

Medication

POLICY AND PROCEDURE

1.0 Purpose

1.1 To promote accountable administration and/or prompting of medication by care staff. To guide staff regarding safe practices in the handling and administration of all medication types and escalation of incidents.

2.0 Scope

2.1 Community: The Medication Policy and Procedures and associated documents are applicable to all Subee Newlake staff in a community setting.

2.2 Facility: Subee Newlake staff working in a facility must follow the Medication Policy and Procedures of the facility they are working in.

This procedure applies to all care staff and case management employees.

3.0 Responsibility and Authority

3.1 The Chief Financial Officer – Clinical Team Leader is responsible for providing resources to facilitate this policy.

3.2 Service Coordinators and Subee Newlake registered nurses are responsible for enforcement of this policy.

3.3 All staff delivering hands on care to any Subee Newlake client are responsible for knowing and adhering to this policy.

3.4 The Quality Coordinator is responsible for monitoring medication incidents

4.0 Definitions

4.1 Subee Newlake staff - Subee Newlake Support Workers (SW), Registered Nurse (RN) & Enrolled Nurse (EN).

4.2 Medication - Any substance that is supplied by a pharmacist or doctor or dispensed by a pharmacist on the prescription of a doctor or supplied directly by a doctor and has a label attached to it. The term also includes any over the counter medications or natural therapy products, vitamins and supplements. Medications come in many forms and may be ingested, inhaled, injected, inserted and applied

4.3 Over the Counter Medications - Any substance purchased without a prescription.

4.4 Schedule 8 Medications – Substances which have the potential for addiction.

4.5 Schedule 4, Appendix D (S4D) refers to Prescription Only Medicines that don't have sufficient addictiveness or risk of abuse to be classified as S8, but for which a significant addiction/abuse risk exists. As such, S4D drugs are subject to additional prescription and recording requirements over S4

4.6 Blister Pack - A sealed oral medication pack prepared by a pharmacist (Webster Pack).

4.7 Dosette Box Compliance Aid - A box with slots that can be filled with oral medication. It is divided into days and times.

4.8 Oral Medication - Medication only taken by mouth.

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4.9 Non-Oral Medications - Medication taken topically (such as creams), inhalers, metered aerosols, injections, per rectum, per vagina, enterally, ear/eye drops, nebulisers, transdermal medication patches, intravenous, oral medications via Percutaneous Endoscopic Gastroscopy (PEG).

4.10 Administration - Refers to the act of physically giving a medication orally, by injection, by inhalation, per rectum, per vagina, topically or enterally and ensuring that the substance has entered the service user's body.

4.11 Prompting - Refers to assisting service users in taking their medication by either reminding or prompting. This includes staff being able to push the medications directly from a Webster Pack into the service user's hand.

4.12 PRN - Pro re nata is a Latin phrase meaning "in the circumstances" or "as the circumstance arises." It is commonly used in medicine to mean "as needed" or "as required" It is generally abbreviated to p.r.n. in reference to dosage of prescribed medication that is not scheduled. Staff must follow the written authority from the medical practitioner regarding the indications for administering the PRN medication. Such administration of medication is not meant to imply, and should never allow for, exceeding a given daily dosage.

4.13 Care Plan - A document developed in response for a request for service. It is developed by an appropriately skilled professional from the service provider. It outlines the tasks, duties and interventions required to meet the care and service needs of the service user. The care plan guides and directs staff in the day to day delivery of services.

5.0 Safe Medication Handling

Medication can have a significant impact on the wellbeing of the service user. Subee Newlake staff must always contact the office, Case Manager or RN, should there be any doubts about the administration or prompting of medication to their Service User.

If a person does not have the capacity to consent to receiving medication, the person's medical practitioner is required to seek consent from a person responsible.

5.1 Subee Newlake staff must adhere to the following to ensure safe medication handling:

- 5.1.1 The right medication - Subee Newlake staff must ensure the medication is the same medication described on the back of the Webster Pack or on the written confirmation from the medical practitioner
- 5.1.2 The right dose - Staff must ensure that the right dose is given
- 5.1.3 The right service user - Staff must ensure they have the right Service User
- 5.1.4 The right route - Staff must give the medication via the right route
- 5.1.5 The right time - Staff must check the medication chart, the doctors written confirmation and the Webster Pack to ensure that the medication is given at the right time
- 5.1.6 The right documentation - Staff complete relevant medication charts following prompting or administration
- The right to refuse

5.2 If administering (as per legal guidelines), staff must document the service user's health status prior to the

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administration of medication, and the time, dose and route of medication; document any effectiveness or side-effects to the medication given.

5.3 Staff must always check the service user's Care Plan before administering or prompting any medications.

6.0 Prompting Medications

Staff should always follow 'best practice' guidelines as recommended by relevant industry bodies.

6.1 Webster Pack

- 6.1.1 Staff are only to prompt from a prepared Webster Pack.
- 6.1.2 Prompting involves reminding the service user to take their medications or pushing the tablets from the Webster Pack into the service user's hand.

6.2 No Webster Pack

- 6.2.1 If medications are in their original packaging, staff should remind the service user to take their medication, however they cannot push the tablets out of the packaging/container.
- 6.2.2 Staff are not to prompt from a Dosette Box at any time.

6.3 Non Oral Medications – this refers to prompting/reminding service users to take their own non oral medications.

7.0 Administration of Medications

Staff should always follow 'best practice'

guidelines as recommended by relevant industry bodies.

7.1 Oral medications and Webster Packs

- 7.1.1 Staff are able to administer medications from a Webster Pack if there is written confirmation of the service user's medications from the medical practitioner or a copy of the prescription.
- 7.1.2 Administration involves staff pushing tablets out of the Webster Pack and putting the tablets in the service user's mouth and ensuring that the medication has been swallowed.

7.2 Oral suspensions

- 7.2.1 If staff are required to measure a dose and assist with administration of oral liquid medications, then written confirmation is required from the medical practitioner or a copy of the prescription.

7.3 Non-oral medications

- 7.3.1 On all medication packaging, the service user's name, medication name, strength, dose, route, and directions for use must be filled in by the pharmacist. Staff can administer from individually dispensed and labelled containers only if there is written confirmation of the service user's medications from the medical practitioner or a copy of the prescription.

7.4 Intravenous medications and injections must only be administered by RNs.

8.0 Written Confirmation

must have the following details:

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8.1 Date of written confirmation, name and address of Service User, drug allergies, name of medication, dose, times, route, frequency, indication, duration, signature and printed name of medical practitioner

8.2 PRN orders must have additional information on when the medication is required and indicated

8.3 If the medication regime changes, a new written confirmation must be received from the medical practitioner

8.4 If there is no written confirmation or copy of prescription available, then Subee Newlake staff must contact the Service Coordinator or RN to obtain advice.

9.0 Department of Veterans Affairs (DVA)

9.1 Only RNs and EENs are able to administer oral and non-oral medications to DVA Service Users.

10.0 Safe Medication Requirements

10.1 The staff member who removes the medication from the dispensed medication container must also administer the medication, observe the service user swallowing the medications and sign the medication chart at the time of the administration.

10.2 Medication should be left in the container as supplied by the pharmacy. All staff who administer medications are to do so from their original container.

10.3 Partially used medications are not to be placed into another container (even if labeled the same).

10.4 Staff must not leave the service user's medications in a separate container for the service user to administer later.

10.5 Medications supplied in Webster Packs are to remain intact to allow for the correct identification of the drug. Staff must report to the Service Coordinator or RN if any doses have not been taken.

10.6 Staff can only administer medications after completing relevant competencies and assessments.

11.0 Schedule 8 & Schedule 4D Medications

Registered nurses and medication endorsed enrolled nurses administering medications, must follow the requirements of their professional registration *Registered nurse standards for practice* in the administering, recording and storage of S4 and S8 drugs.

11.1 Note that injectable and liquid S8 medications can only be administered by a Registered Nurse. Non injectables and liquid S8 medication should be Webster Packed and administered accordingly.

11.2 Webster Pack

- 11.2.1 Staff are to prompt and/or administer as per above guidelines. Report any discrepancies to the Service Coordinator or RN immediately who will seek further clinical support and/or escalate as required.

11.3 No Webster Pack

- 11.3.1 Staff (RNs) must adhere to the following procedures:

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- 11.3.1.1 Count the medication in stock and compare to S8 Register if applicable
- 11.3.1.2 Check written confirmation order as per usual administration procedure
- 11.3.1.3 Administer S8 medication
- 11.3.1.4 Count the medication in stock and record in S8 Register if applicable
- 11.3.1.5 Monitor for effectiveness and side-effects
- 11.3.1.6 Document in progress report, complete medication chart
- 11.3.1.7 **If there are any discrepancies in the recording or administering of medications, these must be reported to the Clinical Team Leader immediately, or Emergency After Hours, who will seek further clinical support and escalate as required.**

12.0 Psychotropic Medication

Psychotropic medications are any drug capable of effecting the mind, emotions, and behaviour. The main classes of psychotropics prescribed are antidepressants, antipsychotics and anti-convulsant.

If Clients are taking psychotropic medication:

A letter from the prescribing doctor is required with intent for use. **If intent for use is mood stabilising the following is required:**

HCP Clients

If any HCP clients are on psychotropic medication for intent of mood stabilising service coordinators are required to: Document the medication on the F-Psychotropic medication chart and keep record that client medication has medical oversight from prescribing doctor every three months.

For NDIS clients

This medication is considered a chemical restraint if prescribed for mood stabilising. Service Coordinator is required to follow the guidelines under the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.

13.0 Medication Charts

13.1 If a service user has a medication chart, staff should ensure it is accurately completed after administration and/or prompting of medications.

13.2 Webster Pack

- 13.2 Ensure correct date and time is signed for by staff.

13.3 No Webster Packs

- 13.3.1 Ensure that the date, time of administration, signature and designation is recorded on the relevant chart.
- 13.3.2 Each medication must be signed for individually.

14.0 PRN medication

14.1 Refer to written medical order before administering. Staff must complete the medication chart and document the indication for administration in the progress notes.

14.2 Monitor client for effectiveness and any follow-up actions required.

15.0 Over the Counter and Non-Prescribed Medications

15.1 Staff are not to initiate any over-the-counter medications.

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15.2 Service users living in their own homes have the responsibility for choosing and administering their own non-prescription medications.

15.3 Staff cannot administer any non-prescribed medication to any service user unless there is a prior written medical order.

15.4 If staff are providing medication assist with over-the-counter medication, it must be in a webster pack with sign off sheet and doctors recommendations. This includes paracetamol.

16.0 Disposal of unused Medication

The Australian Government has a program in place for the safe disposal of unwanted or expired medicines known as “the National Return and Disposal of Unwanted Medicines Program”.

Through this program, pharmacies collect expired and unwanted medicines. People can return any unwanted medicines to pharmacy for disposal at no cost, this should only occur once consent has been obtained from the client and/or their carer.

If a person dies, their medication should be returned to pharmacy for disposal. This program does not include the return of used sharps.

One off medication missed and left in the webster pack can be disposed of safely down the sink or toilet.

An Incident report would be completed and recorded for missed medication. Refer to the following section Medication Error 17.0

17.0 Adverse Reactions to medication

17.1 Consumer Medicines Information (CMI) sheets are developed by the manufacturer to accompany medications and should be provided by the pharmacist when medications are dispensed. The CMI sheet contains information about the purpose of the medication, things to do or know before commencing treatment, how and when to take the medication, what to do if a dose is missed or taken twice, and the side effects.

If the CMI sheet does not accompany the person’s medications, print a copy from the website (www.mydr.com.au or www.medicines.org.au) and refer to this information when supporting people to take their own medications.

17.2 Side effect or client adverse reaction

Common side effects or reactions to medicines include rashes, wheezing, swelling, difficulty breathing, dizziness, nausea or loss of consciousness.

17.3 Support staff are not expected to have the same knowledge as a registered nurse or doctor. However, if the client is not behaving or reacting in their usual way following taking medicine, staff should treat this as a side effect or adverse reaction to medicine.

17.4 This means that staff immediately follows the organisation’s policies and procedures. As soon as staff suspects that the client is having a side effect or an adverse reaction to medicine, staff must:

- Notify their manager immediately
- Document the nature of reaction e.g. rash, wheezing, swelling, difficulty breathing, dizziness, nausea or loss of consciousness

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- Manager will report reaction to the client's doctor immediately
- Observe client and follow supervisors and doctors' instructions.
- Call an ambulance – 000 - straight away if required
- Call the Poisons Information Centre - 13 11 26 – for 24-hour emergency service and advice
- Record the incident in client's notes
- Complete medication incident report and give to supervisor

18.0 Medication Errors

18.1 All medication errors need to be reported immediately after ensuring the safety of the Service User to the Service Co-ordinator or RN.

18.2 Staff are to monitor the clinical status of the service user and document the incident in the progress notes, if available. An Incident report is to be completed as soon as practicable.

18.3 The Service Co-ordinator or RN will then take the appropriate course of action which will include:

- 18.3.1 informing the Business Owner and Company Director
- 18.3.2 escalating to an appropriate clinical support person
- 18.3.3 informing the medical practitioner (if required)
- 18.3.4 ensuring an Incident Report is completed and submitted on TRACK

17.4 Medication incidents will be recorded in monthly TRACK incident report trend at Management review meeting.

17.5 A corrective Action Plan will be developed and implemented if reports show gaps in service, staff training or client safety.

19.0 Cultural Considerations

Aboriginal and Torres Strait Islander people require support with medication management that is culturally sensitive and empowering. A person centred approach provides that support in the following ways:

- use the person's Communication Profile to learn the best way of communicating information about medication and its management
- understand the person's history and experiences, and difficult relationships, especially with hospitals
- ask how the whole-of-life view (life-death-life) of health relates to medication and its management
- record the name of the proper contact person to discuss medication management and provide consent for treatment
- determine which health issues that require medication are sensitive or taboo, and who to refer to if they are
- confirm whether the person or family would prefer to work through an Aboriginal Liaison Officer

20.0 Useful Resources

Health Direct – 24 hours health advice Ph 1800 022 222

Poison Information Hotline – 24 hours advice Ph: 131126

Adverse Medicines Events (AME) Line 1300 134 237 for reporting or advice on adverse drug reactions

Medicines Line (Australia) 1300 633 424 for information on prescription, over the counter and complementary medicines

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21.0 Relevant Legislation and Quality Standards

- The National Disability Insurance Scheme Rules 2018, Practice Standard 4
- New Aged Care Quality Standards 2 & 3.
- NSW Poisons and Therapeutic Goods Act 1966
- Australian Community Industry Standard (ACIS) 2018
- Aboriginal Policy Statement (the Statement)

22.0 Related and Support Documentation

Clinical Governance Policy

Clients Rights and Responsibility

Infection Control Policy

Needlestick & Sharps Policy

Waste Management Policy

Incident Report Policy

Risk Management Policy

F-CA-037 Medication Administration F-CA-037

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