

**What is current medication  
management in district  
nursing practice?**

***EXECUTIVE SUMMARY***

**RDNS Research Unit  
Royal District Nursing Service of SA Inc.**

**March 2003**





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## **EXECUTIVE SUMMARY**

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### **Background**

Assisting clients with medication management comprises a large part of a District Nurse's role in the community. During November 2002, the Royal District Nursing Service (RDNS) registered 3454 clients of which 1013 (30%) received support with medication management. RDNS has a computer system in place to monitor the number and frequency of visits, however a comprehensive picture of current medication practice was lacking. There were also concerns about the increasing complexities surrounding medication administration in the community. These concerns included poly-pharmacy and complex medication regimens attributed to the increasing existence of multiple pathology in clients. In order to meet the changing medication needs of RDNS clients, development of new structures and processes for effective and safe medication management in the community required attention. The intent of this study was to lay the framework for informed decision-making about how RDNS can best meet the medication management needs of clients.

RDNS, supported by a Nursing Practice Committee, develops and maintains current policies. Clients may be referred to RDNS for medication management for a variety of reasons. However, the most common reason for clients needing medication is memory loss. Supervision and administration of oral medication is the most common activity (48%). However, RDNS provides medication management services dealing with cytotoxic and palliative medications given by a variety of routes including epidural, intramuscular, intrathecal, and intravenous. Staff have technical expertise in oxygen therapy, infusion pumps and syringe drivers. Other types of medications are administered via the ear, eyes, rectum and/or vagina.

Although RDNS is involved with clients who do not have dementia, the majority of clients are referred with memory loss and there are established practices for admission to the Service. When clients are first referred to RDNS for medication management and they have a diagnosis of dementia, the District Nurse usually trials a dosette or a Webster pack (in close cooperation with the pharmacist). If this intervention works, the client is discharged from RDNS with documented evidence of adherence, support and education. If the client forgets or mismanages the medications, RDNS provides a service (daily visit) where the District Nurse visits the client's house and actually administers the medication as per medical authority (from a GP, specialist or both). As many of the clients receiving support with medication service have dementia, a locked container (a large red box with a padlock) may be provided for containment of medications. If the client has medication at times, other than when nurses are available, labelled receptacles such as saucers, cups or glasses may be used to contain these medications. This practice has been referred to as dosetting throughout the report.

## **Study Focus**

The examination of the practice role for District Nurses in the Quality Use of Medicines (QUM) by clients living in the community was the focus of this study. The research question was ‘what is current medication management practice in the community?’ The term 'medication management' referred to the processes and support systems that were available to help people administer their medications. While the majority of clients were older people we were inclusive of all age groups. It was important to do this study in light of changes to policy and the realisation that 30 percent of the activities of the District Nurse are in medication management.

## **Research Team**

This project was internal to RDNS and funded by the RDNS Foundation. The Research Team was comprised of:

- Tina Koch, Chief Investigator / Professor of Nursing / Director, RDNS Research Unit
- Debbie Kralik, Senior Research Fellow, RDNS Research Unit
- Kate Visentin, Project Manager seconded from Royal Adelaide Hospital
- Linda Hayford, Research Nurse seconded from position as RDNS Liaison Nurse
- Katherine Trowbridge, Research Nurse seconded from position as Clinical Nurse Consultant
- Natalie Howard, Research Coordinator, RDNS Research Unit
- Jane Smith, Administrative Support, RDNS Research Unit
- Geoff March, Consultant to the study, Lecturer in pharmacology, University of South Australia

## **Project Management Team (PMT)**

A Project Management Team (PMT) was convened monthly for the duration of the project. Membership of the PMT was:

- Tina Koch, Director, RDNS Research Unit
- Debbie Kralik, Senior Research Fellow, RDNS Research Unit
- Kate Visentin, Project Manager seconded from Royal Adelaide Hospital
- Jane Smith, Administrative Support, RDNS Research Unit
- Natalie Howard, Research Coordinator, RDNS Research Unit
- Anne Maddock, Quality Manager, RDNS
- Helene Martin, Clinical Specialist – Informatics, RDNS
- Cathy Isam, Senior Projects Officer, Business Development Unit (BDU), RDNS
- Anne Frewin, Modbury/LMHS Liaison Nurse, RDNS
- Connie Adsett, CNC General, Northern Public Programs, RDNS
- Judy Smith, Executive Director Nursing and Client Services, RDNS

## **District Nursing Teams**

We would like to acknowledge the key stakeholders (RDNS Teams and Team Leaders) for participating in the project:

- Southern Public Programs Division Cityside Team 2 (Gwen Chambers)
- Southern Public Programs Division Hillside Team 3 (Di Kavanagh)
- Focus Health Care Division West Team 2 (Janelle Byrne)
- Northern Public Programs Division Salisbury Team 6 (Peter Carter)
- Northern Public Programs Division St Agnes Team 5 (Bernadine Stidwell)

## **Aims and Objectives**

The primary aim was to identify current medication management in district nursing practice. In collaboration with District Nurses, the objectives were:

- To identify the concerns, claims and issues (CCIs) surrounding medication management
- To articulate current medication management and suggest recommendations
- To guide practice and policy within RDNS and influence the wider Australian community
- To identify a research agenda based on this exploratory study.

## **Ethics Committee**

The RDNS Ethics Committee approved this medication project.

## **Methodology**

Utilising principles from participatory action and fourth generation research (Guba and Lincoln 1989), we collaborated with District Nurses and clients to meet the inquiry's objectives. Data were generated from multiple sources:

- Observing nurses administering medications in the home, across shifts seven days of the week (n=133)
- Client case studies (n=42) - a case study was comprised of the observation account, the analysis of the case notes and the client's blue folder
- Interviews of clients (n=18)
- Interviews of nurses at Clinical Nurse Consultant (CNC), Clinical Nurse (CN), Registered Nurse (RN) and Enrolled Nurse (EN) levels (n=35)
- Research team meetings (collaborative developments of common constructs)
- Interviews of carers (n=5)

The analysis framework was based on CCIs where these were clustered into major constructs or themes. Data was analysed concurrently and this was

complemented with daily meetings for the research team to collaboratively discuss and record the emerging themes (constructs). A stakeholder is anyone involved in the study who has a stake in the outcome. Stakeholders in this project were the individuals in the research team, the clients/carers, the RDNS teams, the PMT and the wider RDNS organisation. A concern is any assertion that a stakeholder may introduce that is unfavourable about a local situation. It may mean that further clarification is required so other questions are asked about a situation. For the purpose of this inquiry, a *concern* was identified as a situation that can be dealt with internal to RDNS. A *claim* is any assertion that a stakeholder may introduce that is favourable. In this inquiry it related to what was working well. An *issue* is any assertion that a stakeholder may introduce that is unfavourable about a situation that describes the state of affairs. An issue was a situation whose resolution required wider community consultation and action. A *construct* is a full account of a main concern, claim or issue. Data from interviews, observations, journal data, and case studies were analysed and accumulated into common clusters.

## TEN CONSTRUCTS – (CCIs)

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Ten constructs are derived from the multiple data sources. There are four concerns, three claims and three issues. These are given in the table below.

**TABLE 1 : Ten Constructs – Concerns, Claims and Issues**

Concerns*	Claims**	Issues***
1. There are gaps in many aspects of the nursing process (including documentation);	5. Clients and carers claim that the service provided by RDNS was both trusted and valued;	8. The majority of RDNS clients receiving medication management have dementia. Few of these clients receive comprehensive care based on current nursing and medical assessment and review;
2. RDNS has excellent structures in place to guide practice, but attention to process is minimal;	6. District Nurses claim that they meet service aims (1) that they promote independence of RDNS clients, (2) that they have appropriate skills and competencies to provide a medication management service, and (3) that they are sensitive to the needs of older people;	9. Medical Authority for medication administration is problematic in terms of legality, legibility and receipt of timely authorities;
3. Nurses are concerned about the number of clients requiring medication management visits in a short time frame. Nurses have not taken control of time management in their practice;	7. Using an approach that is underpinned by primary health care principles it is possible to provide comprehensive care for clients requiring medication management;	10. Lack of intersectoral communication is evident. The District Nurse is often left out of the information loop in the transfer of client information, coordination of services for clients and post discharge from hospital.
4. Narcotic control and administration in the community. There exists a paradox of meeting practice requirements and client needs;		

\* **A concern construct is one that can be addressed locally (within RDNS)**

\*\* **A claim construct is a favourable statement made by stakeholders**

\*\*\* **An issue construct is a problem that requires wider collaboration for its resolution**

## **THE TEN CONSTRUCTS AND THEIR RECOMMENDATIONS**

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### **Concern 1:**

*There are gaps in many aspects of the nursing process (including documentation)*

This study gave particular consideration to the importance of a thorough and comprehensive assessment and while there are wide variations in practice, important elements of the assessment process were deficient. Only a small percentage (approximately 5%) of the 133 clients observed had a completed documentation of Client Needs Assessment (CNA). All clients had compulsory data entered (information that generates the call sheet) and an old Bryan Domiciliary Dependency Instrument (BDDI) in their case notes.

Is medication management just about administering medication? A majority of the clients who are receiving assistance with medication management have dementia and/or have complex social and medical conditions. To achieve a high standard of nursing care it is imperative that District Nurses systematically follow the nursing process to ensure an ongoing cycle of assessment, planning, implementation and evaluation. It is also important that nurses involve the clients and the carers in the process, thus encouraging a comprehensive approach to care. Observational data revealed major gaps in aspects of the nursing process including a less than ideal level of documentation. The lack of documentation made it very difficult to ascertain what was happening to clients who are receiving assistance with medication.

### **RECOMMENDATIONS**

1. It is recommended that all clients be given a comprehensive nursing assessment that is guided by the RDNS CNA tool. Lines of responsibility for the initial comprehensive nursing assessment need to be clearly articulated so that ownership of the assessment process occurs.
2. Implement a systems approach (within the CIMS) to flag the need for clients to have an assessment or review e.g. new admission, post-hospital admission, thus ensuring continuity of assessment, review and evaluation.
3. Implement a monitoring and feedback system to ensure that clients are comprehensively assessed and care is evaluated.
4. Nursing Practice Committee reviews its practice policies for congruence with the nursing documentation requirements.
5. Nursing Practice Committee reviews and streamlines nursing documentation in conjunction with the implementation and evaluation of the CIMS.
6. Further research is needed to identify a model of care that is specific to the practice needs of District Nurses.

**Concern 2:**

***RDNS has excellent structures in place to guide practice, but attention to process is minimal.***

For the purpose of this study, structure is defined as the policies, standards and clinical pathways that guide nursing practice. It refers to advisory committees convened for instituting quality control in both professional preparation and in practice. It also refers to the certification of health care practitioners and the laws that require practitioners to be graduates of specified education programs. Continuing education is viewed as a means of controlling quality. One other way of describing structure is the formal and visible foundations of the organisation, usually accompanied by documents as evidence of their existence. In this study we have been guided by RDNS structures to question medication practice. Process refers to the series of events and actions that produce change or development, which includes the continuous monitoring of structural elements. Process relies on involvement with stakeholders who can provide short loop feedback on the progress of structural elements, for example, that policies are implemented, monitored and evaluated.

RDNS has excellent structures in place to guide practice, but attention to process is minimal. It was apparent that RDNS had already addressed some of the identified problems but it did show that further communication instruction was warranted to address misconceptions. Examples surrounding misconceptions were medication incident reporting, continuity of care, reporting lines and appropriate guidelines for the use of the locked medication boxes in the home. Examples of processes not in place were with the introduction of the Client Needs Analysis tool and the Client Generated Index Quality of Life tool. Although education accompanied the introduction of these tools into RDNS nursing practice, follow up process evaluation regarding their use was not given attention. When follow through processes are absent, it should not be a surprise finding that few (only 5%) of clients observed had used these tools.

## **RECOMMENDATIONS**

1. For RDNS to facilitate a structure and process that includes medication management and/or dementia as a nursing practice core competency.
2. The Nursing Practice Committee acts as a conduit for discussion of nursing practice issues that have been raised in the field. The communication pathway for identified practice issues needs to be clearly articulated and incorporate a 360-degree feedback loop.
3. There is a responsibility to rectify misconceptions about medication management that have been identified in the report. A list of common misconceptions has been supplied for communicating within RDNS.

**Concern 3:**

*Nurses are concerned about the number of clients requiring medication management visits in a short time frame. Nurses have not taken control of time management in their practice.*

The RDNS Nursing Practice Manual only contains one policy pertaining to the scheduling of visits (3.CM.16). The policy outlines the role of the nurse in negotiating a mutually acceptable time for the client and the nurse. Visits for medication management are usually scheduled for a ten-minute duration. Nurses are expected to use their professional judgement to decide what length of visit they require. The nurse's call sheet outlines which clients are priorities for that round. Clients are a priority if their medications need to be given more than once or a day; or before a meal; or if the client was likely to wander later in the day.

Time is the actual amount of time taken to undertake 'a task' and time management refers to principles underpinning practice that can, in the main, be controlled by the District Nurse. Nurses were concerned about the number of clients requiring medication management within a short time frame. Nurses have not used their professional judgement to decide what length of visit clients require. Nurses do not appear to have taken control of time management in their daily practice.

**RECOMMENDATIONS**

1. Prepare District Nurses to take control of their own time and time management.
2. RDNS continues to undertake travel surveys and make changes to rounds and boundaries as required.
3. RDNS continues to investigate and implement shift configurations that assists in delivering client-focussed services.

**Concern 4:**

*Narcotic control and administration in the community. There exists a paradox of meeting practice requirements and client needs.*

The RDNS policy for the administration of Narcotic and Psychotropic Drugs (N&PDs) (2.CP.43) is based on Regulation 19 of the Controlled Substances Act 1984. The policy clearly states the responsibilities of the nurse administering narcotics. The important points to note are that RDNS requires:

- Countersignature from a responsible person (may be carer or client)
- Clients/carers may co-administer N&PDs, and should be encouraged to complete the N&PDs form
- Whenever N&PD medication is administered by persons other than RDNS nurses and not recorded, the RDNS nurse must print this information on the N&PD form

The narcotic count is recorded on the Narcotic and Psychotropic Drug administration record form. For subcutaneous infusions an additional form needs to be completed.

Narcotic administration and recording has the potential to be problematic in a community setting. Unlike the use of narcotics in a hospital setting, the use of narcotics in a community setting is more difficult to control. The reality for many nurses working in the field is that there is not always someone with whom to check narcotics. Nurses also felt that they have little control over maintaining an accurate count of the stock due to the fact that clients and carers co-administer breakthrough doses. The fact that there are regular incident forms being generated around an incorrect narcotic count suggests that the current system needs addressing. Data suggest that documentation for N&DPs may need to be reviewed with the emphasis being on how the carers/clients use the form.

## **RECOMMENDATIONS**

1. That the Nursing Practice Committee review the Policy for N&DPs in the community.
2. That Palliative Care staff in conjunction with the Nursing Practice Committee reviews the documentation for administration of N&DPs.

**Claim 5:**

***Clients and carers claim that the service provided by RDNS was both trusted and valued.***

Clients were interviewed as a part of data generation for the medication study because it was important to hear their accounts of medication management. Of the 18 interviews conducted, 11 clients were able to clearly articulate their perspective. The other seven clients (39%) had some degree of dementia. It is acknowledged that interviewing clients with dementia presents many ethical and interpretive issues. However, when the older person experiences memory deficits, insight into the problem is common and they may welcome an opportunity to discuss their situation. Rather than simply dismiss the claims from clients with dementia, we have made sense of their accounts.

Clients claimed that the service provided by RDNS was both trusted and valued. They claimed that hospitalisation was prevented through regular District Nurse visits to the home. As a result, clients claimed that their quality of life had improved due to the support provided by RDNS.

Five carers were interviewed. Carers are important partners in community nursing care. The carers stated that they felt reassured by the professional guidance offered by the District Nurse. To the carers this was a great support and gave them a sense of relief.

*And I find it a relief too, ...because it means that someone with medical training is going in and if they look at her, and think well "she doesn't look right", I know that they will contact me and I find that reassuring.*

*Family are now sure that she gets her medication regularly and it has meant that she has not needed to go on insulin (diabetes control has improved since the commencement of District Nurse)*

*I'd like to say that I'm really appreciative of the service, really appreciative. And also that I find that the nurses who I have contact with are caring, are very caring. So, I can't speak too highly of that.*

These comments highlight the importance of carers feeling supported in their role.

Carers felt that overall communication with District Nurses worked well. The communication sheet was utilised or notes were left and placed in the blue folder. One carer stated that 'I'm finding them quite accessible in ringing the 1300 number and I can send messages across to them if I need to.' One carer described the importance of reading the communication sheets regularly and perhaps following up any message with a phone call. A couple of carers have experienced incidents where there were communication breakdowns that resulted in the client not getting their medication on that day. Most of the carers felt comfortable with the system of documentation and indeed found it easy to follow.

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Carers and clients trusted the District Nurses. Prominent in the voices of these clients was the reassurance and sense of security that District Nurses provide. Reassurance and security are conveyed when nurses place clients as central to care, inviting participation by working 'with' them rather than only doing 'for' them. This approach increases the client's control over the health matters that impact on their lives. Listening to the voices of our clients and their carers offers District Nurses the opportunity to hear the outcomes of working 'with' people. We encourage the use of participatory approaches to care (throughout the organisation) as a framework for taking action to address the many issues identified by the medication study.

### **RECOMMENDATIONS**

1. For funders to be made aware of the satisfaction that clients and carers have with the service provided by RDNS.
2. District Nurses should be made aware that they are highly regarded by clients and carers.

**Claim 6:**

*District Nurses claim that they meet service aims (1) that they promote independence of RDNS clients (2) that they have appropriate skills and competencies to provide a medication management service and (3) that they are sensitive to the needs of older people.*

A major contemporary social goal is to maintain frail older people in their chosen environment, which is usually their own home. Current government objectives promote three central aims:

- Enable people to live as normally as possible in their own homes
- Provide the right amount of care and support to help people achieve maximum independence
- Using the language of coordinated care, promote inter-agency collaboration and referral in order that the client has the best possible service options

The influence of these themes remains evident in current district nursing practice. District Nurses claimed that their practice promotes client independence, that they possess and apply the skills and competencies necessary to provide an effective medication management service and that they are sensitive to the needs of older people.

The drive toward promoting independence and preventing the need for more costly service features prominently in data generated by interviewing nurses. Nurses claimed that the service being provided was keeping clients out of institutions and they felt good about being able to do this. Nurses felt the service was “valuable” and “positive”, because “it keeps people in their own home where they are happy”.

There was emphasis on the five rights of medication management. As one nurse said: ‘we are expert at following the five “vital rights” – right client, route, drug, dose and time’. The competency of an annual drug calculation review of all nursing staff is mandatory, and nurses felt secure with this structure in place. Moreover, ‘the reporting system for medication errors is quite good and thorough’.

District Nurses, as pivotal practitioners in front line care for older people, bemoan the lack of a coherent, seamless service in community care. While cross sector commitment is limited (refer to construct 10), nurses claim that they are doing their utmost to coordinate and communicate within RDNS and across agency boundaries. They recognise that this requires a greater emphasis on social and interpersonal skills. As one nurse claimed: ‘one thing that we do really, really well, is to get everybody involved’.

Most nurses were aware of the resources available to them to facilitate care for their clients. Nurses viewed the family as an entity rather than responding only to the client, ‘when we've got our regular clients on regular medication, everything runs very smoothly and we do rely on supportive family or friends to help us out and that usually works well’. Working closely with available carers

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or relatives was important, however, it should be emphasised that the majority of clients observed lived alone.

The claims made by nurses about their practice are substantial, however the observational data generated during the study clearly contradicts many of the nurses' claims. It may be timely for RDNS to develop a culture of evaluation, to promote critical reflection as an integral component of community nursing practice.

## **RECOMMENDATIONS**

1. That RDNS continues to provide the appropriate amount of care and support to help people achieve maximum independence.
2. That RDNS continues to foster inter-agency collaboration and referral so those clients have the best possible service options.
3. That RDNS promotes a culture of evaluation and critical reflection as an integral component of community nursing practice.
4. As part of the Divisional Clinical Education and the continued professional development system, provide clinical updates on pharmacology and its related legislation.

**Claim 7:**

*Using an approach that is underpinned by primary health care principles it is possible to provide comprehensive care for clients requiring medication management.*

Observations carried out by researchers indicated that medication practice was predominantly task driven. The ten-minute visit to the client was focused on the administration of medications with particular emphasis on the ‘five rights’ reflecting accountable medication practice. Often this narrow focus was at the expense of offering comprehensive nursing care. One of the many reasons cited for not taken full responsibility for assessment and review of care was concern about time deficits. Although the example to follow is exemplary, it is important to show that some District Nurses use Primary Health Care principles to guide their practice. It shows that providing comprehensive care is possible within current time restrictions. Indeed, some nurses demonstrated that providing holistic nursing practice does not need to be ‘time consuming’ rather it is an approach to care. It is a willingness to look beyond the task at hand and explore ways we can work more closely with clients. This observation is from Sharon’s<sup>1</sup> nursing practice taken from the researcher’s journal.

*We (the researcher and the District Nurse) headed off to see Marg. Sharon (RDNS nurse) warned me that this visit would be an eye opener and visiting Marg was essentially one big occupational health and safety issue, but at the same time visits from RDNS had made a huge difference to Marg’s life. Sharon visited Marg daily. The road to the house was winding and rocky up the side of a hill. We drove for 20 minutes. There were sharp bends that Sharon needed to sound her horn to warn any on coming traffic. The scenery was stunning.*

*We arrived at the house.... It was raining quite heavily and there were many plastic pipes taking water away from the house. The house itself seemed little more than a shed. There were things everywhere (an understatement) and the house had quite an overwhelming smell. A cat had 5 newborn kittens on a lounge chair in the doorway, Susie the dog was barking and jumping all over us, but Marg was nowhere to be found. Sharon kept calling for her, and then a minute later she emerged from the rain. Marg was no more than 5 feet tall of extremely small build, and cropped silver hair. She gave us a warm welcome and growled at Susie the dog for barking. Sharon gave her the medications reminding her of how many tablets she took and engaged in friendly conversation. The connection that Sharon had made with Marg was obviously important to them both. We then made our way back to the car (with Susie at my heels all the way) and made our way down the winding road.*

*Sharon explained that Marg lived alone, and although she had a son, ‘he was a bit weird’. Sharon went five days a week to visit Marg so she could administer 2 tablets. If Sharon did not go then Marg often would not take her tablets and Sharon claimed that the medication had made such a*

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<sup>1</sup> Note: All names used in this report are fictitious for confidentiality reasons.

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*difference to her quality of life. When Marg did not take her medications she was nauseous and vomiting with gastritis. Marg had RDNS visit 5 days a week, because Sharon felt that it was not fair to nurses on the weekends to have to take the long and precarious drive to visit Marg. Sharon had been in close liaison with the prescribing doctor and they had arrived at mutual agreement that if Marg took her medications 5 or 6 times a week then that was much better than not taking them at all.*

Sharon had previously talked with Marg about getting some help to fix up the house but Marg had refused. Sharon had accepted that Marg was happy living the way she was.

Nurses made the claim that it was important for the provision of comprehensive care that where possible, the same nurse visited the client. In this way knowledge of the client's life context builds, rapport develops and ongoing monitoring of the client is more effective. Sharon's nursing approach is shaped by an underlying philosophy of Primary Health Care. Her concern was that she would like to see more of a focus on creating opportunities for health and not just about managing illness. Sharon feels strongly that visits to clients for medication management is not just a task, but:

*'is a Primary Health Care issue ... there is a lot more to it... I can do a lot in that two minutes.'*

### **RECOMMENDATIONS**

1. Primary health care education is provided for all RDNS nursing staff.
2. That RDNS recognises the potentially strategic position the District Nurse holds in the management and monitoring of the quality use of medication in the community.

**Issue 8:**

*The majority of RDNS clients receiving medication management have dementia. Few of these clients receive comprehensive care based on current nursing and medical assessment and review.*

It is estimated that the majority of clients receiving medication support have dementia (RDNS has approximately 800 clients with dementia). Another important finding is that the majority of clients with dementia lived alone (69% of those observed). Despite a need to provide comprehensive care for this client group, a task-orientated rather than a person-centred approach appeared to drive nursing practice. The principles of Primary Health Care as a framework for community nursing care were rhetorical when findings indicate that few clients had documented a complete nursing assessment (using the Client Needs Assessment tool). Importantly, many RDNS clients receiving medication support had poly-pharmacy issues that made a complete and thorough assessment important. The average number of medications taken by observed clients was 6.34. Best practice requires people taking in excess of four medications per day to have their medications reviewed regularly. A Home Medication Review (HMR) had not been arranged for any of the clients who were involved in the research.

The findings, in consultation with the wider literature, suggest that this particular client group is at significant risk. The absence of a confirmed medical diagnosis has been considered a precursor to the 'at risk' status. Diagnosis begins with eliminating treatable causes of dementia. There are clear diagnostic steps, which include a detailed medical history, mental status test, neuropsychological testing, blood work, urinalysis, chest x-ray, electroencephalogram, computerised tomography (CT scan) and electrocardiogram. When a detailed examination is undertaken, the accuracy of diagnosis is 90%. It is considered best practice to undertake an assessment and to confirm a diagnosis so that treatment and drug interventions can be included in the client's care plan.

Observation of the clients' records revealed that there were a vast range of terms used by nurses to describe dementia, such as memory loss, Alzheimer's disease, confusion, mild dementia and severe dementia. There was little evidence that dementia had been assessed (following the diagnostic steps outlined above) by a medical practitioner. Less than 10% of clients in this research had a definitive diagnosis of Alzheimer's Disease.

Both medical and nursing practice was found to focus on medication management. When it was recognised that the majority of clients, who have dementia, live alone, take multiple medications and have not received either a medical or nursing assessment, the opportunity to plan for current or future management was negligible. This community dwelling client group with dementia has been identified as very vulnerable and at significant risk of harm.

## **RECOMMENDATIONS**

1. Clearly articulate the expectation that all staff will complete a comprehensive nursing assessment and regular, systematic review of clients with dementia.
2. Time allocation for working with clients with dementia is negotiated. The District Nurse initiates negotiating additional time with Team Leaders and Consultants.
3. Review the dementia clinical pathway in light of this report's findings.
4. Instigating a planned intersectoral (e.g. with GPs and Pharmacists) collaborative approach for assessment, referral and review of clients with dementia.
5. Provide educational support for RDNS staff in Primary Health Care Principles to guide comprehensive nursing practice (Primary Health Care Package to be developed and evaluated by the Research Unit and rolled out across all RDNS staff by the Education Centre).
6. Ensure District Nurses are conversant with the latest diagnostic, treatment and planning nursing interventions for people with dementia (educational preparation of all staff in dementia care is the professional responsibility of each staff member with support and resources from the Education Centre). Refer to core competency recommendation construct 2.
7. Articulate clear referral guidelines for Home Medication Review that includes all clients.
8. The organisational ability to respond to the needs of this client group (particularly those with stage 2 dementia) should be reconsidered.

**Issue 9:**

***Medical Authority for medication administration is problematic in terms of legality, legibility and receipt of timely authorities;***

The most problematic issue in medication practice in the community was the authorization of medication by the prescribing medical officer. The difficulties associated with obtaining a legal, legible and timely authority made this issue a strong theme in both the observational data and the nurse interviews.

RDNS nurses require the prescribing medical officer to supply a legible authorisation when requesting medication administration and following alteration of any medication (Reviewed 2000). A complete updated authority is obtained on a three-monthly basis, whenever there is change to the client's medication regime or when orders become confusing, thereby compromising safe practice. The RDNS policy for quarterly update of authorities is based on Australian Medical Association (AMA) and Royal Australian College of General Practitioners (RACGP) guidelines that recommend regular medication reviews.

The current practice for medication authorisations involves a medication authority being provided at referral of the client. Referrals to RDNS are channelled through the RDNS Call Centre and the authorisation is usually a facsimile. When admitting the client, the District Nurse (registered) then transcribes the medication list onto the medication administration record for the purpose of noting administration (Policy 2.CP.43). District Nurses are required to administer medications from the medication authority form and not the administration record. It is the role of the District Nurse to request regular updates (three-monthly) of the authorisation record and this has been in place for approximately 7 years. One way this has been orchestrated is through sending a facsimile to the GP or medical officer requesting an authority update. The request describes the need for three-month review and asks the medical officer to complete and return same. One other way to gain an updated authority is when GPs make a home visit.

Observational data raised many concerns about legibility and the time wasted by nurses tracking authorities. Three main concerns were identified; timely authority, legalities and legibility. For the process of a three month authority the nurse alerts the doctor that it is time to review the medications and then the doctor needs to return an authority that is legible. There was an enormous amount of nurses' time and effort put into trying to obtain authorities. There seemed to be a lack of understanding about the rationale for the authorities from both the nurses and the medical officer (usually the GP). A significant issue for nurses is that authorisations were frequently not legible and/or were incorrect, not dated and/or signed. Nurses were concerned about the risk of error that was associated with the transcription of medications from the authority to the administration form and the legalities inherent in this practice.

One other legal issue of concern was the administration of medications without an authority. Observations highlighted that there were illegible authorities, nurses adding to medication authorities with verbal orders, and confusing

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authorities with some medications crossed out. Some authorities did not have dates but the nurse told the researcher that it is acceptable to use the date from the fax. Other observations made were changes to authority forms without a GP signature. Nurses rely heavily on a legible authority when administering medications. Doctors' illegible handwriting increases the chance of error and also wastes time for the nurse who may require that another form be written.

To provide a general guide, the 'standard' of authorities were graded by researchers as good, average or poor. The grading was based purely on legibility and did not take into account other legal issues such as date and signature. Authorities that fell into the category of good were typed, while average were usually handwritten and legible. Poor authorities were bordering on illegible or were illegible. Of the authorities available for viewing, (n=39) 15% were good, 40% were average and 43% were of poor quality. These statistics demonstrate the widespread problem of poor quality authorities.

## **RECOMMENDATIONS**

1. That the Nursing Practice Committee reviews documentation and guidelines for current medication authority and considers:
2. On the authorisation form, increasing the space to write dose, frequency and updated phone numbers.
3. On the authorisation form include a statement outlining the intent of the authority and state preference for signed computerised print out.
4. On the authorisation form, place a review section on the bottom of the authority which enables GP to sign and date that she/he has reviewed medications (space for 4 review dates to ensure new authority written every 12 months).
5. Review wording of the policy for medication administration 2.CP.43, ensuring that the rationale for three monthly review is included.
6. Changing policy 2.CP.43 to read that signed computer printouts are the preferred method of authority as this will improve readability.
7. That nursing staff be instructed to include a spare blank medication authorisation form in the blue folder at all times.
8. Review the process and safety of the transcription process taking into consideration guidelines endorsed by organisations such as APAC and DVA.
9. That a recall system be set up to ensure three monthly review of authority occurs in a timely fashion. A reminder could be placed on the call sheet as to ensure that the GP has plenty of time to review the medications properly.
10. That the organisation consider ways of engaging General Practitioners in discussion and debates around the issues of medication authorisations so that client safety can be assured.

**Issue 10:**

***Lack of intersectoral communication is evident. The District Nurse is often left out of the information loop in the transfer of client information, coordination of services for clients and post discharge from hospital.***

The deficit of collaboration and/or coordination was a common thread throughout both the interview data and the observational data. Findings highlighted the limitations of current practice and intersectoral collaboration. Intersectoral communication referred to the communication channels across different sectors, such as hospitals, pharmacies, community agencies and general practitioners. Direct communication with RDNS post hospitalisation or outpatient visit was shown to be problematic. It was evident that RDNS frequently do not receive a copy of discharge letters (unless arranged by hospital liaison) and that discharge planning from hospital may be less than optimal.

Appropriate communication, discharge planning and documentation are of profound importance when the client has a diagnosis of dementia and/or is a poor historian. The result of poor intersectoral communication is time wasting and frustrating for community nurses and their clients. Data suggest that intersectoral communication is, at best, fragmented and that nursing is often left out of the information loop.

The nurse who visits clients daily for medication management is in an excellent position to provide ongoing monitoring and assessment of clients needs. The GP could be the pivotal point for the coordination of care for clients requiring medication management. The Commonwealth, through provision of financial support for case conferencing and Home Medication Review reinforces this role for GPs. The reality is that GPs may not always use these provisions. Data suggests that the GP appears to be a reluctant partner in communicating the client's treatment details with the District Nurse. While GPs may receive a hospital discharge summary, the District Nurse is excluded from this information source. In addition, the client's readmission to hospital may be related to poly-pharmacy. Risk is intensified when there are few communication strategies in place for District Nurses, GPs, hospitals and pharmacists to work collaboratively in the interest of this client group.

Given the situation described above, it seems vital that services are effectively coordinated for this client group. It is noted that GPs and pharmacists are working together on Home Medication Review but that District Nurses have been left out of the information loop. District Nurses are already involved and visit these clients daily, hence it is timely that District Nurses be incorporated into the existing medication management model to improve the outcomes for this complex client group. Improved assessment, diagnosis, care planning and ongoing monitoring by District Nurses will radically improve outcomes for these clients.

## RECOMMENDATIONS

1. That the organisation consider:
  - 1.1 A grant proposal, to explore ways for collaborating with other agencies to provide an improved model of care for this group of RDNS clients with dementia, be submitted to appropriate funding bodies. Collaboration partners are being identified.
  - 1.2 Explore funding possibilities from the Pharmacy Guild to look at how we can collaborative with GPs and pharmacists towards improving care for an RDNS client group with dementia. Collaborative partners will be the Quality Use of Medicines and Pharmacy Research Centre (QUMPRC), Divisions of General Practice and the Pharmacy Guild. The proposal will explore the addition of District Nurses as partners in the current Home Medication Review model. A proposal was submitted to the Pharmacy Guild 21 March 2003.
  - 1.3 To improve access to medical and pharmacy information for current RDNS clients, utilising the guidelines from the recently published *“Principles for the Continuum of Quality Use of Medicines between Hospital and Community”*.

*What is current medication management*

## **WHERE TO FROM HERE?**

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The Project Management Team has agreed on a number of recommendations to address the concerns, claims and issues raised in this report. The overall recommendation from the report is that RDNS Nursing Executive implements structures and processes for ongoing review of medication management. This process has already commenced with the introduction of the Primary Health Care package for District Nurses. It is envisaged that this package will pave the way for a primary health care approach to community nursing.