Medication management templates

Standards for practice in residential care

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

NHI nursinghomesireland

Boots Care Services

Foreword

These templates for medication management policies, procedures and guidelines have been designed as a suggested framework for staff working in residential care units for older people to adapt for use at local level. Their development has been informed by current evidence, and their format shaped by Health Service Executive recommendations

It is the responsibility of senior management to ensure that the policies, procedures and guidelines have been read and understood by all nursing staff and have been made available to other professionals engaged in any aspect of medication management. They should be refined by key stakeholders before adoption, and implemented in conjunction with an appropriate education programme. It is recommended that comprehensive records are maintained, with details of to whom the documents have been circulated, the date of sign off and review, attendance at education programmes and the audit trail

All policies, procedures and guidelines should be reviewed annually, or more frequently as a consequence of new findings, or in the light of local or other experience. Further policies, procedures and guidelines are under development and will be circulated when finalised

The purpose of policies, procedures and guidelines is to inform best practice and standards of care, and do not take precedence over clinical judgement

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Appendices

Development of the templates for medication management

Since the prescription of medicines is a fundamental component of the care of older people living in residential services, medication management has been recognised as a key factor in maintaining quality of life. The development of standardised policies, procedures and guidelines are a key component which underpin the Health Information and Quality Authority *National Quality Standards for Residential Care Settings for Older People in Ireland 2009*

In partnership with the Health Service Executive national quality initiative in medication management in residential care, and in tandem with a national education programme delivered in nursing homes nationwide, different teams in both the private and public sector have worked together to agree templates for care relating to the safe administration of medicines and medication management. This document has been compiled by a steering group from members of Nursing Homes Ireland based in Dublin Mid-Leinster

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In addition we would like to thank the following staff from Bru Chaoimhin Hospital who provided permission to utilise and edit some of their existing procedures:

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Medication management in residential care settings for older people

"Each resident should benefit from their medication to increase the quality or duration of their life. They should not suffer unnecessarily from illness caused by the excessive, inappropriate or inadequate consumption of medicines"

Health Information and Quality Authority (2009)

Older people living in residential care units in Ireland are large users of medication. This is due to the presence of multiple pathologies, the increasing range of available medicines, inappropriate prescribing, lack of medication review and an increased emphasis on preventative treatments. Since many people are taking five or more medicines, and several diseases may require concurrent drug treatment, polypharmacy is the norm in long-stay care. Polypharmacy is known to be associated with an increased risk of adverse drug reactions, drug interactions and poor compliance

The challenge for the interdisciplinary team caring for older people in residential care is to provide appropriate and beneficial treatment, while minimising inappropriate prescribing and the associated risks to the resident. Treatment should be evidence based and should consider non-drug therapies where appropriate and acceptable to the older person. Residents and their carers, families and advocates should be encouraged to take an active role in their management. Self-administration programmes for older people living in residential care contribute to their independence and self-esteem, improving knowledge and compliance

The purpose of this document is to provide a set of policies, procedures and guidelines templates to support a safe, effective and ethical method of medication management, monitoring and review. The strategy is to ensure that all nurses work within their scope of practice

Principles of safe administration

The five rights of medicines administration (Asperheim,1996; McKenry and Salerno, 1998) are a well-established principle, and underpin the Guidance to Nurses and Midwives on Medication Management (An Bord Altranais, 2007). These five rights have been incorporated into nursing practice with several authors suggesting further additions to reflect the holistic nature of medication management (Sexton, 1999; Woodrow, 2001; DDDS, 2008). However, the five rights are merely broadly stated goals or desired outcomes of safe medication practices that offer no procedural guidance on how to achieve these goals (ISMP, 2007). It is acknowledged that human factors and system weaknesses contribute to medication error and therefore an interdisciplinary approach is required. Nevertheless, each individual involved in medication management is expected to be aware of and comply with these underlying principles. For the purposes of this document, the subsequent additions to the five rights by other authors, have been amalgamated and

reworded to formulate the six rights of medication administration which may be more helpful in the residential care setting

The nurse is responsible for the safe administration of medication and must be knowledgeable of the six rights and take them into consideration in all aspects of the administration of medicines

The six rights of medication administration are as follows:

RIGHT resident

RIGHT medication

RIGHT dose, form, route

RIGHT time

RIGHT position

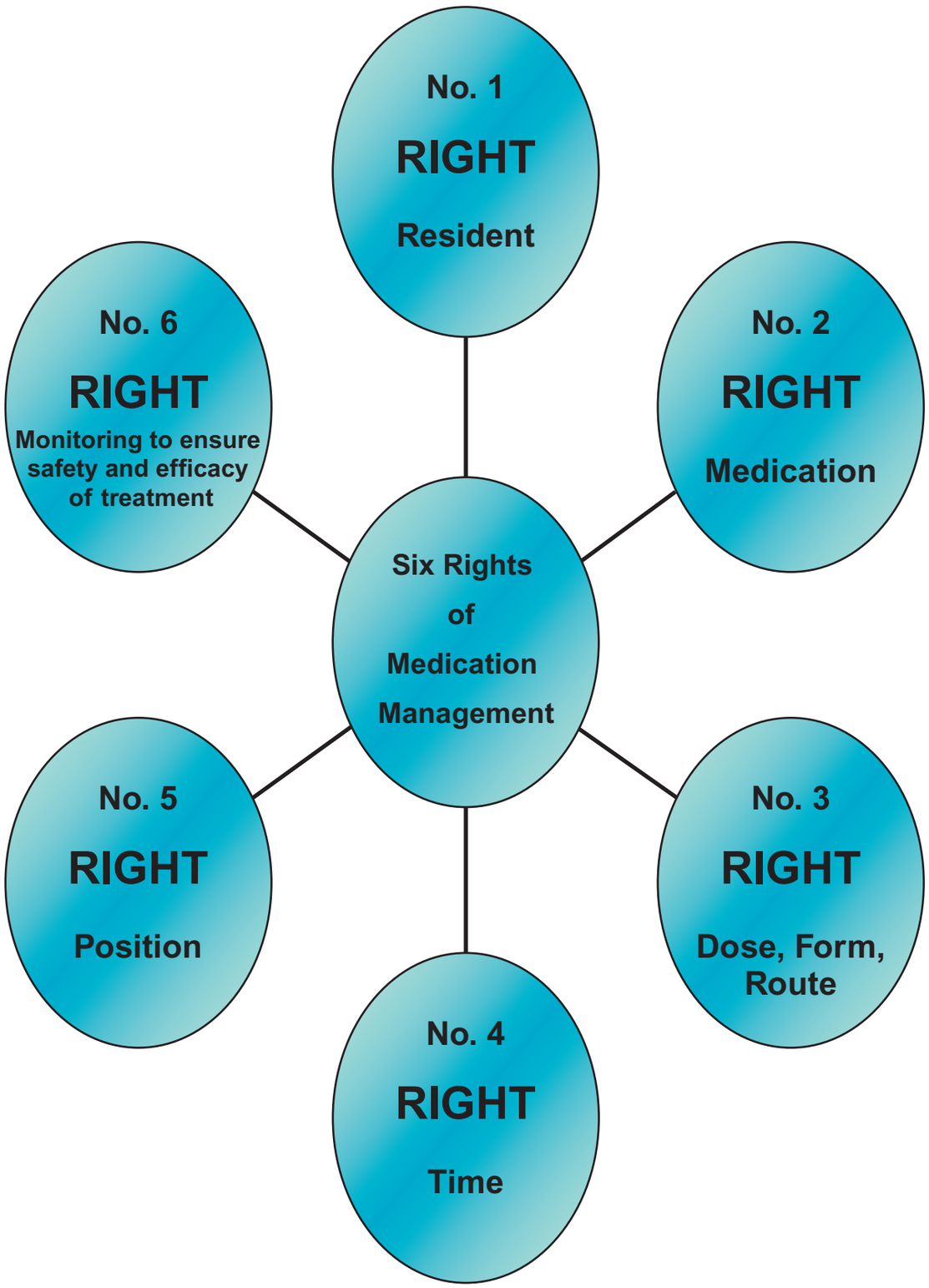
RIGHT monitoring to ensure safety and efficacy of therapy

Best practice in medication management

In residential care, this involves an interdisciplinary and systematic approach with residents and their families or advocate, medical practitioners, pharmacists, nurses, other staff and the health care provider. It should involve:

- ✓ Evidence of an efficient and effective partnership between key stakeholders
- ✓ Monitoring of risks of adverse medication reactions and interactions, particularly if polypharmacy is combined with over-the-counter supplements or complementary therapies
- ✓ Regular reviews of prescribed medication following changes in co-morbidity and progression of disease or frailty
- ✓ Use of alternative oral formulations
- ✓ Requirements for end of life care

Six Rights of Medication Administration



Section 1

PROCEDURES MANUAL		
Section title: Safe administration of medication		
Section No.: SOP	**Revision: 00**	**Page 1 of 4**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date**
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1.0 Policy Statement

Safe administration of medication is an integral part of medication management. The nurse is responsible for the safe administration of all medicines. When engaging in the administration of medication, all nurses should ensure they are competent whilst working within their scope of practice, at all times in the best interest of the residents. Staff education is an essential component required to facilitate the safe, effective and ethical management of medication

2.0 Purpose

To ensure the safe, effective and ethical administration of medication

3.0 Scope

3.1 All nurses involved in the administration of medication

3.2 All residents receiving medication on foot of a prescription

4.0 Glossary of Terms and Definitions

Monitored Dosage System: may be described as a unit of use packaging in containers that provide enough medication for a particular period. They should be subject to the same rigorous safety systems as conventional drug administration

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

6.0 Procedure

6.1 Safe administration of medicines

6.1.1 All medication must be prescribed by the resident's medical practitioner and written in the regular prescription sheet and onto the medication administration record sheet

6.1.2 With resident agreement, all residents should be photographed and their photograph placed on the front page of their medication administration record, their drawer in the drug trolley and in their resident record or nursing notes to enable clarification of the identity of the resident to whom the medication is to be administered

6.1.3 The nurse must check the resident is not allergic to the drug before administration

6.1.4 The nurse must know the therapeutic uses of the medicine to be administered, its normal dosage (including paediatric/geriatric (PG) dosage), side effects, precautions and contra-indications

6.1.5 If the nurse requires further information, consult a reliable drug reference. Under no circumstances should a nurse administer medication that is not known to them

6.1.6 The nurse must be aware of the resident's current care plan and how it relates to medication management

6.1.7 The nurse must check that both the prescription, medication administration record and the label on the medication to be dispensed is clear and unambiguous

6.1.8 The nurse must consider the frailty, weight, dosage, pharmacological preparation of the drug interactions where appropriate, method of administration route and timing

6.1.9 The nurse must check the expiry date of the medication to be administered

6.1.10 Prior to administering medication it is recommended that the resident should be given 150mls of water

6.1.11 The nurse must administer or withhold in the context of the residents condition (i.e. Digoxin is not usually given if the residents heart rate is below 60 beats per minute) and co-existing therapies i.e. Physiotherapy

6.1.12 Any tablets/capsules are given with a glass of cold clear liquid e.g. water or another suitable medium i.e. Avoid cranberry and grapefruit juice as some medicines interact with these juices. Following oral ingestion, it is imperative to determine if the tablet/capsule has been swallowed and does not stay in the mouth. A torch may be used for this purpose in the event of uncertainty

6.1.13 All medication should be administered via the correct route

6.1.14 Ointments, creams, inhalations etc., will be given as prescribed and in line with special product characteristic guidelines

6.1.15 The nurse must make a clear, accurate and contemporaneous record of all medicines administered, intentionally withheld or refused by the resident, ensuring the signature is legible. Where medication is not given, the reason must be recorded

6.1.16 The nurse must contact the medical practitioner without delay where contra-indications to the prescribed medication are discovered, where the resident develops a reaction and where assessment of the resident indicated the medication is no longer suitable

6.1.17 On cancellation of a particular drug or medication or in the event of a course of drugs being completed, the date of cancellation and initials of the person cancelling the drugs is completed in the regular prescription sheet. Drugs will normally be cancelled by the prescriber but in the event of the prescriber not being available or failing to cancel a particular item the nurse has authority to cancel items after consultation with the prescriber. In this instance, the nurse will document same in the daily progress notes. All drugs that have been cancelled by a nurse should be co-signed by the prescriber on their next visit

6.1.18 In the event of a medication being discontinued the nurse has the responsibility to take the medication out of circulation and return it to pharmacy

6.1.19 No staff member should ever administer their own medication to a resident or to another member of staff

6.2 Monitored Dosage Systems:

6.2.1 Where a medication is administered from a pharmacy supplied compliance aid, this must be performed by a nurse only

6.2.2 The nurse must be able to identify all medicines supplied in the compliance aid and be able to distinguish between these where required. A tablet recognition chart/ folder should be kept to hand during the administration of medicines

6.2.3 Compliance aids must be used in chronological date and time order

6.2.4 PRN medication, medication prescribed for a designated duration of treatment only, drugs to be administered via the buccal route, effervescent medication and medication which requires adjusted dosing should not be used in compliance aids

6.2.5 Follow the same steps outlined above in the 'Safe administration of medicines'

6.2.6 Return all unused aids to the pharmacy

7.0 References

7.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

7.2 Dougherty, L and Lister, S.E (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures 7th Edn.* Blackwell Publishing: London

PROCEDURES MANUAL		
Section title: Prescription writing		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

All residents who require a medication for any health condition should acquire it on foot of a prescription from a medical or dental practitioner or nurse prescriber

2.0 Purpose

To ensure safe prescribing of all medicines

3.0 Scope

3.1 All healthcare professionals who have prescriptive authority

3.2 All residents in receipt of medication on foot of a prescription

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 The responsibility for the standard of prescription writing lies with the medical or dental practitioner or nurse prescriber who signs the prescription

5.0 Procedure

5.1 All prescriptions should:

- ✓ be written legibly in black ink or otherwise so as to be indelible
- ✓ be dated
- ✓ state GMS/ unit number
- ✓ state the resident's full name, age, date of birth, room number/ward name or have the resident's addressograph affixed
- ✓ state any known allergies
- ✓ have direction written in English, using only approved abbreviations
- ✓ use the generic name of the drugs and preparations. In circumstances where a specific preparation is indicated by the resident's clinical condition, state the brand name
- ✓ state the names of drugs and preparations in full, using approved titles only
- ✓ state clearly if the medication will need to be crushed
- ✓ clearly state the name of the prescriber
- ✓ be signed in ink by the prescriber

5.2 Never use a decimal point before a trailing zero e.g. 5mg is correct, not 5.0mg; Always use a whole zero before a decimal when the dose is less than a whole unit e.g. 0.5ml not .5ml. The use of the decimal is only otherwise acceptable to express a range e.g. 0.5 to 1mg

5.3 All prescriptions should be rewritten if they become dirty, torn or disfigured; charts should be renewed as part of the three-monthly medication review process

5.4 Computer-generated prescriptions must be signed in the prescriber's own handwriting

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 British National Formulary (2009) *BNF 57*

6.3 Dougherty, L and Lister, S.E (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures 7th Edn.* Blackwell Publishing: London

PROCEDURES MANUAL		
Section title: Use of facsimile (fax)		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

There may be legitimate reasons when it will be necessary to receive a prescription by facsimile (fax) in the interest of the resident, in order to avoid delay in treatment of an immediate unplanned need. A prescription provided via a fax by a medical practitioner for a resident under their supervision should be signed by the medical practitioner, with the original prescription supplied for insertion in the resident's record within 72 hours. A nurse prescriber may not provide a prescription via fax. It is important to note that a fax is not a prescription. The medical practitioner must telephone the pharmacy to request an emergency supply for a patient

2.0 Purpose

To ensure the safe supply and administration of medication on foot of a fax

3.0 Scope

All healthcare professionals involved in the prescribing, supply and administering of medication on foot of a fax

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in the prescribing, supply and administering of medication on foot of a fax is expected to develop and maintain competence with regards to all aspects of medication management

5.0 Procedure

5.1 The nurse receiving a fax should ensure that the prescription is legible and includes the following:

- ✓ resident's name
- ✓ name of resident's medical practitioner
- ✓ the generic name of the drug or preparation or brand name where the resident's clinical condition necessitates
- ✓ name, dose, form, quantity of medication
- ✓ signature of the medical practitioner
- ✓ date signed

5.2 If any of the above information isn't clearly understandable, the resident's medical practitioner or the pharmacist should be contacted for clarification

5.3 The original prescription must be supplied to both the residential care unit and the pharmacy by the medical practitioner within 72 hours

5.4 The medical practitioner should also document the changes on the prescription sheet of the medication administration record within 72 hours

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 Medicinal Products (Prescription and Control Of Supply) Regulations 1996 (Amended by 2007 Amendment and Regulations)

PROCEDURES MANUAL		
Section title: Use of telephone orders		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

The only acceptable time a telephone order for medication should be taken from a medical practitioner is in an emergency situation, where there is an immediate unplanned need. A telephone order from a medical practitioner should not be considered an acceptable substitute for a comprehensive medication policy or protocol for routine medication management

2.0 Purpose

To indicate best practice relating to telephone orders in situations of immediate unplanned clinical need

3.0 Scope

3.1 All healthcare professionals who either provide or accept a telephone order

3.2 Any resident with an immediate unplanned clinical need

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each medical practitioner or nurse involved in the use of telephone orders is expected to develop and maintain competence with regards to all aspects of medication management

5.0 Procedure

5.1 Only a medical practitioner may issue a telephone order in the event of an immediate unplanned need. The nurse accepting a telephone order should repeat the order to the medical practitioner for verification

5.2 A record of the telephone order should be documented in the appropriate section of the resident's medical notes. This should include:

- ✓ date and time of the receipt of the order
- ✓ medical practitioner's full name and their confirmation of the order
- ✓ resident's name and date of birth
- ✓ dose, form, quantity, strength of medication
- ✓ any special instructions

5.3 The justification and rationale for accepting a telephone order should also be documented by the nurse involved to establish clinical judgment exercised in the situation

5.4 The medical practitioner is responsible for documenting the written order on the prescription sheet of the medication administration record and his own records within 72 hours

5.5 The prescription is supplied by the pharmacy in accordance with the directions of the prescriber. The pharmacy is furnished with a prescription within 72 hours

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

PROCEDURES MANUAL		
Section title: **Administration of PRN medication**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
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1.0 Policy Statement

Pro re nata is a Latin phrase that is commonly used in medication management to mean "as needed" or "as the situation arises." It is generally used as the acronym PRN to refer to the dosage of prescribed medication that is not scheduled on a regular basis

PRN administration of medication is an important adjuvant to the administration of medicines in residential care, where the prescriber is not available at all times

2.0 Purpose

The resident should not suffer unnecessarily from excessive, inadequate or inappropriate use of medication

3.0 Scope

3.1 All prescribers and nurses involved in medication management and the administration of PRN medication

3.2 All residents in receipt of PRN medication

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each prescriber and nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 As part of the quarterly review, the interdisciplinary team may decide to include certain drugs on a PRN basis, in order to plan for any likely need the resident may have for medication. Certain medicines such as psychotropic drugs should not be prescribed on a PRN basis other than in exceptional circumstances

5.2 Further PRN drugs may be introduced from time-to-time based on the resident's clinical condition

5.3 The prescription should state: circumstances, interval, maximum dose in 24 hours, review date

5.4 PRN medication should be supplied in the original box rather than a monitored dosage system

5.5 The decision to administer is taken by the nurse based on the resident's request or on their clinical need

5.6 PRN medication should not be offered or given only at the times listed on the medication administration record or at specific medication rounds. As it is for occasional use, the resident should be offered the medication at the times they are experiencing the symptoms either by telling a member of staff or by staff identifying the resident's need as outlined in the care plan. The exact time the medication was given and the amount given should be recorded on the medication administration record

5.7 A record does not have to be made at each drug administration round to show the resident has been offered the medication. However, the resident's care plan should demonstrate that staff know what the medication is for and have made an assessment on whether the person requires the medication

5.8 Medication with a 'when required' dose (PRN) is usually prescribed to treat short term or intermittent medical conditions i.e. It is not to be taken regularly. If PRN medication is given regularly, then a referral to the medical practitioner should be considered for a review of the resident's medication, as their medical condition may have changed and the treatment required may need altering. Similarly, if the medication is not having the expected effects the medical practitioner should be contacted. In both cases, the response to the medication should be clearly recorded

5.9 Where medication is prescribed on a PRN basis, the same procedures should be followed for prescribing, dispensing, supplying, administration and recording

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 Stokes, J.A; Purdie, D.M and Roberts M.S (2004) *Factors influencing PRN medication use in nursing homes.* Pharmacy World and Science. 26 (3) 148-154

PROCEDURES MANUAL		
Section title: Double-checking of medication		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
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1.0 Policy Statement

The administration of medication to a resident is the final result of a series of steps, from prescribing to dispensing. All the steps in this process are potentially exposed to errors. Checking immediately prior to administration is the last chance to ensure that the resident receives the correct medication

Nurses are accountable for their professional decisions and do not require another professional colleague to routinely check their clinical practice. There is no legal requirement that a nurse must double-check the preparation of any medication with a colleague prior to administration

2.0 Purpose

To reduce the incidence of medication error by ensuring that all nurses adhere to strict procedures when checking any medicinal products

3.0 Scope

All nurses involved in the administration of medication

4.0 Glossary of Terms and Definitions

4.1 **High alert medication** – medication which have a high risk of causing injury when they are involved in incidents of medication error

4.2 **Single-checking** requires the clinician administering the medication to review the drug, formulation, dose, route, time, etc before giving it to the resident

4.3 **Double-checking** is the same process conducted by two clinicians independently therefore ensuring independent verification

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

6.0 Procedure

6.1 The drug administration round should be undertaken by a single nurse, who will single-check all medicinal products prior to administration

6.2 Where any medication requires complex calculations, independent verification should be undertaken by two nurses

6.3 Double-checking is the process of a second nurse independently checking the preparation of a medication for administration, and is a significant nursing activity to facilitate good medication management practices

6.4 **Residential care units with a double-checking policy**
All MDA drugs should be double-checked by two nurses unless there are specified alternative arrangements described in the local policy manual

6.41 **Residential care units with a single-checking policy**
For the purposes of stock control or other safety issues, the nurse may request a second person to assist in the count of medication during administration. Although this does not constitute double-checking the clinical aspects, the procedure should be strictly adhered to where it has been described in the local policy manual

6.5 Special consideration should always be given to all medicines which are considered specific high-alert medication for older people, such as warfarin, heparin or any other individual medication identified by the medical practitioner, nurse or pharmacist

7.0 References

7.1 Allen, K (2006) *Single or double checking of medication prior to administration.* Centre of Clinical Effectiveness: Evidence request http://www.mihsr.monash.org/cce/pdf/ers/singleordoublechecking.pdf (accessed 17th April 2009)

7.2 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

PROCEDURES MANUAL		
Section title: **Transcription of prescriptions**		
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

Transcription is the official term used to describe the complex set of tasks involved in interpreting and processing medication orders. Transcribing is not synonymous with prescribing. Transcribing is where a nurse transfers the medication details from the GMS prescription generated by a doctor to the current drug prescription record section of the medication administration record for the purpose of safe administration. It is always preferable that the drug prescription record has been created by the medical practitioner and that this is computer-generated. In the absence of this, nominated nurses should be designated the responsibility of transcriptionist. A nurse who transcribes is professionally accountable for their decision to transcribe and the accuracy of the transcription including the indication for the medicine, omission, duplication of therapy, drug-drug and drug-disease interactions. The decision to transcribe should only be made in the best interest of the resident

2.0 Purpose

To provide a standardised structure, process and outcome for the safe and accurate transference of information from an original prescription to the resident's medication record

3.0 Scope

Designated nurses who have the remit to transcribe in residential care settings where transcribing is local policy

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Transcription of prescriptions is the responsibility of designated nurses and each nurse is accountable for the accuracy and legibility of the information transferred

4.4 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Transcribing should always be carried out in a quiet area. A specific time should be set aside for this activity

5.2 A nurse should not transcribe medication unless they understand the therapeutic uses of the medication. If in doubt, they should consult Summary of Product Characteristics, medical practitioner, pharmacist or reliable drug reference

5.3 Transcribing should either be computer-generated or if in the transcriber's own handwriting, should be written in block capitals in black ink so as to be indelible

5.4 When transcribing use only approved abbreviations

5.5 Transcribing a prescription should involve two registered nurses - one nurse to transcribe and a second nurse to independently verify the prescription which has been transcribed. It is recommended that the format includes read back with spelling

5.6 Ensure the following are correct:

- ✓ resident's name
- ✓ date of birth
- ✓ medical practitioner's name
- ✓ GMS number/unit number
- ✓ allergy status

5.7 Transcribed orders should be signed and dated by the transcribing nurse and the second nurse

5.8 The transcribed order should be co-signed by the prescribing medical practitioner within 72 hours and should not be put into circulation until this has been completed

5.9 Any nurse administering medication who is unclear about a transcribed prescription should not proceed until they verify or confirm the prescription with the medical practitioner or pharmacist

5.10 When a resident is re-admitted following a hospital admission the hospital prescription should be faxed to the medical practitioner to obtain a GMS prescription. The hospital prescription or new GMS prescription should be kept until the medical practitioner documents the medication in the resident's prescription sheet. This medication can be transcribed into the medication administration record sheet where nurses sign after each drug administration

5.11 If transcribing occurs as part of the quarterly review process where the medical practitioner is in attendance then verification by a second nurse is not required

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Managemen*t

6.2 Joint Commission on Accreditation of Healthcare Organisations (2004) *Comprehensive accreditation manual for hospitals.* Oakwood Terrace, IL

6.3 Rich, D. S (2004) *New JCAHO medication management standards for 2004.* Am J Health-Syst Pharm (64) 1349-58

Section 2

PROCEDURES MANUAL		
Section title: Crushing medication		
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

A crushed tablet may be easier for a resident to take if they have trouble swallowing or have a feeding tube in situ. However, crushing may increase the risk of adverse effects and toxicity, and it may be difficult to quantify the dose of medication the resident receives. Crushing may also affect efficacy. Giving a medication in an alternative form such as a liquid formulation or suppositories is nearly always preferable

Crushing medicines and mixing medicines with food or drink to make it more palatable or easier to swallow when the person has consented to this, does not constitute covert administration

All nurses should be aware that crushing renders medication unlicensed or for “off label use”; this decision is legal only where sanctioned by the prescribing medical or dental practitioner

The nurse who administers a licensed medication for “off label use” should be aware of the indications for the medication’s intended use for the resident and the inherent safety implications

2.0 Purpose

To ensure effective, safe and ethical medication management

3.0 Scope

3.1 All health care professionals involved in the ordering, prescribing, dispensing, delivery, receipt and administration of medication

3.2 All residents in receipt of medication which has been crushed

4.0 Glossary of Terms and Conditions

"An **unlicensed or unauthorised medicine** is a medicinal product which is not licensed by the Irish Medicines Board (IMB) or the European Medicines Evaluation Agency (EMEA)"

PEG Percutaneous endoscopic gastrostomy tube feeding tube

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each healthcare professional involved in the administration of medicines which have been crushed is expected to develop and maintain competence with regards to all aspects of medication management

6.0 Procedure

6.1 All new admissions should be fully assessed for their ability to take medication in solid form and ensure all medication is prescribed accordingly

6.2 Where a resident becomes unable to swallow their medication, the nurse should contact the medical practitioner to inform them of the change in the resident's condition

6.3 Since crushing renders the medication "off label", the prescription must always be amended by the medical or dental practitioner

6.4 The nurse should ensure that they have adequate information about the use of the unlicensed medication, and possible adverse reactions

6.5 Before the nurse considers administering a drug in a modified form to that prescribed i.e. crushing a tablet or pill, they should check with the pharmacist, the product literature, or a reliable drug reference to ascertain that crushing is permissible. Enteric coated, long-acting or slow- release tablets, capsules containing powder that irritates the mucous membrane, spansules and sublingual or buccal tablets should not be broken or crushed

6.6 To crush a tablet, leave it in its unit dose packaging and tap it with a pestle and mortar or use a suitably manufactured tablet crusher. Otherwise, use the resident's individually-labelled crushing syringe: wash thoroughly between uses and sterilise in sodium hypochlorite solution

6.7 If the drug has a coating, which usually won't pulverise like the rest of the tablet, remove it before administering the drug and dispose of the coating in a designated sealed container

6.8 Crushed medication should be added to a small amount of suitable foodstuff (according to the resident's preference) such as yoghurt or jelly, or a small amount of cool liquid. Medication should not be added to beverages or meals

6.9 The resident's care plan, medical notes and medication administration records should reflect the decision to change the form of the drug and any specific indications for subsequent monitoring and review

6.10 Special attention is needed when administering medication via an enteral feeding tube. Staff should refer to "Medication administration via enteral feeding tubes"

7.0 References

7.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

7.2 White and Bradnam (2007) *Handbook of Drug Administration via Enteral Feeding Tubes,* Pharmaceutical Press

PROCEDURES MANUAL		
Section title: **Covert administration of medication**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

Covert administration or “disguising” medication in the absence of consent may be regarded as deception, as the person is being led to believe that they are not receiving medication when in fact they are

It is important to clearly distinguish between those people who have the capacity to refuse medication (and that this is respected) and those people who lack capacity. It must be remembered that capacity changes and so regular reviews are needed

There may be some circumstances where it could be acceptable to administer medication covertly, such as when medication is essential and not giving it is more harmful, so it is deemed in the best interests of the person. This will normally involve transfer to a specialised facility. Coercing or manhandling any resident during any stage of the administration of medicines is unacceptable under any circumstances in the residential care unit

Crushing medicines and mixing medicines with food or drink to make it more palatable or easier to swallow when the person has consented to this, does not constitute covert administration

2.0 Purpose

All staff should be aware that the covert administration of medication is unacceptable within the residential care unit

3.0 Scope

3.1 All staff engaged in medication management in the residential care unit

3.2 All residents receiving medication on foot of a prescription

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse involved in the administration of medications is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Guidelines

5.1 All new admissions to the residential care unit should be fully assessed for their ability to take medication orally and all medication prescribed accordingly in the correct form

5.2 Where a resident becomes unwilling to take their medication, every effort should be made to reintroduce the medication. The nurse should contact the medical practitioner to inform them of all changes in the resident's condition

5.3 The medical practitioner should review the resident and assess their capacity to refuse the medication. Unless the resident lacks capacity, their refusal should be respected and documented appropriately. The resident should be advised of the potential problems associated with not taking the prescribed medication

5.4 Where the resident lacks capacity, a decision should be made whether the resident needs to be sectioned under the Mental Health Act, 2001 and subsequent amends

5.5 There should be open discussion and agreements within the interdisciplinary team and the resident's relatives or advocate

6.0 References

6.1 Mental Health Act 2001

6.2 Levin, A (2005) Covert Drug Administration: *'Win Battle, But Lose War'.* Psychiatric News. (40) 10: 10

PROCEDURES MANUAL		
Section title: **Refusal of medication**		
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1.0 Policy Statement

The decision by a resident to refuse administration of a medicinal product after having been provided with information about the drug and the risks and benefits of the therapy, should be respected and the prescriber should be notified

There will be safe and effective management with respect of the resident's right of choice but in the event of refusing medication, all aspects should be explored for the reason and rational for refusal and these must be documented clearly in the medical and nursing records

2.0 Purpose

To ensure accurate reasoning and recording for medication refusal

3.0 Scope

3.1 The medical practitioner and nurse involved in the prescribing and administration of medication

3.2 The resident who exercises their right to refuse medication

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 If a resident refuses any medication the nurse should:

- ✓ ascertain the reason for the refusal
- ✓ explain the purpose, use and effects of the medication
- ✓ document the refusal in the medication administration record and daily progress notes including time, type, dosage, reason for refusal and possible effects
- ✓ inform the medical practitioner at the next available opportunity of the resident's refusal to take the medication

5.2 The medical practitioner should review the resident and assess their capacity to refuse the medication. Unless the resident lacks capacity, their refusal should be respected and documented appropriately. The resident should again be advised of the potential problems associated with not taking the prescribed medication

5.3 Where the resident lacks capacity, a decision should be made whether the resident needs to be sectioned under the Mental Health Act, 2001and subsequent amends

6.0 References

6.1 Advocacy Inc. IR8 (1997) *Your legal right to refuse* www.advocacyinc.org (accessed 21st April 2009)

6.2 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.3 European Charter of Patient's Rights (2002) *Right to Consent*

PROCEDURES MANUAL		
Section title: Withholding medication		
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1.0 Policy Statement:

All health care professionals have a responsibility to monitor medication effects and to report problems to the prescriber. Withholding medication based on a clinical decision must be made in the best interests of the resident and be clearly defined

Each nurse involved in the administration of medicines should exercise their professional judgement to withhold a medicinal product if relevant in a specific resident case

2.0 Purpose

To support the exercise of professional judgement by a nurse when clinical conditions indicate that a specific prescribed medication should be withheld, in the interests of the resident's well-being

3.0 Scope

3.1 All health care professionals involved in the prescribing and administration of medication

3.2 All residents who are in receipt of medication

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse exercising their professional judgement to withhold a medicinal product is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Medication may be withheld from a resident where, in the professional judgement of the nurse, there may be a clinical indication which contraindicates the administration of one or more specific medicinal products

5.2 It may be necessary to consult with a peer, reliable drug reference, medical practitioner, pharmacist or manager with regard to withholding medication

5.3 Where contra-indications of administration exist, the prescriber should be contacted with details, including changes in the condition or circumstances of the resident

5.4 Accurate and contemporaneous documentation, both on the medication administration records and the resident's daily progress notes, should be made for any medicinal product withheld

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

Section 3

PROCEDURES MANUAL		
Section title: Medication review		
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1.0 Policy Statement

Medication review is an essential component of medication management in residential care for older people. It should be undertaken in a proactive and planned manner by the interdisciplinary team. A structured approach to medication review should be implemented and continuously evaluated

2.0 Purpose

To improve the quality of prescribing, while minimising risk and maximising benefit, with an aim of improving the quality or duration of the resident's life

3.0 Scope

3.1 All health care professionals involved in the medication review process

3.2 All residents in receipt of medication

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 A formal, planned, systematic review of the residents physical and psychological condition should be undertaken on a 3-monthly basis by the interdisciplinary team in partnership with the resident and any other people who wish to make a positive contribution such as friends, family, carers, advocates

5.2 The medication administration record should be reviewed, and specific drug problems listed:

- ✓ Drug-drug interaction
- ✓ Drug-disease interaction
- ✓ Contraindication for one (or more) drugs
- ✓ Evidence of an adverse drug event/side effect of a drug
- ✓ Need for review of appropriateness of drug selection
- ✓ Need for review of dose/frequency
- ✓ Compliance/ concordance problems
- ✓ Problems with the safe administration of drug
- ✓ Need for investigations
- ✓ Other
- ✓ None

- ● Following discussion, the action taken should be listed

- ✓ None
- ✓ Discontinue a medication
- ✓ Increase dose
- ✓ Reduce dose
- ✓ Substitute an alternative drug
- ✓ Discuss drug regime with resident or other
- ✓ Discuss side effects with resident or other
- ✓ Continue

5.3 The date of the next medication review should be scheduled

5.4 There should be comprehensive documentary evidence of the rationale of changes in the resident's medication management, including reference to self-administration of medicines, and the use of over-the-counter and complementary therapies

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 Department of Health (2001) *Medicines and Older People: Implementing Medicines – Related aspects of the NSF for Older People.* Crown Copyright

PROCEDURES MANUAL		
Section title: **Self-administration of medicinal products by residents**		
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
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1.0 Policy Statement

Self-administration of medicines in the residential care unit gives the resident greater independence, and enables them to participate in their own care and make informed decisions about their treatment in partnership with healthcare professionals

2.0 Purpose

To ensure that self-administration is implemented and operated in a safe and consistent way to minimise any risks

3.0 Scope

3.1 All residents who have been deemed competent to self-medicate

3.2 All healthcare professionals who will be assessing the resident's competence to self-medicate

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in the safe and ethical assessment, monitoring and review of residents who are self-administering medication is expected to develop and maintain competence with regards to all aspects of medication review

4.4 The self medication process promotes independence and residents who maintain the right to self-medicate should be encouraged to inform the residential care unit if there are any changes to their medication regime or any compliance issues

5.0 Procedure

5.1 The resident is assessed for their suitability to self administer by a nurse (Appendix 2b

5.2 A care plan should be initiated (Appendix 2c)

5.3 The nurse should discuss the self-administration scheme with the resident before starting and give them a resident information sheet (Appendix 2d). The nurse should ensure the resident reads and understands the resident information sheet and is aware of their responsibilities

5.4 The resident's written consent (Appendix 2e) to enter the self-administration scheme should be obtained and filed in the resident's care records

5.5 The resident will be given a medicine information sheet (Appendix 2f), which should be prepared and checked by two nurses. The medicines information sheet should be discussed with the resident

5.6 When discussing and writing about medicines, it is important to use the name of the medicine that the resident is familiar with. The generic name must also be included

5.7 The nurse should sign the medication administration record that they have either administered or supervised i.e. for residents at level 1a and 1b

5.8 For residents at level 2, the resident should tick the self-administration tick chart (Appendix 2g) and the nurse write "self" on the medication administration record

5.9 Throughout the period of self-administration, the resident should be reviewed at least daily. The level of self-administration and any changes should be documented on the ongoing assessment record (Appendix 2h)

5.10 All medicines used for self-administration should be clearly labelled with the medicine's name and strength, the correct dose, any relevant instructions and the resident's name

5.11 If a change is made to the medication regime, e.g. a new medicine is introduced or the dosage instruction is changed, the medical practitioner or nurse should explain to the resident what has been changed and why, update the medicine information sheet held by the resident and tick the chart if used

5.12 Medicines should be stored in a locked cupboard at the resident's bedside. Valuables or other items must be stored separately

5.13 Stock or unlabelled medicine should not be stored in the resident's locked cupboard when the resident is administering their own medication

5.14 Each locked cupboard should have its own key plus a spare

5.15 Residents on Level 2 are given one key. The resident should be assessed as to their ability to look after the key safely at all times

5.16 If an individual key is lost the lock should be changed

5.17 Refrigerated items should be stored in the refrigerator unless further information is obtained from pharmacy on keeping them in the cupboard

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 Commission for Healthcare Audit and Inspection (2002) *Self administration of medicines by hospital inpatients.* Briefing document from Salford Royal Hospital

PROCEDURES MANUAL		
Section title: Staff education		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy Statement

Staff education is an integral component of medication management. All nursing staff involved in medication management should be listed on the active register of An Bord Altranais, be knowledgeable about medication management policies and procedures, and be able to provide evidence of continual professional education relating to clinical practice

2.0 Purpose

All nurses should develop and maintain competence with regards to all aspects of medication management

3.0 Scope

All nurses involved in medication management

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Copies of MIMS Ireland and the British National Formulary should be available in all clinical areas and staff should be familiar with their use

5.2 All staff should be familiar with the An Bord Altranais Guidance to Nurses and Midwives on Medication Management July 2007 and Health Information and Quality Authority National Quality Standards for Residential Care Settings for Older People in Ireland, February 2009 and copies of these should be available in all clinical areas

5.3 All staff should participate in continuous professional development in relation to medication management by attending relevant accredited courses annually, keeping up-to-date with current literature, and reviewing and refining their practice accordingly

5.4 All registered nursing staff should undertake the An Bord Altranais distance learning package Guide to Medication Management and their completion certificates should be filed with their annual appraisals

5.5 There is evidence of regular audit relating to medication management. The content of continuing professional education programmes should reflect both audit findings and clinical need

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

Section 4

PROCEDURES MANUAL		
Section title: Use of complementary therapies		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
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1.0 Policy Statement

The use of complementary therapies is increasingly more common in the delivery of health care with many nurses providing these therapies. Complementary therapies include but are not limited to, acupressure, acupuncture, aromatherapy, herbalism, homeopathy, massage therapy, reflexology and yoga

2.0 Purpose

To facilitate those residents who request access to the use of complementary therapies in a safe and responsible manner

3.0 Scope

3.1 All healthcare professionals who are involved in the delivery of complementary therapies

3.2 All residents receiving complimentary therapies

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 The registered therapist is expected to develop and maintain competence with regards to all aspects of medication management

5.0 Procedure

5.1 All residents should be assessed for their prior and/or current use of complementary therapies and medicines on admission, and their preferences recorded in the care plan

5.2 Prior to the initiation of any complementary therapy, the resident should be assessed and any co-existing conditions and treatments documented in the resident's daily progress notes

5.3 Consent for the specific complementary therapy should be obtained by the therapist from the resident's medical practitioner prior to commencing therapy

5.4 The therapist should discuss the complementary therapy in detail with the resident and their family/advocate. Informed consent should be obtained from the resident and recorded in the care plan

5.5 The proposed complementary therapy should be communicated to the members of the health care team, with written information available

5.6 The individual using complementary therapies should be competent in the specific therapy, having undergone an education programme that provides them with the required skills and knowledge to practice such therapies

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management.*

PROCEDURES MANUAL		
Section title: Over-the-counter medication		
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1.0 Policy Statement

Residential care units aim to facilitate any residents' requests for over-the-counter medication. However, in the interests of resident safety, all access to over-the-counter medication should be obtained on foot of a written prescription

All medication supplied or administered to residents will have been prescribed by a medical or dental practitioner or nurse prescriber

2.0 Purpose

To ensure that residents play a full and active role in the management of their medication and that their choice is respected

3.0 Scope

3.1 All healthcare professionals involved in medication management within the residential care setting

3.2 All residents who request over-the-counter medication

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Where the resident requests an over-the-counter medication the nurse should ensure this is discussed with the resident's medical practitioner who will then prescribe any appropriate additions to the medication regime

5.2 All medication prescribed will then be administered by the nurse unless the resident's competency to self-administer the medication has been established

5.3 Where residents are self-medicating and a new medication has been prescribed, the nurse must ensure that the resident understands:

- ✓ how to use the requested medication
- ✓ therapeutic uses
- ✓ normal dosage
- ✓ side effects
- ✓ precautions and contraindications
- ✓ potential drug interactions

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

PROCEDURES MANUAL		
Section title: **Administration of influenza/pneumococcal vaccine**		
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1.0 Policy Statement

To offer influenza/pneumococcal vaccine to all residents annually between October and early December

2.0 Purpose

To provide a standardised approach to the administration of influenza/pneumococcal vaccinations to residents

3.0 Scope

3.1 All healthcare professionals involved in the prescribing and administering of vaccines

3.2 All residents who are eligible to receive the vaccines

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each medical practitioner and nurse involved in the vaccination programme is expected to develop and maintain competence with regards to all aspects of medication management

5.0 Procedure

5.1 Residents who wish to receive the influenza vaccine should be identified, fully assessed by the medical practitioner, and checked for both allergy to eggs and previous anaphylactic reaction: this should be recorded in the medical notes. The medical practitioner should ascertain whether the resident has received pneumococcal vaccine in the past

5.2 Vaccines should be ordered from the pharmacy on the foot of an individual prescription and stored in the drug refrigerator between 2 degrees and 8 degrees Celsius

5.3 Prior to immunisation the person administering the vaccine should:

- ✓ check whether the resident has had the influenza vaccine within the last 12 months
- ✓ assess the resident's fitness to receive the vaccine at this time: for example, the resident is apyrexial
- ✓ ensure that in the event of an emergency, help is available
- ✓ check anaphylactic shock equipment
- ✓ provide the resident with information
- ✓ check the dosage and route of vaccination with the pharmacist

5.4 The medical practitioner or nurse should subsequently

- ❍ administer the vaccine as a single dose by intramuscular or deep subcutaneous injection into the deltoid muscle. This is usually by deep subcutaneous injection for residents on anticoagulant therapy and those with a bleeding disorder
- ❍ sign the medication administration record and affix the vaccine batch number sticker to the medical records. Record administration in both the nursing and medical records
- ❍ ensure the resident is within easy observation of nursing staff for at least 5-10 minutes, so that any adverse effects can be observed immediately
- ❍ observe for soreness at the site of the vaccination
- ❍ report any reasons for non-immunisation, and any other relevant information, to the medical practitioner on their next visit

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 HSE National Immunisation Office (2008) *Information for Healthcare Professionals: Influenza Vaccine and Pneumococcal Polysaccharide Vaccine*

6.3 National Immunisation Advisory Committee (2008) *Immunisation Guidelines for Ireland: 2008 Edition*. Royal College of Physicians Ireland

PROCEDURES MANUAL		
Section title: Pain management		
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
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1.0 Policy Statement

Pain is under-treated and under-recognised in older adults, with 45-83% of older people living in residential care reporting at least one current pain problem. Assessing pain becomes even more difficult in the presence of severe cognitive impairment

2.0 Purpose

To provide health care professionals with some practical skills in identifying and managing pain in the residents

3.0 Scope

3.1 All health care professionals involved in the care of older adults

3.2 All older people living in residential care

4.0 Glossary of Terms and Definitions

Pain: Pain is an unpleasant, sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage. However, pain is subjective and is “what the person says it is”

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each health care professional involved in the day-to-day care of residents is expected to develop and maintain competence with regards to all aspects of medication management

6.0 Guidelines

6.1 All residents should be assessed on admission for verbal or non-verbal indication that may indicate the presence of pain

6.2 A comprehensive pain assessment should be initiated where pain is reported or observed. This should take cognisance of the resident's ability to communicate and requires the use of different types of scale for assessing pain

6.3 The key components of pain assessment include:

- a description of the type of pain experienced
- observation for signs of pain
- description of pain to include sensory, affective and impact
- measurement of pain
- cause of pain
- any aggravating or relieving factors
- review of current medication regime
- physical, psychological, social and spiritual review

6.4 Where the resident is experiencing more than one type or location of pain, each should be assessed separately

6.5 All necessary actions should be taken to remove or treat any other causes or stimuli that have been identified during the assessment. The resident should then have their pain reassessed prior to the commencement of any pharmacological interventions

6.6 Where this is unsuccessful consider non-pharmacological interventions such as physiotherapy, heat/ cold packs, transcutaneous electronic nerve stimulation (TENS), massage, review of physical environment including mattress and seating and complementary therapies

6.7 If the resident is still experiencing pain, review the medication administration record. If they have been prescribed medication which is appropriate for the assessed pain or have been prescribed this medication on a PRN basis and this medication is due, then this should be administered without delay. The resident should then have their pain reviewed when the therapeutic time for the medication to take effect has been realised

6.8 Where no pain-relieving medication has been prescribed the nurse must report the pain to the medical practitioner to initiate a prescription. A verbal or facsimile order may be required to avoid delay in treatment

6.9 The prescribing of pain-relieving medication should be in accordance the WHO 3-Step Analgesic Ladder and take into consideration the resident's physical and mental health status

6.10 Residents requiring medication for acute pain should be fully reassessed on a daily basis and more often as the resident's needs dictates, in order to monitor the effectiveness of this medication

6.11 Residents requiring medication for chronic pain should be reassessed every three months as part of the regular medication review process

7.0 References

7.1 Royal College of Physicians, British Geriatric Society, British Pain Society (2007) *The Assessment of pain in older people: National Guidelines. Concise guidance to good practice series, No 8.* London RCP

7.2 National Medicines Information Centre (2005) *Pharmacological management of pain in primary care.* Vol 11: Nos 5-6

7.3 Merskey, H and Bogduk, N (1994) Part III: *Pain Terms, A Current List with Definitions and Notes on Usage" (pp 209-214)* Classification of Chronic Pain, Second Edition, IASP Task Force on Taxonomy, IASP Press, Seattle cited by International Association for the Study of Pain (2007) http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Definitions&Template=/CM/HTMLDisplay.cfm&ContentID=1728 (accessed 16th April 2009)

7.4 Sindhu, F(1996) *Are non-pharmacological nursing interventions for the management of pain effective? A meta-analysis.* J Adv Nurs. 24: 1152-9

7.5 The Australian Pain Society (2005) *Pain in residential aged care facilities: management strategies.* Sydney: The Australian Pain Society

7.6 World Health Organisation (1986) *WHO's Pain Relief Ladder.* Geneva: WHO

PROCEDURES MANUAL		
Section title: **Transdermal patch application**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
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Authorised by:		**Date:**

1.0 Policy Statement

It is always preferable that medication is prescribed for oral use. However, situations may arise where other routes of administration are required. Transdermal patches may be a useful alternative in residents where the clinical condition of the resident prohibits the oral route e.g. dysphagia or uncontrolled nausea and vomiting. Patches may also be considered where adverse side-effects have been encountered with oral medication, where there are compliance issues, or where it is more convenient and comfortable for the resident

Due to the delayed onset of action, patches should not be used to treat acute symptoms. Since there are significant physiological skin changes associated with ageing, transdermal patches should only be prescribed for the older person following a comprehensive review and on a case-by-case basis

2.0 Purpose

To provide a standardised approach to the application of transdermal patches

To ensure safety by calculating the risk/ benefit profile for each resident

3.0 Scope

3.1 All nurses involved in the administration of medication via transdermal patch

3.2 All residents, including their relatives, friends or advocates where indicated, who may be involved in the application of transdermal patches

4.0 Glossary of Terms and Definitions

4.1 **Transdermal** – across the skin, particularly with reference to the absorption of drugs applied topically for systemic effect

4.2 **Transdermal patch** – a drug-impregnated adhesive patch applied to the skin for controlled release of the active compound

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes

5.2 The Director of Nursing should ensure that staff have undertaken appropriate programmes of education related to the use of transdermal patches

5.3 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

6.0 Procedure

6.1 Identify the resident and explain and discuss the procedure with them. Ascertain their understanding and reaffirm their knowledge by providing further information as necessary

6.2 Check the transdermal patch against the prescription sheet of the medication administration record to ascertain the following:

- ✓ name of medication
- ✓ dose
- ✓ date and time of administration
- ✓ route and method of administration
- ✓ signature of the prescriber

6.3 Consult the Summary of Product Characteristics to ascertain any special considerations for each patch to be applied

6.4 Wash hands, dry thoroughly and apply non sterile gloves

6.5 Select site of application. This should be a dry, hairless area, preferably on the upper arm, upper trunk or behind the ear. Avoid areas where the skin is inflamed, broken or irritated or where there are skin folds, scars or calluses. Sites should be rotated for each application

6.6 Prepare the skin for application by washing with water and drying thoroughly. If hair is present this should be removed by cutting with scissors, not shaving

6.7 Remove the old patch, where applicable. Since used patches may still contain medication, fold the patch in half so that the adhesive sides stick together and discard in a designated sharps bin

6.8 Remove the new patch from its packaging. Write the date, time and initials on the patch for ease of identification with a ballpoint pen or permanent marker. Peel back the protective liner and apply the exposed adhesive side to the resident's skin. Hold down the side which has been applied with one hand and use the other hand to remove the rest of the protective liner

6.9 Press the patch firmly in place with the palm of the hand for approximately 30 seconds, making sure contact is complete, especially around the edges

6.10 Discard gloves and wash hands

6.11 Document the application in the resident's medication administration record, taking care to record the application site

6.12 If a patch falls off during application, discard it and replace with a new one ensuring care to document appropriately

6.13 If a patch falls off before the date or time of the next application, a new patch should be applied. Document this both in the resident's medication administration record and care plan: adjust the time and date of the next application as appropriate

6.14 Some patches may need to be taped around the edges, if they are beginning to peel off, with suitable skin tape – refer to the Summary of Product Characteristics for further guidance on individual patches. Do not use bioclussive dressings

6.15 Patches should be reapplied at the same time of the day to ensure a continuous effect

6.16 Residents should be advised to avoid external sources of heat such as heating pads, electric blankets and prolonged bathing

6.17 Several transdermal patches have a metallic component in their outermost layer and therefore should be removed prior to MRI scanning

6.18 Different strength patches are available for use. General manufacturer's guidelines state that no more than two patches should be used at the same time. Patches should never be cut

7.0 References

7.1 Institute for Safe Medication Practices (2004) *Medication Safety Alert: Burns in MRI Patients Wearing Transdermal Patches* http://www.ismp.org/Newsletters/acutecare/articles/20040408.asp (accessed 07/07/2009)

7.2 Lippincott, Williams & Wilkins (2008) *Lippincott's Nursing Procedures: Fifth edition.* Wolters Kluwer Health

7.3 Twycross, R; Wilcock, A; Charlesworth, S and Dickman, A (2002) *Palliative Care Formulary 2nd Edition.* Radcliffe Medical Press: Oxon

7.4 www.medicines.ie (accessed 07/07/2009)

PROCEDURES MANUAL		
Section title: **Medication administration via enteral feeding tubes**		
Section No.: SOP	**Revision: 00**	**Page 1 of 4**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
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1.0 Policy statement

Any resident who requires enteral feeding is severely compromised, and it is of paramount importance that nurses maintain the patency of the enteral feeding tube at all times. Where the oral route of drug administration is not feasible, the interdisciplinary team should consider all other methods, i.e. rectal, transdermal, before making the decision to use the enteral feeding tube

If prescribed medicines are to realise their therapeutic potential, healthcare professionals need to focus on the details of drug administration when administering via the enteral feeding tube. A specific medical practitioner's order is required for the administration of any drug via a feeding tube: a specific direction is also required for any tablets that must be crushed

2.0 Purpose

To ensure the safe administration of medication while maintaining the patency of the enteral feeding tube

3.0 Scope

3.1 All healthcare professionals who are involved in medication management and administration of medicines via an enteral feeding tube

3.2 All residents in receipt of medication via an enteral feeding tube

4.0 Glossary of Terms and Definitions

4.1 Cooled Boiled Water:

Cooled boiled water is tap water which has been boiled, allowed to cool and then stored in a refrigerator prior to use. This should be kept for no longer than 24hrs in a clean container that is sterilised between uses with sodium hypochlorite solution

4.2 Gastrostomy tube:

A gastrostomy tube is one which has been inserted directly through the abdominal wall into the stomach. There are different methods of gastrostomy tube insertion available for enteral feeding which include Percutaneous Endoscopic Gastrostomy (P.E.G) tube, Radiologically Inserted Gastrostomy (R.I.G) and Replacement Balloon/ Button Gastrostomy

4.3 Jejunostomy:

A jejunostomy tube is a tube that is passed through the abdominal wall directly into the jejunum

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each healthcare professional involved in the administration of medicines via an enteral tube is expected to develop and maintain competency with regards to all aspects of medication management

6.0 Procedure

6.1 Check that all prescribed medicines to be administered have been verified by the medical practitioner and pharmacist as appropriate for use via an enteral feeding tube and that any medicines which may interact with the prescribed enteral feed have been clearly identified

6.2 If medication is associated with an incompatibility, turn off the pump to stop continuous feeding 1-2 hours prior to medication administration. This will depend on the drug e.g. for phenytoin administration, stop feed 2 hours before and 2 hours after. If the medication should be given on an empty stomach turn off the pump 30 minutes before

6.3 Wash hands, put on gloves and disposable apron

6.4 Establish the privacy of the resident

6.5 Explain the procedure to the resident

6.6 Check the medication administration record to confirm the order; note the medication, dose, route (tube), frequency, volume of diluent

6.7 Prepare each medication for administration separately. Volumes greater than 10mls may be drawn up in a 50ml syringe and administered via the tube:

(a) Soluble tablets: dissolve in 10-15mls water

(b) Liquids: shake well. For thick liquids mix with an equal volume of water

(c) Tablets: crush with a pestle and mortar or tablet crusher and mix with 10-15mls water

6.8 If volumes of less than 10ml are required, measure the dose in a 10ml oral syringe and leave aside until the patient is in the correct position. This should then be administered into the barrel of the 50/ 60 ml syringe and the 10ml syringe rinsed with water which should also be administered via the barrel of the 50ml syringe

6.9 Elevate the head of the bed to 30-40 degrees (semi- or high Fowler's position)

6.10 Check for correct tube placement by visually inspecting the tube. Compare the number on the measuring guide of the tube nearest the fixator with original recorded markings. If the tube has become dislodged this should be treated as a medical emergency and replaced immediately by competent staff

6.11 Check gastric content for residual feeding if using a replacement gastrostomy tube. The pH should be <5.5

6.12 If a pump is being used for continuous feeding turn it off if not already done. Clamp tube. Remove plunger from 60ml syringe and connect syringe to damp tubing. Only 50/ 60ml enteral syringes should be used as smaller lumen syringes exert higher pressure which can potentially damage or rupture the tube. Specifically designed reusable enteral syringes are preferable. Follow manufacturer's guidelines on cleaning. If using single use only syringes then a new syringe must always be used each time the tube is flushed or the resident receives medication

6.13 Pour 15-30ml of water into syringe, open clamp and flush tubing using gravity flow. Clamp tubing once syringe is empty, allowing water to remain in the tube Use only cooled boiled water or sterile water (Jejunostomy tubes). Both cooled boiled water and sterile water should be labelled and dated, kept refrigerated and discarded 24hrs after opening. Do not withdraw sterile water directly from the bottle

6.14 Pour dissolved/diluted/ liquid medication into syringe and unclamp tubing, allowing medication to flow by gravity

6.15 Flush tubing with 15-30ml of water or prescribed amount. (If administering more than one medication, flush with 5ml water or prescribed amount, between each medication). Allow water to remain in tubing

6.16 Clamp tubing and detach syringe

6.17 Restart continuous feeding if appropriate. In the case of a medication with incompatibility issues, the pump should remain switched off for 1-2 hours following drug administration

6.18 Where an enteral tube becomes blocked:

- ❍ make sure all clamps are open and check the tube is not kinked
- ❍ knead/ squeeze the tube in the direction of the stomach
- ❍ try flushing gently with 50mls of warm water. To obtain lukewarm water (40-45 degrees Celsius) put three quarters of a cup (120mls) of cooled boiled water (sterile water for jejunostomy) into a plastic cup and add a quarter (40mls) of a cup of boiling water
- ❍ leave for 30 minutes to act

Where this still does not work:

- ❍ prepare the pancreatic enzyme powder/ pancrelipase as prescribed
- ❍ flush gently into tube and leave for 30 minutes
- ❍ then flush gently with 50mls of water

General manufacturers' guidelines state that the use of pineapple juice, carbonated or sugary drinks should not be used as they may interact with the feed and compound the problem

Where a tube blockage cannot be cleared using the above procedure seek specialist advice

7.0 References

7.1 Clinical Resource Efficient Support Team (2005) *Guidelines for the management of Enteral Feeding in Adults*

7.2 Dougherty, L and Lister, S.E (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures* 7th Edn. Blackwell Publishing: London

7.3 National Institute of Clinical Effectiveness (2006) *Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition*

7.4 National Patient Safety Authority (2007) *Promoting Safer Measurement and Administration of Liquid Medicines via Oral and Other Enteral Routes* Patient Safety Alert 19

7.5 Nutrition Support Interest Group (2007) *Home Enteral Feeding Resource Pack* Irish Nutrition and Dietetic Institute

7.6 Toedter Williams, N (2008) *Medication Administration Through Enteral Feeding Tubes* Am J Health-Syst Pharm. 65 (24):2347-2357

PROCEDURES MANUAL		
Section title: **Administration of drugs other than by the oral or parenteral routes**		
Section No.: SOP	**Revision: 00**	**Page 1 of 6**
Issued by:	**Medication management working group**	**Date: 02/09/09**
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1.0 Policy statement

There are many different routes by which medicines can be administered, other than by oral, intravenous, intramuscular or subcutaneous routes. Drugs are pharmacologically active through these other methods of administration, and therefore merit the same attention to detail at every step of the prescribing, supply, dispensing, administration and monitoring process. The registered nurse is responsible and accountable for administering medication according to the prescription

2.0 Purpose

To ensure safe, effective and ethical method of administering medicines via a specific route of administration

3.0 Scope

3.1 These procedures apply to all health care professionals involved in the prescribing, dispensing, supply, and administration of all medications via the specified route

3.2 All residents in receipt of the medication

4.0 Glossary of Terms and Definitions

4.1 **Ocular route** – medicine is instilled into the eyes

4.2 **Aural route** – medicine is instilled into the ears

4.3 **Nasal route** – medicine is instilled into the nose

4.4 **Topical route** – medicine is applied to the outer surface of the skin

4.5 **Rectal route** – medication is administered via the rectum (also known as PR or per rectum)

4.6 **Vaginal route** – medication is administered via the vagina (also known as PV or per vagina)

4.7 **Inhalation or nebulisation route** – administration of medication via an inhaler or nebuliser

4.8 **Nebuliser** – a device for administering a medication into the chest by spraying a fine mist into the oropharynx. Also known as an atomiser

5.0 Roles and Responsibilities

5.1 Director of Nursing to implement, evaluate and audit all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on this process to all staff

5.2 Each medical practitioner and nurse involved in medication management and the administration of medications is accountable for their practice

6.0 Procedure

6.1 Aural Route:

6.1.1 Ear drops should only be administered as prescribed by the medical practitioner

6.1.2 Nursing staff should explain each step of the procedure to the resident and obtain their verbal consent

6.1.3 The resident should lie on the bed with the affected ear towards the ceiling

6.1.4 Extend the top of the resident's ear upwards and outwards to straighten the external ear canal

6.1.5 Place the filled dropper over the entrance to the resident's external ear canal and squeeze the dropper until the prescribed number of drops is instilled

6.1.6 Ask the resident to maintain that position for five minutes. Wipe the excess drops that pool outside the ear when the resident sits up. Do not insert cotton wool into the entrance of the ear canal as this will absorb the drops

6.1.7 If the drops are to be inserted into both ears, repeat steps three to five on the opposite ear

6.1.8 Record the administration in the resident's medication administration record

6.2 Ocular Route:

6.2.1 Explain and discuss the procedure with the resident

6.2.2 Clean the eyes using gauze squares slightly moistened with sterile water before instilling the eye medication

6.2.3 Consult the resident's drug prescription chart to ascertain the method of administration (including which eye the medication is prescribed for) validity of prescription, the doctor's signature and the expiry date of the medication

6.2.4 Place a moistened gauze square on the lower lid against the lid margin and gently pull down

6.2.5 Ask the resident to look upwards before instilling the eye drops/ointment

6.2.6 Administer the eye medication. For liquid preparation, gently squeeze the dropper to instil the prescribed number of drops to the lower, inner corner of the eye. For gel/ointment preparation, gently squeeze the tube holding the nozzle approximately 2.5cm from the eye then draw a line from the inner aspect of the lower lid outward

6.2.7 Ask the resident to close their eyes and wipe away any excess drops or ointment with a new moistened gauze square

6.2.8 Inform the resident that vision may be blurred for a few minutes after opening the eye

6.2.9 Make the resident comfortable

6.2.10 Remove and dispose of equipment and wash your hands

6.2.11 Record the administration in the resident's medication administration record

6.3 Topical Route:

6.3.1 Explain and discuss the procedure with the resident

6.3.2 Check the prescription sheet

6.3.3 Use aseptic technique if the resident's skin is broken

6.3.4 If the medication is to be rubbed into the skin, the preparation should be placed on a sterile topical swab. The wearing of gloves may be necessary

6.3.5 If the preparation causes staining, advise the resident of this

6.3.6 Record the administration in the resident's medication administration sheet

6.4 Nasal Route:

6.4.1 Explain and discuss the procedure with the resident

6.4.2 Each resident should have their own medication and dropper

6.4.3 Check the prescription sheet

6.4.4 Have paper tissues available

6.4.5 Clean the opening of the resident's nasal passage, with tissues or a damp cotton bud

6.4.6 Hyperextend the residents neck (unless clinically contraindicated e.g. rheumatoid arthritis or cervical spondylosis)

6.4.7 Administer drops whilst avoiding touching the external nostrils with the dropper (to prevent sneezing)

6.4.8 Request the resident to maintain their position for 1-2 minutes.

6.4.9 Record the administration in the resident's medication administration sheet

6.5 Rectal Route: (Enema).

6.5.1 Explain the procedure to the resident

6.5.2 Allow the resident to empty their bladder first if necessary

6.5.3 Warm the enema to the required temperature by immersing in a jug of hot water. A temperature of 40.5 – 43.3°C is recommended. Oil retention enemas should be warmed to 37.8°C

6.5.4 Ensure privacy. Use blanket or sheet to maximise privacy

6.5.5 Position the resident lying on left side with knees well flexed, the upper leg higher than the lower leg and the buttocks near the edge of the bed

6.5.6 Ensure the commode or toilet is readily available

6.5.7 Wash hands and put on disposable gloves

6.5.8 Place some lubricating gel on the topical swab and lubricate the nozzle of the enema

6.5.9 Expel excess air (a small amount of air may be introduced into the bowel if bowel evacuation is desired)

6.5.10 Separate the residents buttocks and introduce the nozzle slowly into the anal canal, advancing for approximately 10-12.cm

6.5.11 If a retention enema is used, introduce the fluid slowly and leave the patient in bed with the foot of bed elevated by 45° for as long as prescribed

6.5.12 If an evacuant enema is used, introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow, until the pack is empty or the solution is completely finished

6.5.13 Slowly withdraw the nozzle

6.5.14 Clean any lubricating gel from the resident's perineal area

6.5.15 Ask patient to retain the enema for 10-15 minutes or until the resident is no longer able to do so

6.5.16 Remove and dispose of equipment. Wash hands

6.5.17 Record the administration in the resident's medication administration sheet

6.5.18 Record the results using the Bristol Stool Chart in the resident's care plan

(Suppository)

6.5.1.1 Explain the procedure to the resident

6.5.1.2 Ensure privacy. Use blanket or sheet to maximise privacy

6.5.1.3 Position the resident lying on left side with knees well flexed, the upper leg higher than the lower leg and the buttocks near the edge of the bed

6.5.1.4 Ensure the commode or toilet is readily available

6.5.1.5 Wash hands and put on disposable gloves

6.5.1.6 Place some lubricating gel on the topical swab and lubricate the rounded end of the suppository

6.5.1.7 Separate the resident's buttocks and insert the suppository's blunt end first, advancing for approximately 2-4cm

6.5.1.8 Repeat this procedure if a second suppository is to be inserted

6.5.1.9 Once the suppository has been inserted, clean any excess lubricating gel from the resident's perineal area

6.5.1.10 Ask patient to retain the suppository for twenty minutes, or until the resident is no longer able to do so

6.5.1.11 If medicated suppositories are given, remind the resident that the aim is not to stimulate evacuation of the bowel and to retain the suppositories for twenty minutes or as long as possible

6.5.1.12 Remove and dispose of equipment. Wash hands

6.5.1.13 Record the administration in the resident's medication administration sheet

6.5.1.14 Record the results using the Bristol Stool Chart in the residents care plan

6.6 Vaginal Route: (vaginal pessary)

6.6.1 Explain the procedure to the resident

6.6.2 This procedure is best preformed late in the evening as the resident is unlikely to get out of bed

6.6.3 Ensure privacy. Use blanket or sheet to maximise privacy

6.6.4 Position the resident lying supine with the knees drawn up and the legs parted

6.6.5 Wash hands and put on disposable gloves

6.6.6 Place some lubricating gel on the topical swab and lubricate the pessary

6.6.7 Insert the pessary along the posterior vaginal wall and into the top of the vagina

6.6.8 Wipe away any lubricating gel from the resident's vulval and perineal area

6.6.9 Make the resident comfortable

6.6.10 Remove and dispose of equipment. Wash hands

6.6.11 Record the administration in the resident's medication administration sheet

6.7 Nebulised Route:

6.7.1 Explain and discuss the procedure with the resident

6.7.2 Check the prescription sheet: nebulisation time for bronchodilators should be less than ten minutes

6.7.3 Seat the resident in an upright position if possible

6.7.4 Administer only one medicine at a time

6.7.5 Add prescribed medication to nebuliser

6.7.6 Attach tubing to nebuliser mask and then attach to nebuliser machine

6.7.7 Place the mask on the resident's face

6.7.8 Turn on nebuliser machine to give fine mist

6.7.9 Instruct the resident to breathe through the mouth

6.7.10 When misting ceases, turn off nebuliser machine and remove mask

6.7.11 Wipe resident's face if necessary

6.7.12 Encourage resident to cough and expectorate

6.7.13 Dispose of mask, tubing and chamber after each use unless being retained for the individual resident, for future use

6.7.14 Record the administration in the resident's medication administration sheet

7.0 References

7.1 British National Formulary (2009) *BNF 57* British Medical Association and Royal Pharmaceutical Society, London

7.2 Dougherty, L and Lister, S.E (2008) T*he Royal Marsden Hospital Manual of Clinical Nursing Procedures 7th Edn*. Blackwell Publishing: London

PROCEDURES MANUAL		
Section title:	**Administration of intramuscular and subcutaneous injections**	
Section No.: SOP	**Revision: 00**	**Page 1 of 5**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
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1.0 Policy statement

As part of medication management within the residential care unit, some residents may require their medication to be administered via injection. Although some residents need long-term medication via the subcutaneous route, the use of intramuscular injection should always be avoided if an equally effective alternative route is available

Indications for intramuscular and subcutaneous injections include:

- When medications cannot be absorbed orally due to the medical condition
- When faster absorption is required, with a reasonably prolonged action
- When precise control over dosage is needed
- When oral drugs may be destroyed in the stomach e.g. insulin
- Intestinal obstruction
- Persistent nausea and vomiting
- Intractable pain unrelieved by oral medications
- Where the person is unconscious

Although the administration of these injections is not an extended role for the nurse, it remains the responsibility of each nurse to inform the Director of Nursing if they require further education or training in relation to the administration of intramuscular or subcutaneous injections. It is the responsibility of the Director of Nursing to assess the competency of nurses undergoing orientation programmes in residential care for older people, before they undertake administration of intramuscular or subcutaneous injections

2.0 Purpose

To promote safe, effective and ethical practice for residents who require intramuscular or subcutaneous injections

To ensure that all nursing staff and students are competent in all aspects of medication management relating to the administration of intramuscular and subcutaneous injections

3.0 Scope

3.1 All staff engaged in medication management relating to the administration of intramuscular or subcutaneous injections

3.2 All residents receiving medicines by injection

4.0 Glossary of Terms and Definitions

4.1 **Intramuscular injections** are given deep into the skeletal muscle, usually into the gluteal, deltoid, rectus femoris, vastus lateralis muscles or upper outer aspect of the thigh

4.2 **Subcutaneous injections** are given into tissue just beneath the skin. Typically at sites including the upper arms and thighs, the abdomen in the umbilical region, the back and lower limbs

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each healthcare professional involved in medication management and the administration of medicines is accountable for their practice

6.0 Procedure

6.1 Administration of medicines via injection

6.1.1 The nurse should demonstrate knowledge of areas or sites which should not be used for intramuscular or subcutaneous injections

- Areas affected by lymphoedema
- Areas of generalised oedema or ascites
- Bony prominences
- Skin areas that have recently been exposed to radiotherapy
- Sites near a joint or crease
- Areas near sites of infection
- Tender areas or an area with lumps or nodules
- Injection sites near to nerves

6.1.2 The nurse must also demonstrate the knowledge and competency required to prepare the medication prior to injection, where required

6.1.3 Collect and check all equipment ensuring that the packaging is intac

6.1.4 Check the prescription sheet to ascertain the following

- Name of the medication
- Dose
- Method of administration
- Validity of the prescription
- Prescriber's signature

6.1.5 Check all details with a second nurse if required by local policy. Ensure that the drug is not contraindicated for intramuscular or subcutaneous injection

6.1.6 Select the medication in the appropriate volume, dilution or dosage and check the expiry dates

6.1.7 Proceed with the preparation of the medication, where required in a suitable environment such as the treatment room. Dispose of the needle used for preparation into an appropriate sharps container and select the correct needle size for the injection

6.1.8 Take the prepared dose to the resident on a procedure tray or receiver, with a sharps container

6.1.9 Proceed using the appropriate procedure for the injection required

6.2 Subcutaneous injection administration

6.2.1 Explain and discuss the procedure with the resident

6.2.2 Assist the resident into the required position and remove or adjust appropriate clothing to expose the injection site. Use a blanket or sheet where necessary to maintain privacy

6.2.3 Assess the injection site for signs of inflammation, oedema, infection and skin lesions. If present, choose an alternative site. Sites should be rotated

6.2.4 Clean the injection site with an alcohol swab (isopropyl alcohol 70%) and allow to dry for 30 seconds

6.2.5 Gently pinch the skin up into a fold

6.2.6 Insert the needle into the skin at an angle of 45 degrees and release the grasped skin (unless administering insulin when an angle of 90 degrees should be used). Inject the medication slowly

6.2.7 Withdraw the needle rapidly and apply pressure to any bleeding point. Do not rub or massage the site post injection

6.2.8 Dispose of equipment in the sharps container and record the administration in the resident's nursing notes

6.3 Intramuscular injection administration

6.3.1 Explain and discuss the procedure with the resident

6.3.2 Select the appropriate site for intramuscular injections using the Z-track technique

6.3.3 Assist the resident into the required position and remove or adjust appropriate clothing to expose the injection site. Use a blanket or sheet where necessary to maintain privacy

6.3.4 Assess the injection site for signs of inflammation, oedema, infection and skin lesions. If present, choose an alternative site. Sites should be rotated

6.3.5 Clean the injection site with an alcohol swab (isopropyl alcohol 70%) for 30 seconds and allow to dry for 30 seconds

6.3.6 Stretch the skin around the injection site

6.3.7 Holding the needle at an angle of 90 degrees, quickly plunge it into the skin

6.3.8 Steady the syringe barrel with one hand and aspirate for blood, by pulling back the plunger with the other hand. If no blood appears administer the medicinal product at a rate of 1ml per 10 seconds. If blood appears withdraw the needle completely and start again with a new injection at an alternative site, titrating the dose according to the amount injected on the first attempt. Explain the reasons for this to the resident

6.3.9 Wait 10 seconds to allow the medication to diffuse into the tissue then withdraw the needle rapidly

6.3.10 Apply pressure to any bleeding point. Do not rub or massage the site post injection

6.3.11 Dispose of equipment in the sharps container and record the administration in the resident's nursing notes

6.3.12 Observe the injection site for 4 hours after injection or as required, observing for bruising, swelling, abscess formation, cellulitis, tissue necrosis, haematoma formation, injury to bone, nerve injury or pain at the site. Fully document any problems which occur post administration, in the resident's notes

7.0 References

7.1 British National Formulary (2009) *BNF 57* British Medical Association and Royal Pharmaceutical Society, London

7.2 Dougherty, L and Lister, S.E (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures 7th Edn.* Blackwell Publishing: London

Section 5

PROCEDURES MANUAL		
Section title: **Pharmaceutical ordering and stock checking of medicinal supplies**		
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
Issued by:	**Medication management working group**	**Date: 20/05/09**
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1.0 Policy statement

Pharmaceutical ordering is a process of obtaining medicinal products for a resident from a pharmacy. Ordering sufficient levels of medication is an integral part of medication management to ensure residents receive medication in a timely fashion

2.0 Purpose

To ensure all nurses are aware of the procedures for ordering medicinal products and stock checking

3.0 Scope

All healthcare professionals involved in the ordering, stock checking and administration of medication

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each nurse involved in the ordering, stock checking and administration of medication is expected to develop and maintain competence with regards to all aspects of medication management

5.0 Procedure

5.1 Pharmaceutical ordering

5.1.1 Interim

- All medication written in the pharmacy order form should:
  - ✓ be written legibly in black ink
  - ✓ be dated
  - ✓ state the resident's full name
  - ✓ state the resident's date of birth
  - ✓ state the GMS number/ unit number
  - ✓ state the name of the prescribing medical practitioner
  - ✓ state name of the medication, dose, frequency and quantity needed
  - ✓ include information on the resident's allergy status
  - ✓ be signed by the nurse ordering the supplies
- Send/fax the prescription for the new orders and the order form to the pharmacy
- Confirm the receipt of the fax message by telephoning the pharmacy

5.1.2 Monthly order

- Stock levels held in either the medication trolley or the medication cupboard are checked prior to re-ordering monthly medication
- The pharmacist receives a current list of medication required for the following month. This list will be:
  - ✓ be written legibly in black ink
  - ✓ be dated
  - ✓ state the resident's full name
  - ✓ state the resident's date of birth
  - ✓ state the GMS number/ unit numbe
  - ✓ state the name of the prescribing medical practitioner
  - ✓ state name of the medication, dose, frequency and quantity neded
  - ✓ include information on the resident's allergy status
  - ✓ be signed by the nurse ordering the supplies
- These details are then forwarded to the medical practitioner so that a prescription can be generated

5.1.3 Medicinal product stock checking

- For weekly/monthly medicinal product stocks, a designated nurse should ensure that the medicines supplied in monitored dosage systems are checked against the prescription sheet before use
- A system of stock rotation must be operated (i.e., 'first in, last out') to ensure that there is no accumulation of expired stocks. Regular stock checks should be carried out
- All medicinal products delivered by a pharmacy must be checked against the inventory sheet
- The inventory sheet should include the:
  - ✓ name and dosage of medicine
  - ✓ quantity of medicine
  - ✓ expiry date
  - ✓ date and name of the nurse who checked the stock
- Expired medicinal supplies are returned to the pharmacy

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

PROCEDURES MANUAL		
Section title: **Storage of medicinal products**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

All medicinal products should be stored in a secure manner in a suitable storage facility. They should be stored in the appropriate environment as indicated on the label or packaging of the medicinal product or as advised by the pharmacist

2.0 Purpose

To ensure the safe, effective and secure storage of all medicinal products

3.0 Scope

All healthcare professionals involved in the prescribing, supply, receipt, storage and administration of medicines

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional is responsible for the safe, effective and ethical storage of medicines and is expected to develop and maintain competence with regards to all aspects of medication management

5.0 Procedure

5.1 All medicinal products should be stored in a secure manner in a suitable storage facility

5.2 Monthly checks should be conducted to ensure all products are within their expiry dates. Those products which have expired should be taken out of circulation and returned to the pharmacy for safe disposal and new products ordered as required

5.3 Medicinal products requiring refrigeration according to package labelling or pharmacy instructions should be stored in a designated refrigerator between 2-8 degrees Celsius. The refrigerator needs to be accessible, capable of being secured and used solely for storage of medicinal products. Daily temperature checks should be carried out

5.4 MDA schedule 2/3 drugs should be locked in a separate cupboard or container within a locked cupboard which is secured to the wall. They must be stored separately from other medicinal products to ensure further security as required in the Misuse of Drugs Act, 1977 and subsequent amends. The keys should be kept on the person of the designated nurse

5.5 All medication should be:

- ✓ stored in accordance with the package labelling or as advised by the pharmacist
- ✓ protected from light, heat and moisture
- ✓ stored separately from antiseptics, disinfectants and other cleaning products

5.6 Mobile medication trolleys and emergency boxes should be locked and secured to the wall when not in use

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 Irish Medicines Board (Miscellaneous Provisions) Act, 200

6.3 Medicinal Products (Prescription and Control of Supply) Regulations, 2003

PROCEDURES MANUAL		
Section title: **Respite admissions**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

All residents will be assessed on admission and a record kept of their current medication regime. Residents or their carers will be asked to bring their own medication with them, so that staff have accurate and comprehensive information about their medication management. Residents maintain the right to self-medicate and will be facilitated to do so within a safe and supportive environment

2.0 Purpose

To ensure that residents experience continuity of care by receiving their medication as prescribed following admission

3.0 Scope

3.1 All healthcare professionals involved in medication management

3.2 All residents admitted for respite care

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in caring for people in respite care is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Prior to admission the resident or their carer should be requested to bring an up-to-date prescription or their full supply of medication with them. All medication should be checked on admission and documented in the resident's record and nursing notes

5.2 Residents who have been self-medicating at home will be encouraged to maintain their independence within the self-medication scheme. When all aspects of competency have been established, the medication will be stored in an appropriate, safe and secure place with access limited to the resident and nursing staff

5.3 Residents who are not self-medicating will be asked to hand their own medication to the nursing staff for information purposes: where the residential unit maintains responsibility for the supply of medication, their family should be encouraged to take the medication home again. Where this is not possible, all medication should be labelled and stored appropriately until discharge. Resident's own medication remains the property of that resident and should not be disposed of without the resident's consent

5.4 The admitting nurse should contact the medical practitioner and inform them of the resident's admission to the residential care unit. Where the resident does not present with an up-to-date prescription the medical practitioner should be asked to assess the resident and to prescribe the resident's current medication and document these on the medication administration record

5.5 Telephone or facsimile orders and the use of the resident's own medication may be required to prevent a delay in the administration of medicines

5.6 Any changes to the medication regime during a period of respite care should be conveyed to both the resident and their usual medical practitioner. An appropriate supply should be provided to the resident, or the responsible person accompanying the resident, on discharge

PROCEDURES MANUAL		
Section title: **Emergency admissions**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

All residents will be assessed on admission to the residential care unit and a record kept of their current medication regime. Residents will be asked to hand-over their own medication on admission for information and safe-keeping, and this should be fully documented. Although residents maintain the right to self-medicate, and will be facilitated to do so where appropriate, this should not be introduced during the initial 72 hours of an emergency admission

2.0 Purpose

To ensure that residents continue to receive their medication as prescribed following emergency admission, and to ensure the safe, effective and ethical approach to medication management

3.0 Scope

3.1 All health professionals involved in medication management

3.2 All residents admitted in an emergency situation

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Emergency admissions should not be considered routine practice: residents should only be admitted in an emergency where there is no other alternative

5.2 The resident's medical practitioner should be informed of their admission to the residential care unit, and be requested to assess the resident and prescribe the appropriate medication regime

5.3 Verbal or facsimile orders and the use of the resident's own medication may be required in exceptional circumstances to prevent a delay in the administration of medicines

5.4 Any changes to the medication regime during their admission should be conveyed to both the resident, their carers and their usual medical practitioner: an appropriate supply should be provided for the resident, or the responsible person accompanying them, as part of a comprehensive discharge procedure

6.0 Reference

6.1 British Geriatric Society (1995) *Acute Medical Care of Elderly People, BGS Best Practice Guide 3.1*, published 1995, revised 2004 http://www.bgs.org.uk/Publications/Compendium/compend_3-1.htm (accessed 12/05/09)

PROCEDURES MANUAL		
Section title:	**Supply of medication for administration by a resident while on leave of absence**	
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

Each resident is encouraged to exercise their choice and control to maximise their independence. Opportunities are given to enable residents to participate in activities outside of the residential care setting and these may require a leave of absence

2.0 Purpose

To ensure that the resident receives an adequate supply of medication to be consumed while on leave of absence

3.0 Scope

All nurses, residents and responsible persons accompanying residents on leave

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 The nurse on the day of the resident's departure has the responsibility for supplying the required amount of medication to the resident or the responsible person accompanying the resident

4.4 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 The capacity of the resident to self-medicate while on leave of absence from the residential care unit has been assessed

5.2 In the event of the resident being unable to self-medicate, the medication should be given to the responsible person accompanying the resident

5.3 Medication should be in the original container where possible. If this is not possible, the container must be clearly labelled with the resident's name, drug name, dose and time to be taken and warnings/cautionary labels should be attached

5.4 Written instructions are given to either the resident or the person accompanying the resident, indicating the dose of medication, the time the medication is to be taken, the route of administration and any other special instructions pertaining to the medication

5.5 In the case of supplying a resident's medication to a relative, the following general information should be given: prior to a relative administering medication, the resident should be given a glass of water. Tablets should be always be given with clear liquid such as water or other suitable medium such as yoghurt

5.6 The required amount of medication is given. An extra day's supply may be given in the event of a resident who may wish to extend the period of leave

5.7 The resident's leave of absence is documented in the medication administration record and in the daily progress notes

5.8 The nurse may supply a resident with a medicinal product when leaving the premises for an outing where they will not be present for the nurse to administer the medication at the prescribed time

5.9 The nurse must clearly document in the medication administration record the details of the supply, recording the time the medicine was supplied, the name of the resident, the name of the person accompanying the resident and the amount signed out

5.10 Consideration should be given to the further education and training required by any nurse involved in the supply of medicinal products

6.0 References

6.1 An Bord Altranais (2002) *Scope of Nursing and Midwifery Practice Framework*

6.2 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.3 Irish Medicines Board (Miscellaneous Provisions) Act, 2006

6.4 Medicinal Products (Prescription and Control of Supply) Regulations, 2003

Section 6

6.1 Supply and possession of MDA 2 & 3 drugs to and within residential care settings

PROCEDURES MANUAL		
Section title:	**Supply and possession of MDA 2 & 3 drugs to and within residential care settings**	
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
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1.0 Policy Statement

The nurse in charge of a residential care unit may be supplied with an MDA-2 or 3 drug, solely for the purpose of administration to residents in that residential care unit, on foot of a requisition issued to them in accordance with the directions of a medical practitioner

2.0 Purpose

To ensure that the supply and possession of MDA-2 & 3 drugs is in accordance with the directions of a medical practitioner

3.0 Scope

3.1 The Director of Nursing employed in the residential care unit

3.2 All healthcare professionals involved in the ordering, prescribing, supply, receipt and administration of MDA drugs

4.0 Roles and Responsibilities.

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in the management of MDA drugs must be aware of and comply with their legal and contractual obligations

4.4 Each healthcare professional involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Supply and possession is only permitted for MDA-2 & 3 drugs that are obtained on foot of a medical prescription. The prescription must:

- Be written legibly in black ink or otherwise so as to be indelible, dated and signed by the practitioner with their usual signature
- Specify the address of the person issuing it, except in the case of a GMS prescription
- Specify, in the prescriber's handwriting, the name and address of the person for whose treatment it is issued
- Specify, in the prescriber's handwriting (capital letters):
  - ✓ the brand name of the drug
  - ✓ dose to be taken(in both words and figures)
  - ✓ the form
  - ✓ the strength (where appropriate)
  - ✓ in both words and figures, either the total quantity of the drug or preparation or the number of dosage units to be supplied
  - ✓ in the case of a prescription for a total quantity intended to be dispensed by instalments, specify the quantity, the number of instalments and the intervals between instalments to be observed when dispensing

5.2 Validity of the prescription. An MDA prescription should be dispensed within 14 days of the date of the prescription. If the MDA drug is to be dispensed by instalments, no instalment should be dispensed after two months of the date of the prescription

5.3 All MDA drugs must be stored separately in a locked cupboard within a locked cupboard, secured to the wall and the keys kept on the person of the designated nurse

5.4 An MDA drugs register must be kept for the possession of MDA-2 drugs only. The MDA drugs register must contain details of MDA-2 drugs received including:

- ✓ name of drug
- ✓ dose/preparation
- ✓ date and time received
- ✓ amount received
- ✓ resident name
- ✓ prescribing doctor
- ✓ signature of nurse receiving the drug
- ✓ signature of nurse dispensing the drug
- ✓ running balance of each individual MDA-2 drug, counted at each log entry with two signatures
- ✓ residential care unit register of signatures

5.5 In the event of the MDA drugs being discontinued, the number of remaining drugs should be counted by two nurses, recorded in the MDA drugs register for MDA 2 drugs only and returned to the pharmacy for safe disposal

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

6.2 Medicinal Products (Prescription and Control of Supply) Regulations, 2003 as amended by the 2005 regulations

6.3 Misuse of Drugs Regulations 1988-2006

Section 7

PROCEDURES MANUAL		
Section title: Medication error		
Section No.: SOP	**Revision: 00**	**Page 1 of 3**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

Medication error is the most common type of error affecting resident safety and is the most common single preventable cause of adverse events. Medication errors and near miss events should be seen as opportunities to assess practices, identify what went wrong, learn from mistakes and institute changes to the medication system

2.0 Purpose

To encourage honest reporting of medication errors within a no blame culture provided local policies have been followed and there is evidence of this consideration

3.0 Scope

All healthcare professionals involved in medication management

4.0 Glossary of Terms and Definitions

4.1 **Medication errors:** Preventable events that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional or resident

4.2 **"Near miss" event:** a situation where the error does not reach the resident and no injury results

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 Each healthcare professional involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

6.0 Procedure

6.1 The nurse should establish that a medication error has occurred, and assess the level of error to indicate the action required, which will be one or more of the following:

- ➢ Emergency action involving resuscitation and possible transfer to the acute general hospital
- ➢ Continuing monitoring of residents clinical condition
- ➢ Remedial action indicated to avoid further error
- ➢ Single or on-going documentation error identified and corrected

The poisons unit in Beaumont Hospital (01) 8092566 can be contacted if necessary for further information and emergency guidance

6.2 Monitoring resident for vital signs checklist includes:

- ✓ Resident awake and responsive to simple command?
- ✓ Warm and well-perfused?
- ✓ Temperature, heart rate, respirations, blood pressure
- ✓ Pupils equal and reacting to light? NB may need to proceed to Glasgow coma scale where indicated
- ✓ Blood sugar level
- ✓ Colour and overall reaction of resident?

6.3 Contact the medical practitioner or call the ambulance according to the clinical status of the resident

6.4 Information relating to the circumstances of the medication error should include:

- ❍ List of current medication
- ❍ Details of medication error
- ❍ Any known allergies
- ❍ Previous medical history and current diagnosis
- ❍ Any recent medical interventions
- ❍ Current clinical status

This information should be transported to the hospital by the health care worker accompanying the resident

6.5 Staff should always contact the resident's next of kin where a resident needs to be transferred to hospital

6.6 Once the resident's safety has been established, senior management should be informed. A medication error report form should be completed and filed in the resident's record

6.7 There should be immediate and honest disclosure of all medication errors. Each error will require thorough and careful investigation, and will take full account of the circumstances and context of the event and the position of the nurse involved. The review of the medication should identify the stage at which the error took place, review all documentation, both review and interview all staff members involved, and check environmental and other resident-related factors

6.8 In the event of a "near miss" or omission a medication error form should be always be completed and reported to senior management without delay

7.0 References

7.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

7.2 Department of Health (2000) *An organisation with a memory*

7.3 Delaney, T (2004) *Experience with medication error reporting systems in an Irish hospital.* In OCED Health Care Quality Indicators Seminar on Improving Patient Safety Data Systems. June 29-30, 2006. Dublin

7.4 National Medicines Information Centre (2004) *Medication Safety* Vol.10 No.6

PROCEDURES MANUAL		
Section title: **Adverse drug event reporting**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

Although prescription drugs must meet certain safety standards before they are approved for the market, unexpected adverse drug events (ADEs) can occur after a drug is used in a larger population over a longer period of time. Reporting of ADEs in the residential care setting is thus a vital component of drug safety

Health care professionals should be aware of the indications for the medication's intended use for the resident, and have knowledge of the desired effect and potential undesirable effects of those medicines

2.0 Purpose

To report all adverse drug events to the Irish Medicines Board

3.0 Scope

3.1 All health care professionals involved in the ordering, prescribing, dispensing, delivery and receipt and administration of medication

3.2 All residents receiving medication in the residential care unit

4.0 Glossary of Terms and Definitions

A serious reaction:

A serious reaction is defined as one which is fatal, life threatening, results in persistent or significant disability or incapacity, and results in or prolongs hospitalisation

5.0 Roles and Responsibilities

5.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

5.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

5.3 All health care professionals including medical and dental practitioners, pharmacists and nurses are responsible for reporting suspected adverse reactions observed in any resident

5.4 All residents receiving medication in the residential care unit should be encouraged to report any unexpected adverse drug events or changes in their health status

5.5 Each nurse involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

6.0 Procedure

6.1 The residential care unit should hold a supply of ADE reporting forms

6.2 Staff should report all suspected adverse reactions to new medicinal products i.e. those available on the market for less than 2 years and any serious suspected reactions to established medicines

6.3 Staff should report any suspected increase in the frequency of minor reactions and any suspected reactions associated with the use of vaccines

6.4 The residential care setting should seek further advice on monitoring and reporting of ADEs from the Pharmacovigilance Department of the Irish Medicines Board 01-6764971

7.0 References

7.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

PROCEDURES MANUAL		
Section title: **Unexpected death of a resident**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
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1.0 Policy Statement

Following the death of a resident, all medication prescribed for that resident should be returned to the pharmacy for safe disposal. The only exception is where a death occurs suddenly or unexpectedly, or from a cause which is unknown or unclear or unnatural; the circumstances of these deaths must be reported to the coroner who will order a post-mortem (autopsy). In this instance, all medication should be stored securely within the residential care unit whilst awaiting further instruction by the coroner

2.0 Purpose

To provide a standardised approach to the management of medication following the unexpected death of a resident

3.0 Scope

All healthcare professionals who are involved in medication management

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

5.0 Procedure

5.1 Following the death of a resident, staff should establish whether or not a post mortem has been ordered

5.2 In the case of a post-mortem, all of the deceased person's current medication should be stored securely on site until further instructions are received

5.3 In the case of an expected death, all medications should be returned to the pharmacy for safe disposal

6.0 References

6.1 An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*

PROCEDURES MANUAL		
Section title: **Unauthorised removal of medication from the work place**		
Section No.: SOP	**Revision: 00**	**Page 1 of 2**
Issued by:	**Medication management working group**	**Date: 20/05/09**
Adapted for local use by:		**Date:**
Authorised by:		**Date:**

1.0 Policy Statement

Any member of staff working in the residential care unit will not self-medicate from the residential care setting's supply nor will remove any medication from the unit for their own personal use

It is not appropriate for a healthcare professional to ask a work colleague with prescriptive authority to write a prescription for them. Any healthcare professional who removes medication from their place of employment for personal use may be subject to employment disciplinary procedures and/or criminal charges. In addition, nurses may be subject to a fitness to practice inquiry by An Bord Altranais for professional misconduct

2.0 Purpose

To prevent the unauthorised removal of medication

3.0 Scope

All healthcare professionals working in the residential care setting

4.0 Roles and Responsibilities

4.1 The Director of Nursing should ensure the implementation and evaluation of all policies, procedures, protocols and guidance in a timely and structured manner and provide feedback on the associated audit outcomes to all staff

4.2 The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures, protocols and guidelines and that staff have undertaken appropriate programmes of education

4.3 Each healthcare professional involved in the administration of medication is expected to develop and maintain competence with regard to all aspects of medication management

4.4 Each healthcare professional is responsible for ensuring that no medication is removed from the residential unit's supply for personal use

5.0 Policy

5.1 Any healthcare professional who requires medication for a personal health condition should acquire it through appropriate means i.e. from a pharmacy or on foot of a prescription

5.2 It is not acceptable practice for any healthcare professional to remove or take medication from their workplace for personal use or for supplying for use by family, friends or significant others. This is applicable to all forms of medicinal products (e.g. prescription medication including analgesia, antibiotics, and non-prescriptive/over-the-counter medication)

6.0 References

6.1 An Bord Altranais (2007) Guidance to Nurses and Midwives on Medication Management

Section 8

Appendix 1

Compliance aids

Compliance aids are 'aids designed to help patients remember when to take their medication and to act as a visual prompt for carers that patients have taken their medication, or at least removed it from the medication system'

Non-compliance means medicines are not taken as they should be and can be attributed to:

- not knowing how to take the medication (such as orally, twice daily, with food etc)
- not understanding the importance of drug treatment in managing disease
- taking many drugs
- anticipation and experience of side effects
- forgetfulness
- impaired physical function

Simple measures can be taken to improve compliance

- educate residents about their disease and treatment
- simplifying drug regimens: minimising the number of drugs/ frequency of dose.
- using modified/controlled release preparations to decrease dosage frequency
- involving carers in the management of medication
- inform residents about side effects
- using drug diaries, calendars or medication charts
- using ordinary bottle tops instead of child resistant containers
- using large print or jumbo labels on containers
- using compliance aids, such as dose reminders for tablets and devices
- daily dose reminders and monitored dosage systems

A nurse who is considering the use of a medication compliance aid to facilitate self-administration of medicinal products by a resident should have regard to the following guidelines prior to implementation of the aid:

- the resident's individual requirements should be assessed to ensure there are no contraindications related to using the device
- the consent of the patient/client should be obtained
- the nurse employing such an aid in the practice of medication management is accountable for their actions. They should be competent in undertaking this activity
- consultation with the local pharmacist should be considered for guidance in supplying medicines in this manner

If a resident has a medication compliance aid on admission:

- the nurse should label the device with the resident's name, address, GMS number and place in resident's own drawer for collection
- inform the pharmacist that the resident uses a medication compliance aid and specify the type so it can be refilled if necessary
- if new medicines are added to the resident's regimen by their medical practitioner, the pharmacist will inform the medical practitioner and nursing home if they are unsuitable for the compliance aid

Medicines that are incompatible with blister packs include:

- buccal medication
- effervescent medication
- dispersible medication
- MDA Schedule 2/3 medication

It is important to note that medicines should not be kept in sealed monitored dosage systems for more than eight weeks. They should be stored in a cool, dry, place, protected from sunlight, and kept away from children as most of these devices are not child resistant

	Compliance Aid/feature:	**Skills resident must have to use aid effectively:**
	**Medication list** **(text only)**	• Adequate vision • Able to read • Able to recognise and monitor time • Able to match written word to time drug, and task
	**Medication schedule** **(illustrated drug + time)**	• Adequate vision • Able to read OR • Able to match word, picture, or pill to actual drug • Able to match written word or picture to number of pills and time of day and task • Able to monitor time
	**Pill box**	• Adequate vision and fine motor skills • Able to read OR • Able to match word or picture on box to day of week, time of day, etc. • Able to monitor time of day

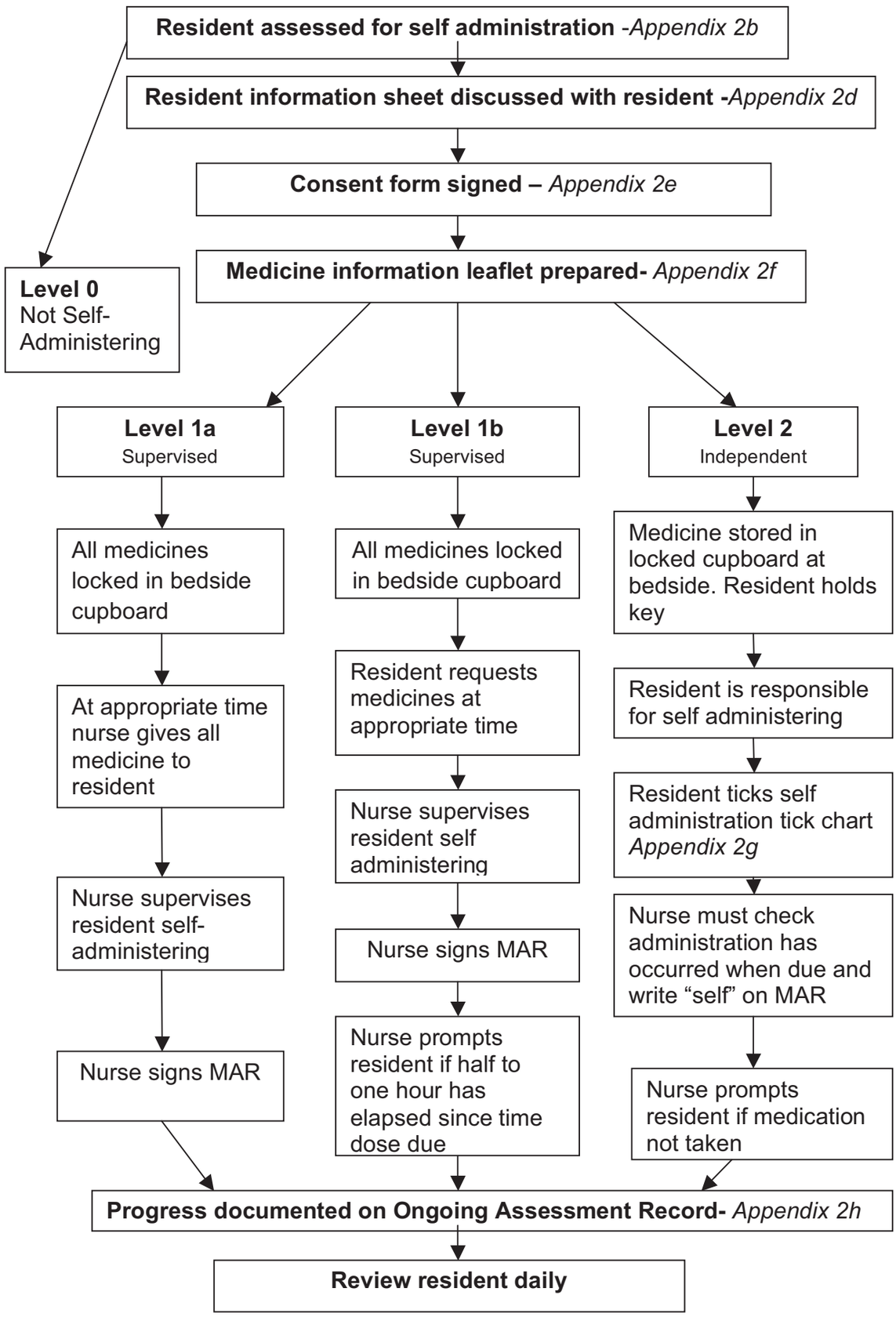
	Compliance Aid/feature:	Skills resident must have to use aid effectively:
	**Compliance packaging:** **(i.e., blister packs-nomad /medisure/manrex)**	• Adequate vision and fine motor skills • Able to read OR • Able to match word, picture on pack to number of pills and time of day
	**Medication alarm** **(illustrated drug + time)**	• Adequate hearing to recognise auditory alarm OR • Adequate vision and access to recognize visual cue • Able to match alarm to drug and task • Able to access and take drugs once reminded
	**Recorded Message**	• May require resident to initiate message playback • Adequate hearing to detect auditory message • Able to match spoken word to object/task
	**Telephone Reminder**	• Adequate phone access & use (auditory or adapted means) • Able to match instruction to drug and task • Message length/complexity must be within patient's processing capacity
	**Automated Dispensing**	• Adequate hearing to recognise auditory alarm OR • Adequate vision and access to recognise visual cue • Able to match alarm to task

References

Atkin, P.A and Ogle, S.J (1996) *Issues of medication compliance and the elderly*. Adverse drug reactions and toxicology review: 15, 109-118

Cook, P.F. (2001) *Methods for assessing medication compliance*: *research summary*

Appendix 2a **Self Administration of Medicines Flow chart**



Appendix 2b Self-Administration Assessment Form

Residents name _____ Date _____

DOB _____

	Question	**Yes/ No**	**Action to be taken**	**Comments and issues raised and action to be taken/ interdisciplinary team involvement**
1	Is the medicine regime relatively stable?		Should not self-administer rapidly changing regime until more stable. Discuss with medical practitioner	
2	Has the resident been given the Resident Information Leaflet and had it explained?			
3	Does the resident understand what is involved and their responsibilities?		Explain again using the Resident Information Leaflet	
4	Is the resident willing and motivated to self-administer?		Aim to improve motivation	
5	Does the resident understand the dosage instructions and how to take the medicine?		Discuss with resident using a Medicines Information sheet and other aids if necessary	
6	Are there any other reasons why the resident is unable to self-administer?		Please state reasons and actions to be taken. Refer to interdisciplinary team	
7	Is the resident confused, or disoriented to time and place?		Resident may need to self-administer if need to take own medicines on discharge. Refer to interdisciplinary team	

Question		Yes/ No	Action to be taken	Comments and issues raised and action to be taken/ interdisciplinary team involvement
8	Is the resident depressed, suicidal or have cognitive impairment?		Need to assess benefits of self-administration against the risk. Refer to interdisciplinary team	
9	Does the resident have history of drug abuse or alcoholism?		Need to assess benefits of self-administration against the risk. Refer to interdisciplinary team	
10	Would the resident self-administering their medicines present any foreseeable risk to other residents in the residential care unit?		Steps need to be taken to resolve risk and reassess. Refer to interdisciplinary team	
11	Can the resident read and understand the instructions on the label well enough to be safe?		Contact pharmacy for advice on large print labels or discuss with pharmacy for other visual aids	
12	Can the resident open child resistant caps?		Request screw caps for bottles	
13	Can the resident open bottles or boxes?		Discuss with pharmacy	
14	Can the resident remove tablets from the blister pack?		Discuss with pharmacy	
15	Can the resident pour out liquid doses or dissolve tablets in water?		Review medication. Discuss with pharmacy or Doctor.	
16	Can the resident open the cupboard/ drawer?		Discuss with pharmacy	

	Question	Yes/ No	Action to be taken	Comments and issues raised and action to be taken/ interdisciplinary team involvement
17	Can the resident safely look after the key?		Consider risks to others and discuss with pharmacist.	
18	Can the resident access their medicines at appropriate times and frequency?		E.g. Parkinson's/ asthma. Discuss with pharmacy	

Assessed by (nurse, Print Name): _____ Date_____

Levels

0 Resident not Self-Administering

1a Resident Self-Administers the medicines with full supervision

1b Resident requests medication from the nurse at the appropriate time

2 Resident administers medicine without supervision

Level of Self-Administration on first assessment:

	Tick	Sign and date		Tick	Sign and date
Level 0			**Level 1b**		
Level 1a			**Level 2**		

Daily assessment of self-administering residents must be recorded on the Ongoing Assessment Record

Appendix 2c **Self-Administration Scheme Care Plan**

Resident Name_____ GMS Number _____

Aims:
• For the resident to be able to safely administer his or her own medication
• To understand the purpose, dose and side effects of their medication

	Action	**Sign & Date**
1	Assess resident on admission using Self administration assessment form *(Appendix 2b)*	
2	Give the resident information leaflet on Self-Administration (*Appendix 2d*), discuss and obtain resident consent (*Appendix 2e*)	
3	Ensure resident prescription chart has been reviewed, simplified and is stable and has been checked by a pharmacist	
4	Document on prescription chart that resident is self-administering	
5	Ascertain *any* special needs for self-administration *e.g.* Large print labels and refer to pharmacist	
6	Complete medicine information sheet *(Appendix 2f)* and discuss with resident	
7	Complete and demonstrate the Self-Administration Tick Chart for residents on Level 1b and 2 *(Appendix 2g)*	
8	Re-assess at monthly intervals and document on ongoing Assessment Record (*Appendix2h*)	
9	For Level 2: Issue the key to the resident for the cupboard/ drawer – agree safe method of custody	
11	Changes in medication communicated to resident. Medicines Information Sheet (*Appendix 2f*)and Resident Tick Chart (*Appendix 2g)* updated	

Appendix 2d

Resident Information Sheet on Self-Administration of Medicines

The self-administration scheme is designed to help you understand why you are taking your medicines.

If you self-administer in the residential care unit, the nurse will give you as much information, help and support as you need.

Before starting, the nurse will explain:

- What self-administration of medicines is about
- What medicines you are taking and why you are taking them
- The dose and how and when to take your medicines
- Any side-effects that you should know about

Self-administration is not compulsory, and you must not feel that you have to take part, even if asked. If you agree to participate, the nurse will ask you to sign to say that you agree to take part, but you can change your mind at any time.

Your own medicine will be kept in a locked cupboard by your bed.

The medicine will be given to you at the correct times for you to select and take according to the instructions on the label.

You will be given a medicine information sheet as a reminder of the times and doses of your medicines.

When you are taking your medicines independently, you may be given your own key for your cupboard or drawer.

If you are looking after your medicines yourself you should:

- Keep your medicines locked in the cupboard/ drawer at all times except when you are taking your dose and keep your key safe
- Tick on the self-administration chart so the nurse can see what you have taken
- Let the nurse look at your medicines regularly, so they can monitor your progress
- Do not take more tablets that you have been told to
- If you forget what medicines you have taken, tell your nurse immediately
- Tell the nurse if anything is unclear or anything is missing or running out
- Do not take any medicines that are not written on your chart
- Do not allow other residents or visitors to use your medicines

If you have any questions or need any help, ask any member of the nursing staff

Appendix 2e

Resident consent to take part in self-administration of medicines

Resident Name: _____

DOB: _____

The self-administration scheme has been fully explained to me and I have read and understand the resident information sheet.

I wish to take part in self-administration scheme.

I understand that I can withdraw from it at any time.

I understand that I can be withdrawn from the scheme by a nurse or doctor at any time and the reasons for this will be explained to me.

Resident Signature: _____

Date: _____

Nurse: _____

Appendix 2f Medicine Information Sheet

This sheet shows all medicines prescribed by the doctor and how and when to take them.

- Please check with your doctor before taking any medicines not on this list
- Do not take any extra medicines that you can buy yourself without asking the doctor or pharmacist.

Name, strength and form of medicine	Reason for taking the medicine	When and how many to take				Special directions and other instructions you need to know
		Morning	Lunch	Evening	Bedtime	

Refer to Resident Information Leaflet or ask you doctor or pharmacist if you have any questions.

Prepared by: **Checked by:** **Discussed with resident (sign/ date)**

Appendix 2g **Self-Administration Resident Tick Chart**

Resident Name: _____ **DOB:** _____

After you have taken your medicines, tick beside the medicine and time on the record chart. Use your resident information sheet to h
you to take them correctly. If you have any problems or need help please ask the nurse.

Pharmacy quantity date	Medicine and strength	Document amount to take and when	Date and time medicines taken																																			
		Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea	Bedtime	Breakfast	Lunch	Tea

Chart Prepared By: _____ Checked By: _____ Date: _____

Appendix 2h **Ongoing Assessment Record**

Resident Name _____ Room no. _____

Date / Time	Current Level	Comments	New Level	Signature

Levels

0 Resident not Self-Administering

1a Resident Self-Administers the medicines with full supervision

1b Resident requests medication from the nurse at the appropriate time.

2 Resident administers medicine without supervision

ADVERSE REACTION REPORT FORM

IN CONFIDENCE

(FOR COMPLETION BY HEALTH PROFESSIONALS)
PLEASE SEND TO: -
FREEPOST
PHARMACOVIGILANCE UNIT
IRISH MEDICINES BOARD
EARLSFORT CENTRE
EARLSFORT TERRACE
DUBLIN 2
Telephone: 353-1-6764971
Fax: 353-1-6762517

REPORTERS NAME & ADDRESS:

AREA OF SPECIALITY:

E-mail: IMBPHARMACOVIGILANCE@IMB.IE

Patient Name/Initials/ID No:		Sex: M F
Age/D.O.B.	Weight: (if known)	Pregnancy: Y N (If yes, state gestational age at time of exposure)
Indication for Use:		
Suspect Drug:	Daily Dose:	Duration of Treatment:
Suspected Reaction: (Brief description of the toxic effects or side effects)		
Onset of Reaction: (Date)	Duration of Reaction:	
Any other drugs used over this period? (Please state below)		
Drug	Daily Dose	Indication for Use:
Recovery from Side Effects: Complete Continuing Fatal		
Drug Discontinued: Y N	Drug Rechallenge: Y N	
Supply of Report Cards Required: Y N		

Signature: _____ Date: _____

Thank you for taking the time to complete this form

Special considerations when prescribing drugs for older people in residential care

Checklist when prescribing

The prescriber should always write clearly when prescribing, using un-joined lower case text or block capitals

Medication should be prescribed using the approved (generic) name, except in the case of multi-ingredient preparations and modified release formulations when the brand name must be used. Drug names should never be abbreviated under any circumstances

Doses

The following table indicates units which may be abbreviated:

Approved abbreviation	***Unit***
mg	Milligram
g	Gram
kg	Kilogram
kcal	Kilocalorie
mmol	Millimole
ml	Millilitre
L	Litre

Never abbreviate the following: International Units, Micrograms, Nanograms, Units

Decimal points

- Never use a decimal point before a trailing zero e.g. 5mg is correct; not 5.0mg
- Always use a whole zero before a decimal when the dose is less than a whole unit e.g. 0.5ml not .5ml
- The use of the decimal is only otherwise acceptable to express a range e.g. 0.5 to 1mg

Frequency of administration

- Always specify the dose and frequency

In the case of preparations to be administered “as required” or “PRN”, always specify the specific dose and the minimum dose interval e.g. Paracetamol tablets 500mg 2 every 6 hours PRN

For acute behavioural problems, the prescription for any psychotropic medication should be written up on a PRN basis. After 72 hours the resident should be reviewed and the prescription either discontinued or re-written on a regular basis

The exception to this is in the maintenance of an anti-emetic drug as a PRN prescription

- Directions must generally be in English without abbreviations (exceptions are given in the table below)

Acceptable Latin terms and abbreviations:

Latin Terms and Abbreviations	**English Meaning**
AC	Before food
BD	Twice daily
MANE	In the morning
NOCTE	At night
PC	After food
PRN	When required
QDS	Four times daily
STAT	Immediately
TDS	Three times daily

In the case of drugs that are being prescribed at particular hourly frequencies, the only acceptable ways of writing these are:

- 12 hourly
- twelve hourly
- every 12 hours
- every twelve hours

No other abbreviation or Latin terms should be used unless agreed by the Director of Nursing and the Medical Practitioner and included in the local policy for specified reasons

Medication Review Form

Resident Name				Date of review:	
GMS Number				Page	
Date of Birth		Weight		Next review due:	
Allergy					

Medication History				**Medication Problems Identified**	**Plan of Action**
Medication (generic/ brand name and strength	Prescribed dose/ frequency	Actual dose/ frequency/ method of use	Treatment goal (reason for medication)	Record type of problem and any additional information required 1. Drug-drug interaction 2. Drug-disease interaction 3.Contraindication for one (or more) drugs 4. Evidence of an adverse drug event/side effect of a drug 5. Need for review of appropriateness of drug selection 6. Need for review of dose/frequency 7. Concordance/compliance problems 8. Problems with the safe administration of drug 9. Need for investigations 10. Other 11. None	Record decision made and additional information required 1. None 2. Discontinue a medication 3. Increase dose 4. Reduce dose 5. Substitute an alternative drug 6. Discuss drug regime with resident 7. Discuss side effects with resident 8. Continue 9. Other

Signature of Medical Practitioner: _____ Signature of Pharmacist: _____ Signature of Nurse: _____

Medicines that cannot be crushed

FORMULATION	NOTES AND ABBREVIATIONS	REASON FOR NOT CRUSHING	COMMON EXAMPLES
MODIFIED RELEASE	Identified by the following on original packaging of medication: 1. MR/ XL (denote Modified Release) 2. LA (Long acting) 3. SA (Sustained Action) 4. CR (Controlled release) 5. SR (Sustained Release) 6. 'Retard' or 'Slow Release' indicate modified release	These are designed to release their contents over an extended period of time, typically 12 to 24 hours. If the tabs are crushed the medicines will be absorbed in a much shorter period, perhaps 1-2 hours. This will lead to increased toxicity as a full days dose is absorbed in 1-2 hours resulting in topic peaks and low troughs	MST Continus (Morphine Sulphate) Priadel Tablets (Lithium Carbonate) Distaclor LA (Cefaclor)
ENTERIC COATED	Usually identified by the two letters EC (Enteric coated) on original packaging	Formulated to pass through the stomach intact. The coating maybe used to protect the stomach against local toxicity or it may be used to ensure the medicine is released at the correct site for absorption or action. Therefore crushing the drug may increase toxicity or reduce effectiveness. Also enteric coatings are very hard to crush and may cause tube blockage	Caprin (aspirin) Naprosyn (Naproxen) Bisacodyl (Dulcolax)
HORMONAL CYTOTOXIC STEROIDAL	A risk assessment form should be completed if the drug is to be crushed before administration	Crushing may cause the release of aerosolised particles which could potentially harm staff. There is always the risk of sensitisation or anaphylaxis in susceptible individuals	Tamoxifen (Tamox) Methotrexate Dexamethasone Prostaglandin Inhibitors (Misoprostol)
BUCCAL OR SUBLINGUAL TABLETS	This route can be used as an alternative to the oral route	Designed to avoid the gastrointestinal tract and metabolism via the liver. Crushing the drug will allow it to go through the gastro-intestinal tract and it maybe removed by metabolism in the liver	Prochlorperazine (Buccastem)
NITRATE TABLETS	Risk assessment form requires completion if the drug is to be crushed before administration	Concerns raised over potential explosive nature	Glyceryl trinitrate Isosorbide mononitrate (Imdur, Isomonite) Isosorbide dinitrate

Specific drugs and guidelines for administration via enteral feeding tubes

Please Note: Information listed in this table is for guidance only and may be subject to review. Always check the most recent BNF or SPC for each product. This list is not exhaustive

DRUG	INFORMATION FOR USE VIA NG/PEG
ACICLOVIR (Zovirax®)	200mg & 800mg dispersible tablets available.
AMINOPHYLLINE (Phyllocontin continus®)	Consider changing to THEOPHYLLINE (see advice below).
AMIODARONE (Cordarone®)	Crush tablets and mix with water for administration via enteral feeding tube.
ANTACIDS (Gaviscon®, Maalox®)	For antacids containing aluminium, magnesium or calcium, stop feed for 1hr before and 1hr after administration as antacids may bind to components of the feed and impair absorption.
ASPIRIN (Nu-Seals®, Disprin®)	75mg dispersible tablets available. DO NOT USE Caprin® or Nu-Seals®.
ASPIRIN + DIPYRIDAMOLE (Asasantan Retard®)	Open capsule, discard mini aspirin tablet & give micro-granules via tube without crushing them. The aspirin may be replaced an additional 75mg dispersible tablet once daily.
BACLOFEN (Lioresal®)	Lioresal® liquid 5mg/5ml available.
BISOCODYL (Dulco-Lax®)	10mg suppositories available. DO NOT CRUSH tablets as they are enteric coated.
BISPHOSPHONATES: e.g. Alendronate Na^+ (Fosamax®) Risedronate Na^+ (Actonel®)	DO NOT CRUSH tablets due to risk of oesophageal irritation. Consider temporary discontinuation of therapy ***or*** Strontium ranelate (Protelos®) 2g sachets available. Stop feed for 2 hrs before and 2hrs after administration to avoid impaired absorption.
CARBAMAZEPINE (Tegretol®)	Tegretol® liquid 100mg/5ml available. Dilute in an equal volume of water before administration. Contains sorbitol. If changing from retard formulation to liquid preparation, give an equal total daily dose but increase the frequency of administration: e.g. MR tabs 400mg BD = Liquid 200mg QID ***or*** 125mg & 250mg suppositories available. Licensed for short term use only: max 7-days. NOTE: 100mg PO = 125mg PR. Stop feed for 2 hrs before and 2hrs after administration to avoid impaired absorption. Monitor carbamazepine levels
CEFUROXIME (Zinnat®)	**DO NOT USE ZINNAT SUSPENSION** as it may be too viscous to administer via fine bore tubes. If enteral tube ends in stomach, disperse tablets in water and administer immediately via tube. Do not administer via enteral feeding tubes ending in jejunum as absorption is reduced.
CHLORPHENIRAMINE (Piriton®)	Promethazine (phenergan®) 5mg/5ml elixir available.
CHLORPROMAZINE (Clonactil®)	25mg/5ml elixir available.

CIPROFLOXACIN (Ciproxin®, Truoxin®)	Consider alternative antibiotic. Seek pharmacy or microbiology advice if necessary. Tablets may be dissolved with STERILE WATER for administration via enteral feeding tube. Enteral Feed DELAYS but does not decrease absorption. Feed should be stopped for 1 hr before and 2 hrs after administration to avoid delayed absorption.
CITALOPRAM (Cipramil®)	Cipramil® drops 40mg/ml available.
CLARITHROMYCIN (Klacid®)	Change Klacid LA® 500mg tablets to Klacid® suspension 250mg/5ml BD. Flush tube with WARM water after administration to prevent clogging.
CLODRONATE SODIUM (Bonefos®)	Capsules may be opened for administration via enteral feeding tube. Avoid calcium containing preparations (e.g. antacids & milk) to reduce risk of impaired absorption.
CO-AMOXICLAV (Augmentin® & Augmentin Duo®)	Change Augmentin Duo® 625mg BD to Augmentin Duo suspension® 10 mls BD and dilute each dose with a further 10mls of water. Total volume to be administered is then 20mls per dose.
DIAZEPAM (Valium®, Anxicalm®)	Use 5mg rectal tubes if possible. Doses administered rectally and orally are equivalent. DO NOT USE oral liquid via enteral feeding tubes due to absorption into plastic tubing. Tablets can be crushed and flushed through the enteral feeding tube.
DIGOXIN (Lanoxin PG®)	Lanoxin® 50 microgram/ml elixir available. DO NOT DILUTE. Dose adjustments may be necessary due to different bioavailabilities of various formulations. Monitor plasma digoxin levels. Absorption may be affected by high fibre feeds (e.g. jevity). Avoid such feeds for 2 hrs before and after administration of digoxin.
DILTIAZEM (Tildiem®, Dilzem®, Adizem®)	Convert to non modified release formulation (Tildiem®), crush tablets, give total daily dose IN THREE DIVIDED DOSES ***or*** Consider changing to a different calcium channel blocker, or another agent. DO NOT CRUSH modified release preparations.
DOMPERIDONE (Motilium®, Domerid®)	Motilium® 1mg/ml suspension ***or*** 10mg, 30mg & 60mg suppositories available.
DOXAZOSIN (Cardura®, Cardura XL®)	Disperse standard release Cardura® 1mg & 2mg tablets in STERILE WATER. DO NOT USE TAP WATER. DO NOT CRUSH CARDURA 4mg & 8mg XL® TABLET.
ERYTHROMYCIN (Erymax®, erythroped®, Zineryt®)	250mg/5ml liquid available.
ESOMEPRAZOLE (Nexium®)	Nexium® tablets can be dispersed in water for administration to enteral feeding tubes. Pellets remain after dispersion-DO NOT CRUSH.
ETIDRONATE (Didronel®)	Dissolve and administer tablet immediately. Stop feed 2 hours before and after administration to avoid interactions with feed.
FERROUS SULPHATE (Ferrograd®) FERROUS FUMARATE (Galfer®)	Galfer® (ferrous fumarate) liquid iron preparation available. 5ml galfer® = 45mg elemental iron.

FLUCLOXACILLIN (Floxapen®)	Floxapen® syrup 125mg/5ml or 250mg/ 5ml available. Feed should be stopped for 2 hrs before and 1hr after each administration as food affects bioavailability. If this is not possible, prescribe parenterally or prescribe an alternative antimicrobial to which the infection is sensitive. Seek pharmacy or microbiology advice if necessary.
FLUOXETINE (Prozac®)	Prozac® liquid 20mg/5ml available.
FOLIC ACID	Tablets can be crushed and mixed with water for administration via enteral feeding tube. 2.5mg/5ml liquid unlicensed but available from the pharmacy.
FRUSEMIDE (Lasix®, Fruside®)	20mg/5ml liquid unlicensed but available from the pharmacy.
FUSIDIC ACID (Fucidin®)	250mg/5ml suspension available. INCREASE DOSE BY 50%.
GABAPENTIN (Neurontin®)	Open capsule, dissolve contents in a small amount of water and use immediately due to limited stability in water.
GLICLAZIDE (Diamicron® and Diamicron® MR)	Crush standard release tablets and mix with water for administration via enteral feeding tube. DO NOT CRUSH diamicron MR® tablets.
HYDROCORTISONE (Hydrocortone®)	Crush tablets and mix with water for administration via enteral feeding tube. DO NOT CRUSH CORLAN PELLETS.
HYOSCINE BUTYL BROMIDE (Buscopan®)	20mg/ml injection available to be given via NG tube. DO NOT CRUSH tablets.
HYOSCINE HYDROBROMIDE (Kwells®)	Transdermal patch (scopoderm®) unlicensed but available from pharmacy.
ISONIAZID	50mg/5ml liquid available. Stop feed 2 hrs before and after administration.
ISOSORBIDE MONONITRATE (Elantan®, Imdur®)	10mg & 15 mg GTN Patches available. Standard release tablets can be crushed and dispersed in water for administration via enteral feeding tube.
LACTULOSE (Duphalac®)	Diluted with water for administration via enteral feeding tube. If dose is administered via NJ or PEJ tube dilute lactulose with 3 times its volume of sterile water.
LANSOPRAZOLE (Zoton®)	Give orally where appropriate and allow to dissolve on the tongue. or Disperse Zoton fastabs® in water for administration via enteral feeding tube.
LEVODOPA (Madopar®)	62.5 mg & 125mg Madopar® dispersible tablets available. Dosage adjustment may be necessary. Seek pharmacy advice if necessary.
LEVO-THYROXINE (Eltroxin®)	Crush tablets and mix with water for administration via enteral feeding tube. Avoid feed formulas containing soybeans due to increased faecal elimination.
	Monitor thyroid function tests if clinically indicated.
LITHIUM (Camcolit® Priadel®)	Priadel® (lithium citrate) 520mg/5ml liquid available. 200mg lithium carbonate = 509mg lithium citrate. Different preparations may vary widely in bioavailability. Seek pharmacy advice if necessary. Monitor plasma lithium levels.

LOPERAMIDE (Imodium®)	Imodium® syrup 0.2mg/ml available. DO NOT DILUTE.
METOCLOPRAMIDE (Maxolon®)	Maxolon® syrup 1mg/ml available.
METRONIDAZOLE (Flagyl®)	Crush tablets for administration via enteral feeding tube. DO NOT USE Flagyl® suspension as it causes diarrhoea.
MISOPROSTOL (Arthrotec®, Cytotec®)	Dangerous to crush tablet as this may be hazardous. Consider switching to alternative drug available in liquid or parenteral formulation (e.g. Ranitidine 150mg/10ml). Tablets can be dispersed in water for immediate administration via enteral feeding tube.
MORPHINE (MST continus®)	MST continues suspension available as sachets of granules (20mg, 30mg, 60mg, 100mg & 200mg) to be mixed with water for administration via enteral feeding tube. DO NOT CRUSH MST tablets
MORPHINE (Sevredol®)	Oramorph liquid 10mg/5ml & 30mg/5ml available.
NIFEDIPINE (Adalat®, Adalat LA®, Adalat Retard®)	*Sustained release preparations e.g. Adalat Retard®, Adalat LA® must NEVER be crushed.* Adalat® capsules: **Flush line with normal saline.** Remove liquid from Adalat® capsule via a syringe and give immediately via the enteral feeding. Flush line once again with normal saline. Nifedipine is poorly soluble in water. Nifedipine is very short acting; if long acting preparation is substituted with short acting preparation side-effects (e.g. hypotension) may occur. Tablets are light sensitive and should be given immediately via enteral feeding tube as tablets degrade rapidly once crushed. Consider changing to a long acting calcium antagonist (e.g. amlodipine) if clinically appropriate
NIMODIPINE (Nimotop®)	Crush tablets down to a fine powder and mix with water. Tablets are light sensitive and should be given immediately via enteral feeding tube as tablets degrade rapidly
OLANZAPINE (Zyprexa®)	Orodispersible tablet (Velotab®) may be placed under the tongue and allowed to dissolve, if appropriate, otherwise consider alternative agent.
OMEPRAZOLE (Losec®)	Switch to ESOMEPRAZOLE (Nexium®) or LANSOPRAZOLE (Zoton®). See above.
OXYBUTININ (Cystrin®, Ditropan®)	Ditropan® elixir 2.5mg/5ml available. DO NOT CRUSH modified release tablets.
PANTOPRAZOLE (protium®)	Switch to ESOMEPRAZOLE (Nexium®) or LANSOPRAZOLE (Zoton®). See above.
PARACETAMOL (Panadol®, Maxilief®)	500mg soluble tablets available. May contain high levels of sodium. 500mg & 180mg suppositories available.
PAROXETINE (Seroxat®)	Seroxat® 2mg/ml liquid available. Dilute with an equal volume of water before administration.
PHENOXYMETHYLPENICILLIN/ PENICILLIN V (Calvepen®,	KOPEN® & CALVEPEN® 250mg suspensions available. Absorption is unpredictable 30-80%.
PHENYTOIN (Epanutin®)	Epanutin® 30mg/5ml oral suspension is available. Mix with an equal volume of distilled water to minimise adsorption to tube and to
POTASSIUM CHLORIDE [KCL] (Slow-K®)	Sando-K® effervescent tablets (12 mmol K+/tab) or
PREDNISOLONE (Prednesol®)	Prednesol® 5mg soluble tablets available.
PREGABALIN (Lyrica®)	Capsules can be opened and the contents dissolved in water for administration via enteral feeding tube.
PROCHLORPERAZINE(Stemetil®)	5mg & 25mg suppositories available.
PROPRANOLOL (Inderal LA®)	Inderal LA® capsules can be opened and granules flushed down the enteral feeding tube.

QUINOLONE ANTIBIOTICS:	Note: The information provided below is relevant for ALL quinolone antibiotics (i.e. it is a "class effect").
RABEPRAZOLE (Pariet®)	Switch to ESOMEPRAZOLE (Nexium®) or LANSOPRAZOLE (Zoton®). See above.
RANITIDINE (Zantac®)	150mg/10ml syrup available.
RIFAMPICIN (Rifadin®)	100mg/5ml liquid available. Stop feed for 2 hours before and ½ hour after administration.
SALBUTAMOL (Ventolin®)	Give by inhalation if possible. 2mg/5ml liquid available.
SENNA (Senokot®)	Senokot® syrup 7.5mg/5ml available.
SODIUM VALPROATE (Epilim®)	Epilim® liquid 200mg/5ml available. Epilim® tablets (crushable) 100mg can be crushed. Do not crush enteric coated, "CR" or chrono tablets
SOTALOL (Sotacor®)	Tablets can be crushed and mixed with water for immediate administration via enteral feeding tube. Food decreases absorption by 20%.
SUCRALAFATE (Antepsin®)	Not suitable for administration through enteral feeding tubes. May bind to protein in feed and has been associated with oesophageal benzoar formation. Consider alternative drug (e.g. proton pump inhibitor such as lansprazole (zoton®).
TEMAZEPAM (Nortem®)	Euhypnos® 10mg/5ml liquid available.
THEOPHYLLINE (Nuelin®, Slo-Phyllin®, Uniphyllin®)	Calculate the daily dose of theophylline & multiply by 1.1. Administer the total daily dose as Nuelin® liquid 60mg/5ml in THREE DIVIDED DOSES. Ideally the feed should be held for 2 hrs pre and 1 hr post dose. Patients should have symptoms and theophylline levels monitored.
VENLAFAXINE (Efexor®, Efexor® XL)	Efexor® 75mg &150mg **XL CAPSULES** can be opened; mix the powder with water and give via the enteral feeding tube. Efexor® 37.5mg and 75mg **TABLETS** can be crushed, but must be given immediately via the enteral feeding tube.
WARFARIN	Tablets can be crushed and mixed with water for administration via enteral feeding tube. Adjust warfarin dose in response to INR (may vary depending on the vitamin K content of an enteral feed).

Reference:

Holland, D (2008) *Administration of drugs via enteral feeding lines.* HSE Dublin Mid-Leinster Pharmacy Department Guideline

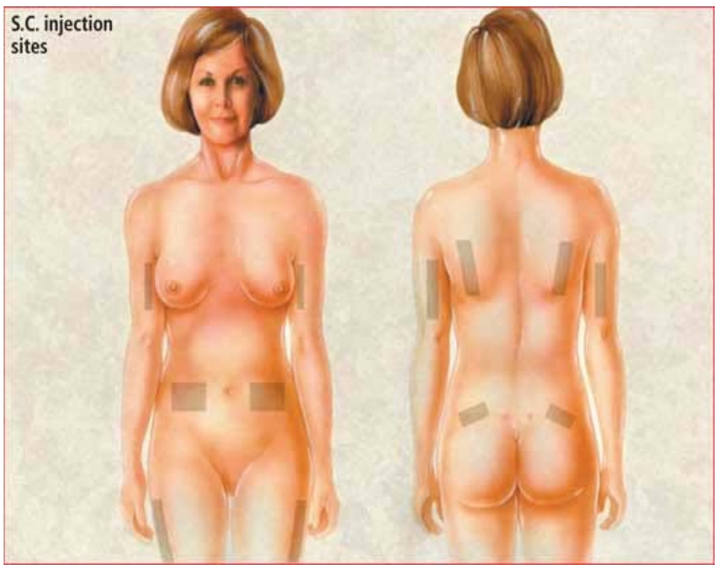
Guidance notes for subcutaneous and intramuscular injections

Subcutaneous Injections

Sucutaneous injections are administered beneath the epidermis into the fat and connective tissue underlying the dermis. Injections are given with a 25 G needle, at a 45 degree angle. Insulin syringes now have shorter needle lengths and therefore should be given at 90 degree angles. Gently pinching the skin prior to administration lifts the adipose tissue away from the underlying muscle. A slow steady injection rate promotes comfort and minimises tissue damage

Recommended sites for subcutaneous injection:

- ✓ Abdomen – umbilical region
- ✓ Lateral or posterior aspect of the lower part of the upper arm
- ✓ Thighs – under the greater trochanter rather than mid-thigh
- ✓ Buttocks



Intramuscular Injections

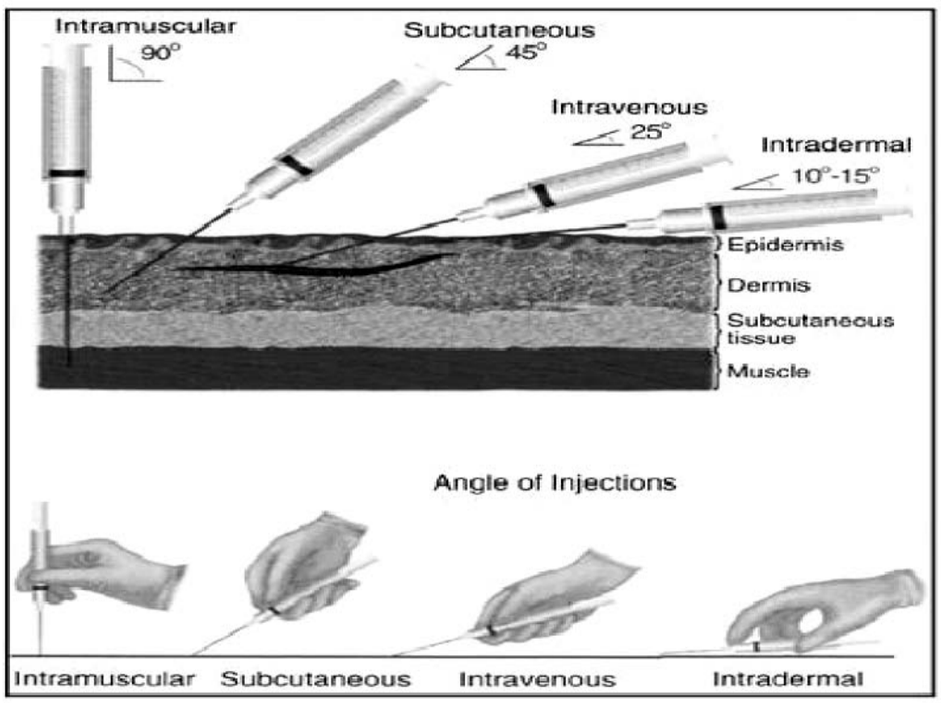
Intramuscular injections should be given into the densest part of the muscle. This route of administration provides rapid systemic action and absorption of relatively large doses. Needle length will be determined by the site chosen, the resident's muscle mass, the amount of subcutaneous fat and the resident's weight. The injection site is critically important because the medication effect can be enhanced or diminished depending on the site of injection. Each site has a maximum volume which is tolerable therefore for injections of more than the recommended volume, the dose should be divided between two or more sites. Two or more medicinal preparations cannot

be given via the same needle at the same site. Ensure a new site is 2.5cm away from the previous puncture site. All intramuscular injections should be given at a 90 degree angle

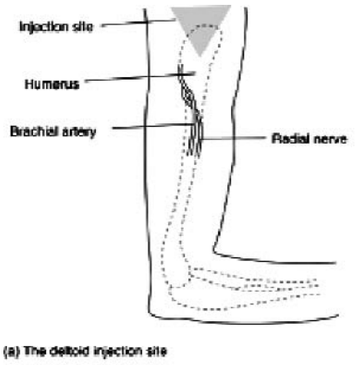
Complications of intramuscular injections

- Leakage: medication loss and poor absorption, if not “Z” tracked
- Fibrosis and muscle contracture: resulting mainly from multiple intramuscular injections into one muscle
- Abscess and granuloma formation: these are nodules of liquefied fat, where the intramuscular injection doesn't reach the muscle or there is back flow of medication
- Necrosis: severe cellular trauma in muscles, leading to cell death, due mainly to the toxicity of medication, dependent on the volume injected and the speed at which the injection is given
- Nerve and vascular injuries (palsies and paralysis): sciatic, femoral, radial and axillary nerve injury and accidental intra-arterial injection into the gluteal arteries.
- Local discomfort and redness at the site. Often from incorrect administration

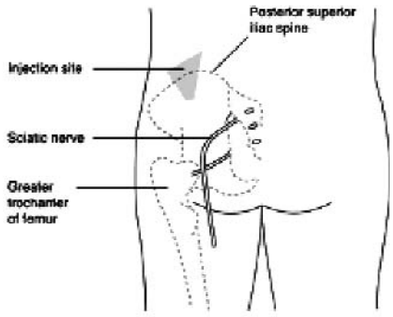
Recommended Angles for Injections:



Recommended sites for intramuscular injection:



(a) The deltoid injection site

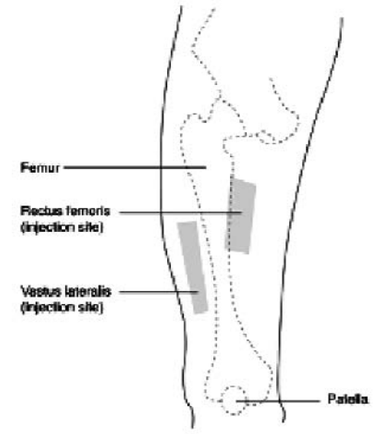


(b) The dorsogluteal injection site

Ventrogluteal site

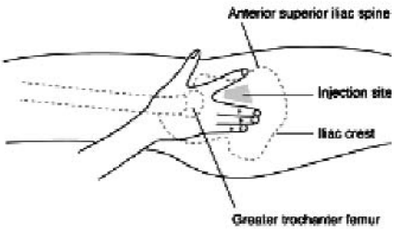
Mid-deltoid site

Dorsogluteal site



(c) The rectus femoris and vastus lateralis injection sites

Vastus lateralis site



(d) The ventrogluteal injection site

Rectus femoris site

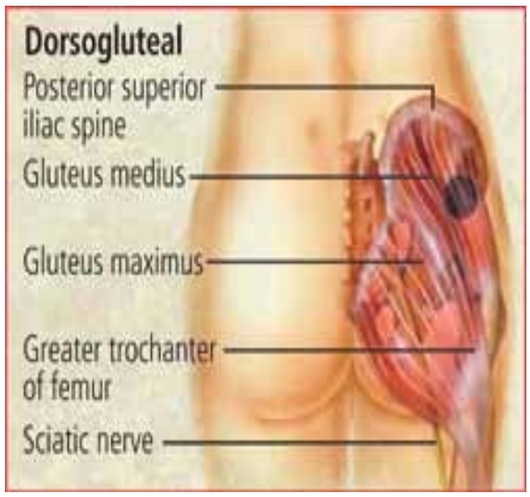
Ventrogluteal site:

The Ventrogluteal site is free of major blood vessels and nerves with less fatty tissue distribution. It is considered as the safest and least painful site. It is generally used for antibiotics, antiemetics, deep intramuscular and Z track injections in oil, narcotics and sedatives. Up to 2.5ml can be safely injected into this site.To find the correct site palpate the greater trochanter, then cover with the palm of your hand. Palpate anterior superior iliac crest with index finger and spread middle finger to palpate the bony ridge of the iliac crest. The centre of the formed triangle is the ventrogluteal site

Mid-deltoid site:

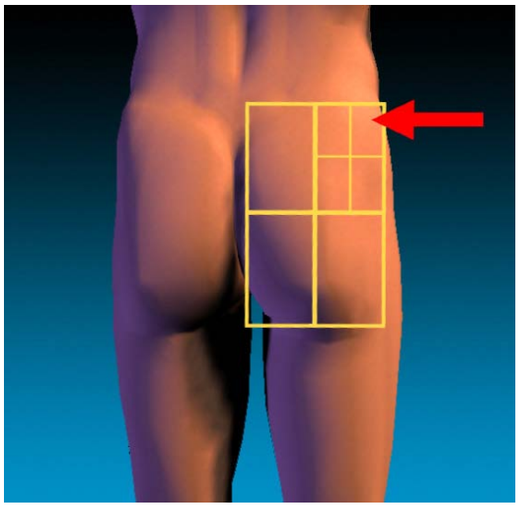
The **mid-deltoid** site has the advantage of being easily accessible whether the resident is standing, sitting or lying down. It is generally used for narcotics, sedatives, vaccines/ immunisations and non-irritating medicines which are smaller in volume and therefore can be tolerated better. The maximum volume for injection at this site is 1ml. There is a potential risk of injury to the brachial artery and radial nerve. Locate the **Acromial Process** landmark. Place index & middle finger on the landmark and create an inverted triangle. Inject 1-2 inches below the **Acromial Process** in the centre of the triangle

Dorsogluteal site:



The Dorsogluteal site (the upper outer quadrant of the buttocks) is used for deep intramuscular and Z-track injections. The muscle mass is likely to atrophied in the elderly, non ambulant and emaciated residents. Up to 4ml can be safely injected into this site

This is a preferred site for oily, painful and irritating injections/depot medication



The target muscle for dorsogluteal injection is the gluteus maximus

Position the resident prone or lateral, locate the superior iliac spine and the greater trochanter of the femur. Draw an imaginary diagonal line between the two. The site is the upper outer aspect several inches below the iliac crest. Alternatively divide the buttock into 4, then divide again so that the injection is given into the upper outer quadrant of the upper outer quadrant.

Complications associated with injecting into the dorsogluteal site include:

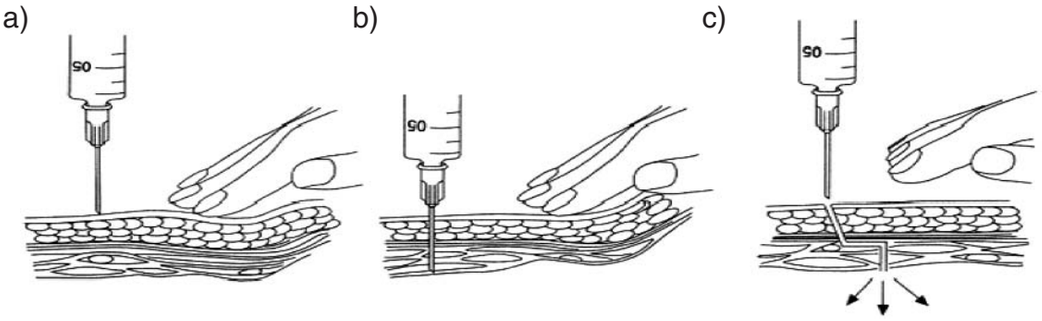
- Inadvertent injection of medication into the sciatic nerve, causing pain and temporary or permanent paralysis
- Inadvertent administration of medication intravenously or injection into the superior gluteal artery
- Inadvertent injection of the medication subcutaneously, especially if you use a short 23 Gauge (Blue needle) 30mm needle

Z –track technique:

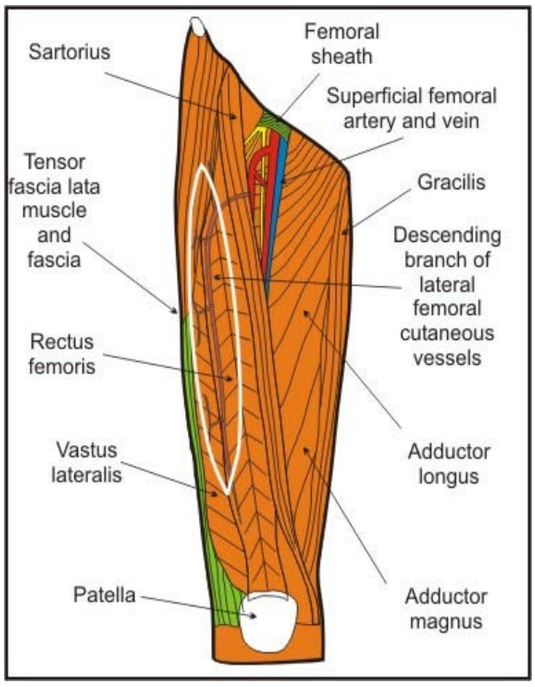
The Z-track technique reduces the risk of complications and should be used in intramuscular injections

- ❖ Displace the skin laterally by pulling it away from the underlying muscle (You should move the skin about ½ inch or 1 cm)
- ❖ Hold the needle at a 90 degree angle, insert quickly into the skin
- ❖ Pull back plunger. If no blood is aspirated, depress the plunger at approx. 1ml per 10 seconds and inject the drug slowly
- ❖ When withdrawing the needle, release the retracted skin at the same time. This manoeuvre seals off the puncture tract and traps the medicine in the muscle

a) b) c)



Vastus Lateralis and Rectus Femoris Site:



The **Vastus Lateralis** site is used for deep intramuscular and Z-track injections. There are no major blood vessels or significant nerve structures associated with this site therefore reducing the risk of complications. Up to 5ml can safely be injected at this site

The **Rectus Femoris** site allows safe rapid absorption; this site can be used for infants, children and adults. The needle length required is usually 1 inch or less. The location is one handbreadth above the knee and one handbreadth below the greater trochanter, at the medial lateral portion of the thigh. This is rarely used by nurses but is easily accessed for self-administration of injections

Needle selection for intramuscular sites:

- ✓ To reach muscle in the Ventrogluteal, a standard 21 gauge (Green) or a 23 gauge (Blue) needle will penetrate this muscle
- ✓ To reach muscle in the Dorsogluteal, the needle length needs to be a 21 gauge (Green) needle

Medication Management Competency Assessment Drug Round

Name of Nurse Assessed: _____

Name of Assessor: _____

Date/ Time: _____

	Performance Criteria	**Needs Theory** Date/ Initials	**Needs Practice** Date/ Initials	**Meets Competency** Date/ Initials
1	The nurse washes hands prior to drug round			
2.	The nurse prepares the drug trolley with the necessary equipment for the drug round			
3	The nurse checks that there is a valid, clear prescription for each drug on the medication administration record signed by the prescribing doctor			
4	The nurse checks the medication administration record that the resident's name, date of birth and GMS number are clearly written on each page and where there is a photograph attached that this is a true likeness of the resident			
5	The nurse checks the name of each prescribed drug			
6	The nurse checks that each drug has not been discontinued			
7	The nurse has knowledge of the therapeutic use of each drug, it's normal dosage, side effects, precautions and contraindications			
8	The nurse checks if the resident has any known allergies			
9	The nurse checks the prescribed time each drug is to be administered			
10	The nurse checks when the drug was last administered			
11	Prescribed medicines are administered as close as possible to the time written on the prescription (only a delay of one hour is acceptable)			
12	The nurse checks the prescribed dose of each drug			
13	The nurse checks the prescribed route and form of each drug			
14	The nurse checks the specific instructions regarding administration of certain drugs are adhered to e.g. If drugs are best taken on an empty stomach			
15	The nurse selects the appropriate drug from the drug trolley, reads the name and strength of the drug on container/ box			
16	If drugs are in a monitored dosage system the nurse checks same for the name and strength of the drug, in addition to checking the box			

	Performance Criteria	Needs Theory Date/ Initials	Needs Practice Date/ Initials	Meets Competency Date/ Initials
17	The nurse checks the expiry date of the drug			
18	The nurse uses medicine pots, cups or spoons to avoid making contact with the drug			
19	Where medicines need to be crushed, the nurse establishes that these have been sanctioned by a medical practitioner or pharmacist. A clean pestle and mortar is used and it is cleaned after each resident with warm water and detergent and wiped with a dry hand towel			
20	The nurse double checks the drug name and dosage with the prescription sheet and measures or counts out the correct dose prior to administering			
21	The nurse verifies the resident's identity prior to administering medication			
22	The nurse communicates information sensitively to the resident prior to and during administration of medication			
23	All medicines are administered personally by the dispensing nurse immediately following preparation			
24	The nurse stays with the resident until the drug has been swallowed			
25	The nurse does not leave medicines for the resident to self administer at a later time			
26	If the drug is delayed, refused or omitted the nurse documents the reason for this using the appropriate coding detailed on the medication administration record/ prescription sheet			
27	Any delay or omission is documented in the nursing notes/ resident's record and reported to the medical practitioner at the next available opportunity			
28	If a medication is signed for but not given the nurse puts one line through the mistake and initials the mistake			
29	Non-administered and wasted drugs or sharps are disposed of in the appropriate designated sealed container			
30	The nurse signs their usual abbreviations on the medication administration record/ prescription sheet as soon as the medication has been administered			
31	The nurse cleans their hands between residents			
32	The nurse does not leave the medicine trolley unattended during the course of the medicine round or when unlocked			
33	The nurse recognises the needs of the resident and their relatives in relation to medication			
34	The nurse understands the 7 rights of medication management			

Notes.....

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Medication Error Report Form

(Adapted from the AMNCH Medication Safety Incident Report Form)

Affix an Addressograph label here or complete this section if a specific resident was involved:

Resident Name:

GMS Number:

Date of Report (DD/MM/YYYY): _____
Date of Occurrence (if different): _____
Time of Occurrence (24 hr clock): _____

Residential Care Unit: _____

Medication(s)/Dose(s) involved:

1) _____ Route given: _____
2) _____ Route given: _____

	Nurse	Doctor	Pharmacist	Technician	Other (specify)
Profession of staff that discovered incident (tick)					
Profession of staff reporting the incident (tick)					

Stage(s) of the process where incident/near miss occurred:

Prescribing ☐ Ordering ☐ Dispensing ☐ Storage ☐ Administration ☐ Monitoring ☐

Medication incident /near miss related to:

Adverse Drug Reaction	☐	Unauthorised self-administration	☐
Allergy	☐	Drug-drug interaction	☐
Wrong resident	☐	Drug-food/enteral nutrition interaction	☐
Wrong medication	☐	Drug-disease interaction	☐
Wrong dose (over/under/extra dose)	☐	Incorrect storage/security	☐
Omission (no. of episodes……..)	☐	Expired drug	☐
Wrong route	☐	Unclear/incomplete documentation	☐
Wrong time	☐	Unclear/incomplete prescription	☐
Wrong dosage form	☐	Unclear/incomplete/incorrect labelling	☐
Wrong diluent/ method of constitution	☐	Wrong strength/concentration	☐
Non-compliance with unit policy	☐	Medication on Admission/ Discharge/	
Wrong rate	☐	Transfer Incorrect or not reconciled	☐
Wrong frequency	☐	Duplicate therapy	☐
Contra-indication to use of medication	☐	Infusion Pump Incident	☐
Resident's BMI recorded incorrectly	☐	Other:_____	☐
Wrong duration	☐	_____	

Outcome of incident/near miss:

Reached the resident (note an omission does reach the resident)? Yes ☐ No ☐
Resulted in harm (e.g. Pain, injury, symptoms)? Yes ☐ No ☐ Uncertain at time of reporting ☐

Action required due to the incident/near miss (tick all that apply):

No action required	☐	Initial hospitalisation	☐
Observation	☐	Prolonged hospitalisation	☐
Vital signs monitored	☐	Intervention necessary to sustain life	☐
Tests performed (lab/X-ray etc)	☐	Intensive care	☐
Drug therapy added or changed	☐	Other (specify): _____	☐

MEDICAL PRACTITIONER notified? Yes ☐ No ☐ Not Applicable ☐

Patient aware? Yes ☐ No ☐ Not Applicable ☐

Please complete details of incident/near miss overleaf

Description of Incident/Near Miss:

Follow-up and actions:

Please describe any follow-up or actions identified ☐ or taken ☐ to reduce the chance of this incident recurring:

Note: Do not delay submitting the report to fill out this section

Name of Reporter _____ Contact phone number/bleep/e-mail _____

Note: Name of reporter and contact details are optional; however it can facilitate follow-up and feedback if they are provided.

Please fill out the form as completely as possible, and action accordingly in line with local risk management policy appropriate to your setting.

In addition if there are adverse drug reactions/ events identified please also complete the Adverse Reaction Report Form and send to:

FREEPOST
PHARMACOVIGILANCE UNIT
IRISH MEDICINES BOARD
EARLSFORT CENTRE
EARLSFORT TERRACE
DUBLIN 2

Medication Management Audit

A.	Individual Residents' Medication	Yes	No
1.	Storage suitable		
2.	Treatment room/ cupboard locked		
3.	All medication levels acceptable (no excess)		
4.	Discontinued/ expired medication removed, stored and disposed of		
5.	External/ internal medication stored separately		
6.	Medicine properly labelled		
7.	All medication used by intended patient (i.e. no borrowing)		
8.	Medication trolleys locked and secured		
9.	Keys held by designated person		
10.	Lockable facilities provided for self-medicating residents		
11.	Individual medication satisfactory		
12.	Protocol used to assess self-medication		
13.	Protocol for handling drug recalls		

B.	MDA Medication	Yes	No
1.	Separate cupboard/ cabinet locked		
2.	Discontinued MDAs correctly disposed of		
3.	Keys held by designated person		
4.	Correct stock rotation		

C.	Over-the-counter Medication	Yes	No
1.	Protocol in use		
2.	Storage suitable		
3.	Internal/ Externals stored separately		
4.	Correct stock rotation		
5.	Records kept of over-the-counter medication administered		

D.	Refrigerated Items	Yes	No
1.	Refrigerator clean and between 2-8 degrees Celsius (max/ min thermometer used)		
2.	Medicines separate from food		
3.	Medicines properly labelled		
4.	Expired items removed and disposed of		

N.B. Adapted from the Boots Care Services, "Pharmacy Advice Visit"

E.	Records (Non Monitored Dosage System Homes)	Yes	No
1.	Stock records completed		
2.	Medication profile completed		
3.	Administration record completed		
4.	Request record completed		
5.	Medical practitioner review record completed		

F.	Monitored Dosage System (if applicable)	Yes	No
1.	Procedures manual available		
2.	Medication administration record completed		
3.	Medical practitioner regularly reviews records		
4.	Monitored Dosage Systems being used in line with local policy		

G.	Storage of gases and hazardous substances	Yes	No
1.	Correct storage (as per COSHH regulations)		
2.	Appropriate notice displayed		

H.	Training	Yes	No
1.	All staff have received accredited medication handling training		
2.	All staff have received Monitored Dosage System training		
3.	All staff are competent in medication management		

Give Comments on ticks in 'No' column
(if more space is required please use separate page and attach to form)

Unit Name:.....

Date Reviewed:.....

Signature of Nurse Representative:.....

Signature of Pharmacist:.....

Acknowledgments

We would like to acknowledge the support and assistance of all the people that have given generously of their time since the inception of this project including:

- Residents and staff, Belmont House Nursing Home
- Dean Maxwell Community Unit, Roscrea Co Tipp
- Community Hospital of the Assumption, Thurles, Co Tipp
- St Conlon's Community Unit, Nenagh, Co Tipp
- Dr Mary Teeling, Director, Centre for Advanced Clinical Therapeutics, St James' Hospital
- Dr. Almath Spooner and Dr Niamh Arthur, Pharmacovigilance Unit, Irish Medicines Board
- Dr. Tony Mc Dowell, General Practitioner
- Gráinne O'Malley, Senior Pharmacist, National Medicines Information Centre, St. James's Hospital
- Ms Ciara Kirk, Pharmacy Department, Adelaide and Meath Hospital Incorporating the National Children's Hospital, Tallaght
- Ms Sinead Maher, Nurse Practice Development, Adelaide and Meath Hospital Incorporating the National Children's Hospital, Tallaght
- Ms. Michelle M. Bell, Safe Medication Management Fellow, Institute for Safe Medication Practices
- Ms Muriel Pate ,Associate Drug Safety Co-ordinator , Adelaide and Meath Hospital Incorporating the National Children's Hospital, Tallaght
- Ms Anne Costello, Director of Nursing, Tara Care Centre
- Ms Bairbre Hickie, Parenteral Nutrition Product Manager/ Home Care Nurse, Fresenius-Kabi

Glossary of Terms and Definitions

Dentist is any person who is registered and whose name is entered in the Register of Dentists established under the Dentists Act 1928

Double checking is the same process as single checking conducted by two clinicians independently

High alert medicines are medicines which have a high risk of causing injury when they are involved in incidents of medication error

IMB is the Irish Medicines Board whose role is to protect and enhance public and animal health through the regulation of human and veterinary medical products. Among its many activities, the IMB regulates clinical trials, as well as monitoring and inspecting products on the market to ensure their safety and efficacy

Medical practitioner is a person who is registered and whose name is entered in the General Register of Medical Practitioners established under the Medical practitioners Act 1978. This includes General practitioners, hospital doctors, locum doctors, consultants

NMIC is the National Medicines Information Centre which provides an enquiry answering service to healthcare professionals on all aspects of the therapeutic use of medicines

Monitored dosage systems are compliance aids which include blister packs, nomad, medisure and manrex

Nurse is a person registered with An Bord Altranais and is on the live register of nurses

PEG Percutaneous endoscopic gastrostomy tube feeding tube

Pharmacist is a person registered with the Pharmaceutical Society of Ireland under the Pharmacy Act 2007

Pharmacy is a place where registered pharmacists dispense medicine on foot of a valid prescription written by a registered prescriber

A **reliable drug reference** includes an up to date British National Formulary (BNF), Monthly Index of Medical Specialities Ireland (MIMS Ireland) and/ or Summary of Product Characteristics (SPC)

Single-checking requires the clinician administering the medication to review the drug, formulation, dose, route, time, etc. before giving to the resident

Summary of Product Characteristics (SPC) is a legal document providing approved prescribing information (including licensed indications, precautions for use and safety and efficacy data) in a format standardised throughout the EU. Final wording agreed by regulatory body (EMEA/ IMB) and text reviewed regularly and updated. Website access: www.imb.ie or www.medicines.ie

“An **unlicensed or unauthorised medicine** is a medicinal product which is not licensed by the Irish Medicines Board (IMB) or the European Medicines Evaluation Agency (EMEA)”

References

1. Advocacy Inc. IR8 (1997) *Your legal right to refuse* www.advocacyinc.org (accessed 21st April 2009)
2. Allen, K (2006) *Single or double checking of medication prior to administration*. Centre of Clinical Effectiveness: Evidence request http://www.mihsr.monash.org/cce/pdf/ers/singleordoublechecking.pdf (accessed 17th April 2009)
3. An Bord Altranais (2000) *Guidance to Nurses and Midwives on the Development of Policies*, Guidelines and Protocols
4. An Bord Altranais (2002) *Recording Clinical Practice: Guidance to Nurses and Midwives* 1st Edition
5. An Bord Altranais (2002) *Scope of Nursing and Midwifery Practice Framework*
6. An Bord Altranais and National Council for the Professional Development of Nursing and Midwifery (2005) *Review of Nurses and Midwives in the prescribing and administration of medicinal products*. An Bord Altranais and National Council for the Professional Development of Nursing and Midwifery, Dublin
7. An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management*
8. An Bord Altranais (2007) *Requirements and Standards for Education Programmes for Nurses and Midwives with Prescriptive Authority.* An Bord Altranais, Dublin
9. An Bord Altranais (2007) *Decision Making Framework for Nurse and Midwife Prescribing*. An Bord Altranais, Dublin
10. An Bord Altranais (2007) *Practice standards for Nurses and Midwives with Prescriptive Authority.* An Bord Altranais, Dublin
11. Asperheim, M. K. (1996) *Pharmacology: an introductory text*, Philadelphia: W.B.Saunders Company, 8th ed. p. 64
12. Atkin, P.A and Ogle, S.J (1996) *Issues of medication compliance and the elderly*. Adverse drug reactions and toxicology review: 15, 109-118
13. Audit Commission (2002) *Medicines Management – Review of National Findings.* Audit Commission, London
14. Beauchamp, T and Childress, J.F (2001) *Principles of biomedical ethics* (5th ed), Open University Press: New York
15. Bennett, P.N and Brown, M.J., (2003) *Clinical Pharmacology* (9th ed). Churchill Livingstone
16. Bickley, S (2002) Bates *Guide to Physical Examination and History Taking* (8th Ed.) Lippincott, Wilson & Wilkes

17. British Geriatric Society (1995) *Acute Medical Care of Elderly People,* BGS Best Practice Guide 3.1, published 1995, revised 2004 http://www.bgs.org.uk/Publications/Compendium/compend_3-1.htm (accessed 12/05/09)

18. British National Formulary (2009) *BNF 57* British Medical Association and Royal Pharmaceutical Society, London

19. Bruckenthal, P (2007) *Controlled substances: principles of safe prescribing.* Nurse Pract 32(5):7-11

20. Caulfield, H (2005) *Accountability*. Blackwell, Oxford

21. Clinical Resource Efficient Support Team(2005) *Guidelines for the management of Enteral Feeding in Adults*

22. Commission for Healthcare Audit and Inspection (2002) *Self administration of medicines by hospital inpatients*. Briefing document from Salford Royal Hospital

23. Cook, P.F (2001) *Methods for assessing medication compliance: research summary*

24. Corlett, A.J (1996) *Caring for Older People: Aids to Compliance with Medication.* BMJ 313:926-929

25. Davis, D.A and Taylor-Vaisey, A (1997) *A systematic review of theoretical concepts, practical experience and research evidence in the adoption of clinical practice guidelines.* Can Med Assoc. 157(4): 408-416

26. Delaney, T (2004) *Experience with medication error reporting systems in an Irish hospital.* In OCED Health Care Quality Indicators Seminar on Improving Patient Safety Data Systems. June 29-30, 2006. Dublin

27. Department of Health (2000) *An Organisation with a Memory*

28. Department of Health (2001) *National Service Framework for Older People*

29. Department of Health and Children (1998) *Report of the Commission on Nursing - A Blueprint for the future.* Dublin, Stationary Office

30. Department of Health and Children (2008) *"Building a Culture of Patient Safety"* Report of the Commission on Patient Safety and Quality Assurance

31. Department of Health and Children (2009) *Economies in Drug Usage in the Irish Healthcare Setting*

32. Department of Health (2001) *Medicines and Older People: Implementing Medicines –Related aspects of the NSF for Older People.* Crown Copyright

33. DDDS (2008) *Medication Pass Checklist.* Division of Developmental Disabilities Services: Delaware Health and Social Services: http://dhss.delaware.gov/dhss/ddds/files/aam_passchecklist.pdf Accessed 08/04/09

34. Dimond, B (1995) *Legal Aspects of Nursing,* Prentice Hall

35. Donnelly, M (2002) *Consent: Bridging the gap between doctor and patient.* Cork University Press, Cork

36. Dooley, D and McCarthy, J (2005) *Nursing ethics: Irish cases and Concerns.* Gill and Macmillan, Dublin

37. Dougherty, L and Lister, S.E (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures* 7th Edn. Blackwell Publishing, London

38. Edwards, C and Stillman, P (2000) *Minor illness or major disease?* (3rd ed) Pharmaceutical Press, London

39. European Charter of Patient's Rights (2002) *Right to Consent*

40. Feeney Mahoney, D (1994) *Appropriateness of Geriatric Prescribing Decisions Made by Nurse Practitioners and Physicians*. IMAGE, Journal of Nursing Scholarship. Vol. 26, No. 1, 41 – 46

41. Gommans, J; McIntosh, P; Bee, S and Allan, W (2008) *Improving the quality of written prescriptions in a general hospital: the influence of 10years of serial audits and targeted interventions.* Intern Med J. 38(4): 243-248

42. Green, R.J. and Harris, N.D (2000) *Pathology and Therapeutics for Pharmacists. A Basis for Clinical Pharmacy practice.* Pharmaceutical Press

43. Health Act 2007 *(Care and Welfare of Residents in Designated Centres for Older People)* Regulations 2009

44. Health Information and Quality Authority (2009) *National Quality Standards for Residential Care Settings for Older People in Ireland*

45. Health Service Executive (2007) *The Introduction of Nurse and Midwife Prescribing in Ireland: An Overview.* Health Service Executive, Dublin

46. Holland, D (2008) Administration of drugs via enteral feeding lines. HSE Dublin Mid-Leinster Pharmacy Department Guideline

47. HSE National Immunisation Office (2008) *Information for Healthcare Professionals: Influenza Vaccine and Pneumococcal Polysaccharide Vaccine*

48. Irish Medicines Board (Miscellaneous Provisions) Act, 2006

49. Improving Medication Safety (2001) *Building a safe NHS for patients – implementing An Organisation with a Memory*

50. Institute for Safe Medication Practices (2009) *What is a "high-alert" medicine?* http://www.ismp.org/ (accessed 27/04/2009)

51. Institute for Safe Medication Practices (1998) *Frequent Problems with Medication Systems noted during ISMP Hospital Evaluations*. ISMP Medication Safety Alert

52. Institute for Safe Medication Practices (2007) *The Five Rights: A destination without a map.* ISMP Medication Safety Alert. Vol 12 Issue 2

53. Joint Commission on Accreditation of Healthcare Organisations (2004) *Comprehensive accreditation manual for hospitals.* Oakwood Terrace, IL

54. Kennedy, I and Grubb, A (2000) *Medical Law* Butterworths, London

54. Levin, A (2005) Covert Drug Administration: *'Win Battle, But Lose War'.* Psychiatric News. (40) 10: 10

55. Longmore, M; Wilkinson, I and Rajagopalan, S (2004) O*xford Handbook of Clinical Medicine* Oxford University Press

57. Madden, D. (2002) *Medicine ethics and the law.* Butterworths, Dublin

58. McKenry, L. & Salerno E. (1998) *Pharmacology in Nursing,* St. Louis: Mosby, 20th ed. p 52-53

59. Medicinal Products *(Prescription and Control of Supply)* Regulations, 2003

60. Medicinal Products *(Prescription and Control of Supply)* Regulations, 2003 as amended by the 2005 regulations

61. Mental Health Act 2001

62. Merskey, H and Bogduk, N (1994) Part III: *Pain Terms, A Current List with Definitions and Notes on Usage"* (pp 209-214) *Classification of Chronic Pain,* Second Edition, IASP Task Force on Taxonomy, IASP Press, Seattle cited by International Association for the Study of Pain (2007) http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Definitions&Template=/CM/HTMLDisplay.cfm&ContentID=1728 (accessed 16th April 2009)

63. Mill, S (2002) *Clinical Practice and the Law.* Butterworths, Dublin

64. Misuse of Drugs Regulations 1988-2006

65. National Immunisation Advisory Committee (2008) *Immunisation Guidelines for Ireland:* 2008 Edition. Royal College of Physicians Ireland

666. National Institute of Clinical *Effectiveness (2006) Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition*

67. National Medicines Information Centre (2005) *Pharmacological management of pain in primary care.* Vol 11: Nos 5-6

68. National Patient Safety Authority (2007) *Promoting Safer Measurement and Administration of Liquid Medicines via Oral and Other Enteral Routes* Patient Safety Alert 19

69. Nursing and Midwifery Council (2008) *Standards for Medicines Management*

70. Nutrition Support Interest Group (2007) *Home Enteral Feeding Resource Pack* Irish Nutrition and Dietetic Institute

71. O'Malley, P (2007) *Accounting for Pharmacokinetic and Pharmacodynamic variability: ten factors to consider before prescribing.* Clin Nurse Spec. 21(6):274-5

72. Prosser, S. (2000) *Applied Pharmacology: An Introduction to pathophysiology and drug management for nurses and healthcare professionals.* Mosby

73. Rich, D. S (2004) *New JCAHO medication management standards for 2004.* Am J Health-Syst Pharm (64) 1349-58

74. The Royal Australian College of General Practitioners (2006) *Medical Care of Older Persons in Residential Aged Care Facilities. 'Silver Book'* National taskforce

75. Royal College of Physicians, British Geriatric Society, British Pain Society (2007) *The Assessment of pain in older people: National Guidelines. Concise guidance to good practice series, No 8.* London RCP

76. Sexton, J (1999) *The nurse's role in medicines administration, legal and procedural framework.* In: Medicines Management for Clinical Nurses. (Eds K Luker and D Wolfson) Blackwell Science

77. Sindhu, F(1996) *Are non-pharmacological nursing interventions for the management of pain effective? A meta-analysis*. J Adv Nurs. 24: 1152-9

77. Stevenson, F; Cox, K; Britten, N and Dundar, Y (2004) *A systematic review of research on communication between patients and health care professionals about medicines: the consequences for concordance*. Health expectations. 7 (2) 235 – 245

79. Stokes, J.A; Purdie, D.M and Roberts M.S (2004) *Factors influencing PRN medication use in nursing homes.* Pharmacy World and Science. 26 (3) 148-154

80. The Australian Pain Society (2005) *Pain in residential aged care facilities: management strategies.* Sydney: The Australian Pain Society

81. Toedter Williams, N (2008) *Medication Administration Through Enteral Feeding Tubes* Am J Health-Syst Pharm. 65 (24):2347-2357

82. Trounce, JR and Gould D (2000) *Clinical Pharmacology for Nurses,* (16th Ed.) Churchill Livingstone, Edinburgh

83. Walker, R and Edwards, C (eds) (2003) *Clinical Pharmacy and Therapeutics* (3rd ed). Churchill Livingstone, Edinburgh

85. White and Bradnam (2007) *Handbook of Drug Administration via Enteral Feeding Tubes* Pharmaceutical Press

85. Woodrow, R (2001) *Essentials of Pharmacology for Health Occupations.* Cengage Learning, 4th Edition. p.89

86. World Health Organisation (1986) *WHO's Pain Relief Ladder.* Geneva