Healthcare Assistants as Second Checkers of Controlled Drugs for Timely Symptom Management in a Hospice Setting

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Summary
Staff at a palliative care unit identified the need to improve symptom management for patients. The goal was to look at a complete change in process to establish a facilitated training programme to allow healthcare assistants to second check controlled drugs. A successful application was submitted to the Foundation of Nursing Studies (FoNS) Patients First Programme for support with the project.

The project team consisted of the clinical nurse specialist, ward sister, two staff nurses and four health care assistants to represent each area of the nursing team. The project team identified key stakeholders and engaged them in order to promote the project, enhance successful change management and support the implementation and development. Various methods and approaches were used to ensure continued engagement throughout the project. It was felt it was important for the team to establish common ground in relation to beliefs and values when looking to develop patient centred care through workshops incorporating various methods to achieve this. A new policy was developed for the project and a competency framework was developed to ensure robust risk management and continued guidelines for future practice.

Skills acquired by team members through being involved in this project include facilitating learning and development days, report writing, project management and witnessing the administration of controlled drugs.

The project has resulted in improved symptom management for patients on the inpatient unit. In addition, it has improved the HCAs level of knowledge and feeling of worth and fostered a culture where change and innovation are embraced by the team. The project continues to be successful with continued learning and development days for new and existing HCAs.

Background
Compton Hospice is an established charity that provides clinical and support services for people with life limiting illnesses and their carers and families. The hospice provides care to a population of 1.3 million people and provides care that is commissioned by six clinical commissioning groups (CCGs) (Compton Hospice, 2011), namely Wolverhampton, Walsall, Dudley, Sandwell, South Staffordshire and East Shropshire. The hospice comprises of an 18 bedded inpatient unit (IPU) that specialises in palliative and end-of-life-care.
The inpatient Unit (IPU) team consists of:

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
<th>Shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior sister</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td>4</td>
<td>4 day and 2 night shift</td>
</tr>
<tr>
<td>Staff nurses</td>
<td>16</td>
<td>16 day and 4 night shift</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>17</td>
<td>17 day and 10 night shifts</td>
</tr>
</tbody>
</table>

The goal of symptom management in palliative care is to prevent or treat as early as possible the symptoms of a disease (Buckley, 2008). If not treated effectively, unnecessary suffering, depression, impaired sleep and immobility occurs (Adams and Field, 2001). Furthermore, studies of inadequate symptom management have shown families/carers are dissatisfied with end-of-life care and this increases their psychological burden (Ersek and Wilson, 2003). Patients at end of life frequently require strong pain killers (analgesia) and often only controlled drugs such as diamorphine or morphine are effective.

National policy dictates a controlled drug has to be administered by a registered nurse (Nursing and Midwifery Council, 2008). However, the process of second checking drugs is not clearly specified. It is recommended as best practice that for the administration of controlled drugs a second person is required to check the prescription, the preparation, the administration and complete the process with a signature in secondary care and similar healthcare settings (Nursing and Midwifery Council, 2007; National Patient Safety Agency, 2006). Furthermore, the Misuse of Drugs Act (Department of Health, 1971) states that all drugs under schedule two of the register, that is diamorphine, methadone and morphines, are subject to the full controlled drugs requirement relating to prescribing and safe keeping. All controlled drugs, when administered, are recorded on the relevant drug chart but also in a register by law to ensure there is continued documentary evidence on the amount of each controlled drug held and administered on the premises. These control measures are to prevent misuse, to prevent drugs being obtained illegally and to prevent harm as specified by The Misuse of Drugs Act Regulations (Department of Health, 2001).

At Compton Hospice the process of administering a controlled drug requires two registered nurses to check the prescription, the preparation and administration and the process is completed by signing the relevant drug prescription sheet and the controlled drug register. However, the Nursing and Midwifery Council (2007) states that, although normally the second person in the checking process should be another registered healthcare professional, in the interests of patient care, where this is not possible, a second suitable person who has been assessed as competent, may support the process.

Feedback from a family member about the length of time it took for their relative to receive analgesia highlighted to the project team at Compton Hospice that due to workforce pressure, sometimes symptom management for patients was not timely and this was a cause for concern. When a patient requires strong pain relief such as a controlled drug, registered nurses often spend time looking for another registered nurse to ‘second check’ the drug. This can mean interrupting patient care or waiting for a nurse to become free, in the interim, the patient is left waiting, sometimes for a considerable length of time in pain.

### Internal audit
Initially following the feedback from the family member, a mini internal audit was conducted by the clinical nurse specialist, to identify the extent of the problem. Using a stopwatch and table, the time taken from the patient requesting medication for symptom management to actually obtaining the drug
was recorded over a month period. Prior to the audit, the senior nursing team met, discussed and agreed that a standard of ten minutes would be best practice for completion of this process, taking into account everything that needed to be done: Locating trained staff members, obtaining the treatment chart, measuring and checking of the drug, recording in the Controlled Drug (CD) registers, getting back to the ward and administering it to the patient. Fifteen measurements were taken randomly by the clinical nurse specialist over the month period by observing and recording a request for symptom management and waiting until the patient was actually administered the medication.

Comparison of audit data times against 10 minute standard (beginning of project)

As can be seen from the graph, length of time ranged from 8 – 20 minutes with a mean score of 16 minutes. Only 13% of patients (2 out of 15) were given their pain relief within the ten minute standard, 87% were outside the accepted range. Furthermore on thirteen occasions it was a healthcare assistant who was initially informed that the patient was in pain, indicating a search for not only one member of trained staff but two.

The results of this audit led to an application to the Foundation of Nursing Studies Patients First Programme which was successful and provided direct workplace support and a small bursary for the project team. It was hoped by the project team that this project had the potential to achieve in several areas: Primarily reducing the time taken for patients to receive medication to relieve distressing symptoms and secondly for the nursing team to have the opportunity to increase their knowledge, skills, competence and confidence in practice.

Aims and objectives
The aim of the project was to develop the healthcare assistants’ skills and role to enable them to become second checkers for controlled medication and introduce this new process to the hospice.

Objectives
- To engage stakeholders to ensure organisational support regarding change management
- To adapt the current medication policy
To design a new policy to be used at the hospice looking at witnessed checking by healthcare assistants, to underpin good practice
To organise workshops for staff by acting as facilitators, to support the change
To design training and development specific to the needs of the organisation
To incorporate HCAs as second checkers into practice

Methods and Approaches
A number of approaches were used to facilitate the changes in practice. These included:
- Stakeholder engagement, including nursing staff survey and regular project team meetings
- Develop of new Medicines Policy
- Preparation for HCA second checker role:
  - Introductory workshops
  - Learning and development skills days
  - Competency development
- Evaluation

Below is a summary of the methods used and the timings involved.

<table>
<thead>
<tr>
<th>Method</th>
<th>Timings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder engagement</td>
<td>Jan-Aug 2014</td>
</tr>
<tr>
<td>Review medicines policy</td>
<td>Jan-March 2014</td>
</tr>
<tr>
<td>Preparation for HCA 2nd Checker role</td>
<td>May-Aug 2014</td>
</tr>
<tr>
<td>Introductory workshops for all nursing staff</td>
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<tr>
<td>Development of competencies and training programme</td>
<td></td>
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<tr>
<td>Learning and development skills days - Phase 1</td>
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<tr>
<td>Competency assessment - Phase 1</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>March 2015</td>
</tr>
</tbody>
</table>

Stakeholder Engagement
In a multi-faceted organisation, such as Compton Hospice, it is vital that employees and stakeholders understand the goals they are working towards and just as importantly feel motivated to do so (Elvin, 2012). After a stakeholder analysis at one of the FoNS workshop days, the team identified stakeholders. The following stakeholders were identified: the Board of Trustees, who would need to ensure risk to patients was minimal and staff on the inpatient unit, who needed to see the benefits of the proposal. Furthermore patients would need to be consulted for their feedback and engagement. The vision of engaging all stakeholders to support and influence the suggested changes was seen to be challenging; there were difficulties associated with accessing board members and the rapidly changing health needs of end of life patients, but they were not considered insurmountable.

Hospice board presentation
As Govier and Nash (2009) discuss, a major challenge for nurses is how to ‘take the bedside to the boardroom’. The hospice board meetings are only usually attended by trustees, chief executive and directors and accountants, therefore gaining access for the project team was perceived to be a challenge. To overcome this, the project lead in conjunction with the team identified that the annual board report meeting was a good opportunity to introduce the project to the board members. The project lead used a PowerPoint presentation to introduce and promote the positive aspects of
improving patient symptom management. This presentation was received positively by the board of trustees.

**Heads of departments**
Within the hospice, monthly meetings with heads of departments, which the project lead routinely attends, were used for promoting the project and to ensure continued engagement with this group of staff within the hospice.

**Nursing staff – inpatient unit**
The project lead designed a survey (see Appendix 1) to explore the opinions and feedback of staff on the inpatient unit. The survey was accompanied by an introductory letter (see Appendix 2). The survey was designed to:

- investigate nursing staff thoughts about whether the proposed change would improve efficiency and patient symptom management
- gauge the level of commitment to the project
- explore thoughts and feelings and give the team an opportunity to voice recommendations or suggestions to ensure successful implementation of the project

The survey was anonymised to allow for truthful thoughts and feelings to be expressed. A total of 56 questionnaires was sent out to include all nursing staff members on the inpatient unit, of which 15 were returned completed (27%). This was a disappointing return rate as it was felt by the project lead that the enthusiasm for the project would have encouraged a higher return rate. The main factor thought to affect the return rate was time as the ward was extremely busy when the questionnaire was sent out. Despite this, the return rate is representative of a third of the nursing team on the inpatient unit, and the results are discussed below.
**Results of questionnaires**

**Response to initial Staff Survey**

- Lecturer Practitioner: 1
- Sister: 3
- Nurse: 4
- Health Care Assistant: 7

**Do you feel the proposed change will improve patient symptom management?**

- Strongly agree
- Agree
- Neither Agree or Disagree

**Are you confident that using HCAs to second check controlled drugs will improve efficiency?**

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree

**How committed are you to the success of this project?**

- Moderately Committed
- Very Committed
- Strongly Committed
- Agree

**With the proper training you will have the necessary knowledge and skills to adapt to the new system (HCAs only)**
The project team themed the results of the survey and formulated an analysis. It was interesting that the largest group of returned surveys were from HCAs (lecturer practitioner=1, sister=3, nurse=4, HCA=7). All staff agreed (n=8), strongly agreed (n=2) or had no concerns either way (n=5) that the proposed change will improve symptom management. Only one person disagreed that HCAs would improve efficiency regarding symptom management, the majority of respondents agree efficiency would indeed be improved (n=14). All of the seven healthcare assistants that responded either agreed (n=4) or strongly agreed (n=3) that with the proper training, they would have the necessary skills to adapt to the new system. Lastly, all respondents indicated that they were either very committed (n=7) or moderately committed (n=8) to the project.

<table>
<thead>
<tr>
<th>Thoughts</th>
<th>Feelings</th>
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<tbody>
<tr>
<td>• Staff nurses will need to feel confident that the training is effective and knowledge from a HCA perspective is robust</td>
<td>• Great morale boost for HCAs</td>
</tr>
<tr>
<td>• Will benefit patients</td>
<td>• Feel the staff nurses won’t accept change</td>
</tr>
<tr>
<td>• Will free up busy staff nurses</td>
<td>• Worried about using controlled drugs</td>
</tr>
<tr>
<td>• Give HCAs more responsibility</td>
<td>• Feel worried, nurses have a NMC registration number for a reason</td>
</tr>
<tr>
<td>• Tremendous opportunity for staff and the organisation</td>
<td>• Feel nurses risk losing their jobs</td>
</tr>
<tr>
<td>• How long will it take?</td>
<td>• Feel concerned about responsibility</td>
</tr>
<tr>
<td>• Will all HCAs be checking drugs or just those who choose to?</td>
<td></td>
</tr>
<tr>
<td>• If something goes wrong what support will staff receive?</td>
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Suggestions and recommendations were robust guidelines and training, continued support for the HCAs and nurses and a meeting for all staff members to voice concerns.

**Patients and carers**

The project team also felt it was important to involve patients and carers for their feedback. The story telling of life, illness and of dying is a dynamic process which nursing textbooks can’t capture (Hawkins and Lindsay, 2006). Moreover, Fairbairn (2000) suggests that story telling should be used less as a method of data collection and more of a way of listening and learning from the patient. This was discussed at a workshop as an excellent way of engaging patients to be part of the project and to hear their ideas. To ascertain the patient perspective from a symptom management view, key questions were established to draw the focused narratives:

• What are your symptoms?
• How long have you been having these symptoms?
• How quickly have we responded to your symptoms?
• How long was it before we got your symptoms under control?

A team member, who was a registered nurse, interviewed five patients, who were well, on the inpatient unit over a period of a week. Although there was some degree of qualitative data collection due to using open questions, no new information was obtained by doing this exercise. In hindsight the questions were related more to health assessment than patient讲故事telling and if using this exercise in the future, there would be a need to rethink our strategy, maybe using Evoke cards (Stokes, 2014)
(www.evokecards.com) to assess thoughts, feelings, and ideas. However the patients shared the team’s enthusiasm for the project and felt it to be an excellent idea.

The project team
The project team was recruited from the inpatient unit staff by advertising using a poster in the nurses office asking for motivated individuals to contribute to the project. As more team members applied than were places, individual names were drawn out of a hat to promote equity. The project team consisted of the project lead, senior sister, two staff nurses and two healthcare assistants. Initially the team met regularly to assess progress of the project and to assign individual tasks to team members. This enabled focus on the project, the objectives and on a plan to design a pathway to achieving the project. It was also a platform for ensuring continued motivation, momentum and communication with other stakeholders (see Appendices 3, 4 and 5 for minutes of the meetings). The minutes of each meeting were communicated to the wider inpatient team via communication folders at the nursing station.

Newsletter
Finally the project was promoted via the monthly Compton Hospice magazine which goes out to all staff, volunteers and stakeholders. This promoted the ward’s successful application for the Patients First Programme and outlined the suggested proposals.

Development of policy
In order to provide organisational guidance, a policy was needed to define the HCA second checker role according to current evidence and risk management. This policy would support the necessary measures to strengthen and support this role for care quality (Royal College Nursing, 2009). Research was undertaken into the practice of other Health Authorities that had established the witnessing of controlled drugs by perusing the internet and speaking to other hospices. Furthermore, a neighbouring hospice sent their version of a policy which was current and up-to-date; this was a great asset. Using the online literature evidence from current policies and guidelines around medication administration and the current literature from the Nursing and Midwifery Council (2007) and the National Patient Safety Agency (2006), the team created a new policy following guidelines on the Compton Hospices intranet. This was proof read by the team and sent to the governance board for ratification. In addition, a gold standard competency framework was inserted as an appendix for all HCAs to work towards. This was developed using standards for medicine management (Nursing and Midwifery Council, 2007) and follows the expectations in drug administration of a registered general nurse. It was planned that this would be used following the training to assess competency prior to becoming a second checker.

Preparation for the HCA second checker role
The project team undertook a variety of workshops and learning and development skills days to enable HCAs on the inpatient unit to look at the benefits of developing their role. These were:

1. Introductory workshops
2. Learning and skill days
3. Competency assessment

1. Introductory workshops
The FoNS facilitator visited Compton Hospice with the project team to discuss potential workshop content. Items considered for inclusion were:

- What does patient centred care look like?
- How is patient centred care achieved?
- What does participation look like?
Describe your workplace culture?

Elvin (2012) suggests that a facilitative two way process is an effective way of communicating organisation values ensuring change is embedded in workplace culture. This evidence is further supported by McCormack and McCance’s (2010) model, which states that active learning in and from practice, along with systematic approaches in the use of the heart, mind and creative energies will lead to person-centred cultures for human flourishing. To enable this to happen, a programme for the workshops was developed that included a values and beliefs exercise with an element of reflection and included creative activities. Manley (2000) suggests that engaging staff in workshops and values clarification when preparing for change gives ownership of the project to all, opportunities for discussion and to voice concerns. As the change in effect would create challenges for the whole team it was vital for an opportunity for two way communication to be created.

A poster was created for the office advertising these introductory workshop events and inviting nursing staff to attend. The workshops were two hours long; two were scheduled to take place in one day with the attendance of the FoNS Facilitator for support and to facilitate the initial session. A room was booked that was large enough for all attendees. Refreshments and arts and crafts materials were purchased from the bursary to be used during the workshops. The bursary was also used to pay for backfill to cover the ward to ensure patient care was not compromised.

During the workshops, by way of introduction, two of the project team introduced the project to the participants to start their journey on the ‘second checker project’. The project team decided to use Evoke cards to help stimulate conversations and make it easier for participants to talk about their feelings (Stokes, 2014; www.evokecards.com). Participants were invited to select an Evoke picture card which best represented their personality. This ice breaker set the tone for the event and the atmosphere was upbeat.

After that, participants were asked to work individually on the values clarification exercise and answer the key questions for themselves in relation to person-centred care, but then were asked to share and turn their responses into a team view focusing on common themes and highlighting differences. This was used as the foundation for creating a poster of what patient centred care looks like. An evaluation of the exercise was conducted and without exception participants found they had similar values and beliefs. It was felt that there was a strong team ethos already embedded in culture on the inpatient unit which could drive forward successful change.

The participants were then offered the opportunity to reflect on a patient who they had cared for at the end of life utilising Gibbs (1988) reflective model. Again, these were shared and common themes were identified through discussion and analysis. Verbal feedback suggested all staff were fully committed to improve and drive excellent patient care. After the project team delivered the workshops they viewed a positive change in the engagement and participation of staff. The project was discussed more confidently and with anticipation as opposed to dread.

2. Learning and skills development days

Preparation

In preparation for the learning and skills development day, the project team met to analyse the policy and competencies to design an effective programme that would incorporate objectives. This was arranged away from the hospice to enable effective and uninterrupted working. The aim was to look at scenarios, symptoms and their impact on the patient and controlled drugs. Pharmacological and non-
pharmacological symptom management were also discussed including, symptom management with drugs and holistic symptom management strategies such as position change and fan therapy. The objective was not just to assume symptoms can be managed by drugs alone. Including the HCAs ensured it was pitched at the right level and ensured HCAs had ownership of their training programme.

There were six team members involved, four HCAs, the project lead and another registered nurse, split into three groups initially to research controlled drugs, their effectiveness, side effects and interactions which the HCAs found a really good learning exercise. Non-pharmacological interventions were also discussed as first line treatments. We separated into groups to look at each symptom from a holistic and drug management perspective for the training day. It was to ensure that from a HCA perspective it was pitched at the right level for understanding. Due to some of the challenges identified in the earlier survey, a discussion around assertiveness to enable effective communication as a second checker was incorporated into the programme for the day and was felt to be an important part of the training. HCAs had identified challenging a nurse if an error was identified as an issue.

From a legal perspective the team felt that asking the pharmacist to be involved would be an effective way of delivering accountability, documentation and controlled drug laws. The pharmacist agreed to be involved in the training.

It was decided that the morning part of the learning and skills development day would be quite in-depth with symptom management, pharmacology, the law and the 6 Rs (right patient, right date, right time, right drug, right dose and right route). It was felt to continue engaging trainees, the afternoon would be scenario based where complete interaction would be needed. The scenarios were designed by the two nurse facilitators outside the planning meeting so that the HCAs that were involved in planning the workshops wouldn’t know the content and to ensure fairness for other staff members. The team designed and made replica controlled drug books for documentation, created ‘pretend’ drug liquids, ‘tic tac’ tablets and used water ampuoles for drawing up, thereby creating the props for the three different assessment scenarios. A chart was devised defining the key objectives for the day following discussion (see Appendix 6). Concerns were discussed around how to help participants remember the checking procedure and a mini booklet was designed for use once competent to explain the 6 Rs checking procedure, calculation formulae and basic principles (see appendix 7).

To ensure learning competencies had been identified the team needed a way of assessing. To conclude the day a maths test would be required related to each of the different scenarios. These were devised using realistic scenarios of daily events on the ward. To establish validity and staff ‘buy in’ to the training, nurses were also asked to complete it. This caused great hilarity and team working as nurses realised the test was actually quite difficult. As the test required working out to be shown with the formulae, nurses had to revisit the basics of their training and it was a very interesting assessment process.

So finally, there was a plan, a method of delivery and an assessment. The two team leaders were going to deliver the initial training with pharmacy support and had creative materials to enable effective learning that had been learned during the FoNS workshops. Finally the training programme was assessed by our Director of Nursing as the accountable officer to ensure it was robust from a risk management perspective.
**Implementation of learning and development day**

As agreed at the team meetings one nurse and the clinical nurse specialist facilitated the learning and development day because as nurses, competencies for administering medication had already been obtained. A room at our partner site, the Cedars was arranged. A promotional poster was designed and marketed looking for six HCA volunteers. Due to high levels of demand, names were chosen out of a hat to ensure equity; six HCAs attended to pilot the initial training (see Appendix 8 for agenda for the day).

The six HCAs selected to participate in the pilot learning and development day attended with some reservations. However, the icebreakers and cakes and biscuits broke the tension. The introduction commenced with comical pictures that lightened the mood. One of the facilitators attempted a creative tap dance, using different ways of getting the message across. The facilitators established confidentiality by stating that anything discussed that day would remain in the room and told all participants not to be afraid to ask questions. The aims and objectives of the day were explained including the fact that although there was a ‘maths test’ at the end, the participants would have plenty of prior practice there would be no judgements on their part.

The morning was theory based and was quite intense; therefore to break the tension the facilitators commenced a role play scenario with comedy including maths calculation using the formulae. This will be part of the agenda in future training sessions. Lunch was provided using the bursary and was welcomed as a treat by the HCAs.

The practical sessions during the afternoon supported the theory based knowledge and reinforced learning. The HCAs were split into two teams with the scenarios and treatment sheets. Each had to take it in turns to be the second checker, nurse and observer and give feedback to each other. This established that some of the scenarios didn’t link closely to the treatment sheets; therefore in future the patient in all scenarios will have the same name. It was felt that reinforcing the importance of documentation occurred numerous times during the day and so this will be added as an agenda item for the next learning day.

All HCAs were successful in getting 100% in their tests. We provided them with a certificate and their HCA competency booklet.

An evaluation form that the facilitators had devised to identify future training needs and concerns was given to all participants for feedback. The questions are listed below:

- In your opinion were the course objectives met: fully, mostly, partly, not at all?
  All participants ticked **fully**.
- How useful were the sessions outlined below: very, to some extent, not really?
  All participants ticked **very**.
- Was a safe learning environment established: yes or no?
  All participants ticked **yes**.
- How would you rate the quality of the course facilitation: excellent, very good, good, satisfactory, not so good, poor?
  Three participants ticked **excellent**, 3 participants ticked **very good**.
- How was the timing and pace of the course: too fast, about right, too slow?
  All participants ticked **about right**.
What has been the most useful aspect of the course?

- All aspects useful
- Drug calculations
- The drawing up of medications, practical part, what categories different drugs are

What has been the least useful aspect of the course?

No participant identified any aspect

How will this learning affect the way you work?

- To be able to act as a second checker with confidence
- Enhanced my practice skills
- Given me the appropriate knowledge to bring into practice effectively
- Help to work more as a team

Comments

- Fab day, fab tutors, most enjoyable
- A very good day
- Thoroughly enjoyed the day

The feedback from the training session was extremely beneficial and gave the facilitators the confidence to continue. As it was the initial training feedback was requested on different aspects of the day to establish whether changes would be needed for future learning and development days. Verbal feedback also identified that the maths test wasn’t as ‘scary’ as had been thought.

3. Competency assessment

In accordance with the competency framework in the new policy, all the HCAs that attended the training had to observe three different types of controlled drugs being given and all the checks. They then had to be observed acting as a second checker for three controlled drugs; injection, tablet, patch or liquid to achieve their competency. This stage proved challenging. Firstly, it proved to be difficult and challenging to get nursing staff to ask the HCAs to be supervised in checking controlled drugs and furthermore, the HCAs were often busy giving care to another patient. However, champions were identified in the nursing team who encouraged HCAs to accompany them to the treatment room and the learning and development day facilitators would regularly attend to witness also. Some HCAs achieved their competency quicker than others as these stages happened as and when the opportunity arose. Moreover some HCAs felt they needed longer to practice. The facilitators only signed HCAs off as competent following feedback from staff and personally observing them second check controlled drugs and give them to the patient. The process took from two weeks to two months to achieve, factors which slowed it down included workforce pressure, staff being rostered on night duty only and personal confidence to practice. However, all six HCAs have achieved their competency and are now successfully practicing on the ward. Some nurses had been worried about the change initially. So observing the HCAs in practice served to build confidence amongst the nursing staff that the HCAs were following their training and checking the 6 Rs.

Future development of HCA skills

In order for the six HCAs to become established and confident as second checkers it is noted that they need time to practice in order for their skills to become embedded. There will be a six month rolling programme of continued learning opportunities for all staff and new starters in the future.

Findings and evaluation

Numerous interventions were used to evaluate the success of the project.
Internal audit - before and after project implemented
Initially an audit was conducted to re-evaluate timings from the time the patient requested symptom management to receiving medication. This was conducted over a week period using the HCA second checker with a staff nurse.

At the beginning of the project: pre second checker training

![Graph showing time in minutes before second checker training](image1)

On analysis, post second checker learning and development times ranged between 3 and 12 minutes showing a significant improvement against the 10 minute standard. 73% of patients received their medication within the accepted range, 27% did not. Much of the variation is due to the location of room. However, the team have achieved their objective of significant improvements in patient symptom management.

Post second checker training

![Graph showing time in minutes after second checker training](image2)

In patient nursing survey
The survey was reintroduced slightly changing the initial questions to ascertain stakeholders’ thoughts and feelings and whether they felt the project had made a difference to patient care. In total out of 56 surveys sent out 15 surveys were returned, 27% of staff, again with the majority from healthcare staff. This reflected the same rate as the initial survey and was again disappointing because of the hard work that had been put in by the team. On reflection voluntary paper based surveys did not elicit the volume of response required for this exercise. Therefore for future opinions, different methods would be considered to obtain data.
Do you feel the change has improved patient symptom management?

- **Agree**
- **Strongly agree**
- **Neither Agree/Disagree**

Do you feel that using HCA's to 2nd check controlled drugs has improved efficiency?

- **Agree**
- **Strongly Agree**
- **Neither Agree, Disagree**

Do you feel the HCA's as 2nd checkers have the right knowledge and skills?

- **Strongly agree**
- **agree**
- **Neither agree/disagree**

Are you committed to the Success of this project?

- **Moderately Committed**
- **Very Committed**

Response to Staff Survey Evaluation

<table>
<thead>
<tr>
<th>Staff position</th>
<th>Surveys returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecturer practitioner</td>
<td>0</td>
</tr>
<tr>
<td>Sister</td>
<td>3</td>
</tr>
<tr>
<td>Nurse</td>
<td>5</td>
</tr>
<tr>
<td>Health Care Assistant</td>
<td>7</td>
</tr>
</tbody>
</table>
Thoughts and feelings regarding the new training for HCA second checkers

*I think it has been well thought out, planned effectively, implemented efficiently and delivered excellently*  
Makes dispensing medication quicker, my only fault is forgetting to ask them.  
*It has been very helpful although I do forget to ask them*  
As long as they don’t get too involved with medications that patient care is neglected  
*Good idea in that it speeds up time when staff nurses are not available. Should allow patients quicker access to their pain relief with more persons being able to check drug doses*  
*Some staff nurses are more committed than others to making this a success, but it needs to be a positive move forward*  
*As long as it doesn’t impact on patient care, it has got to be helpful in the long run*

Suggestions or recommendations for future training of HCA second checkers

*I think all staff should have regular competencies, yearly or three yearly*  
Give role daily to a HCA second checker so they have that role whilst on duty.  
*Can second checkers check tablets to take out (TTO)*  
To make trained staff aware and be more positive, we are there to help.  
*Some HCAs do not wish to become second checkers*

An analysis was conducted thematically grouping the information obtained. 73% of staff felt the change had improved patient symptom management with 27% not having an opinion either way. 80% of staff felt using HCAs as second checkers had improved efficiency with 20% neither agreeing nor disagreeing. 87% of staff felt the HCAs had the right knowledge and skills to complete the task and 100% of staff were either committed or moderately committed to continuing the success of the project.

Comparison data from the inpatient nursing survey

<table>
<thead>
<tr>
<th>Questions</th>
<th>1st Survey pre training</th>
<th>2nd survey post training</th>
</tr>
</thead>
</table>
| Do you feel the proposed change will improve symptom management? | Strongly agree 2 (13%)  
Agree 8 (54%)  
Neither agree/disagree 5 (33%) | Strongly agree 6 (40%)  
Agree 5 (33%)  
Neither agree/disagree 4 (27%) |
| With the proper training you will have the knowledge and skills to adapt to the new system? HCAs only | Agree 4 (58%)  
Strongly agree 3 (42%)  
*Only 7 HCAs answered this question* | Agree 6 (40%)  
Strongly agree 7 (47%)  
Neither agree/disagree 2 (13%) |
| Are you confident using HCAs will improve efficiency of delivering controlled drugs? | Strongly Agree 1(7%)  
Agree 10 (66%)  
Neither agree/ disagree 3 (20%)  
Disagree 1 (7%) | Strongly agree 6 (40%)  
Agree 6 (40%)  
Neither agree/ disagree 3 (20%)  
Disagree 0 |
| Are you committed to the success of this project? | Moderately committed 8 (54%)  
Very committed 7 (46%) | Moderately committed 3 (20%)  
Very committed 12 (80%) |
Comparatively, there is a 6% increase in the number of staff feeling the change has improved symptom management for patients. 100% of HCAs felt they would have the new skills and knowledge to adapt to the new system whereas when we asked this question of all staff 87% feel the HCAs have the right skills and knowledge with 13% not having an opinion either way. However it is noted that nobody suggested that the HCAs did not have the correct skills so that is a positive step forward. There is a slight increase of 7% of staff feeling the change has improved efficiency. There is a huge 34% increase in staff feeling very committed to the project suggesting the benefit to both staff and patient has already been felt.

From the qualitative perspective, the majority of staff were positive about the change and could see the benefits of HCA second checkers, the only issue is that sometimes RGNs forget to ask. The more HCAs who develop their competency, the more embedded it will become as a practice and potentially the more utilised they will be.

A healthcare assistant’s experience by HCA Scott Cockayne

“The second checker project has been a very enjoyable experience. Working in a group that includes all team members has bought our team closer together and helped build stronger working relationships that has been beneficial both to ourselves and the patients to whom we offer the highest levels of care possible. From a personal perspective this group has encouraged me to want to ‘learn more, do more and research things’ that would be beneficial to my role and from a work viewpoint, it has meant we can serve our patients better. The nursing staff at Compton Hospice are a dedicated team and putting the patient first is a priority regardless of what else is needed.

The training was thorough and enjoyable. Angela and Caroline with input from me have been very supportive and developed the training plan. We were taught the legal aspects of medication and the appropriate legislation, looked at medications used within the hospice and dose ranges. Furthermore we were taught to read a treatment sheet with particular emphasis on the 6 Rs and documentation. We all had to pass a drugs calculation test that had been tested on the RGNs. It was highlighted that patients sometimes had to wait small periods of time to receive pain relief, which from a specialist centre, we felt we could improve. From a HCA role, this would delay our working day as sometimes we could wait between 10 and 30 minutes for trained members of staff to be free to give pre-care medication so we could start hygiene needs. It could be distressing at times if the patient needed the toilet and needed pain medication in order for them to be able to move. By being able to second check, it has meant these delays are avoided and patient dignity has been protected. Other aspects of being able to second check have been the impact on not only the patient but their visitors who could become upset by the time spent waiting.

I have noticed that since a small group of HCAs have been able to second check controlled drugs, the atmosphere on the ward seems to have improved. Before, it was usual to see a trained member of staff walking up and down the ward seeking another trained member of staff and on a busy day appeared stressed. Now the ward feels calmer as there are now extra people who can assist and this, I believe, helps patients feel calmer due to their surroundings. The project has been generally well received and some staff that were opposed to it have changed their opinion, and are now accepting of the change and finding it very useful. There are still times when staff walk by holding a treatment sheet and don’t ask a HCA, but hopefully in time, once we have established our usefulness it may change.

Some staff have asked whether we deserve a pay rise to reflect our changing role, I said it would be nice to have a reward for doing it, however, by helping speed things up for our patients as well as being able to do our jobs in a timely fashion, this is reward in itself. We build good relationships with our patients and if we as HCAs can do more to improve that, it improves our working experience.”
Discussion
The team felt that the key to the success of the project was engaging the whole team, sharing communication via emails, posters and meeting minutes. The ward team were engaged in workshops which were successful and have had a ripple effect with regard to our way of working. The sisters ‘away day’ incorporated a values clarification exercise which enabled the team to view clarity on our culture. The sisters ‘did the work’ and came up with their own solutions to problems they had identified using posters, art and lots of glitter, which was incredibly empowering. We now have our own workbox, purchased using the bursary to enable us to use art as an expression of ideas in the future. Because the project was implemented over time, this facilitated a thought out change process that was established and embedded into practice successfully. A recent incident form highlighted the fact there wasn’t an HCA second checker on duty at the time, which suggests that some staff are beginning to see an HCA second checker as an expectation on every shift. As more HCAs undertake their learning and development this will become a reality.

Piloting the initial learning and development session was beneficial as it identified changes that were necessary to facilitate learning and to streamline the day. Although the two facilitators felt novice in this role, it was felt the day went well, was extremely positive, with excellent feedback. The FoNS workshops were instrumental in providing grounding and development of facilitation skills which gave us confidence to achieve.

The majority of the bursary was used to provide backfill, using bank staff to cover the ward whilst the team had meetings, training and workshops. This we found was the most successful way of enabling the project to continue and guaranteeing success. As a team, the workshops that we ran for Compton staff enabled them as key stakeholders to actively participate in the foundation stages of the project. The values clarification exercises bought realisation to many staff who initially felt they had different views, that they were united in many significant common values, mainly patient centred care. From the team’s experience, ‘the key is to enjoy the journey, not focus on the end result’.

Challenges
To keep us to plan a GANTT chart was produced (see Appendix 9). This analysed the project objectives, set goals and enabled us to focus. Meetings were scheduled around holidays, staff meetings and doctors round to ensure as many people as possible could attend. However, other hospice commitments often took precedence. During the latter part of the project, high levels of sickness and staff vacancies did have an impact on the project, however these have now resolved and just ‘paused’ the project rather than derailing it. Having the Foundation of Nursing Studies support facilitated continual focus and ensured we refocused to revisit the project and set dates for further learning and development sessions.

Finding suitable patients to interview for the project was also a huge challenge. Patients, who the team had identified as suitable, became too ill or died before further discussion could be completed. This also included the carers as stakeholders who were burdened with the potential loss and grief of their situation. Whilst the team felt burdening the carers with involvement of the project was perhaps inappropriate at times, patient and carer involvement are empowering and transform healthcare (King’s Fund, 2010; National Health Service, 2013).

A second phase of the learning and development sessions has taken place incorporating the recommendations from the pilot. Some of the HCAs that took part in phase 1 of the project will contribute to phase 2 of the project, embedding their change in practice and engendering confidence in new skills and competencies.
Successes
Our project was presented with the inaugural Sue Pembrey Award at the Foundation of Nursing Studies Celebration event for the recognition of innovation in person-centered care. The Sue Pembrey Award was established in order to recognise the memory and contribution of Sue Pembrey, one of the UK’s outstanding nursing leaders, who supported the academic development of clinical nursing and the development of nursing practice through the strengthening of the ward sister’s leadership role. We were proud and honoured to receive this on behalf of the team.

Conclusion
The FoNS team helped us to plan, facilitate the change and progress this project through to successful implementation in ways that we would not have envisaged. The creativity and alternative ways of approaching problems we were shown have helped us immeasurably in our efforts to break down barriers and foster an atmosphere of inclusion and joint ownership. This project has been instrumental in widening the scope for further practice development and instilled confidence and vision in all staff touched by it. Since the initial learning and development day (Phase 1) a further six HCAs have completed their competencies (phase 2) and are now confident second checkers. The picture shows the six HCAs being welcomed by the growing team of HCA checkers.

Picture showing 12 fully competent HCA second checkers post training with the Sue Pembrey Award. The project team have also successfully presented the project at two events.
1) A poster was presented in October 2015 at a local pharmaceutical innovation day in Birmingham. The poster contained an introduction, aims, objectives and methodology as well as results of the project.

2) An oral presentation to a palliative care event for middle managers at Dougie Mac Hospice looking at innovations. This took place in November 2015. Other hospices were interested in changing the delivery of controlled drugs to improve symptom management for their patients.

References


Appendix 1  

Survey

Putting Patients First: A Drive to Improve Efficiency by Utilising Health Care Assistants as Second Checkers in the Delivery and Administration of Controlled Drugs for Timely Symptom Management

Your role at Compton Hospice.

HCA  

1) Do you feel the proposed change will improve patient symptom management?

Strongly agree  Agree  Neither agree or disagree  Disagree  Strongly disagree

2) Are you confident that using HCAs to second check controlled drugs will improve efficiency?

Strongly agree  Agree  Neither agree or disagree  Disagree  Strongly disagree

3) With the proper training you will have the necessary knowledge and skills to adapt to the new system (For HCAs)

Strongly agree  Agree  Neither agree or disagree  Disagree  Strongly disagree

4) How committed are you to the success of this project?

Not committed  Moderately committed  Very committed

5) What thoughts and feelings do you have regarding the proposed change?

6) Please provide any suggestions or recommendations to ensure a successful implementation process?

Thankyou
Appendix 2 (Introductory Letter)
10th October 2013

Dear ________________

We have been successful in obtaining a place on the patients’ first programme run by FoN’s, The Foundation of Nursing Studies. This programme offers support and facilitation in the workplace as well as access to a bursary fund of £5000.00 to support innovative ideas. It is an exciting opportunity for staff to develop skills, attend workshop days in London and improve patient care substantially.

Working title for the innovation:
‘Putting Patients First’, a drive to improve efficiency by utilising health care assistants as second checkers in the delivery and administration of controlled drugs for timely symptom management.

Our initiative was devised following conversations, audit and experience of patients and families and looks at ways of delivering timely symptom management. Although it is ‘good practice’ to 2nd check controlled drugs, the second person does not need to be a trained nurse; this is endorsed by the Nursing and Midwifery Council, Patient Safety Agency and NICE guidelines. However, the 2nd checker does need to be deemed competent to check controlled drugs, therefore robust training need to be designed and initiated.

Providing the Healthcare Assistants (HCA) with the knowledge and skills to second check medication in order to support this activity will increase the available staff to undertake this procedure by 45%. This will undoubtedly enhance the patient’s experience of symptom control. For the HCA this will be a valuable opportunity to increase their knowledge, skill, competence and confidence in practice. For night staff, it will ensure staff are available continuously to provide checks of controlled drugs for timely and efficient care and symptom management.

I will be looking for a small project team of two HCA’s and two Staff Nurses who are motivated to take this initiative forward and who will be available to attend at least two of the workshop days in London. In the event of more staff interested than places we’ll put names in a hat and draw securely to ensure equity.

I do appreciate however there will be concerns regarding this change of process. Therefore I enclose a survey that I would urge you to complete to acknowledge your fears, feelings and thoughts regarding the initiative. It will be completely confidential. I am also available for those members of staff that would like to discuss the innovative with me directly.

Regards
Angela Ives, Clinical Nurse Specialist. Compton Hospice I.P.U.
**Appendix 3  Minutes of Meeting - Foundation of Nursing Studies (FoNS) Project Team - 12th December 2013**

<table>
<thead>
<tr>
<th>Present:</th>
<th>Apologies:</th>
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</thead>
<tbody>
<tr>
<td>Angela Ives (Project Lead)</td>
<td>Caroline Marks</td>
</tr>
<tr>
<td>Scott Cockayne</td>
<td>Surinder Raja</td>
</tr>
<tr>
<td>Vickie Hartland</td>
<td>Amanda Yapp</td>
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<tr>
<td>Claire Gibbons</td>
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<tr>
<th>Item</th>
<th>Discussion</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1 | **Review of staff survey** – Concerns highlighted fell into four categories:  
  a. Roles and responsibilities  
  b. Liability, PIN numbers and insurance  
  c. What rewards were available for taking on increased responsibility  
  d. Perceived as opportunity to cut staff levels  
  Angela stressed that the project is based on putting the patient first and will not impact on staffing levels. It was generally agreed that in a Hospice environment there are limited opportunities for personal development and this is an ideal scenario for staff to extend their skills base whilst contributing to improving patient experience. | FoNS team |
| 2 | **How to we keep staff informed** – It was agreed that staff will be provided with a copy of the minutes of the FoNS meetings. | FoNS team |
| 3 | **Documentation** – all team members have been asked to keep records/diaries of activities as these will help contribute toward the reports that the team are expected to submit to FoNS – Angela confirmed that each team member will be expected to contribute to report writing. | FoNS team |
| 4 | **Project planning** – As the project will run for 18 months a visual representation of key project tasks and the period during which they will be completed would be useful, examples of what these look like to be presented at the next meeting for discussion. | Caroline |
| 5 | **Pilots** – the FoNS team will work together to develop an in depth training programme for Clinical Support Workers to achieve second checker status. All team members to participate in delivery of training. It was agreed that once developed this should be implemented on a ‘pilot’ basis as a test of effectiveness. It was also agreed that those who complete the initial training participate in a ‘pilot’ implementation of Clinical Support Workers as second checkers. At this point another staff survey will be undertaken to get feedback on how effective the pilots have been. | Claire FoNS team |
| 6 | **Review of policy documentation** – Current medicine administration policies are to be reviewed/rewritten to accommodate proposed changes. | Angela Vickie |
| 7 | **The patient and carer perspective** – It was agreed that the patient and carer perspective should be obtained. Focus groups are to be instigated at which experiences and expectations regarding speed of response in management of symptom control can be discussed and shared. | Mandy Caroline |
| 8 | **What does it look like in practice** – Scott and Surinder to visit Severn Hospice where Clinical Support Workers act as second checkers and report back on:-  
  a. The positive aspects of the practice  
  b. Challenges and concerns experienced  
  c. How is item 1(b) above managed at Severn Hospice | Scott Surinder |
| 9 | **Future training days** – A brief overview was given of the initial training days in London and it was confirmed that although Angela will have to attend all future dates for continuity other team members will be given the opportunity to participate alongside her. All FoNS team members to be given copies of handouts provided on training. | Angela |
| 10 | **Link to Productive Ward** – It was agreed that initiatives on the ward should be integrated and Scott is to act as link between FoNS team and Productive Ward team to ensure that information is shared and duplications do not take place. | Scott |
| 11 | **Next Meeting** – February 2014, date to be confirmed | Angela |

**SHOULD YOU WISH TO DISCUSS THE FoNS PROJECT, ASK QUESTIONS, MAKE RECOMMENDATIONS OR RAISE CONCERNS PLEASE TALK TO ANY ONE OF THE FoNS TEAM WHO WILL BE HAPPY TO HELP.**
Appendix 4: Minutes of meeting - Foundation of Nursing Studies (FoNS) Project Team 13th February 2014

**Present:**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Angela Ives</td>
</tr>
<tr>
<td>Vicky Hartland</td>
</tr>
<tr>
<td>Claire Gibbons</td>
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</tbody>
</table>

**Apologies:**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Jo Odell</td>
</tr>
<tr>
<td>Scott Cockayne</td>
</tr>
<tr>
<td>Amanda Yapp</td>
</tr>
</tbody>
</table>

| Caroline Marks|

Although Caroline sent her apologies, she asked if we could check out the documentation in the folder she had been working on. These were a rough attempt at putting together a PowerPoint presentation, an incomplete pocket booklet designed as an aide memoir to give to HCA’s on completion of their training and a Gantt chart mapping the progress of the team and project mapping. The Gantt chart is a useful tool to monitor our progress and give time scales for completion. We’ll look at training of the HCA’s once the workshops have been completed and the booklet is definitely a good idea for the final quarter of the project.

Jo Odell came towards the end of the meeting to introduce herself to the team and explain about FoNS and the Burdett Trust.

A copy of the final draft of the policy was introduced to the team for their perusal and comments. Thanks to Caroline for her work in adapting this from other versions to be utilised at Compton. This is to be presented at the pharmacy meeting, and clinical issues group.

Scott hasn’t had a reply from the Severn Hospice about him and Surinder spending a day to look at the 2nd checker system as yet. A suggestion was made to try St Giles as they have also trained their HCA’s to 2nd check controlled drugs.

Mandy and Caroline have looked at the idea of a carers and patient group; however this has been a difficult task. They have looked at obtaining information from questionnaires to include patient feedback. Jo suggested rather than continue to organise questionnaires, patient stories are a good way to ascertain real concerns and issues. That way there is a two way conversation to share narratives through emotions rather than a tick box exercise. Furthermore using the evoke cards, pictures on one side; words on the other may give further clues to the patient experience. Jo stated we could purchase these from the bursary. Using open questions, such as “can you tell me about an episode when you were in pain/nausea/tired” may open up lots of information to provide accuracy in our project.

Jo also suggested instead of repeating a survey for the health care assistants to look at concerns and issues, having workshops similar to our workshop days in London may be a more productive idea. We could purchase an activity box from the bursary to allow staff to be creative with their ideas and explore beliefs and values and their role in relation to someone in pain. A suggestion was made to look at this idea post FoN’s workshop on the 06/03/2014.

Vicky has been investigating previous concerns regarding accountability of both HCA’s and staff nurses. RCN: The principle of delegation would apply, nurses are responsible for the delegation but not for the individuals practice. If HCA’s are trained and competent they must recognise the limits of their own practice. When HCA’s undertake training as part of their employment, the employer is vicariously liable for the actions of its employees. The employer should have indemnity insurance. There may be a need to have amendments made to the job description or an extension of the current role.

UNISON: If a registered nurse is working with a HCA as the 2nd checker the errors would be the responsibility of the nurse with the Pin number. However if professional indemnity is required the employer is liable. Awaiting response from the NMC.

The training plan will need to be robust to ensure we encompass the above points and to ensure the safety of our patients.

The next meeting will be scheduled in April following the second workshop date.
Appendix 5

Minutes of Meeting - Foundation of Nursing Studies (FoNS) Project Team - 18th June 2014

<table>
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<tr>
<th>Present:</th>
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<tr>
<td>Angela Ives (project Lead)</td>
<td>Scott Cockayne</td>
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<td>Mandy Yapp</td>
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<td>Caroline Marks</td>
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<th>Item</th>
<th>Discussion</th>
<th>Action</th>
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</table>
| 1    | **Visit to St Giles** - Surinder gave feedback on her visit to St Giles Hospice with Scott Cockayne. The original intention had been to observe HCAs as second checkers in practice, however, it transpires that HCAs do not do second checking at St Giles. Instead the time was spent observing practice and comparing it to that at Compton. Differences were:  
  - Kitchen staff (not ward staff) do breakfasts  
  - Monitoring of patients food intake does not take place  
  - The morning handover is longer than the afternoon handover  
  - Shift patterns are different, with an additional twilight shift and longer overlaps during shift changes  
  - St Giles do not use disposable bed pans, they wash out reusable ones  
  - A large separate area is allocated for families which has TV and drinks facilities away from the main ward  
This exercise had been useful as a ripple effect and that some of the differences in practice were a good sources for future improvements at Compton, but not all.                                                                                                                                                                                                                       | N/A        |
| 2    | **Workshops** – Claire and Caroline reported that the initial Workshops in May had been well received. Claire is using the availability of the Stephen Moreton Room and reviewing the off duty to set a future date for further workshops.                                                                                                                                                                                                                                               | Claire + FoNS team                               |
| 3    | **Medicines Management Policy** – Angie confirmed that the updated policy had been ratified and was now available as Policy 69                                                                                                                                                                                                                                                                                       | N/A        |
| 4    | **Report** – Angie advised that the interim FONs report is taking shape. She has used the journey as the basis for the report including how we got the funding and the mini audit. Graphs and thematics illustrate what has been achieved so far. Caroline and Claire have drafted a section covering the Workshops, the team approved the content. Vickie will source a reference to support comments on attendance. Once completed this should be passed to Angie for inclusion in the draft report. Angie may require the FONs team to review and comment on the report before submitting it to Jo Odell. | Angie + Vickie + FONS team                       |
| 5    | **Training** - A sub-committee (made up of Vickie, Angie, Surinder, Scott and possibly Debbie Guest) will develop a training plan for HCAs. The plan will include learning objectives for HCAs, methods of delivery, introduction to the competency framework and have a claims and concerns section (recommended by Jo Odell). The PowerPoint presentation developed by Severn Hospice will be used as a basis but it was agreed that our training will be less powerpoint driven and be more practical. Renate Boetang has agreed to deliver the legal side of the training. August off duty will be designed to allow the committee to develop training. Caroline will prepare a draft training plan for the team to use and circulate this along with the competency framework and Severn Hospice documentation. It was agreed that the first training should be delivered before the next FONs meeting on 18th September. It was agreed that pins/badges should be sourced for HCAs to wear post training to denote their status as second checker. | All FONS team                                    |
| 6    | **Competency framework** – as this forms part of the Medicines Management Policy which has now been ratified it will be used in its present format for training purposes.                                                                                                                                                                                                                                                                                   | N/A        |
| 7    | **Any other business** – The team were informed that there is now a folder on the shared X drive called ‘FONs’ which contains all documentation relative to the project.                                                                                                                                                                                                                                                                              | N/A        |
| 8    | **Next Meeting** – August 2014, date to be confirmed. Debbie Guest to be invited to attend                                                                                                                                                                                                                                                                                                                            | FONS team  |

**SHOULD YOU WISH TO DISCUSS THE FoNS PROJECT, ASK QUESTIONS, MAKE RECOMMENDATIONS OR RAISE CONCERNS PLEASE TALK TO ANY ONE OF THE FONs TEAM WHO WILL BE HAPPY TO HELP.**
### Appendix 6

**COURSE TITLE:** HEALTHCARE ASSISTANTS AS SECOND CHECKERS

<table>
<thead>
<tr>
<th>Key areas of learning</th>
<th>Learning Outcome/Learning Objectives</th>
</tr>
</thead>
</table>
| **1** Background to and principles of drug administration | - Apply the principles for checking medication including the 6 Rs, legibility of treatment sheet and use by dates.  
- Explain the reasons for second checking medication. |
| **2** The law and controlled drugs | - Understand what constitutes a controlled drug by law.  
- Discuss the legal aspects of ordering, storing and disposing of controlled drugs. |
| **3** Methods of administration | - Describe the different routes of administration of medication.  
- Explain the circumstances in which alternative routes are considered appropriate.  
- Interpret the abbreviations related to this. |
| **4** Frequency of administration | - Understand the frequency of medication.  
- Relate frequency of medication to specific symptoms.  
- Interpret the abbreviations related to this. |
| **5** Introduction to symptom control | - List common symptoms observed in palliative and end of life care.  
- Discuss non pharmacological interventions. |
| **6** Pharmacological interventions | - Demonstrate a basic knowledge of which drugs are used for which symptoms.  
- Understand the normal doses (ranges). |
| **7** Understanding the treatment sheet | - Read a treatment sheet.  
- Establish if a drug has been given or is due by reading the treatment sheet. |
| **8** Introduction to formula (the dreaded maths). | - Describe the standard formulae for calculating doses.  
- Convert grams to milligrams to micrograms. |
| **9** Worked examples | - Calculate a scenario based medication using the standard formulae. |
| **10** Practical session | - Calculate a scenario based medication using the standard formulae and draw up pseudo medication into syringes and dispensing pseudo tablets. |
| **11** Common Side effects | - List common side effects of medication. |
| **12** Signs of anaphylaxis | - Recognise signs of anaphylaxis.  
- Discuss what action is required to be taken. |
| **13** Introduction to competency framework | - Understand the competency framework and how it applies to them. |
| **14** Summative assessment | - Pass a scenario based maths test with a mark of 100%. |
| **15** Claims and Concerns | - Assertiveness themselves in the role as second checker  
- Challenge colleagues when they do not agree with calculations or interpretation of treatment sheet. |
| **16** Course close and evaluation | |
# Appendix 7

## Health Care Assistant

### Second Checker Handbook

## Contents Page

1. General Rules for Checking
2. Methods of administration
3. Frequency of Administration
4. Common Symptoms and Medication
5. Opioid Medication
6. Conversions
7. Formulae for Drug Calculations
8. Examples
9. Side Effects
10. Signs of Anaphylaxis
11. Certification 1
12. Certification 2

## General Rules for Checking

- Right Patient
- Right Date
- Right Time
- Right Drug
- Right Dose
- Right Route

- Prescription signed and legible
- Controlled Drugs written in numbers and words

## Method of administration

<table>
<thead>
<tr>
<th>Abv</th>
<th>Translation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO</td>
<td>Per oral</td>
<td>By mouth</td>
</tr>
<tr>
<td>SL</td>
<td>Sub lingual</td>
<td>Under tongue</td>
</tr>
<tr>
<td>S/C</td>
<td>Sub cutaneous</td>
<td>Injection into fat</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
<td>Injection into muscle</td>
</tr>
<tr>
<td>TD</td>
<td>Transdermal</td>
<td>Via patch applied to skin</td>
</tr>
<tr>
<td>PR</td>
<td>Per rectum</td>
<td>Inserted into anus</td>
</tr>
<tr>
<td>PV</td>
<td>Per vagina</td>
<td>Inserted into vagina</td>
</tr>
<tr>
<td>NEB</td>
<td>Nebuliser</td>
<td>Inhaled via nebuliser</td>
</tr>
<tr>
<td>INH</td>
<td>Inhaler</td>
<td>Inhaled via puffer</td>
</tr>
<tr>
<td>TOP</td>
<td>Topical</td>
<td>Applied to skin eg. Skin</td>
</tr>
<tr>
<td>CSCI</td>
<td>Continuous sub cutaneous infusion</td>
<td>Syringe driver</td>
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## Frequency of administration

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tr>
<td>OD</td>
<td>Once a day</td>
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<tr>
<td>BD</td>
<td>Twice a day</td>
</tr>
<tr>
<td>TDS</td>
<td>Three times a day</td>
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<tr>
<td>QDS</td>
<td>Four times a day</td>
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<tr>
<td>Nocte</td>
<td>At night</td>
</tr>
<tr>
<td>Mane</td>
<td>In the morning</td>
</tr>
<tr>
<td>PRN</td>
<td>As required</td>
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</table>

Frequency must coincide with times circled on treatment sheet.

## Common Symptoms & Medicines

### Excess Secretions
- Hyoscine butylbromide
- Glycopyrronium
- Hyoscine hydrobromide

### Confusion and agitation
- Midazolam
- Levomepromazine
- Haloperidol

### Shortness of Breath
- Oromorph
- Lorazepam
Common Symptoms & Medicines
Nausea and Vomiting
Haloperidol
Cyclizine
Levomepromazine
Metoclopramide
Ondansetron

Pain (See pg. 5, opioid medication)
Buscopan for Gastrointestinal pain
Diazepam for Muscle spasm
Gabapentin for Neuropathic pain
Paracetamol for Bone pain

<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength compared to oromorph</th>
<th>Duration of action</th>
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<tr>
<td>Oral Codeine</td>
<td>10 x weaker</td>
<td>3-5 hours</td>
</tr>
<tr>
<td>Oral Tramadol</td>
<td>10 x weaker</td>
<td>4-5 hours</td>
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<tr>
<td>Oromorph</td>
<td>Baseline</td>
<td>3-6 hours</td>
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<tr>
<td>Oral Oxycodone</td>
<td>1.5 x stronger</td>
<td>4-6 hours</td>
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<td>S/C or IV Morphine</td>
<td>2 x stronger</td>
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<tr>
<td>S/C Oxycodone</td>
<td>3 x stronger</td>
<td>4-6 hours</td>
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<tr>
<td>S/C or IV Diamorphine</td>
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<td>3-4 hours</td>
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<tr>
<td>Oral Hydromorphone</td>
<td>7.5 x stronger</td>
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<tr>
<td>S/C Hydromorphone</td>
<td>15 x stronger</td>
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<td>S/C Alfentanil</td>
<td>30 x stronger</td>
<td>10 minutes</td>
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<td>Transdermal Fentanyl</td>
<td>100 x stronger</td>
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<tr>
<td>Transdermal Buprenorphine</td>
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<td>days</td>
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Conversion
1000 micrograms = 1 milligrams
1000 milligrams = 1 gram

Micrograms = mcg
Milligrams = mg
Gram = g

Formula for Drug Calculations
For tablets:
Dose required
Dose available

For liquids:
Dose required x volume
Dose available

For PRN doses:
Regular dose x frequency
6
EXAMPLE 1
Mrs Jones has been prescribed 20mg of Zomorph.
In stock we have 10mg capsules.

Dose required = \(20\text{mg} = 2\) capsules
Dose available 10mg to be given

EXAMPLE 2
Mr Dell has been prescribed 20mg of oral morphine.
In stock we have 10mg in 5ml syrup.

\[
\text{Dose required} \times \text{volume} = 20\text{mg} \times 5\text{ml} = 10\text{ml}
\]
\[
\text{Dose available} = \frac{10\text{mg}}{10\text{mg}}
\]

EXAMPLE 3 (PRN dose)
Mr Smith is prescribed 15mg of oral morphine, QDS.

Regular dose \times frequency = \(15\text{mg} \times 4 = 10\text{mg}\)

Side Effects
- Nausea
- Constipation
- Drowsiness
- Twitching
- Confusion
- Slow breathing

Side Effects
- Reduced respiration rate
- Cognitive impairment
- Myoclonic jerking
- Hallucinations
- Drowsiness

Signs of Anaphylaxis
- generalised flushing of the skin
- nettle rash (hives) anywhere on the body
- sense of impending doom
- swelling of throat and mouth
- difficulty in swallowing or speaking
- alterations in heart rate
- severe asthma
- abdominal pain, nausea and vomiting
- sudden feeling of weakness (drop in blood pressure)
- collapse and unconsciousness

Signs of Opioid Toxicity
- Reduced respiration rate
- Cognitive impairment
- Myoclonic jerking
- Hallucinations
- Drowsiness

I certify that ……………………… has successfully completed the medicine checking assessment
Signed………………………..Title……………………
Date………….

I certify that ……………………..has been observed completing medicine checking in practice and has been passed as competent
Signed………………………..Title……………………
Date………….
Appendix 8

Timetable

9.00-10.45 Introduction
  
  Role of Second Checker

  Basic Principles of Drug Administration

  Common Symptoms and treatments

  Opioids/Non-Opioids

  The Maths!

10.45  Coffee

11.00-12.30 The Legalities of Controlled Drugs. Renate Boethling

12.30  Lunch

13.00  Assertiveness

13.45  Scenarios

14.45  Coffee

15.00  Drug Calculation Test

16.00  Finish
## Foundation of Nursing Studies (Patients First Programme) Project Plan

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- Red indicates completed tasks.
- Yellow indicates ongoing or upcoming tasks.

*Appendix 9: GANNT Chart*