The Derbyshire Policy for Informal Carer's Administration of As Required Subcutaneous Injections in Community Palliative Care

Reference Number	**Version:** 2.5		**Status** **FINAL**	**Author: Dr Mary Lewis** **Job Title** Palliative Medicine Consultant, UHDB
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	V1	20/8/17	Dr M. Lewis	New policy developed
	V2	4/5/18	Dr M Lewis	North Derbyshire Integrated
	V2.1	14/6/18	Dr M Lewis	DCHS changes integrated
	V2.2	28/9/18	Dr M Lewis Jonjo Heneghan Dr S Parnacott	Ashgate Hospice changes integrated and training update. Nursing procedures added
	V2.3	1/4/19	Dr M Lewis Jonjo Heneghan Dr S Parnacott	References to NMC standards of medicine management withdrawn. Replaced by guidance from Royal Pharmaceutical Society: 'Professional Guidance on the Administration of Medicines in Healthcare Settings' and NMC Delegation and accountability supplementary information.
	V2.3	Jan 2021	Dr M Lewis Dr S Parnacott	Reviewed and agreed no changes

	V2.4	Dec 2022	Dr M Lewis Dr S Parnacott	Notification list reviewed and updated Remove diamorphine (draw up powdered drugs) Re format some appendices Remove audit sheet and ask for all stock sheets to be returned to CPCT CNS for local audit Formalise within the policy need for second set of anticipatory meds Write into policy process for adjusting SC doses when SD changed Integrate advice regarding safeguarding and mental capacity assessment for patient. After discussion with Mary Driver, DCHS. role: clinical assessor, quality always. Remove supply of labelled boxes as they have not been utilised by carers
	V2.5	Jan 2023	Jonjo Heneghan	Nursing procedures updated

Intended Recipients:

This policy provides guidance to:

Royal Derby Hospital, Derby

Ashgate Hospice, Chesterfield

Chesterfield Royal Hospital, Chesterfield

Derbyshire Community Health Services NHS Foundation Trust, DCHS

DHU Healthcare

Treetops Hospice, Risley

Blythe House

East Midlands Ambulance Service, EMAS

Marie Curie

Derbyshire CCG's

Development Meetings:

July 2017 NMU presentation

October 2017 CPCT presentation

January 2018 NMU nurses group

24.11.17 Pain and symptom management group, Toll Bar House, Ilkeston

2.3.18 Bola Owolabi and Anna Braithwaite, DCHS teleconference

11.4.18 Pain and Symptom Management Group, Toll bar House, Ilkeston

4.5.18 Meeting with Ashgate Hospice leads. Dr Parnacott, Dr Brooks, Clare Blakey

7.6.18 End of Life Committee, Royal Derby Hospital, Dr Swanwick, Gill Ogden, Karen Bussooa, Jane Moreland

13.6.18 Jo Hunter, Adelle Clements, Walton Hospital, Chesterfield, DCHS

21.6.18 JUC Derbyshire End of Life Workstream presentation – Babington Hospital

19.7.2018 – Stakeholder map shared with JUC Derbyshire Workstream membership

16.8.2018 – Policy development update shared with JUC Derbyshire Workstream membership by Dr Maelie Swanwick

20.9.2018 - Policy development update shared with JUC Derbyshire Workstream membership by Dr Mary Lewis

24.9.2018 – Authorisation received by email from Kay Howard, Macmillan CNS, Lincolnshire Community Health Trust for the Derbyshire policy to be based upon Lincolnshire's policy.

August 2018, September 2018 Royal Derby SPC nurses group

October 2018 Care Unit Governance Chesterfield Royal Hospital approval

8.11.18 Clinical and Professional Reference Group, Joined Up Care Derbyshire

13.11.18 CPCT team RDH approval

22.11.18 Palliative Medicine CMG ratification at RDH (followed by clinical and divisional governance)

December 2018 South Derbyshire leaflet agreement from RDH readers group

8.1.19 DHU Healthcare, Pride Park, Derby

31.1.19 Stakeholder meeting at Babbington Hospital, Belper

6.11.19 Final agreement at Ashgate Hospicecare

21.2.19 Quality Review Group approval at Royal Derby Hospital UHDBFT

22.3.19 Final Approval Given for use at Chesterfield Royal Hospital Foundation Trust

21.5.19 Trust Inclusion Group at Royal Derby Hospital UHDBFT

5.6.19 General manager Rob Bridges UHDBFT – deaf and language interpreter services

6.6.19 Derby and Derbyshire Local Medical Committee approved

June 2019 Submitted to DCHS and DHU for standard operating procedure development

1.10.19 Final Agreement at Trust Operational Group, UHDBFT

Development of version 2.4

16.12.2022 Developed 'safeguarding and capacity assessment of the patient' with advice from Mary Driver, Clinical Assessor Quality Always, DCHS

Training and Dissemination:

Coroner sent a copy of the policy with cover note by RDH legal team

Training within specialist palliative care teams

Dissemination: please contact specialist palliative care within Derbyshire.

Available on the Derbyshire End Of Life Toolkit

To be read in conjunction with:

UHDBFT Policies

- Safeguarding Adults: Trust Policy and Procedure
- Inoculation Incidents Management: Trust Policy and Procedure

  (Includes needle sticks, sharp instruments, splashes, bites or scratches)
- Consent and the Mental Capacity Act (Lawful Authority for Providing Examination, Care or Treatment) - Trust Policy and Procedures

Chesterfield Royal Hospital policies

- Safeguarding adults policy, organisational policy 2.16
- Mental Capacity Act Policy organisational policy 1.24
- Medicines Management Policy
- Consent to Examination or Treatment Policy, Clinical practice policy 2.40
- The Safe Use and Disposal of Sharps, Infection Prevention and Control policy 1.4
- Contamination with Blood or Body Fluids Following SHARPS Injury or other Significant Exposure, Infection Prevention and Control policy 1.5

Ashgate Hospicecare policies

- Safeguarding Children & Adults Policy
- Mental Capacity Policy
- Consent Policy
- CRH linked policies 1.4 and 1.5 (above)

DCHS Policies

- Safeguarding Adults Policy
- Prevention and Management of Sharps Injuries and Contamination Incidents Policy
- Mental Capacity Act Policy
- Procedure for the Disposal of unwanted patient's medicines in the community setting (patient's own home)

In consultation with:

University Hospitals of Derby and Burton

Community Palliative Care Team October 2017 through to November 2018

Nightingale Macmillan Senior Nursing Team 6th Nov 2017

Palliative Medicine Clinical Management Group Jan 2018 and November 2018

End of Life Committee October 2018

Clive Newman, Chief Pharmacist & Accountable Officer for Controlled Drugs, February 2019

DCHS

Dr Bola Owolabi, Deputy Medical Director, Derbyshire Community Health Services (DCHS) NHS Foundation Trust

Jo Hunter, Deputy Nursing Director, DCHS

Specialist Palliative Care, North Derbyshire

Dr Sarah Parnacott, Medical Director, Ashgate Hospice, Chesterfield, North Derbyshire

Dr David Brooks, Chesterfield Royal Hospital, Chesterfield, North Derbyshire

Southern Derbyshire Clinical Commissioning Group EOLC Lead

Steph Austin Head of Clinical Quality (End of Life) NHS Southern Derbyshire Clinical Commissioning

Group 1st meeting 24.11.17 University of Derby Sharan Watson, Post Registration Lecturer Palliative care; Therapeutics & Prescribing Practice; University of Derby 09.02.18 Derbyshire Alliance Sharan Watson, Chair of Derbyshire Alliance 8.11.18 Joined Up Care Derbyshire Dr Avi Bhattia JUCD clinical lead and chair, Derbyshire CCG's DHU Healthcare Dr Ian Matthews, Dr Aquib Bhatti, Tracy Steadman, Paul Tilson, Jenny Doxey, Jenny Tilson Derby and Derbyshire Local Medical Committee Ltd. Dr Kath Markus (Chair)	
EIRA Discussed at Inclusion Group on 21st May Discussion outcomes taken back to Inclusion Group	
Procedural Documentation Review Group Assurance and Date	Quality Review Group Assurance on 21st February 2019. Comments incorporated.
Approving Body and Date Approved	Trust Delivery Group
Date of Issue	October 2023
Review Date and Frequency	October 2024, every 1yr thereafter for the first 5 years
Contact for Review	Dr Mary Lewis
Executive Lead Signature	 Executive Medical Director

THE DERBYSHIRE POLICY FOR INFORMAL CARER ADMINISTRATION OF AS REQUIRED SUBCUTANEOUS INJECTIONS IN COMMUNITY PALLIATIVE CARE

1. Introduction

A small number of dying patients' relatives request permission to administer subcutaneous medication at home to enable symptom control. UK statutory law supports this practice within a safe governance structure. Without a policy, health professionals have found it difficult to support carers in Derbyshire with this.

Palliative care services strive to support patients to live and to die within a setting of their choice, with optimal symptom control and with a pattern of care that is also supportive of the carers (East Midlands Cancer Network 2012). National documents recognise the importance of effective symptom control in achieving the patient's preferred place of death (Department of Health 2008).

The input of informal carers is often fundamental for in achieving a patient's choice to be cared for and die at home. Informal carers enhance the likelihood of patients remaining symptomatically well managed at home, and there are times when they may request to administer subcutaneous medication. (East Midlands Cancer Network 2012).

Within the UK and internationally, carer administration of subcutaneous drugs is promoted (Lee and Headland 2003, Bradford and Airedale PCT 2006, Twycross and Wilcox 2011, Healy et al, Caring Safely at Home Project Brisbane 2009). Education and resources are needed to manage this confidently. (East Midlands Cancer Network 2012).

UK Government statutory law, 2001 'The mis-use of drugs regulations' legislates for the administration of controlled drugs states "Any person other than a doctor or dentist may administer to a patient, in accordance with the directions of a doctor or dentist, any drug specified in schedule 2,3 or 4"

NHS National Prescribing Centre (which became part of NICE in 2011) stated, in 2009, 'A carer/relative can, with consent, administer a controlled drug that has been individually prescribed for a third party.' A recent NICE update 'NG 46 Controlled drugs. Safe use and management' endorse this guidance. (April 2016)

Importantly, there is no differentiation between routes of administration in legislation.

The Royal Pharmaceutical Society (RPS) and the NMC (Delegation and Accountability: Supplementary Information to the NMC Code) both issue guidance regarding delegation of administering medication.

The RPS states that:

1. 'Organisational policies define who can administer medicines, or when appropriate delegate the administration of medicines, within a particular setting.

2. Registered healthcare professionals who administer medicines, or when appropriate delegate the administration of medicines, are accountable for their actions, non-actions and omissions, and exercise professionalism and professional judgement at all times.'

The NMC states an expectation that people on the NMC register:

• only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand the instructions.

• make sure that everyone they delegate tasks to are adequately supervised and supported so they can provide safe and compassionate care.

• confirm that the outcome of any task delegated to someone else meets the required standard.

For the purposes of the Derbyshire policy:

Accountability lies with the specialist palliative care multi- disciplinary team.

This policy is based on the Lincolnshire policy for informal carer administration of as required subcutaneous injections in community palliative care, with permission.

The policy is only applicable to those patients who are registered with a Derbyshire GP. The carer may be registered with a GP in another county.

The policy only supports carers to give subcutaneous medication in the community. If the patient is admitted to hospital, the trained informal carer must not continue to administer medication within the hospital environment.

2. Purpose and Outcomes

2.1 This policy is developed specifically to support informal carers who request training to provide subcutaneous anticipatory medication at home to patients with palliative needs.

The **purpose** of the policy is to ensure:

- There is a robust method to assess the suitability of the informal carer in terms of emotional, physical and psychological resilience.
- There is a comprehensive, appropriate and accessible training programme.
- There is clarity on prescribing and dispensing of medication for the use of the informal carer.
- There is a structure to document a record of training, outcomes and audit.

- There is dissemination of information across stakeholders in the community.
- There are safeguards in place for the carer should the informal carer wish to access more support or stop giving subcutaneous injections.
- There are safeguards in place for the patient who has lost capacity to consent
- There is bereavement support in place.

2.2 The **Expected outcomes** of the policy are:

- A procedure for health care professionals, carers and patients in the administration of an agreed medication via a subcutaneous injection line or subcutaneous injection.
- Facilitate effective symptom control, patient choice, carer involvement and preferred place of care. This will be delivered within a safe and supportive environment.
- A registered nurse will be responsible for ensuring this procedure is conducted safely with reviews and monitoring at least weekly.
- A registered nurse will ensure that the carer who will administer the injection has been taught using a step-by-step training procedure.
- The small number of carers who request to give subcutaneous medications in the home will be formally assessed and supported. This is in line with national guidance.
- Uptake of the policy will be audited annually.

3. Definitions and Abbreviations Used

3.1 'A patient with palliative care needs'

For this policy the patient must be known to have an advanced, progressive, life shortening diagnosis and is believed to be in the last months of life.

3.2 'Carer'

'Carer' refers to an informal carer e.g. a friend or relative of a patient with palliative care needs in the community. In this case the carer is not employed by an organisation to provide formal care to the patient.

Though the carer may have current or previous registration and licence to practice with the GMC or NMC the policy is to support them giving subcutaneous medication in their role as friend or relative.

3.3 'CPCT CNS'

The Community Palliative Care Team Clinical Nurse Specialist is a band 7 nurse working solely within specialist palliative care services within Derbyshire.

3.4 'Inpatient Specialist Palliative Care Unit'

- Nightingale Macmillan Unit (Derby)

  The Nightingale Macmillan Unit is a 21 bedded specialist palliative care inpatient ward at Royal Derby Hospital staffed by professionals trained in specialist palliative care.

- Ashgate Hospice (Chesterfield)

  Ashgate Hospice is an inpatient specialist palliative care unit in Chesterfield staffed by professionals trained in specialist palliative care.

3.5 'DN' District Nurse

The Derby Community Health Service District Nurses are employed by Derbyshire Community Health Service (DCHS). The service functions between 8am and 6.30pm.

3.6 'Out of Hours Nurses'

Out of hours nurses are employed by Derbyshire Health United (DHU). The service functions between 6.30pm and 8am

3.7 'Assessing professional'

For this policy the carer will be assessed by either a CPCT CNS or specialist palliative care unit doctor (consultant or associate specialist) before being discussed with the patient's GP, and the specialist palliative care MDT.

3.8 'Training nurse'

The nurse training the carer is either a CPCT CNS or an inpatient specialist palliative care unit staff nurse, with the appropriate skill and training as agreed by the specialist palliative care team.

3.9 DCHS SOP

Derbyshire Community Health Services NHS Foundation Trust Standard Operating Procedure.

3.10 SPC

Specialist Palliative Care

3.11 MDT- Multi disciplinary team.

This refers to a team of professionals that are providing care to the patient.

This policy refers to specific multi-disciplinary teams, either the community MDT or inpatient SPC MDT.

4. Key Responsibilities/Duties

4.1 It is the responsibility of the CPCT clinical nurse specialists and inpatient specialist palliative care unit clinical staff to be familiar with this policy and procedure.

4.3 Registered nurses are responsible for recognising any limitations in their knowledge and competence and declining any duties they do not feel able to perform in a skilled and safe manner (NMC: The Code – Professional standards of practice and behaviour for Nurses and Midwives 2015).

4.4 If the patient is on a ward in the acute hospitals (Royal Derby Hospital (RDH) or Chesterfield Royal Hospital (CRH), when the carer requests training to administer the subcutaneous injection the patient will be seen by a hospital palliative care team (HPCT).

In RDH the patient will be transferred to the inpatient specialist palliative care unit (NMU) for assessment, consultation with GP and, if agreed, training.

At CRH if it is not possible to transfer the patient to Ashgate Hospice for reasons agreed by the specialist palliative care team, the specialist palliative care consultant can assess the patient and liaise with the GP and DN prior to discussing with CPCT colleagues. The training will need to be delivered by either the SPC consultant or HPCT. The consultant will take responsibility for informing the community that the carer has been trained to give subcutaneous medication.

If the patient is an inpatient within the specialist palliative care unit when the carer requests training to administer the subcutaneous injection the patient and carer will be assessed by the unit staff and discussed with the GP and DN team.

If the patient is in the community when the carer requests training to administer the subcutaneous injection, the patient and carer will be assessed by the CPCT nurse and discussed with the GP, DN and CPCT multidisciplinary professionals.

4.5 The GP must be included at all stages and be part of the multidisciplinary decision.

4.6 Out of hours advice will be available 24hrs a day, 7 days a week, for professionals and carers when using this policy. Specific contact information will be provided to the carer dependent on whether the patient is under the care of a North Derbyshire or South Derbyshire GP (appendix).

4.7 Each patient will have a named palliative medicine consultant who will be available for advice and discussion from any member of the healthcare team looking after the patient and supporting the informal carer. During leave they will ensure effective handover of clinical information to a consultant colleague.

5 **Risk Management**

5.1 Carer choice

The assessing nurse or doctor must ascertain that the informal carer has not been put under pressure by a professional, relative or patient to administer injections.

A patient cannot demand a level of care from relatives that those relatives do not feel able to provide (Randall and Downie 1996).

If more than one informal carer requests the training to give the same patient subcutaneous drugs then each informal carer must be assessed as a separate individual and trained equally to the expected standards.

Members of the palliative care team, hospital or community professionals must not knowingly place the informal carer in a situation whereby a patient may ask the carer to end their life by using a subcutaneous injection meant to manage symptoms.

A risk assessment SystmOne/EMIS template will be completed by the assessing nurse or consultant for each carer being considered for assessment to administer injections. (Appendix)

A training checklist will be completed by the assessing nurse or consultant (Appendix)

The carer's consent will be sought to enable a member of the MDT to approach the carer's GP. This is to ensure the carer's physical or mental health will not impact on their ability to give subcutaneous medication to the patient.

5.2 Carer Support

It must be made clear from the outset to the patient (if feasible) and informal carer that they are able to discontinue this procedure at any time, should they wish to.

Before every dose of subcutaneous medication given (in and out of working hours) the informal carer will be required to inform and discuss this with the specialist palliative care team. Phone numbers and instructions are supplied on the appropriate information leaflet and discussed with the carer during training. (Appendix)

Out of hours support is provided from each inpatient unit. If there is not a timely reply from the out of hours advice line, carers are advised to phone Royal Derby Hospital Switchboard or Ashgate Hospice and ask for the palliative medicine consultant on call.

After the phone call, if a subcutaneous injection is agreed as the best action, the following options are available:

- The carer phones the specialist palliative care team to report the effectiveness of the drug and discuss.
- The specialist palliative care nurse requests a DN visit to the patient.
- The carer requests a DN visit.
- None of the above if the carer feels the drug has worked well and both patient and carer plan to rest/sleep.
- If the patient is not having routine daily calls from the DN's (e.g. syringe driver changes) the carer needs to request a routine visit to align the stock balance sheets as a minimum level of support.

Every time an injection is given the circumstances will be different. The patient must be visited/contacted by the District Nurse, GP or CPCT nurse within 24hrs of the carer giving a subcutaneous injection. This facilitates support; including a review of the patient and a review of other prescribed medication e.g. syringe driver doses or other anticipatory medications. Specific needs will be assessed and discussed for each individual patient and carer.

Consideration should also be given to the bereavement process and how professionals will support an informal carer should they be involved in symptom management in relation to death after giving the "last injection". Planned bereavement support will be provided.

5.3 Medicine management

The prescriber and multi-disciplinary team must decide:

- The appropriate drugs to prescribe for the carer to administer.
- The dose, frequency and maximum number of doses per 24hrs.

In order to reduce risk, easy dosing (e.g. using full vials/ easy drawing up of part vials) should be considered and this may guide drug choices/ vial sizes. Part used vials will be disposed of. There will be no storage of open glass vials in the home.

Medication agreed for carer administration will be documented on the 'Carer's Instruction to Administer Medication' chart. (Appendix 6)

Medication agreed for carer administration will be prescribed by the GP as a second set of anticipatory medication. This stock balance will be documented and reflected on the carer's stock balance sheet. (Appendix)

All anticipatory medication administered by health professionals will be recorded on a standard DCHS administration/stock balance sheet.

All syringe driver medication stock will be recorded on a standard DCHS administration/stock balance sheet.

All patients will be provided with a sharps box, drawing up needles, syringes, water for injection and Saf-T-Intima subcutaneous needle and dressing. The specialist palliative care team will provide the initial pack containing this equipment.

If the carer is a health professional with prescribing authority, i.e. doctor or non-medical prescriber, they will not be supported to both prescribe and administer the same drug by this policy.

5.4 Communication

Once the carer has been trained the trainer will notify CPCT and the advice line in the South.

The assessment and training documents will be uploaded to systemone/EMIS. Copies will be kept in the home and in the medical notes.

The notification (appendix) informs the health community that the carer has been assessed and trained to give subcutaneous medication by the palliative care multidisciplinary team in conjunction with the patient and carer's GP

To ensure high quality information is available to DHU healthcare the patient should have a Derbyshire Health and Social Summary Care Record completed to a high standard.

The Summary Care Record must state that:

1. The carer (insert name and relationship to the patient) has been trained to give subcutaneous drugs.

2. That in the event of the carer calling 111 about administration of the subcutaneous drugs he/she is trained to give, the carer should be redirected to specialist palliative care, using the numbers provided by specialist palliative care.

To ensure that the wider healthcare community can access the policy a copy of the policy is available to view on the Derbyshire End Of Life Care Toolkit, https://derbyshire.eolcare.uk. This is also stated in the letter.

5.5 Incident reporting

Should a drug error occur and either the informal carer's competency is in question, or the carer's intentions are in doubt, then the right for the carer to administer medication must be revoked immediately and the reasons why explained to the patient and carer.

All adverse incidents and significant untoward events are to be reported back to the organisation that provided the training i.e. NMU, Ashgate Hospice or Chesterfield Royal Hospital.

The specialist palliative care team that provided the training will follow their local reporting requirements (e.g. Datix) to document details of the incident. They will communicate details to all involved in the patient's care at the earliest opportunity. These incidents will also be shared with 'Heads of Safety' at all involved organisations for further learning.

A Central Thematic Review of all incident reports across Derbyshire will be undertaken by The Nightingale Macmillan Unit palliative medicine consultant annually.

This will be reported to the Derbyshire STP end of life group, Acute Trusts end of life Groups and SPC departmental audit meetings by the specialist palliative care team to facilitate on-going learning.

5.6 Audit of carer experience

All carers will be asked for feedback on their experience.

The stock charts will be collected to audit drugs given against calls to the specialist palliative care team to discuss drug choice before administration.

These will be sent to the SPC consultant in North or South Derbyshire for collation. This data will be presented annually to Derbyshire STP end of life group, Acute Trusts end of life Groups and SPC departmental audit meetings

5.7 Needle Stick Policy

The risk of a needle-stick injury is negligible. The drug is drawn up with a blunt needle away from the bedside. The needle is disposed of prior to approaching the patient.

The drug is not dispensed using a needle. The subcutaneous line will already have been inserted by a nurse caring for the patient.

If a needle-stick injury occurs, it must be reported back to the training nurse to enable a discussion around technique and any further practice needed. Carers will be informed of the steps to take in the event of needle-stick injury. Make it 'bleed, wash it, cover it'. The carer must report to the GP if there are concerns regarding inoculation with infectious disease.

First sharps boxes will be provided by the training trust. The GP will provide any further sharps boxes.

Please refer to local policy for sharps box collection

5.8 Mental Capacity Assessment

Where the patient has capacity to consent to the carer being permitted to administer subcutaneous medication by injection, this will be sought. Where a patient lacks capacity to agree to this procedure, the procedure may still be undertaken if considered to be in the patient's best interest and risk assessment criteria are met. The patient's lack of capacity will be documented with a formal capacity assessment.

Carers will be required to have the mental capacity required to undertake this delegated task.

5.9 Safeguarding

Carers will not be given permission to administer medication by subcutaneous injection if there are any safeguarding concerns.

The specialist palliative care team must assess the capacity of the patient to consent to the carer being trained to give subcutaneous medication.

If the patient has capacity to consent to the carer giving SC medication; the specialist palliative care team must ask the patient if there are any concerns about the carer being trained. This conversation should occur away from the carer if possible.

If the patient has lost capacity to consent to the carer giving SC medication; the specialist palliative care professional acts as the best interest assessor.

5.10 Bereavement

The specialist palliative care service must offer bereavement support, which specifically acknowledges the carer's responsibility in being trained to give subcutaneous medication, and the effect that this process may have had on the carer.

6. Assessment criteria

6.1 Criteria that indicate suitability

- Patients with unpredictable symptoms where 'as needed' injections may be required.
- Patients who may require a single dose of a medication in an anticipated palliative care emergency, for example, a seizure.
- Patient already known to CPCT or agrees to a referral to CPCT on discharge if in specialist palliative care inpatient unit or acute Trust.
- The willingness and capability of the carer to undertake the procedure has been ascertained.
- The carer is over the age of 18 years.

6.2 Criteria that indicate lack of suitability

- This procedure must not be undertaken by any carer with a known history of substance misuse or where there is someone known to misuse substances who has access to the house.
- There are relationship issues or safeguarding concerns between the patient and carer.
- The patient indicates they do not consent to the carer giving subcutaneous medication.
- There is concern that the carer will not be able to cope physically, mentally or emotionally with administering medication by injection.
- There is concern the carer does not have the mental capacity to understand and retain the information given.
- The carer is under 18yrs
- The carer is unwilling to take on the task
- Other methods of administration of medication (for example, oral, transdermal, sublingual) have not been considered.

5. Monitoring Compliance and Effectiveness

Monitoring Requirement :	*At a minimum this needs to be compliance with / performance against the criteria identified at L3 in the NHSLA standards but should also include other key elements of the policy*
Monitoring Method:	1) Each specialist palliative medicine clinician leading on this policy will ensure any updates are taken through the appropriate clinical governance processes within their organisation and that any learning from audit or clinical incidents is shared across the STP through the STP End of Life group 2) A Derbyshire audit will be reported back annually to each organisation's End of Life Care Committee and the local audit meeting.
Report Prepared by:	Dr Mary Lewis Dr Sarah Parnacott
Frequency of Report	Annual

6. References

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Lee, L., Howards, K., Wilkinson, L., Kern, C. and Hall, S. (2016) Developing a policy to empower informal carers to administer subcutaneous medication in community palliative care: a feasibility project. International Journal of Palliative Nursing 22 (8) 369-378

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Randall, F; Downie, RS (1996) Palliative Care Ethics; A Good Companion. Oxford University Press. Oxford 76

Royal Pharmaceutical Society (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings

Palliative Care Formulary (PCF6). 6th Edition (UK). ISBN: 978-0-8571134-8-1. Editors: Robert Twycross, Andrew Wilcock, Paul Howard.

9. Order of Appendices

1. Leaflet: Giving subcutaneous medication at home (different versions for North and South Derbyshire)
2. Risk assessment template for SystmOne/EMIS
3. Audit form
4. Checklist for Palliative Care Nurse to Train Informal Carer to Administer as Required Subcutaneous Medication at Patient's Home.
5. Consent form
6. Carers instruction to administer medication
7. Template to email community agencies
8. Flo chart for policy
9. Carer's Administration/stock balance sheet
10. Carer's information pack
11. Procedure for informal carer to be assessed, trained and perform subcutaneous injection

Essential Contact Details

Palliative Care Specialist Nurse Team

01246 565026

9am to 5pm Monday—Sunday

Inpatient Unit Ashgate Hospicecare

01246 568801

5pm—9am Monday—Sunday

Chesterfield Royal Hospital

01246 277271

Ashgate Hospicecare
Every Person Matters

Chesterfield Royal Hospital NHS
NHS Foundation Trust

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Joined Up Care Derbyshire

Giving subcutaneous medication at home

A guide for families and informal carers in North Derbyshire

Chesterfield Royal Hospital NHS
NHS Foundation Trust

University Hospitals of Derby and Burton
NHS Foundation Trust

Joined Up Care Derbyshire

Can I give the subcutaneous medicines?

You have expressed an interest in giving subcutaneous (SC) medication to a loved one who is at the end of their life and wishes to have care at home.

Subcutaneous medication for symptom control can be kept in vials at home and given any time of day or night by the district nurses (DN) This works well for most patients and ensures shared responsibility in assessing the patient as the DN has the expertise to support carers, consider the wider picture and next steps.

For a few relatives the delay in waiting for a DN is frustrating and they request the ability to give SC medication themselves.

There will be situations where it is not in the carers or patient's best interests for this approach to be supported. In this circumstance the palliative care team will clearly explain this to you and the DN's will provide their usual care.

What happens next?

A multi disciplinary team of health professionals, including your GP, will discuss your situation and what is in the best interests of the patient.

If it is agreed you will be taught how to give SC medication by the palliative care team.

What you will be taught

1. How to use a SC line to deliver injections
2. What the medication(s) are for and how much to give, when to give it and any likely side effects.
3. How to draw up the right amount of drug into a syringe and then give it.
4. How to flush the SC line with 1ml of water to ensure the drug reaches the patient.
5. How to document each injection you give so that each time a health professional visits the regular medication can be reviewed. This may result in fewer injections given
6. How to contact the palliative care team before and/or after each injection for support and reassurance.

Steps involved in giving an injection

1 **Safety and contacting the palliative care team**
2 **Hand washing**
3 **Preparation**
4 **Drawing up medication**
5 **Drawing up a flush**
6 **Preparing the cannula**
7 **Administering medication**
8 **Administering the flush**
9 **Disposing of equipment**
10 **Updating records**

At *any* time you no longer feel you can do these injections please ensure someone knows. They will arrange for a community nurse to take over the role.

Chesterfield Royal Hospital NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation Trust

Joined Up Care Derbyshire

Essential Contact Details

Community Palliative Care Team Secretary
01332 787582
9am to 4pm
Monday—Friday

Outside of these hours (including bank holiday) please contact: -
Nightingale Macmillan Unit Out of Hours Advice Line
01332 786040

In case of difficulty or delay with the numbers above please call:
Royal Derby Hospital
01332 340131
and ask for the Palliative Medicine Consultant On Call

Ashgate Hospicecare
Every Person Matters

Chesterfield Royal Hospital NHS
NHS Foundation Trust

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Joined Up Care Derbyshire

Www.derbyhospitals.nhs.uk
Trust minicom 01332 785566

Giving subcutaneous medication at home

A guide for families and informal carers in South Derbyshire

Chesterfield Royal Hospital NHS
NHS Foundation Trust

University Hospitals of Derby and Burton
NHS Foundation Trust

Joined Up Care Derbyshire

Can I give subcutaneous medicines?

You have expressed an interest in giving subcutaneous (SC) medication to a person who is at the end of their life and wishes to have care at home.

Subcutaneous medication for symptom control can be kept in vials at home and given any time of day or night by the district nurses (DN). This works well for most patients and ensures shared responsibility in assessing the patient as the DN has the expertise to support carers, consider the wider picture and next steps.

For a few relatives the delay in waiting for a DN is frustrating and they request the ability to give SC medication themselves.

There will be situations where it is not in the carer's or patient's best interests for this approach to be supported. In this circumstance the palliative care team will clearly explain this to you and the DN's will provide their usual care.

What happens next?

A multi disciplinary team of health professionals, including your GP, will discuss your situation and what is in the best interests of the patient.

If it is agreed you will be taught how to give SC medication by the palliative care team.

What you will be taught

1. How to use a SC line to deliver injections
2. What the medication(s) are for and how much to give, when to give it and any likely side effects.
3. How to draw up the right amount of drug into a syringe and then give it.
4. How to flush the SC line with 0.5ml of water to ensure the drug reaches the patient.
5. How to document each injection you give so that each time a health professional visits the regular medication can be reviewed. This may result in fewer injections given.
6. How to contact the palliative care team before and/or after each injection for support and reassurance.

Steps involved in giving an injection

1	**Safety and contacting the palliative care team**
2	**Hand washing**
3	**Preparation**
4	**Drawing up medication**
5	**Drawing up a flush**
6	**Preparing the cannula**
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Risk Assessment Template For SystmOne/EMIS

The patient and carer involved in this procedure must undergo a comprehensive assessment led by a senior specialist palliative care nurse or a palliative medicine doctor.

Advice and agreement MUST be sought from the patient's GP.

The decision must be discussed and formally agreed by a specialist palliative care multidisciplinary team before training is given.

- For a community patient this is the **Community Palliative Care Team (CPCT)** led by the palliative medicine consultant with agreement mandatory from the GP and District Nurse teams of the patient and GP of the carer.
- For a hospital/hospice inpatient this is the **Specialist Palliative Care Unit inpatient team** led by an inpatient palliative medicine consultant with agreement mandatory from the GP and CPCT of the patient and GP of the carer.

Separate risk assessments must be undertaken for each carer involved in administration of subcutaneous drugs.
A copy of this assessment must be scanned and attached to the patients SystmOne/EMIS electronic records.

Assessing Risk

There should be none of the following contraindications:

1. Known history of substance misuse in family or visitors to home
2. Known relationship issues or concerns between patient and carer
3. Known safeguarding issues
4. Patient does not agree (if has capacity) to carer undertaking this procedure

All of the following must be answered yes before the procedure can be used

1. Have alternative routes of administration been considered?
2. Carer is willing to undertake task
3. Carer is over the age of 18 years
4. Carer has mental capacity
5. Carer is deemed physically, mentally and emotionally capable of the task by MDT.
6. Carer's GP expresses no concern about the carer taking on this responsibility.
7. Patient has agreed to procedure or best interest assessment has occurred

MDT agrees that carer can be trained yes / no

Signed by MDT lead:

Location of MDT:

Date of MDT:

Checklist for Palliative Care Nurse to Train Informal Carer to Administer as Required Subcutaneous Medication at Patient's Home.

Patient Name

Address

DOB

NHS number

Date of checklist completion:

Diagnosis:

Drug Allergies:

Name and designation of palliative care nurse and/or doctor providing training:

Name:	Designation:
Name:	Designation:

Name of informal carer receiving training and support:

Name:

INSTRUCTION	Date completed	Signature
Agreement to proceed with training: Verbal consent from carer to approach carer's GP Patient's GP name: Patient's DN name:		
Carer's GP has no concern about carer's physical or mental health		
Patient consents to procedure or a best interest decision by trainer is documented on consent.		

Check that medication, dose and vial size, frequency and maximum dose in 24hrs has been agreed		
Palliative medicine doctor completes 'Carer's Instruction to Administer Medication Sheet'		
Set of anticipatory medication is prescribed specifically for use of the carer as agreed by specialist palliative medicine		
Explain medication • Use • Side effects • Dose/route/frequency		
Provide contact details and support.		
The carer understands the patient can refuse medication, and in this event must be supported in this decision.		
Carer is aware to contact specialist palliative care before proceeding to give an injection.		
Provide with an equipment pack		
Explain and demonstrate the process of subcutaneous administration of medication based on diagrams in appendix: 'Carer Information pack' until the carer feels competent and confident to give a subcutaneous drug when unsupervised.		
Complete with carer the consent record, allowing time for carer to ask questions/ express concerns		
Plan a visit to support carer, reassess symptom control and check stock balances. (Ongoing visits/telephone contact by DN or CPCT will be minimum weekly or within 24hrs of an injection being given).		
Upload to SystmOne (email to GP to upload to EMIS) • Training checklist • Risk assessment • Consent • Carer's Instruction to Administer Medication • Notification of informal carer giving SC drugs in the home		
Print out for the home • Information leaflet • Carer's Instruction to Administer Medication • Carer administration/ stock balance sheets • Carer information pack • Copy of training checklist • Copy of consent • Out of hours advice card/advice line number (N.Derbyshire) • Out of hours advice card(S. Derbyshire)		

RECORD OF CONSENT

Policy for Informal Carer's Administration of As Required Subcutaneous Injections in Community Palliative Care

Date

I, *(Carer name)* _____have been fully informed about my role in administering subcutaneous medicines to_____ *(patient name, DOB, NHS number).*

I have given consent for my GP to be contacted regarding my physical and mental health.

I have been taught the procedure and completed associated documentation and I have been observed in administering at least a flush of water for injection.

I agree to proceed with this delegated task in the knowledge that I have contact numbers for support and can relinquish the role any time I wish.

I feel confident to undertake this role in administering subcutaneous medicines.

I will discuss with the specialist palliative care team on the telephone numbers provided before I give each dose of subcutaneous medication.

I have been given an information leaflet.

I *(patient name)*_____ agree to delegate administration of drugs to the carer and I have been given the opportunity to decline.

Patient signature (if feasible for patient to sign) _____

Carers Signature

Print name

Date

For health care professional:

I have assessed the patient as having capacity to agree to the carer administering SC medication: **yes / no**

OR I am acting as best interests assessor and have weighed up the risks and benefits of training the carer to administer subcutaneous medication to the patient: **yes / no**

Signature

Print Name

Designation

Date

Carer's Instruction to Administer Symptom Management Drugs

Patient name

DOB

NHS number

Drug Allergies

Doses to be as simple as possible; this may direct medication choices/vial sizes.

Carer to record doses given on carer administration/stock balance sheet

If a drug is prescribed for two indications eg morphine for breathlessness and pain, document max combined total dose/24hrs

Date agreed	Indications For Use	Drug (CAPITALS)	Dose (No dose ranges)	Route	Frequency		Name and signature
					Dose interval	Max dose/24hrs	
	Pain			**sc**			
	Nausea Vomiting			**sc**			
	Agitation, restlessness, confusion			**sc**			
	Noisy breathing			**sc**			
	Colic			**sc**			
	Breathlessness			**sc**			
	Anxiety			**sc**			
	Other			**sc**			

Please call CPCT/palliative care nurse if the syringe driver doses are changed – this will prompt a review of drug doses.

NAME OF DRUG	INDICATION FOR USE	COMMON SIDE EFFECTS
MORPHINE OXYCODONE	PAIN BREATHLESS	DROWSINESS, CONFUSION, CONSTIPATION, DRY MOUTH
METOCLOPRAMIDE	NAUSEA, VOMIT	DIARRHOEA, TWITCHING/RESTLESS ARMS, LEGS, FACE
LEVOMEPROMAZINE	NAUSEA, VOMIT, AGITATION, CONFUSION RESTLESSNESS	DROWSINESS, DRY MOUTH, LOW BLOOD PRESSURE
CYCLIZINE	NAUSEA, VOMIT	DROWSINESS, DRY MOUTH, BLURRED VISION, INSOMNIA
HALOPERIDOL	NAUSEA, VOMIT, AGITATION. CONFUSION RESTLESSNESS	DROWSINESS, TWITCHING/RESTLESS ARMS, LEGS, FACE
MIDAZOLAM	RESTLESSNESS ANXIETY PANIC	DROWSINESS, SLOWNESS OF THINKING, FATIGUE
HYOSCINE BUTYLBROMIDE	NOISY BREATHING COLIC	DRY MOUTH, CONSTIPATION, BLURRED VISION, DRY SKIN, DIFFICULTY PASSING URINE


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Notification that an informal carer has been trained and assessed as competent to administer as required subcutaneous injections in the home

(Insert date)

(Insert name) is believed to be *deteriorating / dying of* ***(insert diagnosis)*** which is now progressive and irreversible.

His /her ***carers relationship to patient, name of carer,*** has requested to administer subcutaneous medication at home in the role of an informal carer.

(Name of patient) **has/has lost** capacity to agree.

In the event capacity of the patient to consent is lost, a best interest decision has been made by me to proceed to train the carer.

Name of carer has been assessed by the palliative care multidisciplinary team in conjunction with **name of carer's** GP **(insert name of carer's GP and practice)**.

Name of carer has been trained to administer the following medication subcutaneously:

(Insert drug names)

Before each injection ***name of carer*** will discuss with specialist palliative care services but will need to receive usual support from community services for all aspects of the patients care.

To ensure high quality information is available to DHU healthcare the patient must have a Derbyshire Health and Summary Care Record completed to a high standard.

The Summary Care Record must state that the carer ***(insert name and relationship to the patient)*** has been trained to give subcutaneous drugs and that in the event of the carer calling 111 specifically about administration of those SC drugs the carer should be redirected to specialist palliative care, using the numbers provided by specialist palliative care.

The carer training is supported by the policy, 'The Derbyshire Policy for Informal Carer's Administration of As Required Subcutaneous Injections in Community Palliative Care.' A copy of the policy is available to view on the Derbyshire End Of Life Care Toolkit, https://derbyshire.eolcare.uk

If you have any urgent concerns regarding the patient, please phone the patient's:

- *CPCT nurse or Ashgate Hospice for a North Derbyshire patient*
- *CPCT nurse or Nightingale Macmillan Unit for a South Derbyshire patient*

You will be put through to a palliative care nurse aware of the patient. You may be directed to the palliative medicine consultant on call.

You MUST ensure this letter is uploaded to SystmOne/EMIS and shared with all relevant parties, especially the community nursing team.

Yours sincerely,

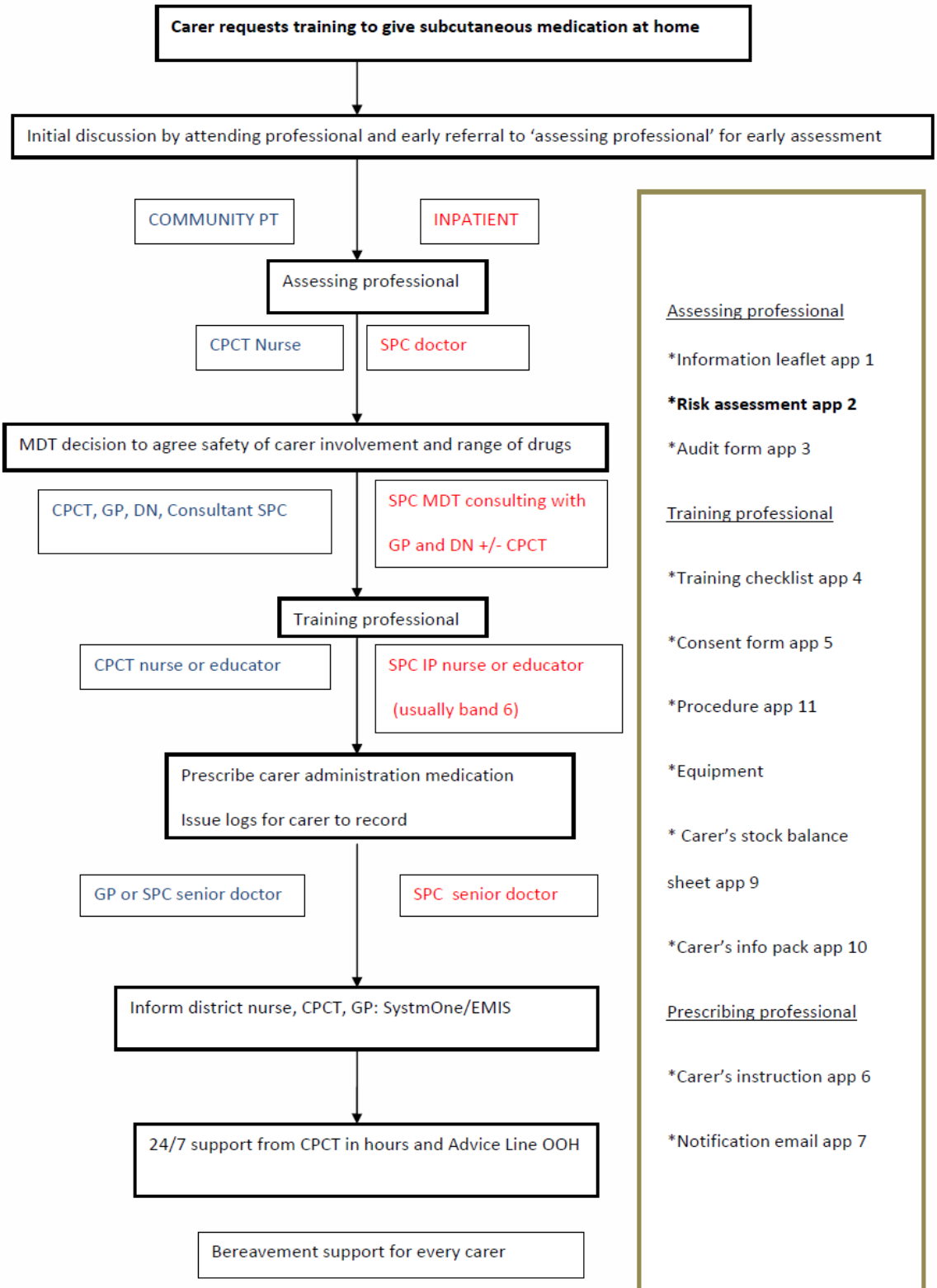
insert name, designation and work address

Health Care Professional Signature

Print Name

Designation

Date


Carer requests training to give subcutaneous medication at home
Initial discussion by attending professional and early referral to 'assessing professional' for early assessment
COMMUNITY PT
INPATIENT
Assessing professional
CPCT Nurse
SPC doctor
MDT decision to agree safety of carer involvement and range of drugs
CPCT, GP, DN, Consultant SPC
SPC MDT consulting with GP and DN +/- CPCT
Training professional
CPCT nurse or educator
SPC IP nurse or educator (usually band 6)
Prescribe carer administration medication
Issue logs for carer to record
GP or SPC senior doctor
SPC senior doctor
Inform district nurse, CPCT, GP: SystmOne/EMIS
24/7 support from CPCT in hours and Advice Line OOH
Bereavement support for every carer
Assessing professional
*Information leaflet app 1
*Risk assessment app 2
*Audit form app 3
Training professional
*Training checklist app 4
*Consent form app 5
*Procedure app 11
*Equipment
* Carer's stock balance sheet app 9
*Carer's info pack app 10
Prescribing professional
*Carer's instruction app 6
*Notification email app 7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SURNAME	**NHS No** _ _ _/ _ _ _/ _ _ _ _
FORENAME	**D.O.B**

CARER

ADMINISTRATION/STOCK BALANCE SHEET

SHEET FOR (*insert drug name*).....

Provided in ___mg/___ml AMPOULES

NEW STOCK SUPPLIER	DATE	TIME	NO IN BOX	DRUG	STRENGTH	AMOUNT GIVEN / ROUTE	BATCH NO	EXPIRY DATE	DRUG DESTROYED	STOCK BALANCE	CARER SIGNATURE	DISTRICT NURSE SIGNATURE DATE AND TIME
Please return this sheet to your CPCT CNS for audit purposes												

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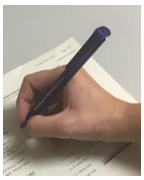
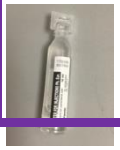
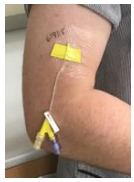
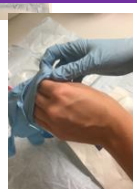
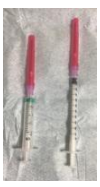
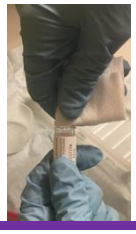
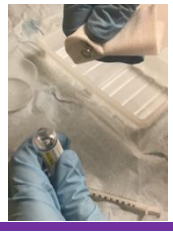
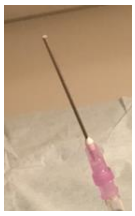
CARER INFORMATION PACK — Equipment Checklist

Phone contact telephone number as found on information leaflet	*for example:* *Nightingale Macmillan Unit Out of Hours Advice Line* *Please have patient details ready*
Documentation and Prescription Pen Clock Clean Surface	   
Yellow Sharps Bin	
Dressing Pack (Optional), containing: Gloves Gauze Plastic Tray	    
Alcohol Wipe	
Needles x 2 Syringes x 2	   
Medication for Injection	
Water for Injection	

Preparation for administration of medication (Step 1-3)

Phone the contact telephone number to discuss any symptoms and the need for an injection.	 *For example: Nightingale Macmillan Unit Out of hours Advice Line* *Please have patient details ready*
Check the prescription, including the drug, dose, frequency, when the patient last had a dose, route and method of administration.	 
Check the subcutaneous site for pain, discomfort, swelling, hard lumps, redness, leakage of fluid, and bleeding. Do not administer medication if you find any of these.	
Prepare a clean area for drug preparation, such as a table or worktop.	
Collect all necessary equipment.	        
Wash hands with soap and water, and then dry your hands well.	
Open and assemble all equipment.	
Apply gloves. Attach the sheathed needles to the syringes.	   

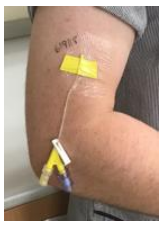
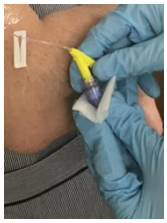
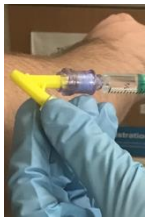
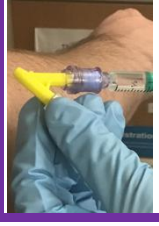
Drawing up solution medication (Step 4)

Tap the neck of the ampoule gently, ensuring all the solution is at the bottom of the ampoule.	 
Cover the neck of the ampoule with the gauze and snap it open, to avoid causing any injury. Some ampoules have a dot on the neck of the ampoule to show where to apply pressure to snap it open.	   
Remove the sheath to expose the needle.	 
Withdraw the required amount of solution from the ampule by pulling back on the plunger of the syringe. Tilt the ampoule if necessary to avoid drawing back any air.	
Hold the syringe upright, tap the syringe with your finger to dislodge any air bubbles, and push the plunger to expel any air from the syringe, ensuring you have the correct dose.	 
Place all needles and glass ampoules into the yellow sharps bin, disposing of any unused drug. Do not re-sheath any needles	 

Drawing up the flush (Step 5)

Open ‘water for injection’ by twisting the cap.	 
Draw up 0.5mls of ‘water for injection’ for the flush.	 
Tap the syringe to dislodge any air bubbles and expel air, ensuring there is 0.5mls of ‘water for injection’.	
Place all needles into the yellow sharps bin. Do not re-sheath any needles.	

Administering the medication and flush (Step 7 & 8)

Place both syringes (the syringe with the drug and the syringe with the 'water for injection') and an alcohol wipe in the disposable tray and take to the patient.	
Assist the patient into an appropriate position, ready for administration.	
Expose the cannula and slide the clamp to the open position.	
Clean the cannula with an alcohol wipe.	 
Wait for 30 seconds for the alcohol to dry, to ensure disinfection.	
Insert the syringe into the blue access device at the end of the cannula, holding firmly, then slowly inject the medication into the cannula, using the plunger, until the syringe is empty, then remove the syringe from the cannula.	 
After the medication has been administered, then administer the 0.5mls 'water for injection' flush, by inserting the syringe into the blue access device and slowly injecting all the 'water for injection', to ensure the patient has received all the medication.	 

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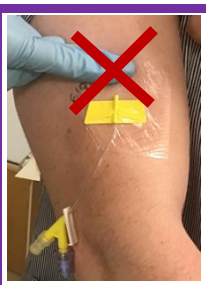
After the administration of medication and flush (Step 9 & 10)

Do not massage the area, as massage can cause injury.	
Dispose of used syringes in yellow sharps bin. Dispose of all other equipment such as tray, gloves and packaging in a normal household bin.	
Wash hands with soap and water, and then dry your hands well.	
Record the administration of medication on the correct documentation, remembering to record the exact time that the medication was administered to the patient.	 
Phone the contact telephone number as found on information leaflet to discuss what to do next, if needed.	 *For example:* *Nightingale Macmillan Unit* *24 Hour Advice Line*

Procedure for informal carer to be assessed, trained and perform subcutaneous injection

ACTION	RATIONALE
Carer and patient assessment	
It is the responsibility of Specialist Palliative Care Inpatient Unit or CPCT MDT to discuss and agree the suitability of the carer to administer the prescribed SC medication. The GP of the patient and carer must be involved in this decision, agree to the procedure and their agreement must be recorded in MDT notes and SystmOne/EMIS.	To ensure the safe selection of a carer to undertake this procedure, minimising risk and protecting the patient and carer from harm. To ensure multi – professional collaboration and co-operation To ensure documented GP consent for the carer to undertake the procedure
A carer risk assessment form must be completed for each carer.	
It is the responsibility of the assessor to meet the patient and assess capacity to agree to the carer administering subcutaneous medication. It is important the patient could decline and therefore, privacy away from the carer should be facilitated if possible. If the patient does not have capacity, it is the responsibility of the assessor to carry out a best interests assessment when deciding to train the carer to give subcutaneous medication.	To be compliant with mental capacity law and to protect the patient.
Medication prescription	
It is the responsibility of the MDT to agree initial medication doses, vial size, frequency, and maximum dose in 24hrs for each drug to be given by the carer.	Safe doses to be agreed by MDT who acknowledge this may change as patient's condition changes.
Inpatients: It is the responsibility of the specialist palliative care inpatient doctor to ensure the agreed subcutaneous drugs and doses are prescribed and dispensed. Community patients: It is the responsibility of the GP or community Palliative Medicine Consultant to prescribe the agreed subcutaneous drugs.	To ensure the medication is dispensed and available in the home
It is the responsibility of the palliative medicine doctor to clearly direct usage of the sc medication on the 'Carers instruction to administer medication sheet', including drug, dose, route, and frequency.	To comply with NMC (2018) standards for administration of medicines To protect the patient from harm (NMC 2018)

Spare instruction sheets must be available as the dose may need changing by the GP as the patient's condition changes.	
Carer Training	
It is the responsibility of the training nurse to discuss and explain the procedure and its implications with the patient (where appropriate) and their carer.	To fully inform the carer and patient to enable them to make an informed choice.
It is the responsibility of the training nurse to explain to the carer the importance, use, relevance, action and possible side effects of the prescribed medication. The training nurse should check the prescription and list the indications for use, possible side effects and any instructions on the 'Carer's Instruction to Administer Symptom Management Drugs' for each individual drug.	To fully inform the carer to enable him/her to make an informed choice To ascertain their willingness to undertake the procedure
The training must provide an opportunity for the carer to express any fears and anxieties that they may have.	To ensure the carer feels listened to and supported To maintain their freedom of choice
The carer has the right to refuse to undertake/ continue this procedure at any given time. It is then the responsibility of the district nurses to continue giving subcutaneous medication in the community. The patient can also refuse to receive an injection from the carer.	To ensure the carer feels listened to and supported To maintain their freedom of choice To protect the patient from harm (NMC 2018)
The training nurse will complete the consent record with the carer. The carer must sign that they feel confident to undertake this role. A copy of the consent record will be scanned into SystmOne/EMIS and a copy left at the patient's house.	To ensure that the carer feels competent and is deemed competent to undertake the procedure To obtain consent and have a paper and electronic record.
To prepare for administration of medication	
Before every dose of SC medication given (in and out of working hours) the informal carer will phone specialist palliative care. Phone numbers and instructions are supplied on the information leaflet and discussed with the carer during training.	
Carer revises process with training documents if needed.	To update knowledge and maintain safety (O'Brien 2012)

Carer check the prescription, including the drug, dose, frequency, route and method of administration, and diluent if needed. Carer confirms when last dose was given.	To ensure the correct drug is given, the correct dose is given, the correct diluent is used, the correct route is used, to prevent any errors occurring (Lister, Hofland and Grafton 2020)
Carer cross-checks drug names and diluents with records. Carer checks expiry date on vial.	To ensure patient safety (O'Brien 2012)
Carer checks the subcutaneous site for pain, discomfort, swelling, hard lumps, redness, leakage of fluid, and bleeding	To reduce risk of infection and to avoid possible trauma to the patient (Lister, Hofland and Grafton 2020)
Carer prepares a clean area for drug preparation (table or worktop and disposable tray)	To minimise the risk of infection and prevent cross contamination (O'Brien 2012)
Carer collects all necessary equipment and visually inspects packaging	To prevent disruption to the procedure and to maintain patient safety (O'Brien 2012)
Cares wash their hands and applies gloves	To prevent risk of cross infection or contamination (O'Brien 2012, Lister, Hofland and Grafton 2020)
Carer opens and assembles all equipment	To prevent disruption to the procedure and to maintain safety and ensure that the correct dose of medication is administered (O'Brien 2012)
To draw up solution medication	
Carer taps the neck of the ampoule gently	To ensure that all the solution is in the bottom of the ampoule (Lister, Hofland and Grafton 2020)
Carer covers the neck of the ampoule with a sterile swab and snaps it open	To minimise the risk of contamination, to reduce the risk of injury (Lister, Hofland and Grafton 2020)
Carer opens packaging and attaches the needle onto the syringe	To assemble equipment (Lister, Hofland and Grafton 2020)
Carer withdraws the required amount of solution, tilting the ampoule if necessary	To avoid drawing in any air (Lister, Hofland and Grafton 2020)
Carer taps the syringe to dislodge any air bubbles and expel air	To ensure that the correct amount of drug is in the syringe (Lister, Hofland and Grafton 2020)
Carer places all needles and glass vials	To prevent injury and risk of infection

immediately into the yellow sharps bin, do not re-sheath any needles	(O'Brien 2012, Lister, Hofland and Grafton 2020)
To draw up a flush for after administration of medication	
Carer opens 'water for injection' by twisting the cap and draws up 0.5mls	To ensure the correct volume of diluent (Lister, Hofland and Grafton 2020), and to ensure the correct dose of drug is administered (O'Brien 2012)
Carer taps the syringe to dislodge air bubbles and expel air	To ensure the correct amount of drug has been drawn up and is in the syringe (O'Brien 2012, Lister, Hofland and Grafton 2020)
Carer places all needles immediately into the yellow sharps bin, do not re-sheath any needles	To prevent injury and cross-contamination (O'Brien 2012)
To administer the medication	
Carer assists the patient into an appropriate positon	To ensure safety, comfort, and access to the cannula (O'Brien 2012, Lister, Hofland and Grafton 2020)
Carer exposes the subcutaneous cannula	To enable ease of access (O'Brien 2012). It is best practice to maximise patient and relative safety by use of a non-sharp or needle-less system, to reduce incidence of needle stick injury (Healy et al 2012). It is also recommended that a subcutaneous port or administration device is used, to support carers in their role (Lee et al 2016)
Carer cleans the cannula with an alcohol wipe and wait 30 seconds for this to air dry	To ensure disinfection (O'Brien 2012)
Carer holds the cannula with one hand, and the medication in the syringe with the other hand, then inserts the syringe into the end of the cannula, and then slowly injects the medication into the cannula, then removes the syringe from the cannula	To ensure comfort and correct administration of medication (O'Brien 2012)
After all the medication has been administered, carer repeats the above with the sterile water in the syringe	Flushing the subcutaneous cannula ensures that the patient receives the complete dose of drug prescribed (Healy et al 2012, O'Brien 2012)

After administration of medication	
Carer does not massage the area	Massage can cause injury (Lister, Hofland and Grafton 2020)
Carer disposes of used needles, vials and syringes in the yellow bin and dispose of all other equipment in the household bin	To ensure safe disposal and avoid injury (Lister, Hofland and Grafton 2020), and to prevent risk of cross infection (O'Brien 2012)
Carer washes hands	To prevent risk of cross infection or contamination (O'Brien 2012, Lister, Hofland and Grafton 2020)
Carer records the administration on the drug specific 'Carer's stock balance sheet'	To maintain accurate records, to provide a point of reference, and to prevent any duplication of treatment Lister, Hofland and Grafton 2020)
After the injection the following options are available: • The carer phones the specialist palliative care team to report the effectiveness of the drug and discuss over the 'phone. • The specialist palliative care nurse requests a DN visit to the patient • The carer requests a DN visit • None of the above if the carer feels the drug has worked well and both patient and carer plan to rest/sleep	
Documentation	
Training nurse ensures the following paper records are in the home 1. Information leaflet (Specific to local area) 2. Copy of training checklist 3. Carer's Instruction to Administer Medication – 5 sheets to enable dose changes 4. Carer stock balance/administration sheet for each drug. 5. Carer information sheet	To ensure the district nurse team and carer have a clear record of training and prescription.

6. Copy of consent record 7. Out of hours advice card (S. Derbyshire)	
On each visit the district nurse will check the balance of ampoules is correct and add any new stock to the balance. Any discrepancies must be reported immediately as per the DCHS SOP. The district nurse will check the carer's stock balance sheet is accurate.	To maintain accurate records which provides a point of reference in the event of any queries and prevent duplication of treatment
After death when the drugs are no longer required, it is the carer's responsibility to accurately dispose of any unused medication to the local pharmacy. If they are unable to do this, the district nurse can dispose of the drugs following their own local policy.	To comply with NMC (2018) standards for administration of medicines
Support	
CPCT will visit as per patient needs. There must be a minimum of weekly contact after the carer completes training to support the carer and to evaluate the effectiveness of the care. CPCT visits will be documented on SystmOne/EMIS.	To ensure continuity of care To protect the patient from harm (NMC 2018) To allow reassessment To ensure multi-professional communication
The GP, DN and CPCT will coordinate so that the carer and patient receive a visit or phone call within 24 hours of them administering a SC medication to the patient.	To ensure continuity of care To protect the patient from harm (NMC 2018) To ensure multi-professional communication