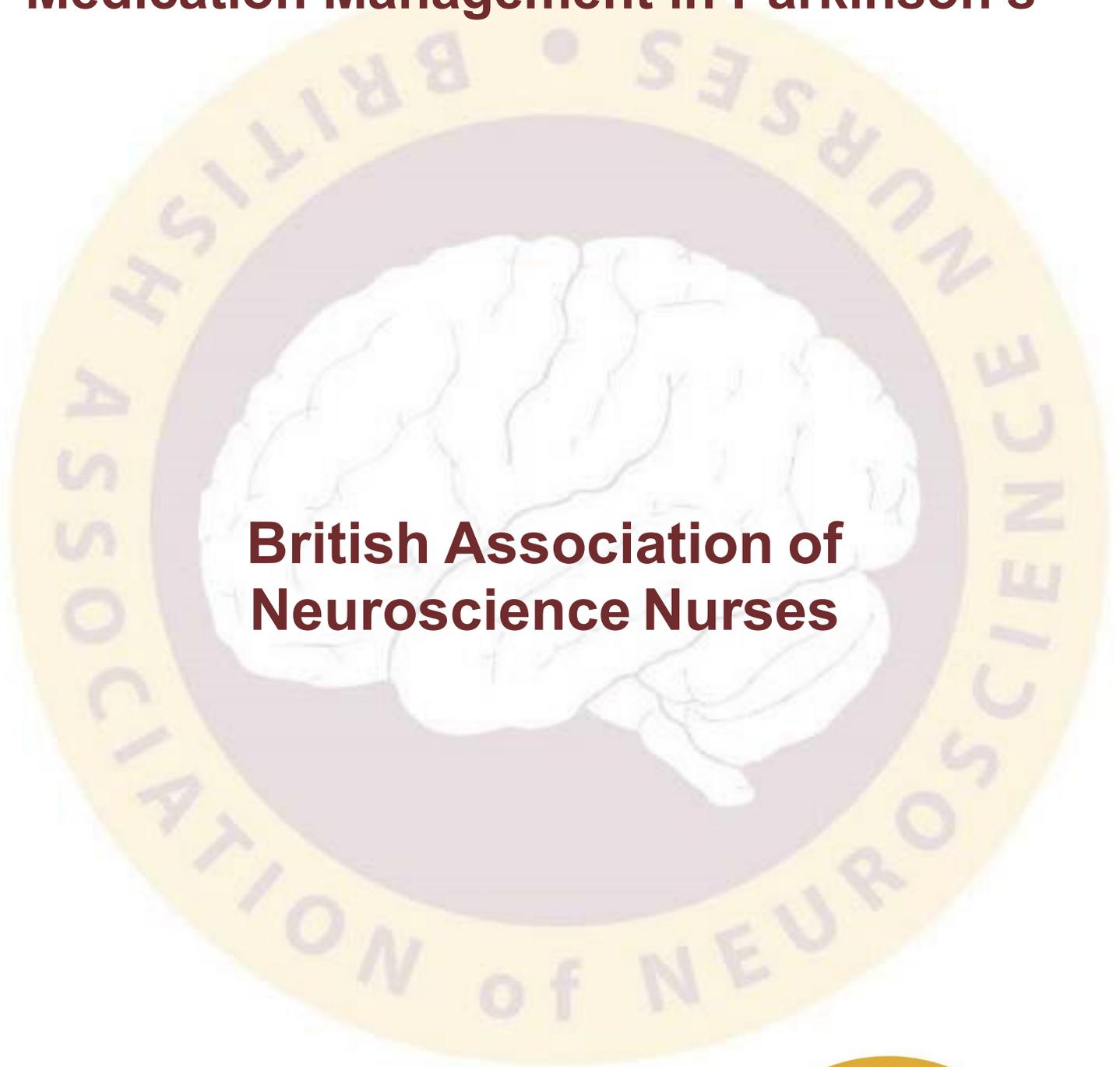
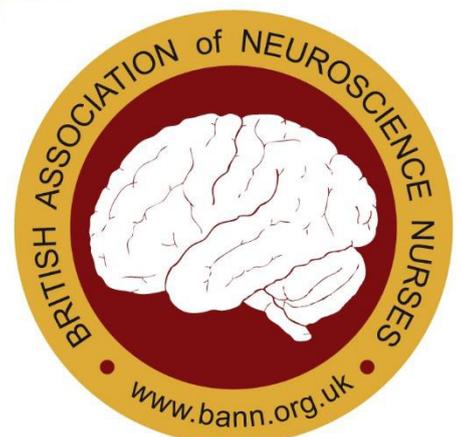


Benchmark No. 17

Medication Management in Parkinson's



**British Association of
Neuroscience Nurses**



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History

The Neuroscience Nursing Benchmarking Group (NNBG) was established in the 1990's as a result of increasing concerns over inconsistencies in practices as part of a subsidiary of BANN. The group aims to improve on the quality of care by comparing and sharing practice with each other, and set explicit standards for comparison of current practice against the ideal standard. The group is committed to searching for the best evidence related to specific areas of neuroscience practice. Membership of the group consists of representatives from neuroscience units within the UK and Ireland, together with educational colleagues from both the NHS/HSC and Higher Educational Institutes. The group is further subdivided into regions and this benchmark was developed by the North East group of the NNBG in 2007.

In 2016, the NNBG consolidated back into BANN and further information about NNBG can be found on the BANN website www.BANN.org.uk.

BANN would like to acknowledge the leadership and significant contribution made by the NNBG, and all its contributors, to neuroscience nursing over the years.

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Medication Management in Parkinson's

Key Points

Parkinson's disease (PD) is a complex and chronic neurodegenerative condition characterised by the loss of dopaminergic neurons in the Substantia Nigra in the basal ganglia. Symptoms include severe motor symptoms (uncontrollable tremor, akinesia and rigidity) and non-motor symptoms (depression, cognitive dysfunction, hypotension and constipation). The majority of problems faced by patients suffering from Parkinson's disease arise from untimely or missed medications resulting in longer length of stay and poor patient experience.

- Following assessment, a patient centred management plan is implemented to ensure seamless delivery of services and continuity of care.
- Evidence based guidelines/protocols are utilised in the medication management of patients with Parkinson's disease.
- Management of medication for people with Parkinson's disease should be carried out by appropriately trained healthcare professionals.
- The Parkinson's disease specialist team are informed of all new referrals and re-admissions.
- A regular review of medications must be undertaken on an individual patient basis.
- To optimise symptom control, patients must receive their prescribed medication at specific times in accordance with a patient centred management plan.
- Medications should never be withdrawn abruptly and if unable to take oral medications, alternatives must be provided.
- Self-medication should be supported wherever possible.
- Patients must have access to information regarding their medication regime.
- Nursing staff and patients have access to 'Get It On Time' (GIOT) clocks to enable timely medication administration.
- All documentation meets the needs of the individual patient and is based upon the best available evidence
- There is evidence of daily multi-disciplinary evaluations of care delivered which must be completed in a full and timely manner.

The care plan is evidence based, dated and reviewed within the last two years and updated accordingly.

FACTOR 1 – Documentation – Assessment and Implementation of Care

STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
<p>1.0 An individualised plan of care will be implemented and evaluated, specific to all aspects of care relating to the patient's individual physical and psychological needs.</p> <p>This must include an assessment of:-</p> <ul style="list-style-type: none"> ▪ Mobility/Falls risk ▪ Saliva ▪ Pain ▪ Bowels and Bladder ▪ Bradykinesia/ dyskinesia/rigidity/tremor ▪ Postural hypotension ▪ Freezing episodes affecting speech, swallowing, facial expressions ▪ Formal assessment of swallowing – signs (pre-existing dysphagia, poor appetite) or symptoms (aspiration pneumonia, weight changes). ▪ 'On/Off' fluctuations in condition e.g., if 'off' cannot take medications ▪ Assessment of sleep disturbances due to PD related motor symptoms, treatment-related disorders, psychiatric symptoms or rapid eye movement behavioural disorders). ▪ Cognitive impairment - confusion, hallucinations, paranoia, history of delirium. ▪ Hypersexuality (linked to medications) ▪ Dopamine dysregulation syndrome (DDS), impulse control disorders ▪ Punding behaviours (obsessive habits) ▪ Psychological aspects e.g. depression and anxiety ▪ Risks associated with other treatment regimes. ▪ 'End of life' concerns 	<p>Hickey J. (2013).</p> <p>Millar <i>et al</i> (2006)</p> <p>Parkinson's Disease Society (2007)</p> <p>McKinley <i>et al</i> (2010)</p> <p>Serrano-Duenas (2003)</p>			

FACTOR 1 – Documentation – Assessment and Implementation of Care

STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
1.1 An initial assessment of the effectiveness of current medication is evident (includes patient self-assessment diaries).	DH (2003 2004)			
1.2 A recognised assessment tool is available which includes guidance on:- <ul style="list-style-type: none"> ▪ The use of on/off charts ▪ Timing of medications ▪ Monitoring response or adverse reactions to medication regimes 	Nice (2017) Manias <i>et al</i> (2004)			
1.3 Parkinson's medications are prescribed and administered in accordance with the patients' personalised regime.	Scottish Govt. (2006)			
1.4 In accordance with Trust policy, continuous assessment of the patient's mental capacity to self-medicate is undertaken and documented. - Where a patient is deemed to be competent, self - medication should be the preferred option in accordance with National guidance.	DH. (2005) MHS (2015) Commission for Healthcare Audit (2007)			
1.5 There is documented evidence of the patient's medication management plan which must be discussed with the patient. This should include: <ul style="list-style-type: none"> ▪ Documented choice of drug(s), route and timings ▪ Prescribe generic named medications rather than branded medications 	PD Society (2015, 2014) NICE (2017)			

FACTOR 1 – Documentation – Assessment and Implementation of Care

STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
<p>1.6 Documentation is completed in a full and timely manner, which includes: -</p> <ul style="list-style-type: none"> ▪ Medication charts - the patients' medication regime including timings. ▪ Patient self-assessment of personal medication regime is supported (i.e. encourage completion of patient diary). ▪ Subcutaneous medication – regular evaluations of the injection site for signs of irritation, and changes to alternative subcutaneous sites. ▪ Practitioner assessment of medication effectiveness and adverse effects i.e. on/off chart. ▪ Measurements of lying and standing blood pressure is performed as per local guidance (<i>postural hypotension is more prevalent due to the autonomic response</i>). 	<p>NMC (2008; 2015)</p> <p>Mitten (2001)</p> <p>Manias <i>et al.</i> (2004)</p>			
<p>1.7 All documentation supports patient centred decision making process and on-going management.</p>	<p>NMC (2008)</p>			
<p>1.8 In accordance with specific medication regimes, clinical tests relevant are completed as a baseline and repeated as clinically indicated (e.g. liver function, ECG, bone density measurement).</p>				
<p>1.9 Adjustments to medication is only undertaken following collaboration between the specialist in Parkinson disease and pharmacist.</p>	<p>PD Society (2007)</p>			

FACTOR 2 – Protocol

STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
<p>2.0 Evidence based protocols are available which provide guidance on the following:-:</p> <ul style="list-style-type: none"> ▪ Patients who are 'Nil by Mouth' or have reduced absorption via the gut (e.g. gastroenteritis, dysphagia). ▪ Patients who are to undergo elective surgery (e.g. abdominal surgery, Deep brain stimulators (DBS). ▪ Patients who are confused (may have poor recollection of their medication regime). ▪ Patients who have other co-morbidities that may interfere with their Parkinson's medication regime. ▪ List of contra-indicated medications and possible alternatives (e.g. Anti-emetics, Neuroleptics). ▪ Information to facilitate conversion of tablets to patches, infusions, dispersible tablets or crushable formulations. <p><i>The abrupt withdrawal of Anti-parkinsonian medication can lead to severe acute akinesia or neuroleptic malignant syndrome (NMS).</i></p>	<p>NICE (2017)</p> <p>Tan <i>et al</i> (2014)</p>			
<p>2.1 Staff should ensure that relevant medical devices to support Parkinson drug administration is readily available'.</p> <ul style="list-style-type: none"> • Staff receive training on the use of relevant equipment. • Clear documentation exists in the event of non availability or equipment failure, as per local policy. 	<p>NHSLA (2007)</p>			

FACTOR 3 – Education

STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
<p>3.0 Following competency based training, all staff will be able to demonstrate the following:-</p> <ul style="list-style-type: none"> ▪ An awareness of the complex needs of patients with Parkinson’s disease. ▪ Anatomy and physiology of the Parkinson disease process. ▪ Pharmacology - types of medication commonly used, dosages, timings, side effects, therapeutic effects. ▪ Timing of interventions to ensure maintenance of the patient’s medication regime. ▪ Risk factors specific to Parkinson’s medication ▪ Pharmacokinetics (absorption, distribution, metabolism and excretion). ▪ The effect of poly pharmacy due to co-morbidities ▪ Medical equipment relevant to the different modes of delivery and in accordance with local trust policy. ▪ Dysphagia Screening and awareness of diet food texture descriptors. ▪ Optimising posture for effective swallowing. ▪ Training on completion of specific risk assessment forms. ▪ Relevant legislation ▪ Evidence of continual practice development 	<p>NICE (2017). DH (2005) Mental Capacity Act (2005) England and Wales. Adults with Incapacity (Scotland) Act (2000) Mental Health Act Scotland (2015). NMC (2008)</p>			

FACTOR 4 – Patient Information

STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
<p>4.0 Patient/ family/carers are given the following information, which should be discussed with their specialist team and clearly documented: -</p> <ul style="list-style-type: none"> ▪ Contact details of the P.D Specialist nurse. ▪ The reason for their current admission. ▪ Information relating to their medication including expected efficacy/effects of the medication regimes. ▪ Education on early signs and symptoms of potential adverse effects of their medication. ▪ Detailed advice concerning maintaining posture and balance activity. ▪ Their entitlement to care assistance, support services and personal independence payments (PIP) ▪ Lasting Power of Attorney 	<p>DH (2003) PD Society, (2007) NICE (2017)</p>			
<p>4.1 Discharge information to patients, carers and family that includes:-</p> <ol style="list-style-type: none"> I. Written detailed information of any follow up(s) II. Supporting documentation to manage their symptoms and medication i.e. symptom diary and a clearly documented medication regime III. Contact details for supplies of medication and equipment IV. Signposting to additional information resources 	<p>DH (2005c) PD Society (2007) Tan <i>et al</i> (2014)</p>			

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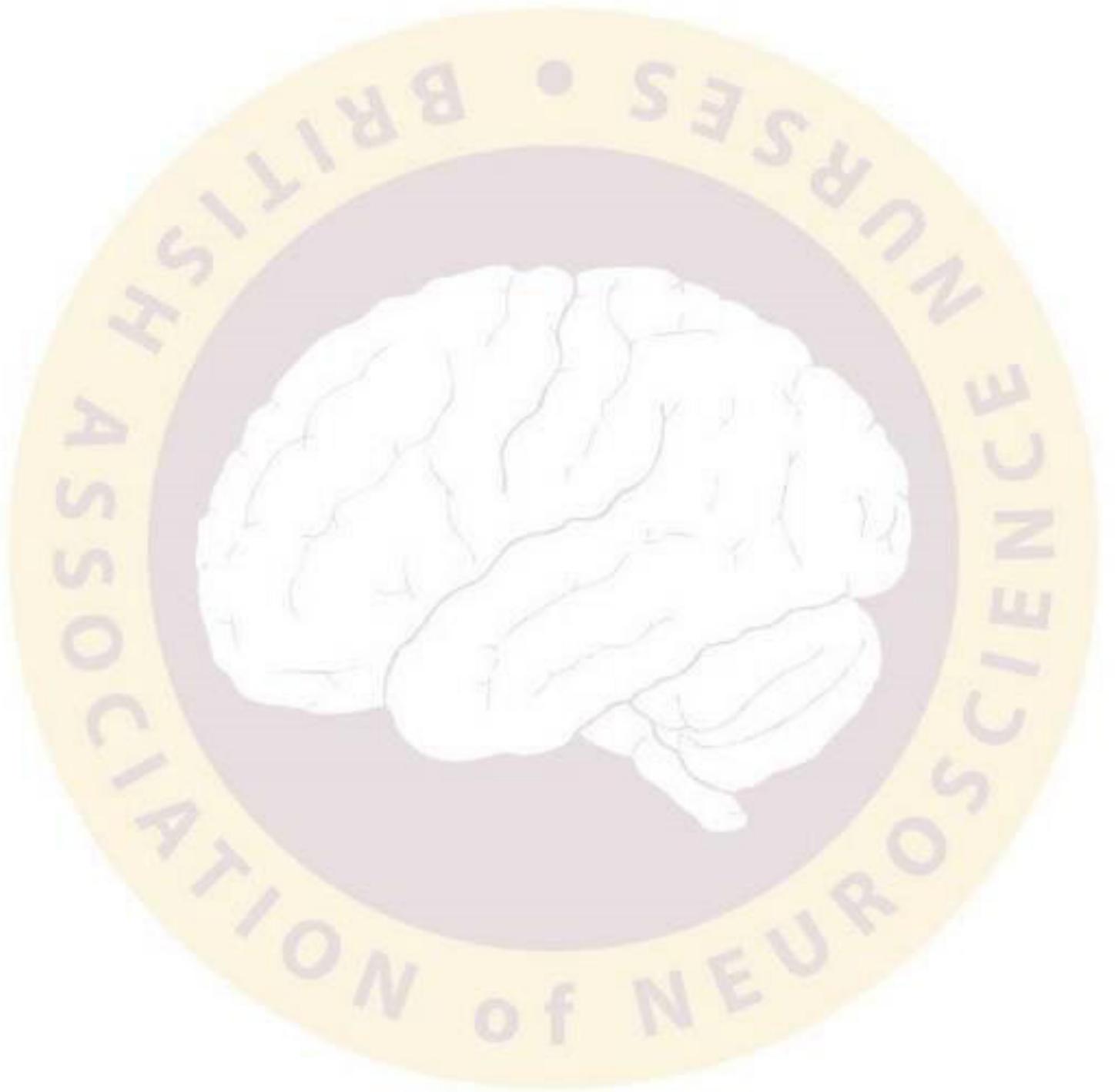
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