

Medicines Management Policy			
Administration			
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Medicines Management Policy - part 3

Administration of Medicines

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ADMINISTRATION OF MEDICINES

There is a separate document for nurses working in the community

General Nursing Principles

The nurse is professionally accountable for acting in the best interests of the patient. As stated in the NMC Guidelines, when administering medicines the nurse must

- Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications
- Be aware of the patient's care plan and where possible have the patients informed consent.
- Have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies.
- Where supervising a student nurse or midwife in the administration of medicines, clearly countersign the signature of the student on a paper chart. On ePMA the student nurse will be closely supervised.
- Contact the prescriber without delay where contra-indications to the prescribed medication are discovered, the patient develops a reaction to the medication, assessment of the patient indicates that the medication is no longer suitable.
- Record the weight of the patient on the prescription sheet where the dose of medication is related to weight.
- Ensure the patient is made aware of changes in drug therapy and inform them of what the main side effects might be. Sufficient information about the medicine will be made available on the ward.

The responsibility for the administration of medicines is invested in one registered nurse, midwife, doctor or Pharmacy Administration Technicians (currently on selected wards – see current job description for further details). All IV drug administration and insulin administration must be carried out by a registered nurse, midwife or doctor employed by the Trust

Second checks

The following are exceptions where a second check is required by a registered nurse, midwife, pharmacist, or doctor. The pharmacy administration technician can act as a second checker for parenteral medicines and controlled drugs only.

- Administration of Controlled Drugs (see SOP for Controlled Drugs)
- Administration where a calculation is required
- Administration of IV medication (this applies whether the medication has already been reconstituted or not. It does not include IV fluids such as glucose 5% or sodium chloride 0.9%).
- Administration of medication via a subcutaneous syringe driver and via epidural route.
- Administration of medicines to neonates (In this case one person must be a midwife and the other a registered nurse).
- Administration of insulin (second check must be by a registered nurse). Self administration of insulin must be checked by one registered nurses when a paper prescription is used but two are required for an electronic prescription

ODPs (Operating Department Practitioners) can check Controlled Drugs once a CD Competency Assessment has been passed.

Medicines must be administered against a signed prescription or in accordance with Patient Group Direction (PGD) (See separate policy if the drug is being administered against a PGD).

Patients must NOT self-medicate unless they have been formally assessed in accordance with Trust guidelines on the Pharmacy microsite

Authorisation and responsibility for the Administration of Medicines

The authorisation of a suitably qualified practitioner should be obtained before medicines can be administered to a patient. This authorisation is given in one of two ways:

- an instruction written by a medical practitioner / authorised prescriber / authorised transcriber
- In accordance with a Patient Group Direction

Administration to the patient will be accomplished by:-

- administration by authorised nurses
- administration by a suitably qualified practitioner
- Self-administration by an inpatient
- Administration by a suitably trained person e.g .ODP
- Pharmacy administration technicians

All drugs prescribed must be administered to the patient unless there is a valid reason for omission. There must be a signature (or initials) for all drugs administered to patients. This applies whether the drug is administered against a prescription or other document.

Parents and relatives of patients are not authorised to administer medicines to inpatients. In exceptional circumstances, where it is deemed to be in the best interests of the patient, their carer can administer the drugs on the ward, but only if they are responsible for doing so at home. These drugs must be marked "self -medicating" so that the drug is not given again by the nursing staff. Refer to self-medication procedure for full details.

The principle of self-administration of medicines is supported at Stockport NHS Foundation Trust. Refer to self-administration procedure on the Pharmacy microsite.

Omitted and Delayed Medicines

It is important that all medicines are administered as close to the prescribed time as possible. Medicines should not be delayed or omitted unless there is a clinical reason.

Critical Medicines must be administered within one hour of the prescribed time and should never be omitted or delayed without a valid clinical reason.

All other medicines should ideally be administered within two hours of the prescribed time.

Critical medicines

They are those medicines where timeliness of administration is critical. Failure to give these medicines at the prescribed time could cause severe harm to the patient.

Critical medicines are:

- parenteral doses of anti-infectives (eg IV antibiotics)
- parenteral doses of anticoagulants and thrombolytics
- parenteral doses of insulin
- parenteral and oral doses of anticonvulsants
- parenteral doses of medicines used in resuscitation
- regular Parkinson's Disease therapy
- opioid analgesia (except when required)

It is vitally important that the **first** dose of the parenteral therapy listed above is given as soon as possible and certainly within the hour of the prescribed time. The first dose of most critical medicines will be prescribed on the once only section of the prescription chart.

Failure to administer a critical medicine at the correct time must be recorded on the prescription chart (omitted and delayed medicines box) stating the reason for the delay and the action taken. The patient should be reviewed by the doctor and the incident must be reported on the Datix system.

The omission of critical doses will be monitored by the audit process

Supply of critical medicines

If a critical medicine is not stocked on the ward then the nurse or pharmacy administration technician should contact Pharmacy. **It should be made clear that this medicine is required urgently.**

If the Pharmacy is closed then any required medicine should be obtained from the Emergency Cupboard via the 1090 bleep. Most critical medicines are also stocked on AMU, ED and ICU. It is possible to borrow drugs from these areas.

If the drug cannot be found in these areas then the on-call pharmacist can be contacted.

It is important that critical medicines are given priority on the drug round

Pre-Administration Checks for Intravenous Products

This applies to all intravenous fluids and flushes in plastic, PVC or similar containers that can be damaged or tampered with intentionally:

The person responsible for administration of this intravenous fluid must:

Visually inspect the fluid, looking for changes in:

- Colour
- Volume discrepancy
- Viscosity

Visually inspect the container for leaks or frothing by:

- Inverting
- Squeezing
- Shaking

If there is suspicion of tampering or intentional damage the product must be:

- Quarantined immediately in the treatment room
- Note: Limit handling of the product (as this destroys evidence if criminal act is suspected)
- Placed in a plastic bag.
- Sealed with a Label
- Label signed and dated by 2 members of staff involved in the checking process

The nurse manager must be informed immediately who will inspect the product and if it is considered suspicious will contact the risk dept (within working hours) or 1090 (out of hours who will contact the Senior Manager on call and who will decide whether/when to contact the police.

A Datix incident form must be completed. This form should include the fluid involved, size, batch number, expiry, details of the problem and name of manager/nurse discovering the container

If the Nurse Manager/1090 believes that the incident is not suspicious then:

- Place in a plastic bag.
- Seal with Label
- Label signed and dated by 2 members of staff involved in the checking process.
- Complete a Datix incident form
- Return to Pharmacy for destruction.

Administration-General

The nursing staff or pharmacy administration technicians are responsible for ensuring that the medicines required for the patients on the ward have been ordered from Pharmacy or Aseptics.

The nurse must check that the medicine has been prescribed on the inpatient electronic prescription in accordance with Trust procedure and signed by an authorised person, (or that it is covered by a PGD). There should be no paper prescription sheets on the ward except in Paediatric and Day case areas.

(Where a paper prescription sheet is used, any pre-printed drugs must be SIGNED by the prescriber before they can be administered to a patient. The nursing staff must remind the medical staff to cross out any pre-printed drugs that are not required).

All medicines must be stored in locked cupboards, bedside cabinets, fridges or drug trolleys. There are certain exceptions- see storage of medicines on the wards. Medicines must never be left unattended anywhere on the ward or transferred between containers.

The nurse or pharmacy administration technician must not administer the medicines if the prescription is ambiguous or unclear in any way. The prescriber must be contacted for clarification.

The nurse must not transcribe medicines on to medicine lists or other sheets of paper unless ordering medications for a specific patient whose medications are prescribed on a paper chart.

Administration Procedure

The Registered Nurse or pharmacy administration technician must:

- clearly identify the patient for whom the medication is intended. The minimum that should be checked is the patient's full name and date of birth. Use the patient's identiband for this purpose. If there is no wrist band then one must be put on the patient straight away.
- check the Allergy / Adverse Drug Reaction Box and wrist identify band to ensure the patient is not allergic (or had an adverse reaction) to the medicine being administered. (The patient should wear a wrist band if they are allergic to any medicines – see Trust Patient Identity Band Policy).
- check the review date or course length, if specified. Where a course length of a medicine e.g. antibiotic is stated, do not continue to administer the medicine beyond this time. Contact the prescriber.
- **ensure the medicine has not already been given. If the patient has recently been transferred from another area check the accompanying documentation e.g. theatre ICP as well**
- select the medicine required. If a label is attached to the box check it is labelled clearly and unambiguous. If using patients own drugs (PODs), refer to the POD checklist for assessing suitability of PODs for use on the wards.

Patient's own drugs must only be administered to the patient whose name is on the label on the container (see policy for full details).

- ensure expiry date has not passed.
- check the medicine name and strength against the prescribed medicine. Do not give the medicine if there is any doubt about it being the correct drug.
- check the route of administration.
- put required dose in a medicine pot or appropriate container. Do not dispense into a medicine pot (or prepare it) if the patient is not at the bedside or on the ward, as the nurse or the pharmacy administration technician will not be able to observe administration. They should make a note to go back later when the patient has returned.
- stop and recheck the dose if:
 - there are more than 4 tablets or 30ml of liquid of the same drug being administered at one time
 - the prescriber has increased the dose of an opioid by more than 50% of the previous dose
- obtain a second check if applicable e.g. if a calculation is required.
- if the dose has been obtained from a box or bottle, reseal it straight away. Never have more than one container open at any one time.
- repeat the steps above for as many medicines as required. Check all sections of prescription to avoid omissions, including any supplementary charts
- administer medicines and observe patient. (If patient is not at bedside, the medicines should be taken to the patient with the prescription. If the nurse is unable to administer the dispensed medicines for the patient straight away then they should be discarded. The medicines should be re-dispensed when the patient is able to take them while being observed. Medicines dispensed into a medicine pot or other container must never be stored.
- only prepare and administer medicines to one patient at a time.

An administration assessment tool is available in appendix 1

Injectable medicines

All injections should be labelled immediately after preparation, except for syringes intended for immediate push (bolus) administration by the person who prepared them. Under no circumstances should an operator be in possession of more than one unlabelled syringe at any one time, nor must an unlabelled syringe be fitted to a syringe driver or similar device.

Nurses must not prepare substances for injection in advance of their immediate use.

Oral and IV drugs should not be taken to the patient's bedside at the same time.

For injectable medicines (e.g. Intermittent IV, continuous subcutaneous injection) the person administering the medication (e.g. nurse or doctor) must take the responsibility for ensuring the medication is reconstituted in the correct diluent, at the correct concentration and given over the appropriate time interval via the correct device e.g. mini bag or syringe driver. If more than two drugs are to be administered together the nurse must ensure they are compatible

Ready diluted solutions of potassium should be used throughout the Trust whenever possible. Please refer to Potassium procedure on the Pharmacy microsite.

Other ready to use IV preparations should be wherever possible eg insulin 50 units in 50ml syringes. Insulin syringes must be available on the wards. Insulin syringes must be used when drawing up insulin from a vial

For medications given intravenously or by continuous subcutaneous injection there should not only be a second check of the reconstitution and label, but also for the medication prepared against the prescription.

Measuring and administering oral liquids:

- Intravenous syringes should NOT be used to measure and administer oral liquids
- Stocks of oral syringes should be available in all clinical areas
- 5ml spoons or measuring cups are acceptable for using to measure most oral liquid medicines. For awkward volumes where a syringe is required, an ORAL syringe (which cannot be connected to an IV catheter or port) must be used
- The contents of the oral syringe must be administered to the patient straight away by the nurse (or authorised person) who has drawn the liquid up into the syringe
- Liquid medicines must not be administered via a 3 way tap on an enteral feeding giving set

Recording of administration

A record of administration must be made immediately **after** a drug has been given to the patient. The record must be made by the authorised person administering the drug. For patients self-administering see self-administration procedure.

On electronic prescribing and administration system

For the majority of patients the record of administration is now done electronically on the electronic prescribing and administration system (ePMA.) Full training for this is delivered via an e-learning package that all staff must complete

On prescription sheet

For the few wards that use paper prescription charts please refer to appendix 2 for full instructions

Prescription Review & Course Length

The Prescriber must review the prescription regularly. To review a treatment at the end of a specified period, the prescriber should insert a review date or course length when prescribing.

The nurse must inform the doctor when the medicine has reached its review date.

Dose Titration

Where medication has been prescribed within a range of dosages it is acceptable for the registered nurse to titrate the dose according to the patient's response or symptom control and to administer within the prescribed range. The prescriber must clearly state the incremental rate at which the drug should be increased (or decreased) on the prescription. It should also clearly state which parameters or symptoms should be monitored before the dose change can be made.

Medication Errors

Any errors or incidents in the administration of medicines must be reported immediately to the line manager and reported as a clinical incident on the Datix system

Omission of certain medicines (e.g. intravenous antibiotic) should be reported as a clinical incident / medication error.

Risk Assessment for Venous Thromboembolism (VTE)

This section of the prescription must be completed by the prescriber (or healthcare professional who has been trained and deemed competent). If this has not been completed then the nurse looking after the patient should ask the prescriber to do so straight away.

Covert administration

Disguising medication in food or drink is not considered best practice by the Nursing and Midwifery Council. The registered nurse would need to make sure what they are doing is in the best interests of the patient if this was undertaken

Disposing of waste correctly

There are risks associated with the handling and administration of certain medicines. This particularly applies to the Safe Handling of Cytotoxic Drugs (See Chemotherapy Intranet Site). The Trust Waste Disposal policy must be followed.

Swallowing difficulties

Crushing medicines may alter their therapeutic properties. Medicines should not routinely be crushed unless a pharmacist advises that the medication is not compromised by crushing and crushing has been determined to be in the patient's best interest.

Administration Post Discharge by Intermediate Care Nurses employed by the Trust

Following discharge from hospital, intermediate care nurses can administer medicines to patients in their own home or the Care home using the HCR (the discharge letter) as an authorisation form for up to 48 hours until the patient has been reviewed by the GP. (The medicines most often administered by intermediate care nurses are insulin and low molecular weight heparin).

Nil by mouth

Unless otherwise directed by a prescriber or the Trust Pre-Op drug policy, all regular medication must be given pre-operatively

Medicines Administration Competency Checklist

Nurse's name: _____

Has all equipment ready for medicines administration e.g clean supply of medicine pots, BNF, sharps bin etc

Right Patient

Confirms it is the correct prescription for the patient

Confirms it is the correct patient (Uses two patient identifiers)

Performs and documents specific pre-administration clinical checks e.g. BM – insulin, BP- antihypertensive, bowel status- laxative, HR – digoxin

Confirms ALLERGY status with patient, prescription and wrist band

Right Medication

Selects correct medication

Checks expiry

Checks strength

Knows (or finds out) what the medication is used to treat and that it is therefore appropriate for that patient e.g. insulin - is patient diabetic?

Right Dose

Confirms appropriateness of dose if unsure e.g. using BNF

If a calculation required, obtains an appropriate second check

Dispenses correct medication & dose using no touch technique (If parenteral dose ensuring ANTT, in treatment room)

Right Route

Confirms appropriateness of route, checks patient can receive the medication by the chosen route. If route not appropriate, refers to prescriber.

Administers the medication via the correct route

Confirms patient has taken the medication (and does not leave the medicine pot unattended)

Right Time

Checks frequency of the medication, double-checks is giving at the correct time

Confirms when last dose was given (checks other charts e.g. AdvantisED & checks PRN/stat sections to make sure no recent doses given)

Right Documentation

Signs for administration after giving medication

Records time if stat/PRN or different to that requested on prescription (only applies to paper charts)

Records any omitted/delayed doses with reason & action.

Actions reviews of medication no longer required e.g review laxative-patient has diarrhoea, review antibiotics- course complete

Informs patient about any new medicines being given – including what they are for and one key side-effect

Disposes of waste correctly

Ensures good hand hygiene throughout

Competent (circle): Y / N

Assessed by (name): _____

Signature: _____

Position: _____

Date assessed: _____

Appendix 2

Record of administration on a paper prescription sheet

The authorised person must:

- For regular prescriptions write the date/month along the **top** of the record of administration section in the boxes provided. This date pertains to the whole of the column below it. No other date must be inserted further down the administration record as this is liable to cause confusion.
- Record the administration immediately after the administration by placing person’s initials in the appropriate box on the ‘administration record’ section of the prescription sheet. The initials must be clearly written and the letters identifiable.
- For once only prescriptions, initial in the ‘given by’ column and record the time it is administered.

For drugs prescribed on supplementary charts eg insulin, the recording of the administration should take place on that supplementary chart

- Where a second check is required for the administration of a medicine, (i.e. CD, IV, Calculations, Neonatal Drugs and insulin) **the identity of the checking person should also be recorded.**

However, the ultimate responsibility remains with the administering nurse.

- Recording of the second check:
For controlled drugs, the person checking should witness the **whole** process, as detailed in the Trust Controlled Drugs procedure. In this case the signature of the witness in the CD Record Book is sufficient.
- Where a second check is required the administering nurse should sign the box on the prescription sheet first followed by the person checking. Use the same box with a diagonal line /
- There should also be a permanent record of the person who reconstituted an injection and the person checking it. Refer to Trust IV Guidelines
- If it is not possible to administer a prescribed drug at the correct time, place a number 2 in the appropriate box on the Administration Record and complete the reason for the non compliance in the Omitted or delayed medicines box on the prescription chart. The action taken to resolve the problem should also be recorded

Date	Time	Medicine omitted or delayed	Reason	Action taken	Signature	Time given and signature

When a delayed dose is given (before the next dose is due) score through the number on the chart and sign. Record the time it is given in the omitted or delayed medicines box. Always check with doctor if it is appropriate to administer a missed dose if there has been a considerable time delay.

Other codes

3	=	patient refused medication
X	=	omit on prescriber's instruction
Self	=	patient self administering

The nurse administering medicines on subsequent rounds must check to see the appropriate action has been taken if the number 2 is still on the recording section of the prescription chart

- Do not affix continuation sheets or other pieces of paper to the prescription sheet if the "Administration Record" is full. The prescription sheet must be rewritten.
- All written entries and signatures should be clear, legible and in black biro.
- Failure to record the administration of a medicine constitutes a medication error
- Contact the nurse in charge or doctor if at anytime there is any doubt about the administration, recording or checking of a medicine.
- For controlled drugs refer to CD section of medicines Management Policy
- File all prescription sheets and supplementary charts in the appropriate section of patient's case notes when no longer in current use.

Emergency Medicine Administration without a Prescription sheet

Instruction by telephone to a practitioner to administer a previously un-prescribed medicine is not acceptable. In exceptional circumstances, where the medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology (such as fax or e-mail) is the preferred method. This should be followed up by a new prescription confirming the changes within 24 hours.

Monitoring

Monitoring Arrangements	Responsibility / Process / Frequency
Process for monitoring e.g. audit	Omitted doses audit
Responsible individual/ group/ committee	Pharmacy staff
Frequency of monitoring	Monthly
Responsible individual/ group/ committee for review of results	Medicines Management Committee
Responsible individual/ group/ committee for development of action plan	Medicines Management Committee
Responsible individual/ group/ committee for monitoring of action plan	Medicines Management Committee

A free interpreting service is available if you need help with this information. Please telephone Stockport Interpreting Unit on 0161 477 9000. Email:eds.admin@stockport.gov.uk

如果你需要他人為你解釋這份資料的內容，我們可以提供免費的傳譯服務，請致電 0161 477 9000 史托波特傳譯部。

W przypadku gdybyś potrzebował pomocy odnośnie tej informacji, dostępne są usługi tłumaczeniowe. Prosimy dzwonić do Interpreting Unit pod numer 0161 477 9000.

যদি এই খবরগুলি সম্পর্কে আপনার কোন সাহায্য দরকার হয় তবে বিনা খরচে আপনার জন্য দোতায়ী বাবস্থা করা হতে পারে। মেহেরবানী করে স্টকপোর্ট ইন্টারপ্রিটিং ইউনিটে ফোন করুন টেলিফোন নম্বর, 0161 477 9000.

اگر آپ کو ان معلومات کے بارے میں مدد کی ضرورت ہے تو منت ترجمانی کی سروس دستیاب ہے۔ براہ مہربانی انٹریپٹنگ یونٹ کو 0161 477 9000 پر فون کریں۔

خدمات ترجمہ رایگان این اطلاعات در صورت نیاز موجود میباشد. لطفاً با شماره تلفن 0161 477 9000 یا واحد ترجمہ (اینترپریٹنگ یونیت) ما تماس بگیرید.

تنوفر خدمة ترجمة شفوية اذا تطلبت مساعدة في فهم هذا المعلومات. نرجو الاتصال اربن رينيول على رقم الهاتف: 0161 477 9000