Benalla HEALTH	TITLE: Medication Management		
Document Type:	**Policy**	Approved by:	**Operational Director PI**
Department:	**Medical Services**	Section:	**Medication**
Author/Prepared by:	**Operational Director PI**	Authorised by	**Chief Executive Officer**

POLICY STATEMENT:

The medication management policy at Benalla Health (BH);

1. Complies with the Drugs, Poisons and Controlled Substances Act (1981) and Drugs, Poisons and Controlled Substances Regulations 2017;
2. Is based on the best available evidence for practice and
3. Is consistent with the National Safety and Quality Health Service Standards (NSQHSS) and Aged Care Standards relating to medication safety and infection control.

For the purpose of this policy medication management includes: prescription, dispensing, access, storage, and drug administration.

PRINCIPLES:

BH adopts in principle the;

- Guiding principles to achieve continuity in medication management as described by the Australia Pharmaceutical Advisory Council, (2005)
- Guiding principles to achieve continuity of medication management in the community, (2006)
- Guidelines for medication management in care recipients in aged care facilities, (2012)

OBJECTIVES:

1. To prevent or minimise the potential risks associated with medication management and therefore potential adverse outcomes for patients.
2. To promote and support the quality use of medications.
3. To ensure safe practice along the continuum of medication management.

DEFINITIONS

The following definitions are based on commonly accepted definitions in the quality use of medicines and/or the national regulations.

Administration	The process of giving a single dose of medicine to a care recipient or patient.
Dispensing	The assessment, supply, labeling and counseling responsibilities in relation to prescribed medication. That is the: • Assessment of the medicine prescribed in the context of the patient's/care recipient's other medication, medical history and the results of relevant clinical investigations; • Selection and supply of the correct medicines and • Appropriate labeling and recording of medicines **AND** counseling of a patient in relation to their medications.
Drug Protocol	A detailed written set of instructions to guide the prescription and administration procedures of a specific drug.
Enrolled Nurse (EN)	EN nurses who are recognised by the Nursing & Midwifery Board of Australia (NMBA) as holding current registration to practice within legislative guidelines as set out by the NMBA. *E.N.'s originally endorsed by the Nurses Board of Victoria to administer medications will no longer have this endorsement on the register. The administration of oral/subcutaneous/IM medications is now a core competency for graduates of EN training. Administration of IV medications is an elective module. If an EN has not completed medication administration training, a notation will be placed on the register against their name reading **"Does not hold Board approved qualifications in administration of medicines".** It is the responsibility of the employing organisation to confirm registration and scope of practice for all their employees but at all times ***an E.N. is responsible for their own actions in relation to the administration of those drugs that they are legally endorsed to administer.***
Healthcare Assistant	An **unregulated healthcare worker** with a Certificate III in Aged Care OR Certificate III in Health Assistance.
Healthcare Assistant Student	A student attending placement as part of their vocational training in Certificate III Aged Care or Certificate III Healthcare Assistant. This includes students enrolled in the VETiS Health Program.
Medical Practitioner	A medical officer with current registration with the Medical Board of Australia.

Medication	**All drugs and substances prescribed** and/or administered for the purpose of pharmacological intervention including inhaled **gases** (oxygen, cylinder air, nitrous oxide and anaesthetic gases), **blood and blood products** and for the purpose of this policy, all **subcutaneous and intravenous fluids**.
Medication Chart	Used by medical practitioners to record medication and treatment orders and by nursing staff to record and monitor the administration of such medications and treatment. Medication charts need to satisfy state or territory regulations and other requirements of the Poisons Acts in each jurisdiction. All entries should be written or printed in black or blue ink. **Red ink should not be used under any circumstances.**
Medication Error	An error can be defined as failure in the medication treatment process that leads to, or has the potential to lead to, harm to the patient/care recipient and includes an unplanned omission. Errors can result from the actions of an individual and/or the result of a series of system failures.
Nurse Practitioner (NP)	RNs recognised by the NMBA as holding current registration to practice as a Registered Nurse in Australia and who are endorsed by the NMBA as a Nurse Practitioner (NP). NP's in Victoria have a notation on their national professional registration indicating a category or broad area of practice. The purpose of this notation is to give NPs the authority to prescribe under the *Drugs Poisons and Controlled Substances Act (1981)* when working in Victoria. The notation is in one of the following areas: • NP category - Acute & Supportive Care • NP category - Care of the Older Person or Aged care • NP category - Critical Care • NP category - Maternity Care • NP category - Mental Health • NP category - Paediatrics • NP category – Perioperative Care • NP category - Primary Care
NP Candidate	A RN enrolled in or who has completed a Masters of Nursing, Nurse Practitioner program, specifically employed at BH in a NP Candidate internship.
Pharmacist	A pharmacist registered with the Pharmacy Board of Australia.

Prescription	An order to supply and/or administer medications for the purpose of treating a medical condition. Medications can only be prescribed by an authorised prescriber. An authorised prescriber is a health care professional who is authorised by legislation to issue a prescription for the supply of medicines. Authorised prescribers include registered medical practitioners, nurse practitioners, dentists and optometrists.
Registered Midwife (RM)	Recognised by the NMBA as holding current registration to practice as a Registered Midwife in Australia.
Registered Nurse (RN)	Recognised by the NMBA as holding current registration to practice as a Registered Nurse in Australia.
Rural & Isolated Endorsed RN's (RIPERN)	**Rural and Isolated Practice Endorsed Registered Nurses** (RIPERN) are nurses with a Scheduled Medicines Endorsement placed on their registration by the NMBA. In Victoria, RIPERN work under the Drugs, Poisons and Controlled Substances Act 1981 (VIC) and its regulations in rural urgent care centres.
Standing Orders	A standing order refers to a therapeutic protocol for a defined clinical condition and circumstances. **Note:** Department of Health (2010) Guidance on the Process for Approval of Standing Orders. **Refer to BH Poisons Control Plan Part 5 for the site permit number.**
Student Nurse/ Student Pharmacist / Medical Student	A student attending placement as part of their training in nursing, pharmacy or medicine. The term student encompasses individuals enrolled in either; • Vocational or professional entry level programs; • Post graduate programs. Vocational entry students include those enrolled in entry level Certificate IV or Diploma programs. Professional entry students include those enrolled in Bachelor or direct entry Masters programs.

PROCEDURE

1. ROLES AND RESPONSIBILITIES IN MEDICATION MANAGEMENT

1.1 Visiting Medical Officers (VMOs)	Medical Practitioners who are authorised to prescribe medications have the responsibility for prescribing and ceasing pharmaceutical treatment and for ensuring that other health care practitioners have sufficient information to ensure a legal and correct supply and administration of medication. VMOs are responsible for ensuring that patients/care recipients are adequately informed about their medication and are agreeable to treatment. VMOs are responsible to ensure that their patients know how to use their medication on discharge and have access to required therapy. They are to provide adequate and timely information to other health care providers involved with the patient's care. A summary of key legislative requirements for Medical Practitioners Prepared by the Drugs and Poisons Regulation Group (DPRG)
1.2 NPs	NPs have the responsibility for prescribing, ceasing pharmaceutical treatment and for ensuring that other health care practitioners have sufficient information to ensure legal and correct supply and administration of medication. Nurse Practitioners are responsible to ensure that patients/care recipients are adequately informed about their medication and are agreeable to treatment. NPs are restricted to prescribe from their specific approved NP formulary lists. Nurse Practitioners are responsible for ensuring that their patients know how to use their medication on discharge and have access to required therapy. They are to provide adequate and timely information to other health care providers involved with the patient's care. Nurse Practitioners guide to key legislative requirements in Victoria (DHHS 2018)
1.3 NP Candidate's (NPCs)	NPCs do not have authority to prescribe until they are endorsed. It is the role of the NPC to work closely with VMOs & NP's to develop the skills and expertise required for endorsement as a NP. The responsibility of NPC's as far as the provision of medication information and discharge is the same as that of a RN, RM and ENs who are qualified to administer medications.

1.4 Pharmacist	The Pharmacist is responsible for; • The acquisition, distribution and supply of medicines; • Provision of pharmaceutical information; • The supervision and direction of the activities of pharmacy assistants and technicians and • Commencement of the discharge service for patients who have been referred, once their medication requirements post discharge have been finalised and documented by a VMO or NP. A summary of key legislative requirements for Intervening to ensure Safe Appropriate and Lawful supply - information for pharmacists
1.5 RIPERN	RIPERN are authorised nurses that can administer and supply medicines in health services that have been approved by the Minister for Health under a gazette notice. RIPERN may possess and supply specified Schedule 2, 3, or 8 medicines under certain conditions.
1.5 RN, RM & EN's who are qualified to administer medications	Administers medications according to BH's medication management policy. Provides basic medication information and refer patient's requests for information to the pharmacist. Contributes to the ongoing professional development, education and supervision of patients, carers, peers and students, appropriate to their scope of practice and competency standards, for medication administration. Engages in ongoing professional development and self-reflection sufficient to maintain their own competence to administer medications. **Any EN, RN and RM responsible for the administration of medications are accountable for their own actions.** Prior to discharge: • Ensure that all patient's own medication is returned to them, unless they no longer want it. • Ensure that patients have or can obtain an ongoing supply of required medication within a clinically appropriate timeframe. • Ensure patient or if appropriate their carer know how to use the medication. • Where a patient wants some or all of their own medication destroyed by the pharmacist, document the patient's consent to this in the patient's history.

	• Refer to the pharmacist in a timely manner those patients who would particularly benefit from pharmacist involvement in their discharge, including patients using dose administration aids and patients transferring to residential care. A summary of key legislative requirements for https://www2.health.vic.gov.au/about/publications/policiesandguidelines/nurses-and-midwives-key-legislative-requirements-in-victoria
1.6 Accredited Nurse Immuniser	Accredited Nurse Immunisers are authorised to administer immunisations and can manage adverse reactions if they occur in contexts where there may not be a medical practitioner. For more details refer to the role and responsibilities of an accredited nurse immuniser. An Accredited Nurse Immuniser must have successfully completed the relevant AHPRA endorsed Nurse Immuniser Program covering the epidemiology of vaccine preventable disease, the role of immunisation in public health, the immunisation schedule as well as guidelines and policy relevant to the field.
1.7 IV Medication Administration Accredited ENs	ENs who have successfully completed training program in IV medications must: • As per BH's policy on Scope of Practice, apply to the Executive Director of Clinical Services to practice at an advanced level; • Complete phased support program for IV medication administration as detailed in section 10.2 of this policy and • Comply with BH policy on Medication.
1.8 EN who is not qualified to administer medications	**EN's who are not qualified to administer medications work within a restricted scope of practice and cannot legally administer, check OR supervise the administration of a medication.** An EN who is not qualified to administer medication however can **WITNESS** the administration of certain medications. **Witnessing** - that the drug prepared for administration, in relation to the drug label including expiry date, drug dose, drug form and administration times are the same as the drug, dose, route and time ordered. **Witnessing IS NOT checking a drug.** **Certain Medication -** includes IV, IM, Subcutaneous or oral medications **EXCEPT ALL** Schedule 8 drugs **AND** any drug that requires a calculation to administer.

	Right to Refuse – An EN with restricted practice related to drug administration has the right to decline the responsibility of witnessing any medication preparation.
1.9 Student Nurses	A student nurse must not calculate, check or administer any medication unless; • They have completed the appropriate components of their undergraduate or post graduate program related to medication administration; **AND** • They complete and gain 100% pass on a medication competency nominated by BH's Student Placement Coordinator. A competency will be set and completed as part of orientation to the organisation; **AND** • They are administered under the direct supervision of a clinical educator/support nurse **OR** the designated qualified clinical nurse they are working with.
1.10 Unregulated healthcare workers	At BH healthcare assistants and healthcare assistant students **should not administer OR check any medication**. In exceptional circumstances unregulated workers may be called upon to witness the administration of certain medications as defined above.
1.11 RN &RMs delegating or supervising medication administration	Must comply with BH's Delegation of Care Policy. The senior RN or RM on shift has authority and responsibility for the drug safe keys. They are responsible for accepting and relinquishing custody of unit drug supplies including inter unit transfer of medication. It is not within the scope of practice for an EN to accept or relinquish responsibility for unit drug supplies. The senior RN or RM on the shift is responsible for delegation of duties related to the administration of medications. An RN or RM may only delegate the administration of medicines to someone appropriately qualified to administer medications. Delegation must be: • Appropriate to the qualification of the individual and within the context of working within a team; **AND** • Following assessment of the patient to ensure patient needs are matched with staff experience and skills; **AND** • In accordance with nursing codes practice and decision making guidelines for supervision and delegation.

	Delegation of medication administration duties to **ENs MUST BE REVIEWED;** • When there are any changes in the patient's condition; **AND/OR** • When there are any changes to the drug administration orders including additions or cessations of any stat, prn or routine drug orders. ENs delegated to administer medications must have ready and available access either in person or via phone to a supervising RN or RM at all times during their shift. When a care recipient is receiving a high level of residential aged care, the DPCS Act specifies that the administration of Schedule 4 and Schedule 8 drugs to that care recipient must be **managed** by a Registered Nurse. The RN with overall responsibility for management of medication must be readily identifiable. The RN who is managing the administration of medications to care recipients can delegate the routine supervision of other workers to whom they have delegated the task of administering medicines refer to Key Requirements for Nurses in Residential Aged Care Services 2012.
1.12 Care recipients, Patients &/or Carers	It is the responsibility of the Care recipient/Patient &/or family carer: • To be open and honest when informing health clinicians about medication history and list of prescriptions. • To make informed decisions about their medication management. • To bring in their medication for safe storage when admitted. • To inform anyone involved in their medication care when they are admitted for care. • Care recipient – to obtain or give BH authority to obtain medication from contracted pharmacist; to pay any and all pharmacy related accounts.

2. PRESCRIPTION & ADMINISTRATION OF MEDICATION

2.1 Admission, Medication History and Reconciliation

2.1.1 Best Possible Medication History

On admission, a best possible medication history (BPMH) of the patient/client/care recipient is to be undertaken within 24 hours by the VMO and or, nurse and or pharmacist.

A (BPMH) is a medication history obtained by a clinician which includes a thorough history of all regular medication use (prescribed and non-prescribed), using a number of different sources of information.

The patient/client/care recipient/carer is interviewed, wherever possible, to obtain details of previous adverse drug events and allergies and information about all medicines that are being taken at the time of presentation to hospital / RAC including:

- Prescribed medicines;
- Non-prescribed, over-the counter medicines complementary/herbal medicines;
- PRN meds;
- Recently ceased or changed medications and
- A second source is used to confirm the medicines information obtained.

Second sources include;

- Medicine containers (including blister packs);
- Patient's medicines list;
- Community prescribers and/or community pharmacist;
- Carer or family and
- Previous medical records e.g. discharge summaries, electronic health records.

2.1.2 Medication Reconciliation

Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines. Medication reconciliation is matching the medicines the patient should be prescribed to those they are actually prescribed. Where there are discrepancies, these are discussed with the prescriber and reasons for changes to therapy are documented. When care is transferred, a current and accurate list of medicines, including reasons for change is provided to the person taking over the patient's/care recipient's care. Points of transition that require special attention are:

- Admission to hospital;
- Transfer from the UCC to other care areas and

- From the hospital to home, residential aged care facilities or to another hospital.

2.1.3 Medication Management Plan

A medication management plan is developed from information gained in the BPMH and medication reconciliation for patients 'at risk' of adverse event or polypharmacy or at the pharmacist's discretion.

2.1.4 Use of Own Medications

Where possible and in accordance with the criteria for the use of own medications flowchart, patients own medications are used.

DPU - Patients requested prior to admission to bring in medications.

Admit from clinic – GP to advise person to take medications to hospital when presenting for admission.

Admit from UCC – Family/carer/friend advised to collect patient's medications and bring back to hospital.

Transfer from other facility – Will depend on what occurred on admission to other facility. Consider requesting family to bring in medications from home.

2.1.5 Use of own Medications Flowchart see Appendix N

2.2 Care Recipient Medication Management Plan

Medication prescriptions for Care recipients are reviewed by the VMO at least quarterly (approx. 3 monthly) plus when the care recipient's condition changes. All Care recipients will have a Care Recipient Medication Management Review conducted by an accredited Pharmacist at least 12 monthly. Any changes to medication management are document in the Care recipient's progress notes on ManAd.

Care recipients are notified immediately of any changes to their medication. Medication changes are discussed with the care recipient's representative at the "Care recipient of the Day" meetings.

For Flowchart for Care recipient Medication Management Review see Appendix A

Benalla Health is currently considering the recommendations of The Australian Commission on Quality and Safety in relation to Medication Management Plans.

2.3 Terminology, Abbreviations and Symbols

Benalla Health uses the following guidelines in the administration of medicines

ACSQH Recommendations for Terminology, Abbreviations & Symbols used in the prescribing and administration of medicines

2.4 Pharmacology Knowledge

Health Professionals responsible for prescribing, administering and monitoring medication therapy must have adequate knowledge to safely perform their roles and

responsibilities. This knowledge can be either knowledge that is prior learned or that can be obtained using a drug reference.

Pharmacokinetics	How the body affects the drug – absorption, distribution, metabolism, therapeutic range and excretion especially pharmacokinetic changes relative to the developing or aging client.
Pharmaco dynamics	How the drug affects the body - mechanism of action and effects of drugs.
Generic and Trade Names	When prescribing medication generic names should be used.
Adverse drug reactions	Adverse drug reactions must be reported to pharmacy via the VHIMS risk management system to enable referral to the Therapeutic Goods Administration (TGA).
Polypharmacy	Prescriber knowledge of issues related to drug interactions and the use of Over The Counter (OTC) medications.
Contraindications of Drugs	Always determine any contraindications to a medication to avoid the potential for adverse reactions.
Client History and Diagnosis	Always determine **Drug Allergies** and document on the drug chart with adverse drug reaction (ADR) identification and in the patient's clinical record and alert sheet.

The <u>seven *RIGHTS*</u> of medication administration

Health Professionals responsible for administering medications must comply with the ***"7 Rights"*** of drug administration.

Right Drug	The drug ordered must be the drug administered. There may be multiple trade names for a single generic name. Drug should be in date. Always follow the directions given by the manufacturer or pharmacist regarding the expiry date of medications as they may denature after opening or removal from a refrigerator. For example: • Most eye drops and ointments should be discarded one month after opening. The date the container is opened should be recorded on the container. • Levothyroxine tablets should be discarded 14 days after removal from a refrigerator. The date of removal from a refrigerator should be recorded on the box.
Right Person	**Identification** is achieved by checking that <u>both</u> of the patient's white name bands contain the <u>3 approved patient identifiers</u> (name, date of birth and UR number). Identifiers on both name bands need to match the same 3 patient identifiers on the drug chart. If no name band is in place, ask the client or family/significant other to verify facts such as client name and date of birth; and/or as in the case of aged care by the use of an identifiable current care recipient photograph. **For Care recipients of MEW** Care recipient's identification photographs are to be placed on the medication charts with the name of the care recipient, date of birth and the date the photograph was printed placed on the back of the photograph. These photographs are updated every 6 months and/or as the care recipient's appearance changes. Care recipients with similar or the same name are to have the relevant box on the front of the medication chart completed.
Right Dose	Dose is consistent with the recommended guidelines for the individual's age and condition. If a **calculation** is required when checking the medication, the calculation is to be done independently by the person responsible for administering the drug **AND** the person checking the order. Calculations should then be cross checked.

Right Time	The EN, RN or RM responsible for administering a medication must; • **Confirm the drug is consumed, applied or injected on the right day and at the right time that it is ordered AND** • **Signed at the time of administration**. Under no circumstances should medications be left with the patient or care recipient OR left on their lockers OR their meal trays for them to consume or apply at their discretion. Administration time needs to account for; • Manufacturers' recommendations e.g. some drugs need to be given with food, some drugs need to be given on an empty stomach and • Potential drug interactions. Depending on manufacturer recommendations related to specific drugs, administration times for inpatients and care recipients are recommended as per National Inpatient Medication Charts (NIMC).
Right Route	For information and recommendations related to different routes of administration refer to specific drug product information guides and the acute & aged care manuals of the Joanna Briggs Institute (JBI) Login details: **Username … benalladmh** **Password … benalladmh** **For information and recommendations related to access and use of Central Venous Access Devices (CVAD) including PICC refer to eviQ …** Login details: **Username … benalla** **Password … benalla** eviQ is the online service of the Cancer Institute of NSW.
Right Reason	It is the right of any individual responsible for administering a drug to confirm the **reason for and/or to question** the order. A change in patient circumstance may require review of current medication orders. Examples include but are not limited to; • New demonstrated allergy; • New relevant information comes to light on medical history and • INR results are indicative of need for change in anticoagulant dose. The nurse administering the drug remains responsible for the decision to administer medication.

Right Documentation including current, legal and legible order, User-applied labelling	A **current, legal and legible order** signed by either a Medical Practitioner or NP is required before a drug is administered. Exceptions apply in the special instances of a nurse initiated medication, recognised drug protocols, approved standing orders and telephone orders. For care recipients of MEW check; • Regular medications; • Short term medications; • Intermittent medications; • All non-packed medications and • PRN medications. Medication must not be administered if a medication order/chart has expired. Medication charts in residential aged care are valid for up to 3 months. It is the right of any individual responsible for administering a drug to refuse to administer the medication if the order is illegible. The nurse who administers the drug must **record** their signature against the order in the drug chart AFTER administration is complete. Under no circumstances should a drug be signed as administered prior to administration. **An EN, RM or RN (unless endorsed as a NP) cannot legally prescribe or supply any medication.** As per the DPCS Act, the **legal responsibility for the administration of any medication** remains solely with the qualified individual administering the medication. All injectable medicines and fluids including bags, bottles, syringes, invasive monitoring lines, administration lines and burettes where the original labelling does not identify the medication should be labelled according to the; National Standard for User-applied labeling of Injectable Medicines, Fluids and Lines

2.5 Other responsibilities related to medication administration

Minimising the risk of error	To minimise the risk of error; • Complete medication administration process for one individual at a time. • There should be no interruptions when preparing or administering medications. If an interruption occurs the process should start again. • Staff administering medications should wear medication vest/apron to signify they are completing medication round. • All sharps should be disposed of in an appropriate manner and container. • In residential aged care; Warfarin dosage is to be documented on the "medication with variable / reducing doses and schedule" section of the compact medication chart.
Adverse Reaction	Monitor patient / care recipient following administration to identify any signs of an adverse reaction. In the event of an adverse drug reaction, an adverse drug reaction report form is to be completed and sent to the pharmacy department.
Changes in medication	Any change to medication management should be noted in progress notes. Changes to medication plans for care recipients of MEW should be recorded in ManAd.
Confidentiality	At all times confidentiality of patient / care recipient information must be maintained. Medication charts and administration folders must be kept closed when the administering staff member is not in attendance.
Use of aseptic technique &/or standard precautions	Aseptic technique and/or standard precautions should be followed in the **preparation** of all medications.

Swallowing difficulty	Refer Appendix F Any individual who is having difficulty swallowing their medications is to be referred to the VMO and alternative preparations such as liquid, powder or patch considered. If no alternative form of medication is available **consultation with pharmacist is required – if medication is not enteric coated or sustained released AND if appropriate** medication may be crushed (refer product information guide and Appendix G). Crushed medications must only be mixed with food/beverage items such as yoghurt, fruit puree or jam. If for any reason they are placed in alternative food preparations the staff administering the medications must remain with the care recipient until all the food containing the medication is consumed.

2.5.1 Double checking of Drugs

At BH it is mandated that certain drugs including high risk drugs be **doubled checked**. These include;

- All Schedule 8 drugs regardless of route of administration;
- All subcutaneous, intra muscular, epidural and intra venous medications;
- All blood and blood products;
- All medications considered to be high risk and
- All medications administered to neonatal and paediatric patients.

Exceptions apply in **special circumstances** when a second person is unavailable. At BH this may occur in;

- Home nursing services;
- During patient escort/transport; and/or
- Operating theatres when a medical officer is administering a drug. Despite this exception, when a medical officer is to administer a Schedule 8 drug or potassium in an operating theatre, the provision of access to the drug by the medical officer is to be witnessed and documented.

Where a drug requires a double check, **both individuals must view the;**

- **Preparation,**
- **Labelling,**
- **Delivery AND**
- **Administration of the drug.**

2.5.2 Drugs that are omitted, withheld or refused

Any drug that is omitted, withheld or refused must be recorded on the medication/drug chart as such. Any notation related to the omission, withholding or refusal of any

medication MUST be followed up with an explanation in the patient progress notes and where appropriate the treating clinician advised.

Refer Appendix A for Flowchart for Care recipient Medication Management.

Documentation in the patient/care recipient progress notes should detail;

- The reason why the drug has not been administered as prescribed;
- Action taken to access the drug (if the drug is currently unavailable);
- That the appropriate Medical Practitioner has been informed and
- The Management plan for that drug order.

Refer to Care Recipient Outings Clinical Practice Guideline

If an individual care recipient or patient is offsite when a medication is due the administering nurse must document the omission using recognised abbreviations and codes.

Refer Appendix I for Benalla Health's specific drug omission codes.

Any drug omission should be considered as a medication error and must be reported via the VHIMS risk management register.

Unavailable Medications

If a drug is unavailable, the authorised prescriber must be notified. If the medication order stands every effort must be made to access the drug. Efforts made to access the drug and any difficulties encountered, plus an estimated date/time of availability should be documented in the patient's/care recipient's progress notes. Medication unavailability should be reported on the VHIMS risk management register.

Right to refuse medications

Unless the circumstance is covered under the Mental Health Act, all patients and care recipients have the right to refuse any recommended intervention including pharmacological treatment.

2.5.3 Drugs administered to women who are pregnant or lactating

Health professionals responsible for prescribing or administering medications to **pregnant women and lactating mothers should ascertain the effect of the drug on both the mother and baby.**

The Therapeutic Goods Authority (TGA) medicines-pregnancy provides information to determine the severity of the effect of specific drugs on the fetus.

The categories ABCDX describes A as safe through to X which has severe effects. Category B is further divided into B1, B2 & B3.

Medication suitable for lactating women

2.5.4 Medication Management in the Home

For clients with memory issues where district nurses are administering medications a locked storage box with prescribed medication will be kept in the client's home. Keys to all locked boxes are kept with Home Nursing Services (HNS) car keys.

Client drug charts will be kept in the client history which should be updated at least three monthly. Medication information sheets including MIMS printouts will also be kept in the client's history.

Supplies of syringes/needles will be carried by HNS to the home where they are required. The first dose of any antibiotic is not to be given in the home setting. First doses should be given in the GP clinic or hospital setting to monitor for any anaphylactic reaction.

2.5.5 Administering Medications via Nasogastric or PEG tube

- Whenever possible use the liquid form of the drug.
- Ensure drug is appropriate to the size of the tube, its location in the gastrointestinal tract and the site of drug absorption. Check with pharmacist or medical officer if unsure.
- Check if drug is to be given before or after a feed. May need to interrupt or stop the feed.
- Enteric coated drugs are not appropriate and could clog the tube.
- Bulk forming laxatives should not be given via the tube as this would occlude the tube.
- Each drug is to be given separately. Do not mix with formula as this may alter the drug's therapeutic effect and also the integrity of the formula.
- Tube should be flushed with 5-10 mL water before, between and after each medication. Attach syringe gently, do not force and damage the gastrostomy tube.
- Use an enteral feeding syringe to flush 60mls of water after drug administration or when feed is finished.

Follow care of the nasogastric tube as advised via JBI:
Login details:

Username … benalladmh
Password … benalladmh

- Percutaneous Gastrostomy Tube with Internal Balloon
- Nasogastric / Nasoenteric Tube Care and Management
- Nasogastric / Nasoenteric Tube Feeding

2.5.6 Administering Medications via Infusion Device

- All S8 Opioid drugs and ketamine to be administered to patients intravenously or subcutaneously are required to be administered via a lockable infusion device.
- For intravenous infusions ensure the infusion is administered via a;
    - Giving set with back check valve to prevent migration into additional line and
    - Spring loaded infuser delivery device.

- Documentation of the infusion will be recorded on at least one of the following charts;
    - Medication Chart;
    - Ketamine Infusion Chart;
    - Subcutaneous Infusion Chart or
    - Patient Controlled Analgesia (PCA) Chart.
- Infusion pump/delivery devices can only be commenced and managed by Registered Nurses who are competent in the use of the specific pump / delivery device.

2.6 Self-Administration of Medication

In relation to the self-administration of medication it must be noted that:

- All medication must be securely stored according to the requirements of the Drugs, Poisons and Controlled Substances Act.
- Any involvement of an inpatient, care recipient or carer in the administration of medication must be done under the direct supervision of a person qualified to administer medication.
- All medication administered to an inpatient or care recipient must be signed as administered by the qualified person supervising the administration.
- Any changes to the medication administration policy or process involving inpatients or care recipients administering their own medication must be done in collaboration with the Chief Pharmacist.
- Assisting a DVA client in their own home with self-administration of medication must comply with criteria outlined in section 6.4 of Guidelines for the provision of community nursing services 2010

2.6.1 Residential Aged Care

A care recipient wishing to administer his/her own medication should be assessed both cognitively and physically to ensure they are able to safely and accurately administer their own medication.

1	RN must complete the Care recipient self-administration of medication assessment form. Refer Appendix C
2	If care recipient meets competency criteria, RN must advise VMO and request counter signature on assessment form.
3	Care recipient must then complete and sign care recipient self-administration of medication consent form. Refer Appendix D
4	Care recipient must sign the care recipient self-administration medication letter. Refer Appendix E

5	Copies of forms and letter to be filed in care recipient's notes.
6	Care recipients competency must be reviewed 3 monthly plus PRN as his/her condition or medication orders changes. If medications are changed and the care recipient will continue to self-administer medications; 6.1 The care recipient's VMO will add/change medication chart according to the new order. 6.2 The medication changes will be documented in the care recipient's progress notes, medication assessment and care plan on ManAd. 6.3 The staff member responsible for administering the medication on that day will educate the care recipient on the new or changed medication.
7	All medications are to be stored in a locked compartment in the care recipient's room. The care recipient will be responsible for the safekeeping of the key to their medications and for the administration of their medications.
8	Care recipients self-administering their own medication will be given a weekly supply of medications in order to monitor their compliance.
9	Medications that are self-administered should be recorded as such. Refer Appendix I
10	A medication sheet is signed by the care recipient's VMO detailing the medications the care recipient is self-administering. This medication sheet will be kept in the medication folder. The medication sheet will be clearly labelled on the front with "self-administering".

2.6.2 Home Nursing Care

In adopting the guiding principles to achieve continuity of medication management in the community BH recommends where clinically possible and appropriate consumers/clients/patients should be encouraged to maintain their independence for as long as possible, including managing their own medicines in a safe and effective way.

In situations where a client requires monitoring (not administration) of medication intake, medications should be supplied in a Dose Administration Aid (DAA) such as a Webster Pack. Refer section 5.1 of this policy.

The nurse will ensure the client is able to access the medication from the DAA and will visit as often as necessary to monitor that the client is taking their medication correctly. It is the responsibility of the nurse to ensure that prior to self-administration, the client understands the function of the DAA and where possible the name, purpose and side effects of their medications as well as the importance of reporting any side effects immediately to their carer, nurse or prescribing officer.

2.6.3 Acute Care

Self-administration of medication in acute care should only occur within the context of patient education in relation to the specific medication.

2.7 PRN Orders

Should an individual require regular PRN medication a review of medication orders should be requested. This should occur if a care recipient of MEW requires more than 7 consecutive doses of a PRN medication. These consecutive doses should be documented in the care recipient's progress notes on ManAd.

2.8 Administration of Cytotoxic Drugs

Safe handling and administration of cytotoxic medication

eviQ is the online service of the Cancer Institute of NSW.

All clinical content on eviQ is available without registration or login.

Resources include:

a) Clinical Procedure – Oral Anti Neoplastic Drug Administration
b) Clinical Procedure – Hazardous Drug Spill Management
c) Resource Document – Safe Handling & Waste Management of Hazardous Drugs
d) Flow Chart – Chemotherapy Extravasation Immediate Management

2.9 Telehealth

The administration of medication to Urgent Care Centre patients by nursing staff may be authorised via Telehealth.

The supply of any medication to Urgent Care Centre patients by nursing staff for the patients to take home, cannot be authorised via Telehealth.

A fax of a prescription is not to be given to patients for ongoing medication supply, as it does not fulfil legal requirements for this to occur.

3. ADMINISTRATION OF ANTIMICROBIALS

Inappropriate use of antimicrobials leads to the emergence of resistant bacteria, an increase in the risk of patient harm from avoidable adverse reactions and interactions with other drugs, infections with multiresistant bacteria, and unnecessary cost.

The aim of antimicrobial stewardship (AMS) at Benalla Health and MEW is to:

a) Promote adherence to good prescribing practice (See AIMED principles below) and alignment with the Therapeutic Guidelines.
b) Promote adherence to local clinical practice guidelines for management of sepsis, pneumonia and staphylococcal bacteraemia.
c) Obtain expert advice from an Infectious Diseases Service for infectious disease syndromes.
d) Provide a strategy for clinical pharmacists to support AMS process.
e) Provide a strategy for IV to Oral antimicrobial conversion.
f) Prescribe appropriate and effective surgical prophylactics.
g) Promote safe use and monitoring of aminoglycosides.

h) Undertake measures of usage of key broad-spectrum antimicrobial agents across the organisation.
i) Measure antimicrobial resistance.
j) Ensure a system is in place that enables diagnostic test results to be reviewed in a timely way.
k) Ensure all clinical staff, inclusive of VMO's, has access to ongoing education regarding antimicrobial stewardship and antimicrobial resistance.
l) Ensure patients and residents receive clear information about their clinical condition and treatment in a form they can understand.
m) Based on the patients or resident's clinical progress (improvement or deterioration) and available clinical information (investigation results), review and refinement of the antimicrobial therapy occurs regularly.
n) Ensure that all clinical staff are informed about the importance of safe antimicrobial use, including making available relevant resources to raise awareness (e.g. posters, pamphlets).
o) At least annual audits of infections and antimicrobial prescribing practices occur.
p) Relevant reports are provided to management and clinicians regarding antimicrobial prescribing safety and quality.

A I M E D: Five principles of good antimicrobial prescribing practice

These elements should be explicitly considered with every prescription of an antimicrobial. Antimicrobial therapy is aimed at improving patient outcomes.

	Principle	Rationale
1	**Antimicrobial selection and dosage** should be compliant with guideline recommendations (Therapeutic Guidelines: Antibiotic as default). Variance should be justified. **Allergy** to antimicrobial(s) must be assessed prior to prescription	Non-compliant practices abound, frequently leading to excessive use of broad spectrum agents that are more prone to drive emergence/selection of antimicrobial resistance. Guidelines also specify correct dosing, another neglected issue with potential to drive resistance. Allergy assessment is frequently neglected and potentially causes an increased risk for adverse events.
2	**Indication for treatment** should be documented.	There should be sound justification for prescribing in every patient. Avoid antimicrobial use in illness likely to be self-limited or of minor degree. Educate patients about antibiotic use.
3	**Microbiological assessment** - always consider and collect necessary specimens PRIOR to administration of the first antimicrobial dose.	Where possible, antimicrobial therapy should be directed against a demonstrated microbial cause of the infection. The corollary is that microbiological results must be available where practical to guide therapy or to support treatment cessation / de-escalation decisions (see 4. below).

4	**Evaluate at 48-72hrs**: assess whether antimicrobial treatment needs to be modified (de-escalation).	At this point in time, patients who are receiving empiric therapy can be assessed to determine clinical progress, revised or confirmed diagnosis and results of initial microbiology. The options then are three-fold: • cease treatment (non-infective diagnosis made, negative microbiology) • de-escalate IV treatment to a defined period of oral treatment (patient improving, afebrile, no other ongoing indication for parenteral treatment) and/or • direct parenteral/oral therapy against a demonstrated pathogen that is thought to be causing the illness.
5	**Duration or review date** should always be specified.	Excessive durations of antimicrobial therapy represent further risk for emergence / selection of antimicrobial resistance and occurrence of adverse events. • For most indications, short and sharp treatment courses work best. • Surgical prophylaxis when indicated should usually consist of one pre-operative dose. • For post-operative patients, always document a treatment plan (duration, agent(s) and dosage).

3.1 Prophylactic administration

Refer to current version Therapeutic Guidelines

3.2 Intravenous to oral administration

3.2.1 Benefits of Early SWITCH to Oral Therapy

a) Decreased risk of complications from IV lines: thrombophlebitis, catheter related infections.
b) More patient / resident friendly (improves mobility and comfort).
c) May lead to earlier discharge.
d) Saves medical and nursing time.
e) Reduction in costs: Direct - medication
Indirect - diluents, equipment, needles

3.2.2 Safety of Switching

A large number of clinical trials support early switching to oral antibiotics, following two to three days of treatment with IV therapy.

a) Equal treatment efficacy
b) No adverse effects on patient outcome

3.2.3 Criteria for Switching

a) Oral fluids/foods are tolerated and no reason to believe that poor oral absorption may be a problem e.g. vomiting, diarrhoea
b) Temperature less than 38°C for 24 to 48 hours
c) No signs of sepsis
d) An appropriate oral antibiotic is available
e) Extra high tissue antibiotic concentrations or a prolonged course of IV antibiotics is not essential.

3.2.4 Conditions where SWITCH should be considered

a) Gram negative bacteraemia
b) Hospital acquired infections
c) Intra - abdominal infections
d) Pneumonia
e) Skin and soft tissue infections
f) Urinary tract infections

3.2.5 Conditions where SWITCH is not appropriate

Conditions which require a prolonged course of IV antibiotics or very high tissue concentrations;

a) Bone and joint infections
b) Cystic fibrosis
c) Endocarditis
d) Deep seated abscess
e) Meningitis
f) S. aureus bacteraemia

3.2.6 Antimicrobials with Excellent Oral Bioavailability

a) Fluconazole (>90%)
b) Ciprofloxacin (70 to 80%)
c) Metronidazole (>95%)
d) Moxifloxacin (~90%)
e) Clindamycin (~90%)

3.2.7 Suggested Conversion Regimens

Refer to Therapeutic Guidelines: *Antibiotic* for dosing in specific indications

IV		**Oral**	
Antimicrobial	**Usual Dose***	**Antimicrobial**	**Usual Dose***
Ampicillin	1-2g IV QID	Amoxycillin	500mg-1g oral TDS
Azithromycin	500mg IV Daily	Roxithromycin	300mg oral daily
Benzyl penicillin	1.2g IV QID	Phenoxymethyl penicillin	500mg oral QID
Ceftriaxone	1g IV Daily	No oral formulation Choice of oral antibiotic depends on infection site/microbiology	
Cephazolin	1g IV TDS	Cephalexin	500mg oral QID
Ciprofloxacin^	200-400mg IV BD	Ciprofloxacin^	250-500mg oral BD
Flucloxacillin	1g IV QID	Flucloxacillin	500mg oral QID
Lincomycin	600-900mg IV TDS	Clindamycin^	300-600mg oral TDS
Fluconazole^	200-400mg IV daily	Fluconazole^	200-400mg oral daily
Metronidazole^	500mg IV BD	Metronidazole^	400mg oral TDS

*Usual dose for adult patients with normal renal function. ^Antimicrobials with excellent oral bioavailability

1. Barlow GD, Nathwani D. Sequential Antibiotic Therapy. Curr Opin Infect Dis. 2000; 13(6):599-607

2. Sevinc F et al. Early Switch from Intravenous to Oral Antibiotics: Guidelines and Implementation in a Large Teaching Hospital. J Antimicrob Chemother. 1999; 43:601-606

3.3 Prescribing Guidelines

Prescribers are expected to be cognisant of clinical guidelines which align with the Therapeutic Guidelines: *Antibiotic.* Adhering to the Therapeutic Guidelines will result in consistent prescribing practices which take into account local microbiology and antimicrobial susceptibility patterns relevant to Benalla Health.

Prescribers need to be aware of Benalla Health's formulary restriction and approval system which includes restricting broad spectrum and later generation antimicrobials to patients in whom their use is clinically justified.

Increasing Point of Care interventions is encouraged to optimize antimicrobial usage, decrease risk and promote consumer participation. Pharmacists are required to check that prescriptions of any restricted antimicrobial are compliant with Benalla Health's list of restricted antimicrobials prior to dispensing. If antimicrobial is restricted Pharmacists are to contact the appropriate medical officer to clarify the order.

3.3.1 Nursing

Ensure antimicrobial prescription complies with the 7 RIGHTS of medication administration and each order is signed by the prescribing officer. Documentation is inclusive of indication and be aware of, and advocate for the MIND ME creed and general principles of antimicrobial use.

MINDME – Antimicrobial Creed

M – Microbiology guides therapy wherever possible

I – Indications should be evidence based

N – Narrowest spectrum required

D – Dosage is appropriate to the site and type of infection

M – Minimise duration of therapy

E- Ensure monotherapy in most cases

3.3.2 Antimicrobials Formulary

Three Categories

- **General use**
- **Use after consideration and Therapeutic Guidelines review**
- **Use in consultation with relevant specialist / ID physician**

Systemic Antimicrobials

GENERAL USE	Comment
Aciclovir - oral	**IV - considered use**
Amoxycillin	
Amoxycillin/Clavulanate	
Ampicillin	
Benzylpenicillin	
Cefaclor	
Cefalotin (Cephalothin)	
Cefoxitin	
Cefuroxime	
Cephalexin	
Cephazolin	
Dicloxacillin	
Doxycycline	
Erythromycin	
Flucloxacillin	
Hexamine hippurate	
Metronidazole oral	**IV - considered use**
Miconazole	
Minocycline	
Nitrofurantoin	
Nystatin	
Phenoxymethylpenicillin	
Roxithromycin	
Terbinafine	
Trimethoprim	
Trimethoprim/Sulfamethaxazole	
Valaciclovir	

CONSIDERED USE – suggest Therapeutic Guideline review	
Acyclovir IV	
Azithromycin	
Cefepime	
Cefotaxime	
Ceftazidime	
Ceftriaxone	
Ciprofloxacin (oral)	
Clarithromycin	
Clindamycin	
Famciclovir	
Fluconazole	
Gentamicin up to 48 hours of use	**Restricted use after 48 hours**
Meropenem	
Metronidazole IV	

Moxifloxacin	
Norfloxacin	
Oseltamivir	
Piperacillin/Tazobactam	
Rifampicin when used in combination for TB or MRSA management	
Rifaximin	
Timentin	
Tobramycin	
Vancomycin	

RESTRICTED USE – ID physician discussion / approval required	
Amikacin	
Amphotericin	**All IV formulations**
Azithromycin IV	
Aztreonam	
Ciprofloxacin IV	
Daptomycin	
Gentamicin after 48 hours use	
Imipenem	
Linezolid	
Rifampicin non TB or MRSA indications	
Sulpha diazine	
Teicoplanin	

Non-Systemic Antimicrobials

Chloramphenicol drops	Eye
Chlorhexidine	Topical
Clotrimazole	Topical
Permethrin	Topical
Povidone - iodine	Topical
Mupirocin	Topical
Neomycin/Gramicidin/Nystatin	Ear or topical
Framycetin	Ear or eye
Framycetin/Gramicidin	Ear
Ketoconazole	topical

3.4 Community acquired pneumonia

Refer to current version Therapeutic Guidelines

3.5 Review Process

Antimicrobial usage obtained through the Dorevitch Antibiogram reports along with the list of restricted antimicrobials will be routinely reviewed by the Antimicrobial Stewardship

(AMS) Working Party and reported to Medical Staff Group (MSG) and the Medication Safety Committee.

At the same time participation in National and local benchmarking activities will occur.

4. NON PRESCRIPTION DRUG ORDERS AND DRUG PROTOCOLS

4.1. Verbal/Phone Orders

4.1.1. Phone orders for In-patients

Verbal orders whether in person or by phone are only acceptable as a **single dose** and only in an **emergency** situation.

1	Must be **heard and confirmed** by repeating the order back to the authorising prescriber **by 2 staff qualified to administer the medication**.
2	*As an emergency typically relates to a change in health status for a patient one staff member receiving the order must be an RN or RM.*
3	The RN or RM must record the phone order on the drug chart under the "Telephone Orders" section.
4	Both individuals who hear and confirm the order must sign the medication chart.
5	Phone orders must be signed by the authorised prescriber within 24 hours.
6	Repeat prescriptions for a medication cannot be accepted via a phone order. The authorised prescriber must write and sign an ongoing order on the medication chart.

4.1.2. Phone orders for Residential Aged Care

Verbal orders whether in person or by phone are only to be used as an interim measure. The VMO is to fax a computer generated prescription through to MEW or to the local pharmacy AND signs the medication chart order within 48 hours.

For interim orders received in business hours only

1	Must be **heard and confirmed** by repeating the order back to the authorising prescriber **by 2 staff qualified to administer the medication**.
2	As a change in medication order typically relates to a change in health status for a patient one staff member receiving the order must be an RN.
3	The RN taking the verbal order will immediately enter the details on the care recipient's medication chart completing all the details in relation to the date, time, medication, dose, route, frequency and the name of the VMO issuing the instructions. These prescriptions are to be recorded in the specific telephone prescriptions section and countersigned by both staff.

4	The pharmacy is contacted to supply the medication or if not urgent the prescription is written in the Pharmacy book.
5	A blue “telephone/verbal order compact card” is to be placed on the care recipient’s medication chart as a reminder to be given to the VMO to sign the medication order. A reminder is also documented in the VMO communication folder with a request for an ongoing order.
6	The change in medication order must be documented in the care recipient’s progress notes.
7	The VMO must send through the completed original confirmation telephone prescription “Compact” label by post or via the pharmacy with an accompanying script. On receiving the Compact label the nursing staff must ensure that the new order is entered into the care recipient’s records.
8	Upon receipt of the original medication prescription the receiving RN must; • Check the telephone medication prescription against the verbal order • Detach the label with the original prescription and place on an unused medication slot in the appropriate section of the medication chart e.g. regular, short term, PRN • Use this prescription to document that this medication has been administered. The telephone prescription is then ceased.

For interim orders received outside of business hours only

1	Must be **heard and confirmed** by repeating the order back to the authorising prescriber **by 2 staff qualified to administer the medication**.
2	*As a change in medication order typically relates to a change in health status for a patient one staff member receiving the order must be an RN.*
3	The RN taking the verbal order will immediately enter the details on the care recipient’s medication chart completing all the details in relation to the date, time, medication, dose, route, frequency and the name of the VMO issuing the instructions. These prescriptions are to be recorded in specific telephone prescriptions section and countersigned by both staff.
4	The pharmacy is contacted to supply the medication or stock is utilised if available from the emergency supply of medication.
5	The telephone prescription is counter signed by the VMO giving the prescription within 48 hrs. The VMO is required to print the medication prescription on the compact medication chart if continuous administration is required beyond the 48 hours.
6	If the medication prescription is hand written it must be legible, signed and dated in the VMO’s handwriting in black or blue ink.
7	The RN will document in the total progress notes on ManAd the effect of the medication prescribed.

4.2 Nurse Initiated Formulary

Registered or Enrolled Nurses cannot, under any circumstance, legally initiate Prescription Only Medications (S4) or Controlled Drugs (S8).

Nurse initiated formulary (NIF) as defined by this policy does not relate to any drug initiated / administered via an approved BH protocol or standing order by individuals qualified via extended practice/advanced practice competency to administer specific medications. The NIF will be reviewed annually.

NPs have a limited formulary including a range of S4 and/or S8 medications which they can initiate for patients in their care after they have established a therapeutic need exists. The range of medications is different for the different categories of NPs.

Any nurse initiating / administering a drug via a protocol, standing order and/or extended/ advanced practice should comply with the;

- Legislative requirements related to their scope of practice;
- The DPCS Act and
- Relevant drug protocol/s, standing order, product information &/or best practice guidelines.

Nurse initiated medication must meet all of the following criteria

1	Given by a RN or RM from a restricted list of medications – **refer to Appendix B of this policy.**
2	Dosage limits, frequency of dosing and total dose are set and cannot be exceeded. Refer Appendix B Any individual who requires further doses beyond the limits stated in appendix B should be reviewed by their treating clinician. **No further doses beyond those stated should be given as a nurse initiated order**.
3	Given without prior approval of a medical officer or NP and only when a medical officer or NP is unavailable.
4	Given ONLY if symptoms are not related to the primary problem.
5	Given ONLY if the nurse is **familiar with the medication and aware of any possible side effects.**
6	Each order is documented in the "ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES" section of the National Inpatient Medication Chart. Details documented must include: date, medication name, strength, form, route, dose, date and time of administration, as well as the signature of the nurse initiator, and their registration status (RN or RM).
7	The nurse who initiated the medication records in the progress notes the reason for and evaluation of administration of the drug.

8	Patient/care recipient is symptomatic and can reasonably expect an improvement in comfort through the administration of this drug.
9	**Dosage administered must not exceed that recommended in MIMS or product information** leaflet.
10	**Subsequent doses must be prescribed by an authorised prescriber.**
11	Patient/care recipient has **no known allergy to that drug.**

4.3 Standing Orders

Standing orders are prepared in accordance with BH's permit to purchase or otherwise to obtain and use a poisons or controlled substance for the provision of health services issued under the DPCS Act.

Standing Orders apply in circumstances related to life saving treatment in the event that an authorised prescriber is unavailable. There are no standing orders for Residential Aged Care.

At BH standing orders apply in regards to advanced life support, emergency management of anaphylaxis, respiratory suppression, management of ischaemic chest pain and obstetric emergencies.

Emergency Category	Drugs
Anaphylaxis Adult and Child	• Adrenaline
Cardiac Arrest	• Adrenaline • Amiodarone
Life threatening bronchospasm	• Salbutamol
Chest pain	• Glyceryl Trinitrate (GTN) spray
Postpartum haemorrhage	• Syntocinon • Ergometrine

To administer standing orders, administration of the specific drug must be within the EN, RN and/or RM's scope of practice and the individual EN, RN and/or RM must have completed the relevant BH competency package/s. Refer section 9.2 of this policy for details related to staff education & training.

4.4 Drug Protocols

At BH a number of drug protocols have been established to guide medication management in relation to preparation, administration and treatment regimes e.g. thrombolysis.

All drug protocols at BH represent current best evidence and are formulated with the inclusion of **external links for current drug information.** At BH all drug protocols are reviewed annually and as required.

4.5 Use of Complementary and Alternative Therapies

Refer to: Complementary Therapy clinical practice guideline
The treating medical officer or nurse practitioner and pharmacist advice must be sought and documented if a patient or care recipient requests use of non-prescription substances or treatments that are not covered under the nurse initiated formulary including homeopathic treatments and over the counter S2, S3 and unscheduled substances.

5. DRUG CHARTS

5.1. National Inpatient Medication Charts (NIMC)

At the Australian Health Ministers' Conference in April 2004, Ministers agreed that;

> "to reduce the harm to patients from medication errors, by June 2006, all public hospitals will be using a common medication chart. The Australian Commission on Safety and Quality in Health Care (ACSQHC) is charged with maintaining national version control of the National Inpatient Medication Chart (NIMC) and with identifying national impediments to implementation"

Information on the NIMC, including guidelines for implementation, are available on the ACSQHC NSMC webpage.

5.2. GP Clinic Medication Charts

All General Practitioners who have visiting rights use the NIMC chart which can be computer generated or handwritten.

Departmental approval has been given in general for a person referred to in regulation 25 to issue computer generated prescriptions under circumstances that satisfy the criteria.

"Approved by the Secretary". DPRG

5.3. Compact Medication Charts (Residential Aged Care)

The VMO is responsible for supplying computer printed medication lists for each care recipient suitable for the Compact medication charts.

The next date of administration for infrequent medicines (e.g. medicines given 2-3 monthly) must be documented on the medication chart or in the medication notes if the next administration date does not occur within the time span covered by the current chart.

5.4. Medication Charts from other Health Care Organisations

Medication charts from other health care organisations, which come to Benalla Health with a patient who is being directly transferred from that organisation to Benalla Health,

and which are in NIMC format, may be used to authorise the administration of medication at Benalla Health for up to 24 hours after the patient is admitted. Medication authorisation after 24 hours must be via Benalla Health documents.

5.5. Faxed Medication Charts

As advised by the Manager Health Practitioner Compliance – Medicines and Poison's Regulation Department (2019) faxed drug charts are a legal means of authorising drug administration.

At Benalla Health faxed drug charts are acceptable;

- For Telehealth consultations OR
- Until original drug charts are available.

At Benalla Health faxed drug charts can be used provided they are;

- Legible and
- Complete and
- Formatted appropriately on a valid and recognisable drug chart as per section 5 Drug Charts and
- Facilitate the appropriate application of the 'rights of drug administration' as per section 2.4 the '7 rights' of drug administration.

Original drug charts are required to be completed during the first medical review after admission typically anticipated to be within 24 Hours of presentation.

5.6 Telehealth

Faxed medication orders can be used for patients cared for via telehealth providing the conditions noted in section 5.5 are met.

If faxed medication charts contain unclear orders or orders which nursing staff otherwise consider to be unsatisfactory for use at Benalla Health, they are not to be used. Under these circumstances, the medical practitioner is to be asked to rewrite and refax the medication chart. This process may be repeated until faxed charts are clear and safe for use. In the event that a faxed chart remains unclear and unusable, all required medication orders are to be provided and confirmed via telephone as per section 4 of this policy.

6. DISPENSING

6.1 Use of Dose Administration Aids

Dose administration aids (DAA) may consist of either 'blister packaging system' such as a Webster Pack or 'compartmentalised boxes'. DAA are devices or packaging systems where doses of one or more solid oral forms of medicines can be organised according to the time of administration.

DAA should be labelled with the name, strength and form of all medications. The DAA should enable the identification of individual medications e.g. brand and generic names, colour, shape, size and manufacturing marks.

DAA should be labelled with instructions on when the medication is to be administered and include cautionary advisory labels regarding alteration of dosage where appropriate.

Medication from DAA must be punched into a medication cup and administered directly to the individual. Administering staff must remain with the individual until the medication is seen to be swallowed.

No medication is to be removed from the DAA and placed into another container. If an individual will be offsite for their next dose the DAA should be sent with them with appropriate instructions for administration.

Any changes to medication orders should be telephoned or faxed through to the pharmacist to arrange for repacking of DAA. The VMO should arrange for the completion of a new prescription for pharmacy.

If a medication is ceased – a "*ceased"* sticker must be applied to the DAA and the care recipient/patient/carer informed of the change/s. The ceased medication should be returned to pharmacy and the change in order recorded in the pharmacy returns book.

6.2 Dose Administration Aids in Residential Aged Care

The nominated Pharmacy will supply care recipient's regular medications in a 7 day Webster system. All remaining prescriptions for care recipients will remain at the pharmacy until such time as the medication is required. No medication will be supplied by the pharmacist until such time as a prescription is supplied by the care recipient's VMO.

The DAA's are made up for 7 days and will be delivered on Tuesdays and placed in the locked cupboard until Thursday. Each DAA will run from Thursday until Wednesday and is dated with the day that it is to commence. The contracted pharmacy has an on call service should it be required. Refer to pharmacy's telephone contact details located in pharmacy book in the pharmacy room.

The pharmacist should be notified immediately should a care recipient be transferred to hospital or is away on extended leave. If a care recipient leaves the facility the DAA should be sent with them so that their medication can be administered at the correct time. All instructions regarding medication management while the care recipient is offsite should be documented in the care recipient's progress notes.

The colour of the DAA will indicate the time of day for administration:

- Pink – morning
- Yellow – midday
- Orange – afternoon
- Blue – nocte

In addition the type of drug is indicated by the following colours of the DAA

- Green – Antibiotics
- Purple – accountable drugs/ drugs of addiction

- White – PRN medication

DAA's may be utilised to assist people who are self-administering their medicines.

6.3 Use of Inpatients Own Medication

A patient's own medications can be used without breaching the Australian Health Care Agreement where:

1	The medication is unrelated to the condition for admission. • A patient is admitted for bowel cancer and has insulin dependent diabetes. His own insulin can therefore be used.
2	The medication has been chronically used by the patient and is required to be continued at the time of admission. • A patient on a waiting list for hip replacement has congestive cardiac failure and arthritis and is on more than 4 medications including a blocker, ace inhibitor, diuretic, lipid lowering medication and non-steroidal anti-inflammatory. The patient's own medication can be used during their admitted episode however pain killers for post-operative pain and antithrombotic will need to be provided by the health service.

A patient's own medication must not be used in the health service where:

1	Pre- admission clinics for elective cases predict and facilitate the supply of future admitted episode pharmaceutical use. • A patient is being treated for breast cancer and the doctor at the pre-admission clinic writes a prescription for paclitaxel for the patient. The patient has their medication supplied at a community pharmacy. This medication is not to be used for the patient during their admitted episode, as this would be a clear breach of the Australian Healthcare Agreement.

Health service responsibilities in relation to the use of patients own medication as per VicHealth.

6.4 Residential Aged Care

Each care recipient will have their own supply of medications. Medication supplies are not shared between care recipients.

Medications that are not suitable for packaging in the DAA such as inhalers/spacers/eye drops etc will be supplied in the original containers with dispensed labels containing individuals name, medication name and when the medication is to be administered. Nitrolingual spray will have individuals name on the bottles as well as the box. They should then be individually packed in a sealed plastic bag to prevent cross infection.

6.5 Discharge Medications

On discharge, a prescriber may provide an updated medication list to a patient. Depending on the prescriber and/or individual patient circumstances, by referral on discharge, the pharmacist may instead provide an updated medication list. To enable the list to be prepared by the pharmacist, a copy of any discharge prescriptions are required to be made available to the pharmacist. In the absence of the pharmacist, "medication list" cards are available for completion by nursing staff.

For the pharmacy department to dispense or to organise for dispensing of medication by an external pharmacist, an original copy of the discharge prescription is required.

Discharge medication for care recipients attending MEW for respite will be organised by care recipient's family/carer.

7. STORAGE OF DRUGS

7.1 Security

All medications must be stored in a secure manner, appropriate to their schedule.

To comply with the DPCS Act all Schedule 8 drugs are to be stored in a metal drug safe. The nursing team leader on each shift is responsible for carrying and/or the location of the drug safe keys.

Medications for inpatients of acute services are stored in a secure bedside locker located within the individual's room.

Medications for care recipients of MEW are stored in a lockable medication trolley. The medication trolley must never be left unattended when it is unlocked. During the medication round the medication trolley must be kept within eyesight of the person conducting the drug round. If the drug trolley is going to be out of the line of eyesight the trolley must be locked and all medication, including those in DAA's, must be locked away safely.

When medication trolleys are not in use in MEW they are stored in the self-locking medication room.

The medications of care recipients self-administering their medication will be stored in a locked compartment in the care recipient's room. Both the care recipient and the nurse team leader will have a key to the locked compartment.

7.2 Drug Refrigerators

Drug refrigerators are to be kept locked and secure at all times, except when accessing their contents. Any fridge that does not have a locking mechanism should be kept in a locked room. Drug refrigerators are reserved for the storage of medications only.

Drugs should be stored to allow airflow around the product.

Drug refrigerators should be maintained at a constant temperature of between 2 and 8 degrees Celsius. We “strive for 5”. The internal temperature of each refrigerator is monitored and recorded. Drug refrigerators have glass doors to facilitate visualisation of contents without the need to open or prolong the opening of the door.

The drug fridge has 3 levels of temperature tolerance monitoring:

1. A local alarm will sound on the fridge if tolerance is exceeded.
2. A general alarm will be triggered via the centralised hospital security system if the tolerance is exceeded.
3. A separate internal temperature monitor is located in each refrigerator. These temperature monitors record data for retrospective analysis.

7.3 After Hours Access

If a patient is admitted after normal business hours and requires a medication not available via imprest, the patient’s own medication may be used. Before being used, the patient’s own medication needs to first be checked (See Appendix N). If the patient’s own medication is not available or it is unsuitable for use, the Nursing Coordinator is to be notified. The Nursing Coordinator will then check availability in the afterhours medication cupboard and/or other units.

If the drug is not available the prescribing authority should be notified

Nurses caring for palliative care clients in the community who require medication when the hospital pharmacy is closed, have access to an emergency supply outside normal community pharmacy hours by contacting the Nursing Coordinator. After retrieving medication from the hospital premises, the nurse should transport single doses only of the medication to the client via the most direct route.

7.4 Emergency Supply of Medications for Residential Aged Care

An emergency supply of medications including some antibiotics is available in the left hand side of the locked medication cupboard in MEW. This medication may be used when a medication prescription is received after hours and the medication must be commenced immediately.

If a care recipient requires emergency drugs of addiction including a fentanyl patch the afterhours Nursing Coordinator should be contacted and the hospital pharmacist called. This should be recorded in the pharmacy communication folder. All requests for drugs of addiction should be made via the drugs of addiction red book.

7.5 Unused Medications on Death or Discharge

All unused medication including medications of discharged or deceased patients/care recipients should be returned to pharmacy to enable safe and secure disposal.

8. CONTROLED & PROHIBITED SUBSTANCES

Information for registered health practitioners can be found at the following;

Drugs and Poisons Regulation Group (DPRG)

Requirements for nurses NOT including nurse practitioners

The term "**nurse**" (as defined in the Regulations) means a registered nurse or an enrolled nurse. This term does not include an enrolled nurse with a notation on registration indicating that he/she is not qualified to administer medication.

- **Any illegal act related to medication management of controlled or prohibited substances must be reported to the police.**

8.1 Schedule 4 (S4) Poison

General Description – Prescription Only Medicine

Requirements for the management of S4 medications

1	The use and supply of S4 medications requires a prescription written by an authorised person.
2	RN, RM and appropriately qualified ENs are authorised to be in possession of a S4 in accordance with a written prescription.
3	S4 medications can only be administered to a patient/care recipient if a prescription is written.
4	In the absence of a prescription it is illegal for unauthorised persons to be in possession, or administer, S4 medications.
5	Administration of medications from an unsigned order is illegal.
6	In the case of an emergency, a verbal or phone order can be accepted but the order must be signed by the authorising prescriber within 24 hours.
7	Self-administration of a S4 medication in the absence of a prescription is illegal.
8	S4 medications must be stored in a locked facility with restricted access available to authorised hospital employees and nursing students under direct supervision only.

8.2 Schedule 8 (S8) Poison

General Description - Controlled Drug

Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence, e.g. Morphine.

Requirements for the management of S8 Drugs/medications

1	An appropriately qualified EN, RN and RM is authorised to be in possession of a S8 medication in accordance with a written prescription, and for the administration to a patient under their care for whom that prescription is written.

2	In the absence of a written authorisation, it is illegal for an unauthorised person to be in possession of, or administer, S8 medications.
3	S8 medications can only be administered to patients if there is a written authorisation. Administration of medications from an unsigned order is illegal.
4	In the case of an emergency, a verbal or phone order can be accepted. The verbal order however must be signed by the authorising prescriber within 24hours.
5	S8 medications must be stored in a drug safe unless they are supplied in a Drug Administration Aid such as a Webster Pack within Aged Care settings.
6	The RN or RM delegated in charge of each shift is responsible for the carrying and/or the whereabouts of the drug safe keys.
7	Except in special circumstance units when only one qualified staff member is available (refer 2.5.1), all S8 drugs must be prepared and administered by two staff qualified to administer the medication.
8	All drugs stored in the drug safe must be counted at the end of each shift by two nurses qualified to administer medication – at least one being an RN or RM. The count must be confirmed in the Drug of Addiction Administration Book by the nurses responsible for the count. Any discrepancy in the count (including noted damage to ampoules or evidence of package tampering) must be reported to; • The nurse in charge of the shift; • The nursing coordinator and • Must be recorded on the VHIMS incident register. If an error occurs in transcription in the Drug of Addiction Administration Book, cancel the documentation by drawing a single line through the error and initialling the entry. **DO NOT USE LIQUID PAPER OR ERASERS** in the Drug of Addiction Administration Book.
9	Schedule 8 drugs which are no longer required are to be returned to pharmacy for appropriate disposal. Any S8 drug left over from a previously sterile container or any unused portions of tablets or lozenges are to be discarded according to the procedure outlined in Appendix L Disposal must be witnessed by the 2 staff responsible for administering the medication, except in special circumstance units when only one qualified staff member is available (refer 2.5.1).
10	Supply of S8 medication to support drug dependency is illegal.
11	To administer an S8 medication; • Collect the individuals medication chart and drug keys and proceed to the storage area • Remove the prescribed drug from the cupboard

	• Count and check the drug stock tally against the Drug of Addiction Administration Book • Complete the register entry • Complete 7 rights for drug administration • Sign administration on drug chart

The DPCS Regulations authorise a nurse to act as the witness when a Schedule 8 poison is to be destroyed by a medical practitioner, nurse practitioner, pharmacist or dentist.

Note: This does **not** mean that two nurses may destroy all Schedule 8 medications. As in the table (above) a nurse may destroy (i.e. discard) the remaining, unused contents of a previously sterile container of a Schedule 8 medication (e.g. a partially used ampoule) provided the nurse makes an appropriate record. The disposal of any unused content of a previously sterile container of S8 medication is to be witnessed by the individual responsible for the checking process, except in special circumstance units when only one qualified staff member is available (refer 2.5.1).

8.3 Schedule 9 (S9) Poisons

General Description - Prohibited Substances

Substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or training purposes with approval of Commonwealth and/or State or Territory Health Authorities, e.g. Heroin.

Any substance identified as prohibited by law and brought on to the premises without approval of the Commonwealth or State Health Authority must be reported to the police. **Refer also to BH guideline on Drug & Alcohol Withdrawal**

8.4 Schedule 11 (S11) Poisons

The term "**drugs of dependence**" is used to describe substances listed in S11 of the DPCS Act and includes all S8 poisons plus those Schedule 2 (S2), Schedule 3 (S3) or S4 poisons known to be subject to misuse and trafficking, e.g. pseudoephedrine, benzodiazepines, dextropropoxyphene, midazolam.

Note: Most regulations relate primarily to whether a drug is a S4 or S8 (not S11) so, to avoid confusion, it is recommended that diazepam and similar substances be referred to as S4 drugs of dependence, rather than as S11 drugs.

8.5 Staff with health issues related to substance use

8.5.1 Nursing and Midwifery Health Program (NMHP) Victoria

Nursing and Midwifery Health Program (NMHP) Victoria

Formerly the Victorian Nurses Health Program, NMHP is an independent support service for nurses, midwives and students of nursing and midwifery experiencing health issues related to their mental health or substance use concerns.

8.5.2 Victorian Doctors Health Program (VDHP)

Victorian Doctors Health Program (VDHP)

The Victorian Doctors Health Program (VDHP) is a confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use problems, or any other health issues.

9. SPECIAL CIRCUMSTANCES

9.1 Benalla Health Services

Special circumstances include those activities whereby EN's, RN's & RM's may be;

- Working in a patient's own home and/or
- Working with Care recipients in an Aged Care settings.
- Organising an Inter-hospital patient transfer

In these instances, when there is only one qualified staff member exemptions may apply to double checking processes and requirements.

BH recommends medication management in residential aged care follow the Guidelines for Medication Management in Residential Aged Care Facilities developed by the Australian Pharmaceutical Advisory Council 2002

BH recommends medication management in community settings follow the Guiding Principles to Achieve Continuity of Medication Management in the Community, 2006

9.1.1 Operating Theatres

Special circumstances also include operating theatres where a visiting medical officer may be administering and discarding medication. Visiting medical officers can administer without a second person to check and sign off.

While medical officers may administer Schedule 8 drugs to which they have been given access, the discarding of the balance of a previously sterile container is to be witnessed by a nurse, with the disposal and witnessing documented in the Drug of Addiction Administration Book.

The requirement for a nurse to witness disposals in the Theatre Unit applies to Schedule 8 medications only, not to Schedule 4 medications.

10. EDUCATION & TRAINING

10.1 Patient/Carer Medication Management Education

The EN, RN or RM responsible for administering a medication should answer any questions that the patient or care recipient may have about the specific medication and/or where appropriate arrange for the Pharmacist to provide the patient/care recipient with an appropriate education session.

Patient education related to medication management is a shared responsibility between all healthcare clinicians involved in patient/care recipient care. Education should commence on admission and occur whenever;

- Patient/Care recipient asks a question;
- There is any change in medication management;
- There is a change in patient/care recipient condition;
- Polypharmacy is evident and
- On discharge.

Education should be provided to both patients/care recipients and their principle carer/s.

10.2 Staff Competency & Training

10.2.1 Orientation

All students and qualified nursing staff with responsibilities related to the administration of medication must successfully complete (100%) the nominated drug calculation package.

All novice clinicians (EN and RN) must complete at least one drug round with a clinical facilitator, clinical support nurse and/or nurse educator as part of their transition to the workplace program/period.

Any nurse with responsibilities related to the administration of medication who is new to the organisation or to a new workplace area can nominate as part of their transition to the workplace plan to complete one or more drug rounds with a clinical facilitator, clinical support nurse and/or nurse educator.

10.2.2 Staff Proficiency

All nursing staff must comply with national Registration and Competency Standards relevant to their qualification as well as Benalla Health's Scope of Practice Policy.

All nursing staff with responsibilities for administering medication are required to complete both the eLearning and the Validation Peer Review as outlined below:

- **Complete the eLearning** appropriate to their scope of practice on ReHSeN:
    - Safe Medication Management module
        - for all RNs
        - For ENs credentialed to administer IV medication.

    OR
    - Safe Medication Management for Enrolled Nurses module
        - For ENs who are not credentialed in administration of IV medication.

- **Complete a** Validation Peer Review – Medication Administration
    - For all RNs and ENs
    - Appendix J

10.2.2.1 Clinical Support

Any staff member with responsibilities for administering medication who are identified by themselves, their peers or their supervisors as struggling with the principles of safe administration of medications or who have been involved in a medication error should be referred to the education unit. The CSN and or Clinical Educator will review the situation to develop a clinical support plan that may include completion of a Validation Peer Review – Medication Administration by a CSN or Clinical Educator.

A formal support program and assessment of competence in regards to medication administration is mandatory for any staff member identified as unsafe.

Nursing and Midwifery - Guidelines for Mandatory Notifications Clinical support is available for both peer review and/or competency assessment.

A peer reviewed drug round is available to all relevant nursing staff as an opportunity for either peer support and/or a nursing portfolio professional development initiative.

A peer reviewed drug round will follow the principles of safe medication management. A peer review is not a formal assessment of competency but a collegial support program.

10.2.3 Phased support program for IV Medication endorsed EN's

To support the transition of an EN new to the role of administering IV medications at Benalla Health, all EN's who are newly qualified to the role of administering IV medications AND all EN's who are qualified to administer IV medications; AND are new to the organisation will be required to complete the phased support program.

Phase 1

Criteria to enter Phase 1

- EN is new to Benalla Health and/or
- Has successfully completed IVT Medication Module – theory and practical components.

Requirements of Phase 1

- EN will under direct supervision and with the support of their supervising RN administer the IV medications of ONE of their allocated patients.
- EN will assume the responsibility to negotiate with a clinical educator, clinical support nurse (CSN) or a senior registered nurse (ANUM, NUM or ADON) to undertake a supervised IV drug round for ALL their allocated patients at least once a fortnight.

To successfully complete phase 1, both the EN and their supporting CSN must be confident that the EN is safe to proceed to phase 2.

Phase 2 Criteria to enter Phase 2

- EN has successfully completed phase 1 of the phased support program.

Requirements of Phase 2

- EN will under direct supervision and with the support of their supervising RN administer the IV medications of TWO of their allocated patients.

- EN will to assume the responsibility to negotiate with a clinical educator, clinical support nurse (CSN) or a senior registered nurse (ANUM, NUM or ADON) to undertake a complete IV drug round for ALL their allocated patients at least once a fortnight.

To successfully complete phase 2 both the EN and their supporting CSN must be confident that the EN is safe to proceed to scope of practice for an EN who is qualified to administer IV medications as defined by Drugs, Poisons and Controlled Substances Act, NMBA Competency Standards for an EN and BH Medication Management Policy.

Phase 3 **Blood and Blood products IV endorsed EN's**

EN's may check a blood transfusion with a RN and participate in the commencement and the ongoing monitoring of the transfusion.

Prior to all EN's involvement with the administration of Blood products, they must have had the appropriate education, Blood safe e-learning package and successfully completed the EN Blood and Blood Product Administration Practical Validation Tool, comprising of a checklist at the patient bedside with a RN who has also completed the Blood safe e-learning package.
Blood and Blood Product Administration Practical Validation Tool

Blood safe e-learning package: Clinical Transfusion Module and Transporting Blood module are required for all nursing staff to complete and should be kept up to date prior to administering Blood and Blood Products.
https://www.bloodsafelearning.org.au/

The duration of the phased program will be dependent on the individual. Successful completion of the phased support program will be noted in the competency data base.

10.2.4 Advanced/Extended Practice

In accordance with the DPRG approval for **standing orders** all staff required to administer standing orders will complete the associated learning package and assessment.

10.2.5 Records of professional development and competence

Staff competencies shall be recorded on the Education Data Base.

10.2.6 Student placement and experience

The qualified staff member remains responsible and accountable for the administration of medication for patients/care recipients allocated to their care. Nursing students can participate in the administration of the medication process providing they;

- Have successfully completed the requisite theory component of their study program;
- Have successfully completed the orientation medication calculation;
- Complete a Validation Peer Review – Medication Administration with a Registered Nurse/CSN or clinical educator and observed to attend all aspects of the review;
- Are under the direct supervision of a suitably qualified nurse able to administer the medication and
- They follow the policies and procedures of Benalla Health.

Any concerns regarding the practice or conduct of a student on placement in regards to medication management should be referred immediately to a Clinical Educator or Clinical Support Nurse (phone ext.14310 or email education@benallahealth.org.au).

11. QUALITY IMPROVEMENT

11.1 Medication Errors

All identified risks, near miss events and errors related to the prescription, access, dispensing, administration and storage of medications must be reported via the VHIMS incident and risk management register. BH advocates open disclosure in the event of error. For **clinical support** from a Clinical Educator or Clinical Support Nurse contact the Performance Improvement Team (Education and Quality) on ext. 14310 or email education@benallahealth.org.au.

Errors related to medication can include;

- Adverse reactions both physical and behavioural;
- Delayed, omitted or duplicated doses;
- Documentation related issues;
- Drug interaction and polypharmacy;
- Errors related to 7 rights of medication administration;
- Drug monitoring procedures and
- Drug access and storage related issues.

11.2 Risk Management

Refer to BH Risk Management Policy.

Any discrepancies or incidents related to medication prescriptions, the packaging of DAA's and/or the administration of medication must be reported via the VHIMS incident reporting system and documented in the individual's progress notes.

Benalla Health advocates open disclosure. Any medication incidents directly involving patients or care recipients should be discussed with the individual and/or carers involved.

Any unresolved discrepancies including any loss, destruction or theft of records relating to S8 medication must be reported to the Department of Health.

11.3 Quality Indicators

A representative of MEW is a member of the local Aged Care Facilities Medication Advisory Committee. Meetings are generally held 2nd monthly at Cooinda Village.

For monitoring and assessment of Care recipient Medication Management refer to Appendix K

MEW conducts monthly audits of Drug Chart legibility; weekly audits of medication chart documentation of allergies, weights and attachment of Care recipient identification photos. Audit results are presented at unit meetings.

BH conducts audits of medication errors reported via the VHIMS risk management system. Medication errors resulting in adverse events are reported to ACHS as a clinical indicator of care.

12. APPENDICES:

Appendix A: Flowchart for care recipient medication management review

Appendix B: Nurse Initiated Formulary

Appendix C: Care recipient self-administration of Medication

Appendix D: Care recipient self-administration consent form

Appendix E: Care recipient self-administration letter

Appendix F: Swallowing Difficulties: Alternation of oral formulations

Appendix G: Crushing Medications

Appendix H: Medicines not to be taken within 2-hours of antacids, iron or calcium supplements or any dairy products

Appendix I: Drug omission codes

Appendix J: Validation Peer Review – Medication Administration

Appendix K: Monitoring and Assessment of Care recipient Mediation Management

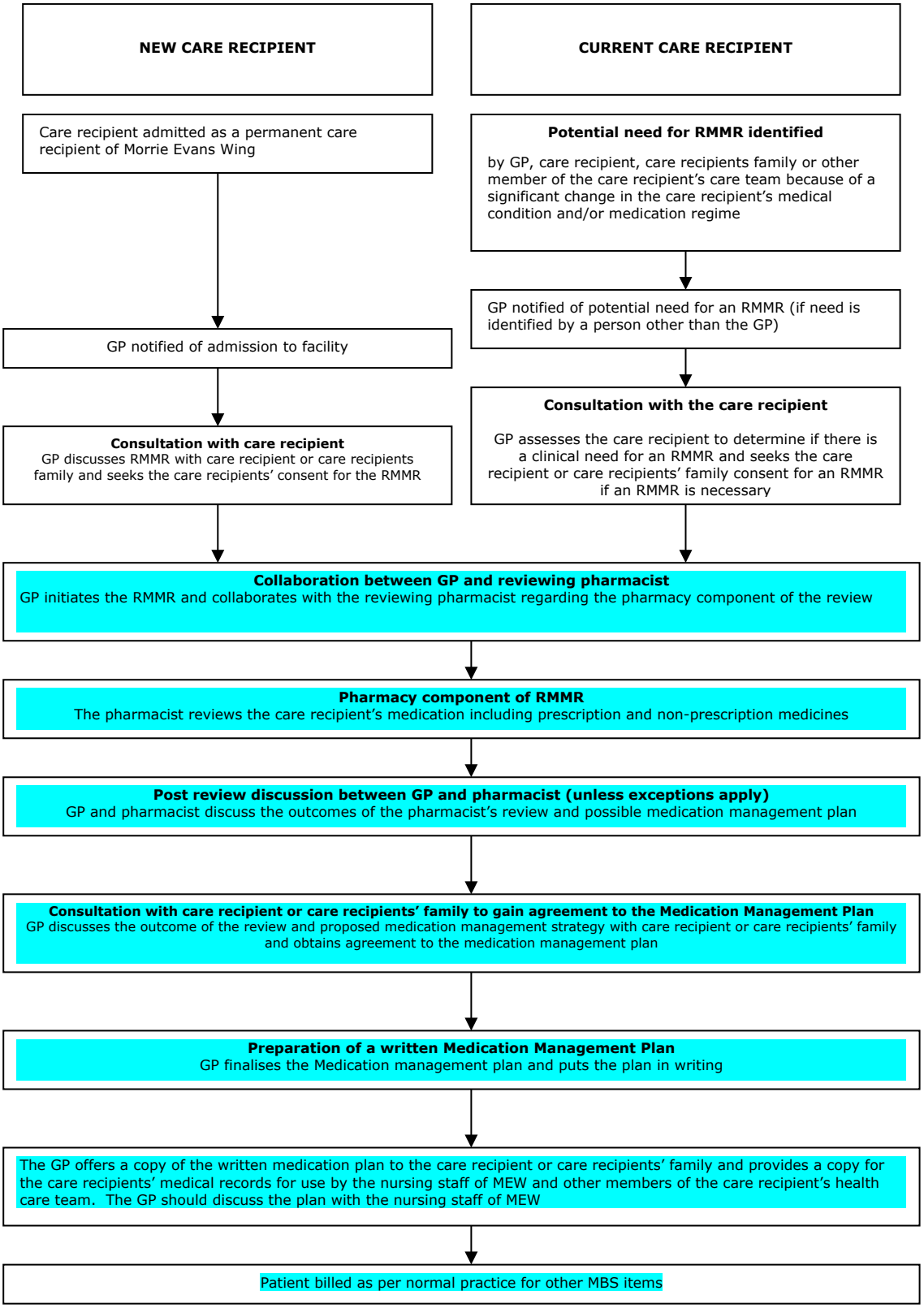
Appendix L: Safekeeping of unusable drugs of addiction for destruction

Appendix M: High Risk Medications

Appendix N: Use of Own Medications Flowchart

Appendix O: Medication Error Management Policy

Appendix A: Flowchart for Care recipient Medication Management Review



Appendix B – Nurse Initiated Formulary

LIST OF DRUGS WHICH A REGISTERED NURSE MAY ADMINISTER TO AN ADULT PATIENT (16 YEARS AND OLDER)

Drug	Dose Limit
ANALGESICS	
Paracetamol tablets	Up to 1g. May be repeated once after 4 hours.
Paracetamol soluble tablets	Up to 1g. May be repeated once after 4 hours.
Paracetamol mixture	Up to 1g. May be repeated once after 4 hours.
Paracetamol suppositories	Up to 1g. May be repeated once after 4 hours. Not to be given to bowel surgery patients.
ANTACIDS	
Aluminium hydroxide gel 250mg, magnesium trisilicate 120mg and magnesium hydroxide 120mg/5ml mixture (Gastrogel)	10 to 20ml. One dose only.
Sodium citrate 8.8% mixture 30ml	prior to elective or emergency LUSCS prior to surgery in at risk patients (e.g. high BMI)
ANTICOAGULANT	
Aspirin soluble tablets 300mg (as part of first line management of chest pain)	1 tablet (if not already administered prior to admission)
LAXATIVE	
Docusate 50mg and Senna 8mg tablets.	1 or 2 tablets. One dose only.
Lactulose Syrup	15 to 45ml. One dose only.
Sodium citrate 450mg, sodium lauryl sulfoacetate 45mg and sorbitol 3.125mg in 5ml (Microlax).	One dose only.
Glycerol 2.8g suppositories	One dose only.
Bisacodyl 10mg suppositories	One dose only.
Macrogol 3350 13.125g sachets.	One dose only.

INTRAVENOUS FLUSH

Sodium chloride 0.9% injection	10ml. Up to 3 doses.

EYE

Sodium chloride 0.9% injection (or Sodium chloride 0.9% for irrigation)	20ml.
Carmellose 5mg/ml eye drops	2 doses only. 4 hours apart.

COUGH SUPPRESSANTS

Pholcodine 5mg/5ml linctus.	5 to 15ml. 2 doses only. 6 hours apart.

EXPECTORANTS

Senega and ammonia mixture.	10 to 20ml. 2 doses only. 4 hours apart.

URINARY ALKALISERS

Sodium citro-tartrate powder (Ural)	4g (1 sachet). 2 doses only. 6 hours apart.

SMOKING CESSATION

Nicotine 21mg/24hr patches.	One patch only.

VAGINAL ANTIFUNGAL

Clotrimazole 1% vaginal cream.	One applicator full. One dose only.

TOPICAL

Calamine lotion.	3 applications only.
Clotrimazole 1% cream.	3 applications only.
Methyl salicylate 28.3%, eucalyptus oil 8.8%, menthol liquid 3.8% cream.	3 applications only.
Peppermint lip ointment	As required.
Lanolin, anhydrous.	As required on nipples.
Lignocaine 2% with chlorhexidine 0.05% gel	As required for catheterization.

MOUTH AND PHARYNX

Nystatin 100,000U/ml oral drops.	1ml. 3 doses only.

ANORECTAL

Zinc oxide 200mg and cinchocaine 5mg per g ointment (Rectinol)	One application only.

ANTIHISTAMINES	
Loratadine 10mg tablets.	One dose only.
ANTIHYPOGLYCAEMICS	
Jelly beans	As needed
Oral glucose gel.	As needed.
Glucagon 1mg injection.	One dose only.
ELECTROLYTE REPLACEMENT	
Sodium chloride 0.47g, sodium acid citrate 0.53g, potassium chloride 0.3g and glucose 3.56g powder (Gastrolyte).	5.1g (1 sachet) in 200ml of water. Up to 3 L.

LIST OF DRUGS WHICH A REGISTERED NURSE MAY ADMINISTER TO A CHILD PATIENT (UP TO 16 YEARS OLD)

Drug	Dose Limit
ANGALESICS	
Paracetamol mixture	15mg/kg. One dose only.
ANTIHISTAMINES	
Loratadine 1mg/ml mixture.	1-2 years: 2.5ml. One dose only. >2 years and <30kg: 5ml. One dose only. >2 years and >30kg: 10ml. One dose only.

Appendix C: Care recipient self-administration of medication assessment form

Benalla HEALTH

Clinical

PO Box 406, Benalla 3672
☎ (03) 57614 222

Date: / / UR No:_____
Surname: _____
Given Names: _____
Date of Birth: / / ☐ Male ☐ Female
Address: _____
_____P/code_____ Phone: _____

CARE RECIPIENT SELF-ADMINISTRATION OF MEDICATION ASSESSMENT

Name of staff member completing form:_____

These questions should be answered in the context of self-administration of medicine

Assessment question	Assessment		Comments
	YES	NO	
Does the care recipient wish to self-medicate?			
Has the care recipient discussed the choice to self-medicate with their family, if appropriate?			
Was the care recipient self-medicating previously?			
Was the care recipient using a dose administration aid previously?			
Is the care recipient orientated in time and place?			
What is the care recipient's mini-mental exam score?			
Does the care recipient have a history of alcohol or drug abuse?			
Does the care recipient have any cognitive disabilities?			
Does the care recipient have gross/fine motor skills deficit?			

Is the care recipient able to communicate effectively?			
Does the care recipient have any visual impairment?			
Can the care recipient open the following:			
• bottles with normal lids			
• bottles with child resistant lids			
• foil packets			
• boxes			
• dose administration aids			
Is suitable space provided for their medicines to be stored securely?			
Can the care recipient unlock and open the drawer in which their medicines would be stored?			
Can the care recipient read the labels on their medicines?			
Does the care recipient understand what the medicine is for?			
Does the care recipient know what to do if they miss a dose?			
Does the care recipient know what to do if they take the wrong dose?			
Can the care recipient identify the medicine?			
Can the care recipient prepare the correct amount of medicine? (e.g.: expel ointment from tube to be applied to affected area)			
Can the care recipient administer eye/ear drops or ointment?			
Can the care recipient administer their insulin? Has the care recipient been assessed as competent? (e.g.: by a diabetes educator)			
Can the care recipient apply their own patches? (and remember to remove them)			
Can the care recipient administer inhaler devices correctly?			

A No answer to any of the above questions indicates that the care recipient may not be competent to safely manage their medicines.

Strategies
Are there any strategies which may assist the care recipient self-administer? Yes No

If yes, list these strategies:

_____

_____

_____

_____

Assessed safety
Did the assessment demonstrate that the care recipient is capable of self-administering their medicines safely? Yes No
If yes, complete the Care recipient Self-Medication Indemnity Form.
If No, discuss the issues with the care recipient. If they insist on self-medicating, ask the GP to arrange a case conference with the care recipient and family to discuss the risks.
Acknowledgement that this decision was made in consultation with the care recipient or care recipient's representative.

RN signature _____

Ongoing review

Date	Nurse Comments	RN signature	GP comments	GP Signature
Initial assessment				
3 month review				
6 month review				
9 month review				
At 12 months complete new assessment and indemnity form				

Note: A care recipient's ability to self-administer medicines should be reviewed more often if their medical condition changes or they are hospitalised.

Appendix D: Care recipient self-administration consent form

CARE RECIPIENT SELF – ADMINISTRATION OF MEDICATION CONSENT FORM

As a care recipient of Morrie Evans Wing Nursing Home and one who wishes to manage your own medications independently, with medications being kept in your own room, it is necessary that **your medication drawer or container be kept locked at all times**. You are also solely responsible for the safekeeping of this key.

This request is in line with;

- Australian Pharmaceutical Advisory Council Guidelines for medication management for care recipient's in aged care facilities (2002).
- Department of Health and Human Services recommendations detailed in resource Kit to enable implementation of the APAC Guidelines for Medication Management for Care recipient's in Aged Care Facilities (2006).

Care recipient (Name): _____

Care recipient Signature: _____

Date: _____

Staff members (Name): _____

Signature: _____

Designation: _____

Date: _____

Appendix E: Care recipient self-administration letter

Dear Care recipient,

As you may be aware, as a care recipient of an approved residential aged care service (RACS) you have a number of rights, including the right to administer your own medicine. This includes the right to choose to administer all or some of your medicines.

Similarly, as an approved RACS, we have a duty of care to ensure that your medication is managed safely and effectively, and we seek your cooperation to make this possible. This includes the need to formally assess your ability to self-administer medicines. This is a similar process to other assessments undertaken to determine your care needs. We will also need to check with you from time to time that you are still managing this task and to determine whether there is any further support or assistance we may need to provide.

Your permission will be sought prior to us seeking any information about your medicines from your doctor or pharmacist.

Should you be able to, and choose to self-administer your medicines, we ask you to do the following:

- Please provide us with an up to date list of all of your current medicines and inform us of any changes that may occur to this list. This list should include complementary medicines or self-selected (non-prescription) medicines that you may be taking.
- Please ensure that all of your medicines are within their expiry date. (If any of your medicines have passed their expiry date please discuss this with our staff).
- Please inform us of any difficulties that you may encounter while self-administering your medicines.
- Please ensure that you have sufficient supply of all of your medicines at all times.
- Please advise us if you are taking any non-prescription medicines such as Panadol on an `as required' basis (e.g. for pain relief).
- Please speak to a member of staff if you are having difficulties with administering your medicines or if you have any questions.

Yours sincerely,

Name: **Designation:**

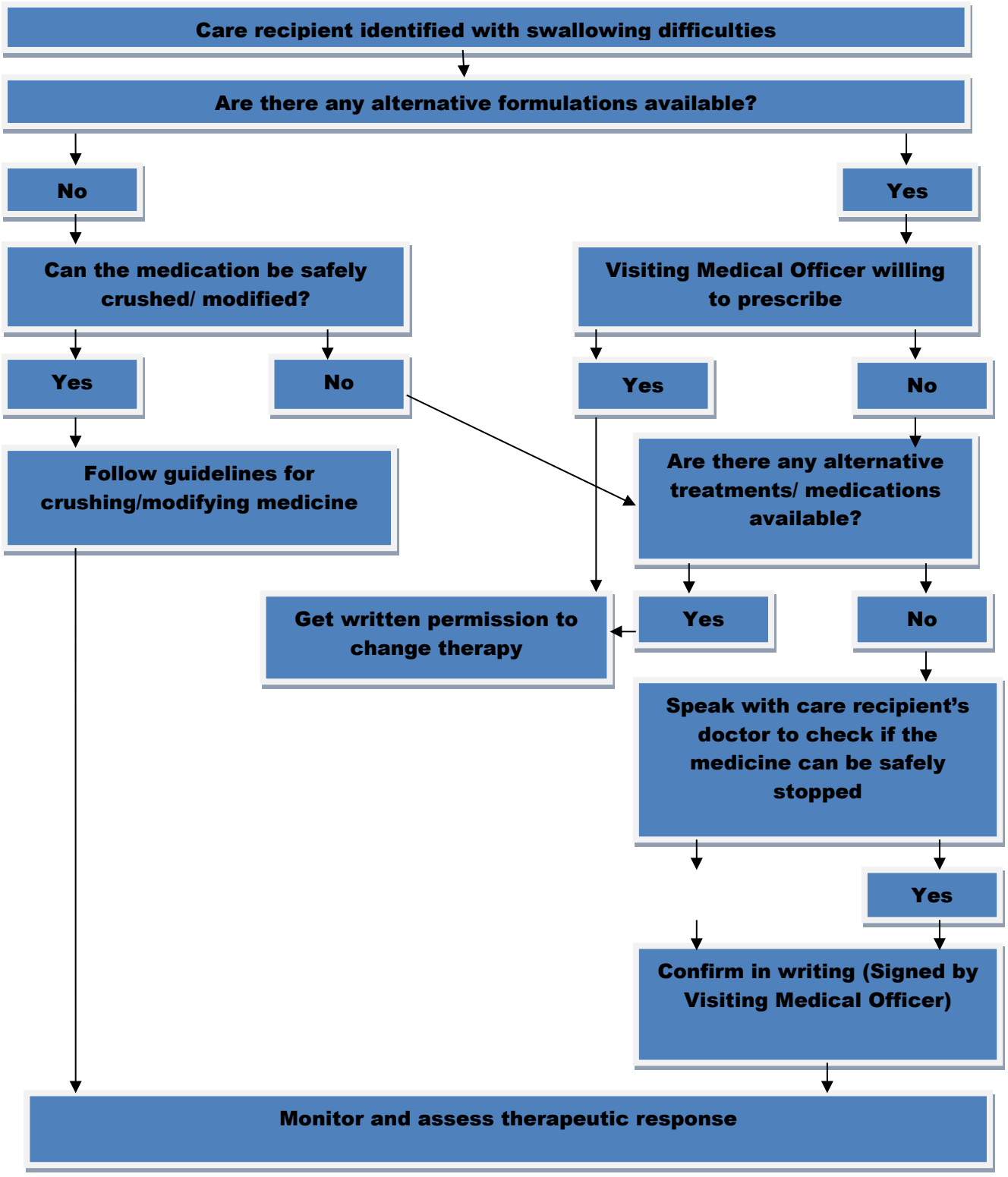
Acknowledgement that care recipient has read and understood the above information.

Care recipient name:

Care recipient signature:

Date

Appendix F: Flowchart for alteration of oral formulations



NOTE: In the absence of a written order to crush medicine, ensure that the above steps are followed and documented in the care recipient's progress notes.

1. Assessment of Swallowing Ability

On admission the patient's or care recipient's swallowing ability will be assessed by a Registered Nurse, Visiting Medical Officer (VMO) and/or consultation by a Speech Pathologist.

Does the individual have difficulty in swallowing their medication as prescribed? Is this due to a:

- Physical inability
- Psychological inability
- Refusal
- Is it a transient problem?
- Is it worse at certain times of the day?

Document the key elements of the process and the outcome of the assessment in the patient's or care recipient's records.

Reassess swallowing ability at time of care recipient's regular medication reviews or more frequent if it is suspected there has been a change in their ability to swallow medications.

2. Review the medication regimen

All patients and care recipients should have their medication regimen reviewed by the VMO, Pharmacist and Registered Nurse upon admission and on a regular basis as appropriate.

As part of the medication review for individuals with swallowing difficulties, it is important to consider:

- Whether there are any solid medications in the regimen that should not be altered.
- Are there alternative formulations available? E.g. liquid
- Is the medicine still necessary?
- Are there alternative medicines available?

Any changes in the medication regimen (including decisions to alter formulation of medications) arising from a medication management review should be documented in the individuals records and on the medication chart.

The VMO and Pharmacist should sign the appropriate section of the care recipient's medication management chart once a medication management review has been completed.

Where it is necessary to commence a solid oral medication between times of medication management review in a care recipient with swallowing difficulties, the details of the new drug prescription will be communicated in the 'Pharmacist Communication Folder'. The pharmacist will provide advice in writing on the appropriateness of alteration of the formulation. This information will be recorded in the care recipient's progress notes and on the medication sheet.

Appendix G: Crushing Medications

To ascertain if a specific medication can be cut or crushed refer to the product information from the manufacturer.

1. Formulations that should not be crushed

Medicines should not be crushed if crushing may:

- Alter the absorption characteristics of the medicine.
- Alter the stability of the medicine.
- Cause a local irritant effect of the medicine.
- Cause a failure of the medicine to reach the site of action.
- Causes an occupational health and safety issue either via exposure or due to repetitive strain injuries.
- Cause an unacceptable or undisguisable taste.

Because new products are always being introduced onto the market, no product list will be all-inclusive. If in any doubt always check with a pharmacist.

2. Suitable techniques for crushing

Equipment should permit complete and reproducible recovery of powdered material and it should be washed and dried after each use for each care recipient. A clean damp cloth followed by a dry cloth, is sufficient for cleaning.

Where cytotoxic medications are used a dedicated set of equipment must be used for each care recipient.

Use correct ergonomic techniques when crushing medication by, for example, positioning the mortar and pestle on a waist-high bench or table so that a healthy and comfortable working posture is maintained.

In most cases multiple tablets may be crushed together. However, there are some exceptions. Note Appendix H for medication which should not be given within 2 hours of other medicines containing iron and/or calcium, antacids, milk and dairy products.

When tablets and capsules are to be given together, crush tablets first. Then open the capsule and add the powder or pellets contained therein to the crushed tablets. **DO NOT CRUSH THE CAPSULE CONTENTS**. This will avoid crushing sustained release or enteric-coated pellets.

3. Alternative treatments

For some medications it is preferable to dissolve or suspend solid dose forms prior to administration to patients, rather than crush them. Seek guidance from the pharmacist

as regards the best dose preparation method for each medication to be administered.

4. Administration to the Care recipient

Ensure that crushed tablets, capsule contents, dissolved solid dose forms or suspended solid dose forms are given to the patient or care recipient as soon as practically possible after altering and mixing with a small amount of food or liquid. **NEVER LEAVE MEDICATION UNATTENDED**.

Some medication should not be mixed together and/or taken with milk or dairy products (see Appendix H).

Avoid sprinkling crushed tablets or contents of capsules onto meals where portions of the meal may be left uneaten.

Wherever possible care recipients should be upright, or as close as practicably possible to upright when taking oral medications.

Always ensure that any solid medications whether altered or not, are given with sufficient water or other suitable liquid to minimize the risk of oesophageal irritation.

Ensure that the alteration of the medication is recorded on the individuals medication chart.

Clear and concise instructions about the alteration of particular medications for individual care recipients should be clearly displayed on the care recipient's medication chart and/or the dose administration aid.

Appendix H: Medicines not to be taken within 2-hours of antacids, iron or calcium supplements or any dairy products

(This list is not a comprehensive list. If in doubt check with Pharmacist)

Medicine	Brands	Comments
Alendronate, Risedronate	Fosamax, Actonel	
Cacitriol	Rocaltrol, Sitriol, Kosteo, Citrihexal	
Ciprofloxacin	Ciprol, Ciproxin, Profloxin, Proquin	
Demeclocycline	Ledermycin	
Doxycycline	Doryx, Doxsig, Doxy, Doxylin, Vibra-tabs, Vibramycin, Doxyhexal, Frakas	Can be taken with milk
Itraconazole	Sporanox	Can be taken with calcium and iron supplements
Ketoconazole	Nizoral	Can be taken with calcium and iron supplements
Minocycline	Akamin, Minomycin	Can be taken with milk
Norfloxacin	Insensye, Norflohexal, Norfloxacin, Noroxin, Nufloxib, Roxin	Can be taken with calcium and iron supplements
Tetracycline	Achromycin	

Appendix I: Drug omitted codes

1. Once the reason the drug is not to be administered is identified the correct symbol is noted and this is documented in the correct medication chart under the correct date.

2. The omission of the medication and the reasons why are documented in the progress notes. The Visiting Medical Officer is notified that the medication was omitted as soon as possible and the reason why.

3. The following codes will need to be circled when a drug dose is omitted:

   A – Absent

   F – Fasting

   L – On Leave

   N – Not available

   R – Refused

   S – Self Administering

   W – Withheld

   V – Vomiting

Appendix J:

Validation Peer Review - Medication Administration

Appendix K: Monitoring and Assessment of Care recipient Medication Management

Clinical/ Care recipient monitoring

Good clinical practice dictates that monitoring and assessment of clinical response is required whenever medications are administered to individual care recipients. This is especially important when alteration of a dosage form is required.

Regular medication management reviews for each care recipient should include a review of both the need for and process of alteration of medication dose forms.

Policy Monitoring

Morrie Evans Wing (MEW) Medication Advisory Committee should regularly review and evaluate:

- The Facility's medication review procedures
- The information provided to the Facility on those solid oral formulations that should not be altered.
- Processes surrounding the alteration of solid oral medications and their administration to care recipients.
- The soundness of communication among health professionals (Visiting Medical Officer, Pharmacist, Registered Nurse etc.) that is essential for the delivery of quality care to care recipients.

With each regular review of these procedures, the MEW Medication Advisory Committee will record that these tasks have been undertaken

Appendix L: Safekeeping of Unusable Drugs of Addiction for Destruction

Schedule 8 Unusable Drugs

- Dropped / damaged / refused tablets / capsules / suppositories / patches / unused portions of tablets or lozenges
- Broken ampoules / bottles
- Refused / unused drawn up injections
- Discarding of partially used IV, Epidural, and PCA syringe containing S8 drugs.
- Expired drugs
- Drugs with illegible or incomplete labels
- Patients own medication which is no longer wanted

A. Dropped / Damaged / Refused Tablets / Capsules / Suppositories / Patches / Unused portions of tablets or lozenges

1. Place in an envelope labelled with name, strength of drug, date and signed by nurses responsible for administering the medication.

2. Retain in Drug of Addiction safe.

3. Document in Drug of Addiction Administration book as follows:-
   - Statement of what occurred in comments column.
   - Inclusion of the unusable item in the count until it is removed
   - Signature of the 2 nurses responsible for administering the medication

4. The Pharmacist is notified and at a suitable time will:-

   - Collect unusable Drug of Addiction from a Registered Nurse.
   - Document its collection in the Drugs of Addiction Administration Book.

B. Broken Drug of Addiction Ampoules and Bottles

1. The broken ampoule / bottle are discarded into the appropriate sharps bin.

2. Documentation is as for (a) except the item is deducted from the count and Drug of Addiction book signed by two appropriately qualified nurses.

C. Refused / Unused Drugs of Addiction Drawn Up for Injection

Once a drug of addiction can be classified as “in use”

1. The Drug of Addiction in the syringe is squirted into Sharps bin and syringe needle disposed into the Sharps container, witnessed by appropriately qualified nurses

2. The following is documented in the Drug of Addiction book;
   - Reason for non-administration.
   - Both nurses responsible for administering the medication must sign the Drug of Addiction Book

3. The following is documented on the drug chart;
   - Coded -Reason for non-administration.

4. The following is documented in the progress notes;
   - Reason for non – administration
   - Both administering Nurses to sign the entry

5. Any unused portion of a parental drug **must not** be discarded in the original ampoule or vial but drawn up into a syringe and its contents discarded into the Sharps container in the presence of a witness.

D. Expired drugs, Drugs with illegible or incomplete labels, Care recipient's own medication which is no longer required

1. Retain in Drug of Addiction safe.
2. Include the unusable item in the count until it is removed.
3. Notify the pharmacist who will at a suitable time, collect it from a senior nurse on duty and document its collection in the Drug of Addiction Administration Book.

E. Discarding of any incomplete IV, Epidural, Subcutaneous, PCA infusions & IV Fluids with Additives

- Except in special circumstance units when only one qualified staff member is available (refer 2.5.1), disposal is to be witnessed by 2 appropriately qualified clinical staff.
- Medication should be discarded by squirting into Sharps bin. Syringe and needle disposed into the Sharps container.

A record of the discarding of the balance of an injection, ampoule or vial should be documented in the Schedule 11 register or Drug of Addiction Administration book, as appropriate. A record of the discarding of the balance of an infusion is to be made on the hospital document recording the administration of the medication to the patient. The record is to include the name(s) of the person(s) involved in the discarding, the date, the time and the amount discarded.

Appendix M: High Risk Medications

Safety Notice – from the Australian Commission on Safety and Quality in Healthcare

Be alert to High Risk Medications

A Antimicrobials
P Potassium
I Insulin
N Narcotics
C Chemotherapy
H Heparin / anticoagulants
S Systems

High Risk medications have a heightened **risk of causing significant or catastrophic harm** when used in error and include:

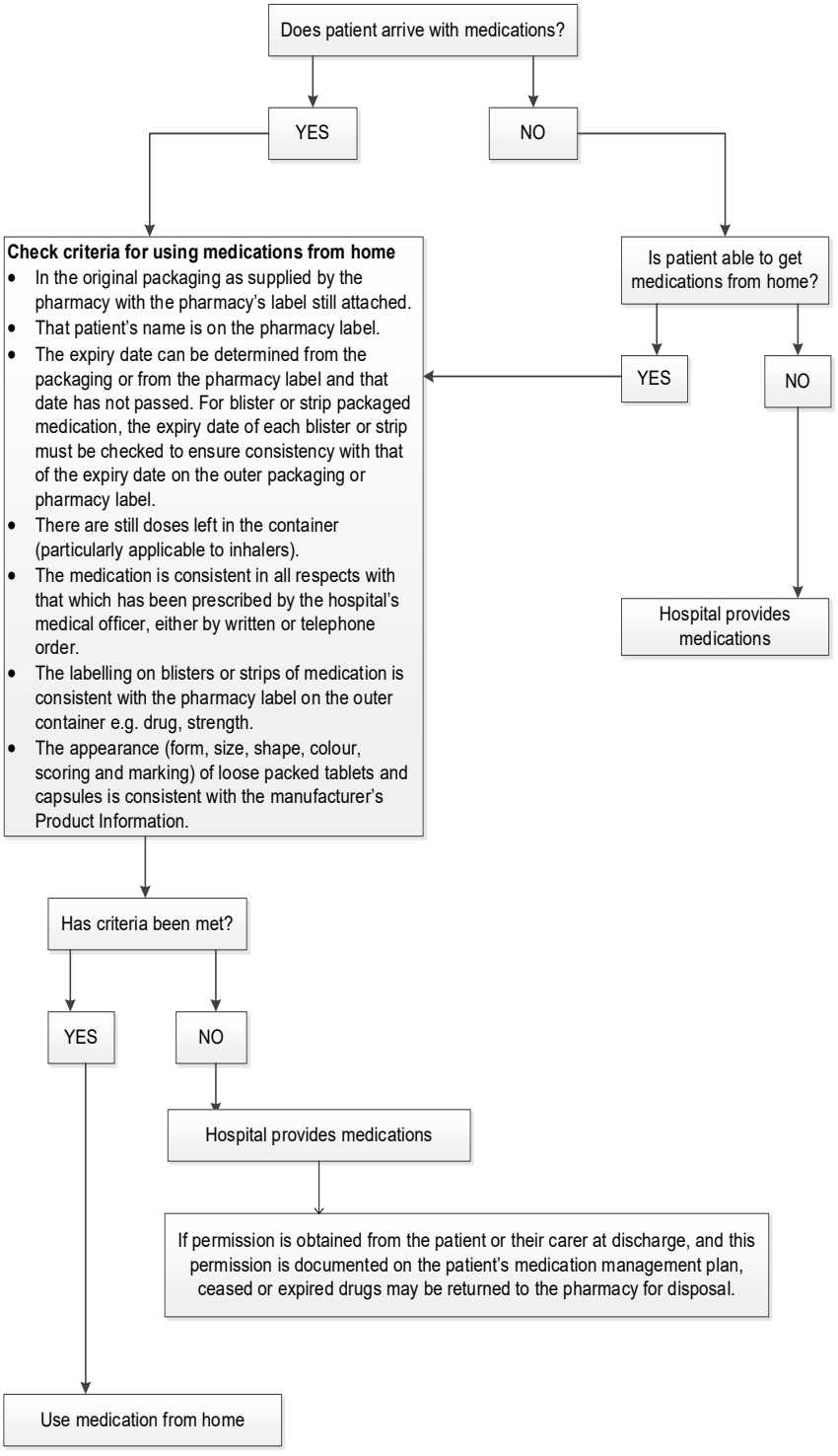
- **Medications with a low therapeutic index.**
- **Medications that present a high risk when administered via the wrong route or when other systems errors occur.**

Examples include the "APINCH" drugs listed above as defined by the Victorian Department of Health's Quality Use of Medicines Program HRM (High Risk Medicines) working party and others such as aminoglycoside antibiotics, **neuromuscular blocking agents, amiodarone, digoxin and colchicine.**
Although mistakes may or may not be more common with these drugs, the consequences of an error can clearly be more devastating to patients.
There are general principles for best practice in management of all high risk drugs. Special safeguards may include strategies such as:

- Standardising the ordering, storage, preparation and administration of these products
- Improving access to information about these drugs
- Limiting access to high risk medication
- Using auxiliary labels and automated alerts
- Employing redundancies such as automated or independent double checks when necessary

Refer to local hospital policies and guidelines for specific information on individual agents.
Audit tools, alerts and further information is available at http://www.safetyandquality.gov.au/our-work/medication-safety/medication-alerts/high-risk-medicines/

Appendix N: Use of Own Medications Flowchart



POLICY STATEMENT:

Benalla Health Organisational core values include 'Accountability' and 'Excellence', and as such, the organisation promotes a thorough Medication Error Management Policy which ensures clinician accountability for medication safety; while embedding principles of clinical education and performance improvement to support the provision of high level service delivery to the patients accessing Benalla Health.

PRINCIPLES:

To ensure that Benalla Health clinical personnel are providing consumers with high quality, safe, efficient and effective health care. This will aim to reduce avoidable harm as a part of the Strategic and Operational Plans.

OBJECTIVES:

To provide a standardized and systemic process for improving medication safety, preventing and responding to medication errors occurring during dispensing and administration.

DEFINTIONS:

Medication Error- 'A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures, and systems including; prescribing; ordering; communication; product labelling; packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use' (National Coordinating Council for Medication Error Reporting and Prevention, 2019).

Process for all Medication Errors

1. VHIMS is recorded

2. ISR 3 & 4

- Medication Peer Review (MPR) to be completed on staff member/s involved, within a two (2) week period. Ensure staff member has a copy of the drug chart and/or understands the error that has occurred.
- Medication Incident Self-Reflection Tool to be completed.
- To complete one (1) audit of a medication chart, to review knowledge/skills.
- If deemed Competent- Staff member to continue administering medications
- If deemed Not yet competent- Staff member to follow 'Not Yet Competent' in MPR Process below.

3. ISR 1 & 2, *OR* if deemed 'Not Yet Competent' in MPR

- Staff member NOT to administer medications
- Staff member to be put on formal Performance Management Plan by Nurse Unit Manager and complete NPS 'Medicine Wise' and/or calculations training package/s designated by Operational Director of Performance Improvement –

as per below table (may include multiple depending on incident). Designated training package to be completed within one week.
- To complete one (1) audit of a medication chart, to review knowledge/skills
- After completion of designated training package/s, staff member is to complete a full supervised medication round with Performance Improvement team member, where another MPR assessment will be completed.
- If deemed 'Competent' after secondary MPR, staff member to resume administering medications.
- If deemed 'Not Yet Competent' further follow up required on Performance Management Plan as per Operational Director for Continuum of Care.

4. Ensure all records are recorded on Medication Error Spreadsheet.

5. When staff member has had two (2) Medication Errors recorded on VHIMS in ≤ 3 month period – Nurse Unit Manager to be made aware by email from Performance Improvement Team.

6. If staff member has had three (3) or more Medication Errors recorded on VHIMS in ≤ 3 month period - then below process to be followed:

   - Staff member NOT to administer medications
   - Staff member to be put on formal Performance Management Plan by Nurse Unit Manager and complete NPS 'Medicine Wise' and/or calculations training package/s designated by Operational Director of Performance Improvement – as per below table (may include multiple depending on incident). Designated training package to be completed within one week.
   - To complete one (1) audit of a medication chart, to review knowledge/skills
   - After completion of designated training package/s, staff member is to complete a full supervised medication round with Performance Improvement team member, where another MPR assessment will be completed.
   - If deemed 'Competent' after secondary MPR, staff member to resume administering medications.

7. Notification to AHPRA

The decision to report a staff member to AHPRA, based on their medication administration, will only occur at an Executive level on an individual case basis.

8. Process for Staff who are NOT to administer medications

- Formal letter to be given to staff member re process and reasoning
- Operational Director of Continuum of Care to be notified by Performance Improvement team via email.
- If PI team are available when staff member is due to administer medications, the staff member can call the PI team and request their attendance to supervise their medication administration or staff member to request nurse in charge to administer medication or delegate to appropriate staff on the ward.

Learning Resources for Performance Management Plan

Incident Relating to	Area of focus as per BH Policy	Learning Module to be completed
Right Patient	1. Patient Identification Procedure – checking both name bands contain 3 approved patient identifiers and that they match the chart- ask patient to state if no name band in place	NPS Medicine Wise • Medication Safety training *(3.5 hours)* ***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/
Right Time	1. Cross referencing time stipulated on order and time written on chart 2. Signed at the time of administration 3. Manufactures recommendations e.g. with food, empty stomach 4. Potential drug interactions	NPS Medicine Wise • Medication Safety training *(3.5 hours)* ***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/
Right Route	1. Ensure the right route is adhered to 2. Process for cross checking if any discrepancies	NPS Medicine Wise • Medication Safety training *(3.5 hours)* ***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/
Right Medication	Process for checking trade names against generic names Ensuring right medication is selected Expiry Date checked	NPS Medicine Wise • Medication Safety training *(3.5 hours)* ***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/
Right Dose	1. Process for completing checking of calculation-	NPS Medicine Wise • Medication Safety training *(3.5 hours)*

	individual is to independently check order-calculations should be cross checked 2. Conversions etc micrograms to milligrams etc 3. Calculations - IV volume required -IV drip rate -IV volume, rate or time -IV dilution -PO tablets required	***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/ ***AND*** Calculations Competency: Benalla Health survey monkey https://www.surveymonkey.com/r/QG9PLJB
Right Reason	1. Reason for administering the medication- not only what the medication is but why is the patient on it	NPS Medicine Wise • Medication Safety training *(3.5 hours)* ***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/
Right Documentation	1. Current, legal and legible order is signed by MP or NP. 2. Chart signed after administration only	NPS Medicine Wise • Medication Safety training *(3.5 hours)* ***AND/OR*** • National Standard Medication Chart online training *(3 hours)* https://learn.nps.org.au/
High Risk Medicines	Errors relating to high risk medications as well as anticoagulants, clozapine and insulin	SA Health- High Risk medicines online course http://www.hrmeducation.health.gov.au/

Appendix O: Medication Error- Management Flowchart

VHIMS is recorded

ISR 3 & 4

- Medication Peer Review (MPR) to be completed on staff member/s involved, within a two (2) week period
- Ensure staff member has a copy of the drug chart and/or understands the error that has occurred.
- Medication Incident Self-Reflection Tool to be completed.
- To complete one (1) audit of a medication chart, to review knowledge/skills

ISR 1 & 2,

***OR* if deemed 'Not Yet Competent' in MPR**

***OR* If staff member has had three (3) or more Medication Errors recorded on VHIMS in ≤ 3 month period**

- Staff member NOT to administer medications
- Performance Management Plan by Nurse Unit Manager
- Complete training package/s designated by Operational Director of Performance Improvement as per policy–Designated training package to be completed within one week.
- To complete one (1) audit of a medication chart, to review knowledge/skills
- After completion of designated training package/s, staff member is to complete a full supervised medication round with Performance Improvement team member, where another MPR assessment will be completed.

If deemed Competent on MPR

- Staff member to continue administering medications

If deemed 'Not Yet Competent' post performance management:

- Further follow up required on Performance Management Plan as per Operational Director for Continuum of Care.

Medication Incident Self-Reflection Tool

Describe Incident:

Describe circumstance that may have contributed to incident:

How will you change your practice to prevent similar incident occurring in the future?

Do you have any suggestions to improve medication practice at Benalla Health?

Audit Tool for Medication Chart

Staff Member Name:
Date:

1.	Patient identification section is completed on all pages of active charts	
2.	Handwritten patient details are legible and complete with at least three identifiers	
3.	Patient's name is handwritten under patient identification label(s) by first prescriber	
4.	Weight documentation is on all charts	
5.	Adverse Drug Reaction (ADR), the following has been documented in the ADR Section:	
• The medicine (or other) section and reaction type has been documented on all active charts		
• The ADR documentation includes signature, name and date on all active charts		
6.	With regard to VTE - The 'yes' box been marked in the VTE risk assessment section:	
7.	With regard to VTE - Prophylaxis 'not required' or 'contraindicated' box has been marked in the VTE risk assessment section:	
8.	With regard to VTE - The signature and date is documented in the VTE risk assessment section:	
9.	With regard to VTE - There is no documentation in the VTE risk assessment section:	
10.	VTE prophylaxis has been prescribed (if No go to 7.1)	
11.	Total number of regular medicine orders	
12.	Record the number of regular orders in this section where the order is not legible	
13.	Record the number of regular orders in this section where the order contains one or more error's with abbreviations	
14.	Record the number of regular orders in this section where the medicine name is not complete and correct	
15.	Record the number of regular orders in this section where the route is not complete and correct	
16.	Record the number of regular orders in this section where the dose is not complete and correct	
17.	Record the number of regular orders in this section where the frequency is not complete and correct	
18.	Record the number of regular orders in this section where the prescriber's name is not legible on the chart	
19.	Record the number of regular orders in this section where the order is not signed by prescriber	
20.	Record the number of regular orders NOT using generic name	
21.	Total number of regular SR medicine orders	
22.	Number of regular orders where SR box is not ticked for SR medicines	
23.	Number of regular orders where indication is not documented	
24.	How many regular orders doses were missed without a reason for not administering specified	

25.	Total number of PRN medicine orders	
26.	Record the number of PRN orders in this section where the order is not legible	
27.	Record the number of PRN orders in this section where the order contains one or more errors in abbreviations	
28.	Record the number of PRN orders in this section where the medicine name is not complete and correct	
29.	Record the number of PRN orders in this section where the route is not complete and correct	
30.	Record the number of PRN orders in this section where the dose is not complete and correct	
31.	Record the number of PRN orders in this section where the hourly frequency is not complete and correct	
32.	Record the number of PRN orders in this section where the maximum PRN dose in 24 hours not documented	
33.	Record the number of PRN orders in this section where the prescriber name is not legible on the chart	
34.	Record the number of PRN orders in this section where the order is not signed by prescriber	
35.	Record the number of PRN orders are NOT using generic name	
36.	Number of PRN orders where indication is not documented	
37.	Total number of once only, nurse initiated & phone medicine orders	
38.	Record the number of once only, nurse initiated & phone orders in this section where the order is not legible	
39.	Record the number of once only, nurse initiated & phone orders in this section where the order contains one or more errors in abbreviations is	
40.	Record the number of once only, nurse initiated & phone orders in this section where the medicine name is not complete and correct	
41.	Record the number of once only, nurse initiated & phone orders in this section where the route is not complete and correct	
42.	Record the number of once only, nurse initiated & phone orders in this section where the dose is not complete and correct	
43.	Record the number of phone orders in this section where the frequency not complete and correct	
44.	Record the number of phone orders in this section where double signature is not complete	
45.	Record the number of once only, nurse initiated & phone orders in this section where the prescriber name is not legible on the chart	
46.	Record the number of once only, nurse initiated & phone orders in this section where the order is not signed by prescriber	
47.	Record the number of once only, nurse initiated & phone orders NOT using generic name	

Medication Administration Peer Review Tool

NAME: _____ **RN/EEN:** _____ **DATE:** _____ **TIME:** _____ **Ward:** _____

NSQHS STANDARDS
A better way to care

Guidelines for assessors:

- Competency assessment must be within the nurses scope of practice (RN or EEN)
- *Key: Assessment NYC= not yet competent C= competent

Skill & Knowledge Competencies		*Assessment NYC	*Assessment C	Comments/Recommendations
Demonstrates an understanding of BH policies and guidelines relating to the administration of medications.				
Administers Medication – complies with the 7 rights of drug administration as per Benalla Health Policy. See back of this form for more details	Right MEDICATION (with expiry check)			
	Right PERSON			
	Right DOSE			
	Right TIME			
	Right ROUTE			
	Right REASON			
	Right DOCUMENTATION			
Correctly relays the information documented/the order is legal and legible.				
Identifies actions required if medication orders are incorrect				
Identifies appropriate actions required in the case of a reaction to the medication				
Identifies resources available to ensure accurate knowledge of medication administration				
Demonstrates understanding of physiological effects of medication expected for that patient				
Delivers medication with consideration of the plan for the patient				
Demonstrates accountability and correct documentation of procedure including Riskman entry for any errors found and/or made				

How many medications were observed to be administered during this peer review?		What routes of administration were observed (circle)	Oral	Topical	SC	IM	IV	SL	IO

Staff Member Signature: _____ Name of Educator or Peer Reviewer and signature (Print name): _____ Signature: _____

The Benalla Health Medication Management Policy can be found at http://benh-intranet/PPG/Policies%20Live/Medication%20Management%20Policy.pdf			
Right Drug	The drug ordered must be the drug administered. There may be multiple trade names for a single generic name. Drug should be in date. Always follow the directions given by the manufacturer or pharmacist regarding the expiry of medications as they may denature after opening. For example: • Eye drops and ointments should be discarded one month after opening. The date the bottle was opened should be recorded on the bottle. • The date of opening anginine must be noted on the bottle. Contents should be discarded 90 days after opening.	***Right Time***	The EN, RN or RM responsible for administering a medication must • **confirm the drug is consumed, applied or injected on the right day and at the right time that it is ordered AND** • **signed at the time of administration**. Under no circumstances should medications be left with the patient or care recipient OR left on their lockers OR their meal trays for to them to consume or apply at their discretion. Administration time needs to account for; • **Manufacturers' recommendations e.g. some drugs need to be given with food, some drugs need to be given on an empty stomach.** • **Potential drug interactions** Depending on manufacturer recommendations related to specific drugs, administration times for inpatients and care recipients are recommended as per National Medication Charts (NIMC).
Right Person	**Identification** is achieved by checking that both of the patient's white name bands contain the 3 approved patient identifiers (name, date of birth and UR number). Identifiers on both name bands need to match the same 3 patient identifiers on the drug chart. If no name band is in place, ask the client or family/significant other to verify facts such as client name and date of birth; and/or as in the case of aged care by the use of an identifiable current care recipient photograph. **For Care recipients of MEW:** Care recipient's identification photographs are to be placed on the medication charts with the name of the care recipient, date of birth and the date the photograph was printed placed on the back of the photograph. These photographs are updated every 6 months and/or as the care recipient's appearance changes. Care recipients with similar or the same name are to have the relevant box on the front of the medication chart completed	***Right Route***	For information and recommendations related to different routes of administration refer to specific drug product information guides and the acute & aged care manuals of the Joanna Briggs Institute (JBI) Login details: **Username … benalladmh Password … benalladmh** **For information and recommendations related to access and use of Central Venous Access Devices (CVAD) including PICC refer to eviQ …** Login details: **Username … Benalla Password … benalla** eviQ is the online service of the Cancer Institute of NSW.
Right Dose	Dose is consistent with recommended guidelines for the individual's age and condition. If a **calculation** is required when checking the medication, the calculation is to be done independently by the person responsible for administering the drug **AND** the person checking the order. Calculations should then be cross checked.	***Right Reason***	It is the right of any individual responsible for administering a drug to confirm the **reason for and/or to question** the order A change in patient circumstance may require review of current medication orders. Examples include but are not limited to; • new demonstrated allergy • new relevant information comes to light on medical history • INR results are indicative of need for change in anticoagulant dose. The nurse administering the drug remains responsible for the decision to administer medication.

Right Documentation including: Current, legal and legible order, User-applied labelling	A **current, legal and legible order** signed by either a Medical Practitioner or NP is required before a drug is administered. Exceptions apply in the special instances of a Nurse Initiated Medication, recognised drug protocols and/or approved standing orders. For care recipients of MEW check; • regular medications • short term medications • intermittent medications • all non-packed medications • PRN medications. Medication must not be administered if a medication order/chart has expired. Medication charts in residential aged care are valid for up to 3 months.	It is the right of any individual responsible for administering a drug to refuse to administer the medication if the order is illegible. The nurse who administers the drug must **record** their signature against the order in the drug chart AFTER administration is complete. Under no circumstances should a drug be signed as administered prior to administration. **An EN, RM or RN (unless endorsed as a NP) cannot legally prescribe or dispense any medication.** As per the DPCS Act, the **legal responsibility for the administration of any medication** remains solely with the qualified individual administering the medication. All injectable medicines and fluids including bags, bottles, syringes, invasive monitoring lines, administration lines and burettes where the original labelling does not identify the medication should be labelled according to the; National Recommendations for User-applied labelling of Injectable Medicines, Fluids and Lines

REFERENCES:

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5. National Coordinating Council for Medication Error Reporting and Prevention. (2019). Retrieved on 4th July 2019 from the NCCMERP website: https://www.nccmerp.org/about-medication-errors
6. National Prescribing Service (NPS). (2018). *LEARN ONLINE WITH NPS MEDICINEWISE*. Retrieved on 4th July 2019 from the NPS website: https://learn.nps.org.au/
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STANDARDS:

National Safety and Quality Health Service (NSQHS) standards

Standard 4 – Medication Safety

Australian Aged Care Quality Standards

Standard 3: Personal Care and Clinical Care

Standard 8: Organisational Governance

Acknowledgements

Safer Care Victoria for providing guidance on available learning resources.

Related Benalla Health Documents

Medication Management Policy

Medication Management Resource Template

Scope of Nursing and Midwifery Practice Policy

Delegation of Care Policy