ALTAIRA
NURSING SERVICES

MEDICATION ADMINISTRATION PROCEDURE

PROCEDURE

Registered and Enrolled Nurses are to read, sign and return a copy of this policy upon commencement of employment. Registered and Enrolled Nurses are to complete a Medication Management Questionnaire upon commencement of employment and a drug calculation test annually thereafter. Registered and Enrolled Nurses must achieve 100% on the Drug Calculation test component of the Questionnaire.

Orientation

- Make yourself familiar with the facility's policies. Check whether any medications need to be countersigned before administration e.g. insulin, Warfarin and what the facility's incident reporting process is.
- Ask for orientation to any electronic medication administration system in use if unfamiliar with any aspect prior to commencing the drug round.

Before administration

- Always take the medication trolley and chart to the resident. Medications must be checked against the chart *immediately prior to* administration
- If using a paper chart, read the chart from front to back including telephone, short-term, stat and nurse-initiated orders
- Check the name on the order
- Pay attention to any 'Similar Name Alert'
- Check allergies
- Check the photograph against the resident
- Ask resident to identify himself/herself by asking "Can you tell me your full name please?"
- If in doubt, or if the resident is unable to identify themselves, ask a regular staff member to identify the resident by stating the resident's full name.
- Do not ask the resident "Are you John?" or "Are you Mr/Mrs Smith?"
- **Only administer medications once the persons first and last name has been confirmed.**
- Under no circumstances are staff to use clothing labels, room numbers or any other method to identify a resident

Packed medications (multidose packs and sachets)

- Ensure that the pack or sachet is the pack or sachet which is due at the time
- Check the medication names on the pack or sachet are correct as per the orders
- Count the number of packed tablets and ensure that the number tallies with the number of tablets documented on the pack or sachet and the number of tablets ordered on the chart
- Identify each tablet by using the description documented on the pack or sachet and/or medication profile

Packed medications (single dose packs)

- Ensure that the pack is the pack which is due at the time
- Check the pack label and ensure that the medication name is correct as per the order
- Count the number of packed tablets and ensure that the number tallies with the amount of tablets documented on the pack or sachet and the number of tablets ordered on the chart

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- Identify each tablet by using the description documented on the pack or sachet and/or medication profile *Medications in original packaging*
- Some facilities only allow the RN to administer from original packaging. If you are an EN, check before administering.
- Ensure that the medication is due as per the order
- Check the medication label and ensure that the medication name is correct as per the order
- Calculate the correct dose
- Check the expiry date

Administration

RIGHTS OF MEDICATION ADMINISTRATION

1) **Right Patient**
2) **Right Medication**
3) **Right Dosage**
4) **Right Route**
5) **Right Time**
6) **Right Documentation**
7) **Right Client Education**
8) **Right to Refuse**
9) **Right Assessment**
10) **Right Evaluation**

- Follow the 10 rights to medication administration
- Check that the medication is due and confirm when the last dose was given
- If using an electronic chart, ensure that the medications 'available' for administration are due at that time
- Check the start and end date of the order. Pay attention to the end date; the only indication that a medication has been ceased may be a signature in the cease box and not a line through the order/CEASED sticker etc
- Check the route and appropriateness of the route ordered
- Confirm that the patient can take or receive the medication by the ordered route
- If the resident requires medications to be crushed ensure that the medications are in a crushable form
- Stay with the resident until all medication has been administered. Never leave medications with a resident
- Never ask a relative / representative or another staff member to administer the medication
- Never mix medications with food or drink unless the instruction is documented on the care plan. If it is permitted to mix medications with food or drink you must observe the resident ingest the food or drink in its entirety
- Eye drops, creams and other **non-packed medications** can be missed easily. Check where these items are stored in the medication trolley

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After administration

- Document administration *immediately after* giving the ordered medication
- Document refusal of medication in the medication chart and the reason for refusal in the progress notes

PRN medication

- Some facilities only allow the RN to administer PRN medications or approval is required. If you are an EN, check before administering.
- Confirm when the last dose was given, including regular medications given.
- Check for any interactions with regular or other PRN medications
- Staff may only give a PRN medication for the reason for which it has been ordered
- Document administration AFTER giving the ordered medication
- Document the reason for administration and the effectiveness of the PRN in the progress notes

Self-administration

- A resident may only self-administer medication as per the facility's policy. Check the policy before allowing a resident to self-administer

After the medication round is complete

- If using paper charts, all charts must be checked from beginning to end for missed signatures prior to the end of shift
- If using electronic charts, the system must be checked for any medications not administered

Nurse Initiated Medications

- Some facilities only allow the RN to administer nurse-initiated medications. If you are an EN, check before administering.
- Nurse initiated medications may only be given as per the facility's policy
- Most facilities hold a 'Nurse Initiated Medications' list which have been pre-approved and the circumstances in which they may be administered
- Staff may only give a nurse-initiated medication which has been approved
- Staff may only give a nurse-initiated medication for the reason for which has been approved
- Document the reason for administration and the effectiveness of the nurse-initiated medication in the progress notes
- Staff may not give any medication that is not ordered by an authorised prescriber on the medication chart or approved as a nurse-initiated medication as per facility policy. This includes 'over the counter' medications.

Telephone Orders

- Telephone orders must only be taken as per the facility's policy
- Telephone orders for S8s must only be taken by a Registered Nurse
- Telephone orders for S8s are only valid for 48 hours. After this another order must be obtained

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Incidents

- Report any medication incidents using the appropriate organisational policies and procedures
- Report any medication incidents to Altaira as soon as possible within office hours
- In the event of a medication chart not being completed correctly e.g. missing signatures, the staff member concerned will need to return to the Aged Care Facility immediately to rectify the situation

Time Sensitive Medications

- Time-sensitive (also referred to as time critical) medications are medications that must be administered at a specific time or in a particular timeframe
- Examples of time sensitive medications are:
    - Paracetamol – must be given with four-hour intervals
    - Anti-Parkinson medications – must be given as ordered.
- Time sensitive medications not administered during the ordered timeframe are considered a medication incident and an incident form will need to be completed.
- Remember to always check the order before administering

S8s (DDAs)

- Check the medication chart for the correct medication, time and dose. The medication chart is the source of truth. Do not rely on the S8 register to inform you when S8s are due to be given.
- Remember that telephone orders for S8s are only valid for 48 hours. Call the doctor or locum service if the order has expired – do not administer the medication.

Under the South Australian *Controlled Substances (Poisons) Act* and associated Regulations you have legal obligations as below:

- Only Registered Nurses can administer an S8 medication
- An Enrolled Nurse may administer an S8 only when there is no Registered Nurse on the premises. An Enrolled Nurse may only count the S8s and sign the register when there is no Registered Nurse on the premises. There are very few facilities to whom this will apply. If you are an Enrolled Nurse and you are aware there is a Registered Nurse on the premises, and you are asked to count the S8s, and/or administer an S8, **please call Altaira immediately 24 hours a day.**
- Checking and administration of an S8 must always be witnessed by a second person. Another registered health practitioner should sign the register if they are on the premises. If there is no registered health practitioner on the premises, then the administration must be witnessed by a 'responsible person' – this may be a personal care worker. (They do not need to be 'med-comped'). In practice, this means that *you can only check with a PCW if there is no other RN or EN available.*
- Ensure that you check the medication order yourself and that the medication and dose is correct. Do not rely on the other person to do so correctly.
- Ensure that you count the remaining doses yourself. Do not rely on the other person to do so correctly.
- Never sign the S8 register without having counted the medications yourself. Politely refuse if a staff member asks you to do so and report this to the Altaira.
- If you are administering the S8 ensure that the person witnessing walks with you to the resident and witnesses the administration.

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- Never hand the dose to another staff member to administer even if you are present. If the resident refuses, discard the dose as per the facility's protocol and document in the S8 register and progress notes.
- If you are witnessing the administration S8 ensure that you walk with the person administering to the resident and witness the administration

Do not be misguided by the practices of others.

This is the law and breaking the law may result in a conviction in court, a $5000 fine payable by you, and a report to AHPRA which may result in loss of your registration.

- Do not open the DDA cupboard without a second person present – it makes others suspicious
- Do not pre-fill the DDA register – write it out when the person checking is present
- If you are administering other medications at the same time as the DDA, offer the DDA first and separately from the other medications.
- If you need to discard a dose, e.g. the resident refuses, discard the dose as per the facility's protocol with the second person witnessing. Adjust the register (e.g. "not administered, discarded in sharps container") and ensure both staff members sign the register. Document in the progress notes.
- If you dispense an incorrect dose or medication, discard the medication and adjust the register (e.g. "dispensed in error, discarded in sharps container") and ensure both staff members sign the register. *Do not return the dose to its original packaging and/or return it to the DDA cupboard.*
- Many facilities undertake DDA 'rounds' – be aware that this greatly increases the risk of getting the wrong resident. In this instance, take especial care to take the medication chart with you and check it prior to administration to ensure that you have the right resident.

High risk S8s

Ordine (morphine syrup)

Morphine syrup (Ordine) comes in four different strengths and sometimes the doctor writes the order in mls and sometimes in mgs. *However, the order is written you must* ***ensure that you check the order for the correct dose and then ensure that the strength and amount is correct.***

Why does this error happen frequently?
ORDINE oral solution is available in 4 strengths (1 mg/mL, 2 mg/mL, 5 mg/mL, 10 mg/mL), and **they are all called Ordine** and there is no difference in the packaging.

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Morphine and Hydromorphone

Confusion between morphine and hydromorphone is one of the most common 'wrong name' mix ups. Adding to the issue is the similarity of packaging of liquid morphine (Ordine) and liquid hydromorphone (Dilaudid) (see picture below). Hydromorphone is much stronger than morphine so if hydromorphone is given instead of morphine, then the resident could suffer an overdose.

Often people are switched from morphine to hydromorphone to treat possible side effects from ongoing use of morphine, such as confusion or uncontrolled jerking movements. All opioids, including hydromorphone, can cause these side effects, but it takes a while for them to develop. Switching opioids allows the body to clear out the previous medication.

Hydromorphone may also be used instead of morphine if the kidneys aren't functioning well or if someone is in kidney failure.

Remember to check the name of the drug on the order carefully against the ampoule or bottle.

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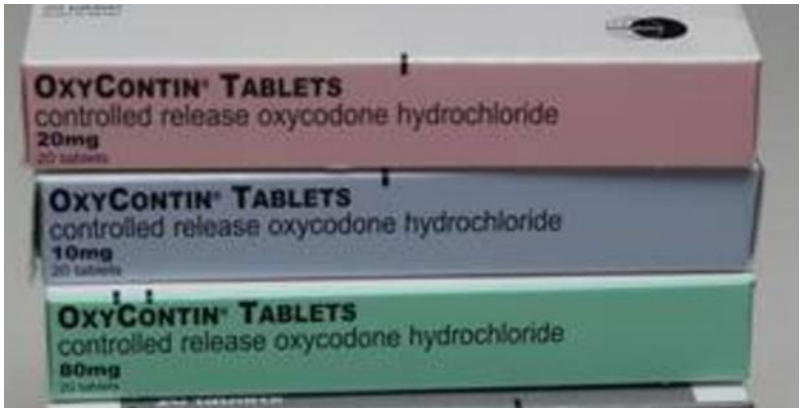
Oxycodone Immediate Release and Slow Release

There are two forms of oxycodone; immediate release and slow release. One of the more common errors is administering the incorrect form of oxycodone. It should be clear from the order which medication is prescribed usually because the doctor has used the brand name to identify the medication. Immediate release brand names are **Endone** and **Oxynorm**:

A common error occurs when administering immediate release oxycodone (Endone or OxyNorm). The order can be for 5mg (1 tablet) or 2.5mg (half a tablet). Often a whole tablet (5mg) will be administered when a half a tablet (2.5) was ordered. This is usually due to the nurse being distracted by the S8 register count which will show a whole tablet having been signed out each time previously. The fact that half a tablet was discarded each time is easily overlooked. Check dose of immediate release carefully.

The slow-release oxycodone brand name is **OxyContin,** and it comes in six different strengths: 10 mg – white, 15 mg – grey, 20 mg – pink, 30 mg – brown, 40 mg – yellow, 80 mg – green



Occasionally a doctor many write the order as oxycodone SR (Slow Release) in which case you will have to check the medication packaging carefully to ensure it is the correct form.

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Targin

Targin comes in four different strengths - oxycodone/naloxone: 5 mg/2.5 mg, 10 mg/5 mg, 20 mg/10 mg and 40 mg/20 mg. Check the medication strength carefully as residents are often on two different doses depending on time of day e.g.: Targin 5 mg/2.5 mg mane, Targin 10 mg/5 mg nocte.