc
5. Identify the most suitable tool/s to be used to ensure the appropriate administration of packed medications. Consider factors such as:
   - Need for medications to be secure
   - Need for easy to open pack
   - Need for easily portable and/or compact pack and maintain integrity of medications
   - Easy to determine which medications are to be taken and at which time/s of the day
   - Whether the Webster-pak DAA has the capacity to remove one or more administration compartments e.g. Webster-pak Flexi-pak (Multi dose)

6. Resident Off Site for less than 24 hours (see flowchart below)

Select the correct resident Webster-pak/s for the dosage times that the resident will be off site. Check also for other Webster-paks e.g. antibiotics, warfarin, Schedule 8, cytotoxics etc and non-packed medications.

Collect a Webstercare Day Out Clamshell-pak. The DOCP is colour coded to identify breakfast, lunch, dinner and bedtime doses and contains enough medication for one day. It negates the need for the resident to take their whole Webster-pak with them and provides a secure way of storing medication.

Using the DOCP, the resident can take the medication dosage times they need and leave the remainder of the medication securely within their Webster-pak.

When using a DOCP it is essential that a resident identification label or the resident’s name and phone number be written on the box. It is important that the medications ordered are NOT transcribed on to the DOCP.

Once the DOCP is labelled correctly, confirm the right resident’s medication chart and Webster-pak/s has been selected. Confirm that the medications to be placed into the DOCP are as prescribed. Remove the medications from the Webster-pak DAA and place them into the corresponding colour coded sections of the DOCP. For example, the lunch time medications into the yellow DOCP compartment.

**Non Packed**

All non-packed medications should be provided to the resident / representative in a sealed bag/container. Each non-packed item should be checked to confirm that they have the pharmacy dispensing label which includes the resident name, drug, strength and route of administration.

Once medications are removed from the Webster-pak and placed in DOCP and non packed medications prepared, enter the O code for Outing (Medication with Resident) or L for Social Leave, for each medication on the medication signing sheet or in MedSig.
Flowchart: Resident Off Site for less than 24 hours

• Determine who the medications will be provided to

• Identify the number of medication dosage times that the resident will be off site

• Confirm the right resident by selecting the right medication chart, Webster-paks and non-packed items

• Select and label the DOCP with resident name and contact number

• Remove the medications from the Webster-pak and place in the DOCP

• Place non-packed items in sealed bag/container

• Document an O or L code on medication signing sheet or MedSig

• Provide an explanation to resident / representative

• Provide resident / representative with a copy of the current medication chart

• Document in progress notes

• Document outcome upon return
7. Resident Off Site for more than 24 Hours (see flowchart below)

Select the correct resident Webster-paks/s for the dosage times that the resident will be off site. Check also for other Webster-paks e.g. antibiotics, warfarin, Schedule 8, cytotoxics etc.

Medications are to remain in the Webster-pak DAA.

In instances where the resident will be away for a period longer than the Webster-pak DAA provides contact the supply pharmacist to arrange for the required dosages to be provided in a Webster-pak suitable to the needs of the resident and/or their representative e.g. Multi Dose Webster-pak. The pharmacist should be contacted at least 48 hours prior.

Non Packed
All non-packed medications should be provided to the resident / representative in a sealed bag/container. Each non-packed item should be checked to confirm that they have the pharmacy dispensing label which includes the resident name, drug, strength and route of administration.

8. Provide an explanation to resident/representative. This should include the following:
   - Correct time, dose and route for all medications that need to be administered, including packed and non packed medications
   - Special requirements for any prescribed medications e.g. take medication ½ hour prior to meal, place patch on in the AM and remove in the PM
   - What to do in the instance they are uncertain e.g. Call the RACF and speak with the person in-charge or the pharmacy
   - Appropriate storage of packed and non packed medications
   - Correct technique for administration of medications.

9. Provide the resident/representative with a copy of the current medication chart if appropriate.

10. Document the arrangements for administration of medication whilst a resident is off site in the resident’s progress notes. Documentation should include:
    - Who the medications were given to e.g. resident or their representative
    - The types of medications provided e.g. packed, non packed
    - The information that was provided to the resident/representative e.g. storage in a cool dry place, contact the RACF or pharmacy if they are uncertain
    - Dates and/or time that the resident will be off site

On the record of medication administration enter the O code for Outing (Medication with Resident) or L for Social Leave, to indicate that the resident is on leave.

11. Monitoring/Return Onsite
When the resident returns from their outing or social leave confirm that the medication administration occurred by checking the DOCP or Webster-pak DAA. If there is any discrepancy noted in the pack complete an incident form and document in the resident progress notes.
Flowchart: Resident Off Site for more than 24 hours

• Determine who the medications will be provided to

• Identify the number of medication dosage times that the resident will be off site

• Confirm the right resident by selecting the right medication chart, Webster-paks and non-packed items

• Place non-packed items in sealed bag/container

• Document an O or L code on the medication signing sheet or MedSig

• Provide an explanation to resident/representative

• Provide resident/representative with a copy of the current medication chart

• Document in progress notes

• Document outcome upon return
### Legislation

- Aged Care Act 1997
- Quality of Care Principles 1997, Schedule 2: Accreditation Standards
- User Rights Principles: Schedule 1 *Charter of residents' rights and responsibilities*

### References

- APAC Guidelines for Medication Management in Residential Aged Care Facilities