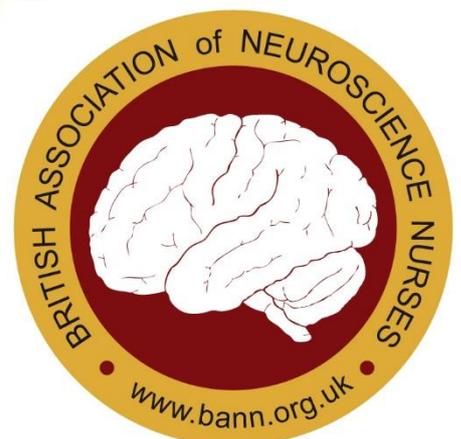


# Benchmark No. 17

## Parkinson's Disease - Medication Management 2<sup>nd</sup> Edition

**British Association of  
Neuroscience Nurses**



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## Parkinson's Disease - Medication Management (2<sup>nd</sup> Edition)

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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](http://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.

## Benchmark No.17

### Parkinson's Disease - Medication Management

#### Key Points

- 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 or 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**

	STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
1.0	<p>An individualised plan of care is implemented and evaluated, specific to all aspects of care relating to the patients` individual physical and psychological needs. This must include an assessment of:</p> <ul style="list-style-type: none"> <li>a) Mobility/Falls risk</li> <li>b) Saliva</li> <li>c) Pain</li> <li>d) Bowels and Bladder</li> <li>e) Bradykinesia/ dyskinesia/rigidity/tremor</li> <li>f) Postural hypotension</li> <li>g) Freezing episodes affecting speech, swallowing, facial expressions</li> <li>h) Formal assessment of swallowing – signs (pre-existing dysphagia, poor appetite) or symptoms (aspiration pneumonia, weight changes).</li> <li>i) 'On/Off' fluctuations in condition (<i>e.g., if 'off' cannot take medications</i>)</li> <li>j) Assessment of sleep disturbances due to PD related motor symptoms, treatment-related disorders, psychiatric symptoms or rapid eye movement behavioural disorders</li> <li>k) Cognitive impairment - confusion, hallucinations, paranoia, history of delirium.</li> <li>l) Hypersexuality (linked to medications)</li> <li>m) Dopamine Dysregulation Syndrome (DDS), impulse control disorders</li> <li>n) Punding behaviours (obsessive habits)</li> <li>o) Psychological aspects e.g. depression and anxiety</li> <li>p) Risks associated with other treatment regimes.</li> <li>q) 'End of life' concerns</li> </ul>	<p>Parkinson's Disease, 2017</p> <p>McKinley <i>et al</i>, 2010</p> <p>SIGN, 2010</p> <p>Wijdicks, 2020</p> <p>NICE, 2017, 2018</p> <p>Balconi <i>et al</i>, 2018</p> <p>RCP, 2020</p>			

**FACTOR 1 – Documentation**

	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).	NICE, 2017,			
1.2	A recognised assessment tool is available which includes guidance on: a) The use of on/off charts b) Timing of medications c) Monitoring response or adverse reactions to medication regimes	NICE, 2017, 2018			
1.3	Parkinson's medications are prescribed and administered in accordance with the patients' personalised regime (including drug administration via Duopa pump)	Scottish Govt., 2006			
1.4	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.	MHAS, 2015 DOH, 2005 MHA, 2001			
1.5	There is documented evidence of the patient's medication management plan which is discussed with the patient. This should include: a) Documented choice of drug(s), route and timings b) Prescribe generic named medications rather than branded medications	PD UK, 2015, NICE, 2017			
1.6	Adjustment of medication is only undertaken following collaboration between the in Parkinson disease specialist and pharmacist	Magennis <i>et al</i> , 2014			

**FACTOR 1 – Documentation – Assessment and Implementation of Care**

	STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
1.7	<p>Documentation is completed which includes:</p> <ul style="list-style-type: none"> <li>a) Medication charts - the patients' medication regime including timings.</li> <li>b) Patient self-assessment of personal medication regime is supported (i.e. encourage completion of patient diary).</li> <li>c) Subcutaneous medication – regular evaluations of the injection site for signs of irritation, and changes to alternative subcutaneous sites.</li> <li>d) Duopa pump – monitoring of PEG-J tube entry site, titration of dosage to effectively control symptoms</li> <li>e) Practitioner assessment of medication effectiveness and adverse effects i.e. on/off chart.</li> <li>f) Measurements of lying and standing blood pressure is performed (<i>postural hypotension is more prevalent due to the autonomic response</i>).</li> </ul>	<p>NMC, 2015</p> <p>NICE, 2018</p> <p>Peel <i>et al.</i> 2013</p>			
1.8	All documentation supports the patient-centred decision-making process and their on-going management	Warren <i>et al.</i> , 2016			
1.9	In accordance with specific medication regimes, baseline clinical investigations are completed and repeated as clinically indicated (e.g. liver function, ECG, bone density measurement)	<p>NICE, 2017</p> <p>Tan, 2014</p>			

**FACTOR 2 – Protocol**

	STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
2.0	<p>Evidence based protocols are available which provides guidance on the following:</p> <ul style="list-style-type: none"> <li>a) Patients who are 'Nil by Mouth' or have reduced absorption via the gut (e.g. gastroenteritis, dysphagia)</li> <li>b) Patients awaiting elective surgery (e.g. abdominal surgery, deep brain stimulators (DBS))</li> <li>c) Patients who are confused who may have poor recollection of their medication regime</li> <li>d) Patients who have other co-morbidities that may interfere with their Parkinson's medication regime</li> <li>e) List of contra-indicated medications and possible alternatives (e.g. Anti-emetics, Neuroleptics).</li> <li>f) Information to facilitate conversion of tablets to patches, infusions, dispersible tablets or crushable formulations</li> </ul> <p><i>The abrupt withdrawal of Parkinson medication can lead to severe acute akinesia or neuroleptic malignant syndrome (NMS).</i></p>	<p>NICE 2017, 2018 RCN, 2020</p> <p>Tan <i>et al</i> 2014</p> <p>McKinley <i>et al</i>, 2010</p> <p>Modi <i>et al</i>, 2016</p>			
2.1	<p>Staff should ensure that relevant medical devices to support Parkinson drug administration is readily available:</p> <ul style="list-style-type: none"> <li>a) Staff receive training on the use of relevant equipment</li> <li>b) Clear documentation exists in the event of non-availability of medications or equipment failure</li> </ul>	<p>RightCare, 2018</p>			

**FACTOR 3 – Education**

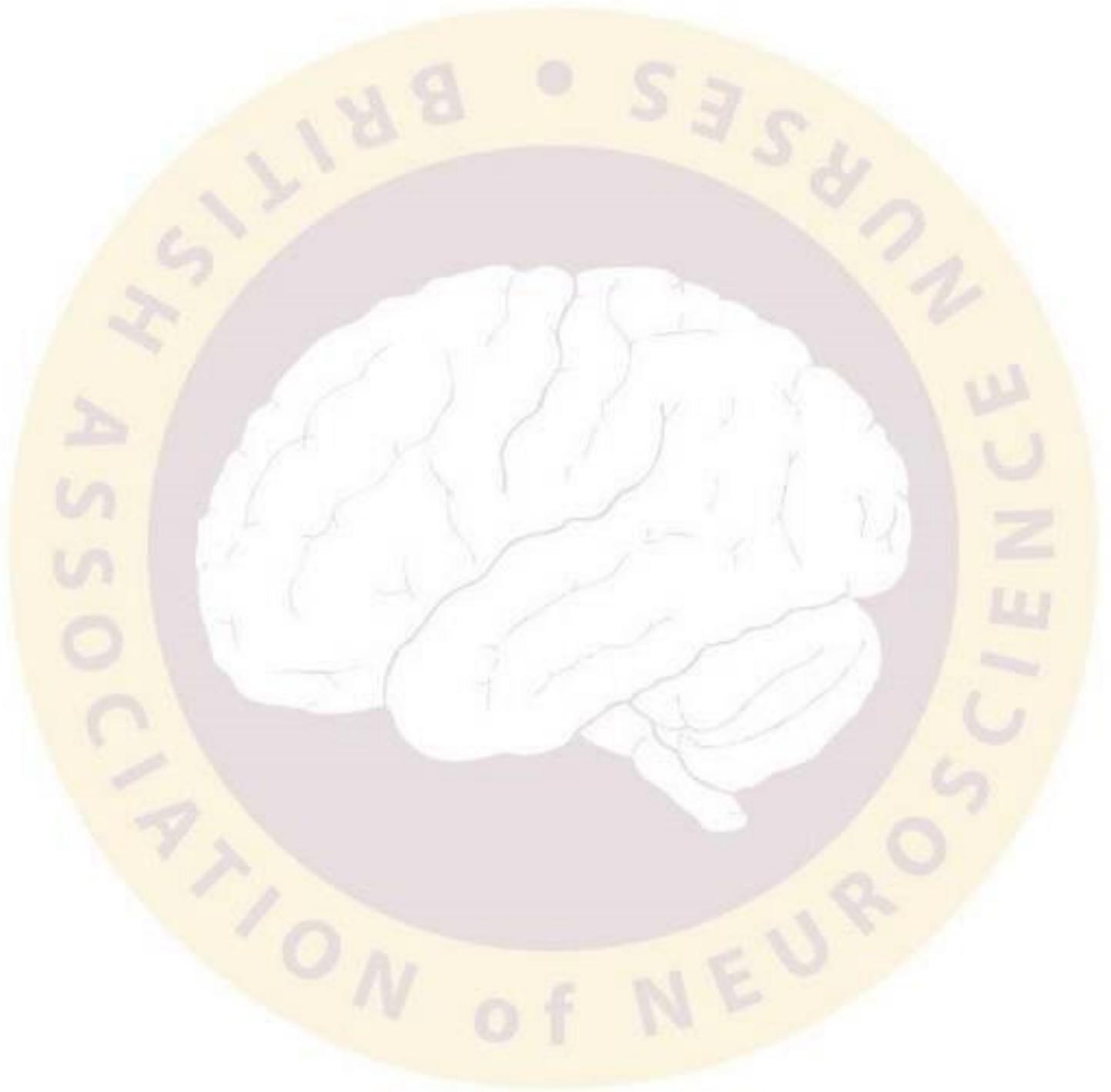
	STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
3.0	<p>Following competency based training, staff can demonstrate the following:</p> <ul style="list-style-type: none"> <li>a) An awareness of the complex needs of patients with Parkinson's disease</li> <li>b) Anatomy, physiology and aetiology of Parkinson's disease</li> <li>c) Pharmacology - commonly used medication, dosages, timings, side effects, therapeutic effects</li> <li>d) Timing of interventions to optimise the patient's collaboration</li> <li>e) Risk factors specific to Parkinson's medication</li> <li>f) Pharmacokinetics (absorption, distribution, metabolism, excretion)</li> <li>g) The effect of poly-pharmacy due to co-morbidities</li> <li>h) Medical equipment pertinent to the different modes of delivery</li> <li>i) Dysphagia Screening and awareness of diet food texture descriptors</li> <li>j) Optimising posture for effective swallowing</li> <li>k) Training on completion of specific risk assessment forms</li> <li>l) Relevant legislation</li> <li>m) Evidence of continual practice development</li> <li>n) The use of 'clocks' to ensure timely administration of medications</li> </ul>	<p>NICE, 2017</p> <p>Cotterell, 2018</p> <p>MCA, 2005</p> <p>Adults with Incapacity (Scotland) Act, 2000</p> <p>MHA Scotland, Ireland, 2015, 2001</p> <p>RCN, 2020</p>			

**FACTOR 4 – Patient Information**

	STATEMENT OF BEST PRACTICE	EVIDENCE & REFERENCES	ACHIEVED	NOT ACHIEVED	VARIABLES
4.0	<p>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"> <li>a) Contact details of the P.D Specialist nurse</li> <li>b) The reason for their current admission</li> <li>c) Information relating to their medication including expected efficacy/effects of the medication regimes</li> <li>d) Education on early signs and symptoms of potential adverse effects of medication</li> <li>e) Advice related to maintaining posture and balance activity</li> <li>f) Entitlements to care assistance, support services and personal independence payments (PIP)</li> </ul>	<p>PD 2017, 2018</p> <p>NICE, 2017, 2018</p> <p>Balconi <i>et al</i>, 2018</p> <p>RCP, 2020</p>			
4.1	<p>To enable continuity of care with Community services and the seamless delivery of care, patients, carers and family are given the following discharge information that includes:</p> <ul style="list-style-type: none"> <li>a) Written detailed information of any follow up(s)</li> <li>b) Supporting documentation to manage their symptoms and medication i.e. symptom diary and a clearly documented medication regime</li> <li>c) Contact details for supplies of medication and equipment</li> <li>d) Signposting to additional information resources</li> </ul>	<p>DH, 2005</p> <p>Tan <i>et al</i>, 2014</p>			

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