catholic healthcare

Medication Manual February 2023 V9

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DEFINITIONS

TABLES

Word	Acronym	Definition
Administer		The process of giving any prescribed medications including packed, non-packed and non-measured medications to a resident.
Adverse drug reaction	ADR	Any unexpected, unintended, undesired, or excessive response to any medicine or vaccine, including prescription medicines, over the counter medicines and complementary and alternative medicines that: • Requires discontinuing the medicine. • Requires changing the medicine. • Necessitates acute admission to hospital. • Results in temporary or permanent harm, disability, or death.
Adverse Medicine Event		A specific adverse event where a medicine is implicated as a causal factor which involves harm resulting from the fundamental nature of the medicine (an adverse drug reaction), as well as harm that results from medication errors or system failures associated with the manufacture, distribution, or use of medicines.
Aged Care Funding Instrument	ACFI	The Aged Care Funding Instrument is a resource allocation instrument which funds Aged Care Homes on the assessed care needs of individual Residents.
Allergy		A hypersensitive state acquired through exposure to a particular allergen which results in a physical allergic reaction and may not be predictable e.g. skin rash, sneezing etc.
Alteration of oral dose form		Where the dosage form of a medication(s) is altered, such as emptying the contents of a capsule or crushing a tablet to form a powder to be mixed with Gloup before administration to a Resident who has difficulty swallowing.
Anaphylaxis		Anaphylaxis is a sudden and severe allergic reaction, which results in sudden respiratory compromise and/or circulatory collapse and may cause unconsciousness and death if not treated immediately. Early signs of anaphylaxis include swelling of face, lips and eyes, skin redness or itchiness, difficulty breathing, wheeze, diarrhoea, nausea/vomiting, alteration in level of consciousness, hypotension, rapid pulse or weak or absent carotid pulse.
Anticoagulant Medication		A medication used to prevent or treat blood clots in people who have had a previous blood clot that has caused a health problem (such as a stroke, heart attack, or deep vein thrombosis) or those who are at risk of developing a blood clot.
Assist and Support		The process of assisting and supporting residents with prescribed medication from a Dose Administration Aid, application of patches and application of non-scheduled/non-medicated creams, ointments, and lotions.
Australian Health Practitioner Regulation Agency	AHPRA	The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. Registered and Enrolled Nurses are required to register annually.

Word	Acronym	Definition
Authorised Prescriber		A person approved to prescribe medications, but only in accordance with any practice conditions imposed by notations and conditions on the person's health practitioner registration. Authorised Prescribers include: • A **Medical Practitioner** registered by the Medical Board of Australia. • A **Dentist** registered by the Dental Board of Australia as a dental practitioner. • A nurse registered by the Nursing and Midwifery Board of Australia with endorsement as a **Nurse Practitioner**, and also authorised under section 17A of the Poisons and Therapeutic Goods Act 1966 by the NSW Director General of Health (or delegate). • An **Optometrist** registered by the Optometry Board of Australia with endorsement to prescribe or supply a limited range of Scheduled medications. • A **Podiatrist** registered by the Podiatry Board of Australia with endorsement to prescribe or supply a limited range of Scheduled medications.
Authorised Representative		A person who has the legal authority e.g. enduring guardian to act on behalf of the Resident, making decisions in regard to the Resident's lifestyle or other personal matters, what services they receive and what medical and associated health treatments they may need.
Care Worker	CW	A Care Worker for the purposes of this document is defined as a staff member who has completed an appropriate training program and competency assessments in medication management. This will include the successful completion of the approved Catholic Healthcare Medication Essentials course and the Catholic Healthcare Medication Competencies (MCs) by a CHL approved workplace assessor.
Chemical Restraint		Chemical restraint means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness, or a physical condition.
Chief Nurse	RM/CM	CHL Homes will employ a Residential Manager or Care Manager as the Chief Nurse or most senior RN. This person has the legal authority to order Emergency S4D and S8 Medications in writing signed and dated from the retail pharmacist for the Home.
Comorbidity		The presence of two or more medical conditions or diseases that are additional to an initial diagnosis. For example, a Resident with Parkinson's disease, diabetes, and dementia.
Competence		The combination of skills, knowledge, attitudes, values, and abilities that underpin effective performance in a profession/occupational area.
Competent		A person who has competence across all the domains of competencies applicable, at a level that is judged to be appropriate for the level of the staff member being assessed.

Word	Acronym	Definition
Complementary and Alternative Medicines	CAM	Complementary and alternative medicines Includes herbal medicines, vitamins and minerals, homeopathic measures, nutritional supplements, some aromatherapy products, Chinese medicines, Australian indigenous medicines, and Ayurveda medicines (Indian). These may be purchased with or without a prescription.
Consent to Medication Administration		The procedure whereby a person consents to or refuses to take medications based on information provided by a health care professional regarding the nature and potential risks (consequence and likelihood) of the medications. Consent may be given as implied consent or expressed either verbally or in writing. In **Queensland** it is a requirement that all Residents or their authorised representative complete a "Request for Carer to Administer Medications" form to enable Care Workers to assist with medications.
Controlled Drug Book / Drug Register		Controlled Drugs Book (QLD) and the Drug Register (NSW) accurately maintains all records involving Schedule 8 medications, including dispensing, receiving, administration, transferring, discarding and allocation for destruction.
Crushing		Refer to Alteration of oral dose form.
Cytotoxic		Medicines that describe a group of drugs that contain chemicals which are toxic to cells, preventing their replication or growth and used for the treatment of cancer and other diseases such as rheumatoid arthritis.
Delegation of Medication Administration		Based on their professional discretion, Registered Nurses (RNs) may make the decision to delegate aspects of care to other nurses and to Care Workers. In deciding whether to delegate particular activities, the RN must take into consideration the needs of the Resident and the skills of the other nurses and Care Workers to ensure that delegation does not jeopardise the provision of safe care.
Destruction		The act of destroying medications.
Discarding		To dispose of expired, unusable, and unwanted medications.
Dispensing		The process which is followed when a Pharmacist provides medications on the prescription or order of an Authorised Prescriber.
Disposal		To get rid of expired, unusable, and unwanted medications.
Dose Administration Aid	DAA	A non-reusable and non-resealable device or packaging system such as blister packs, bubble packs or sachets containing medications according to the time of administration, which has been prepared and labelled by a Pharmacist in accordance with the prescribed regime. DAAs can be either a unit dose (one single type of medications per compartment) or a multi-dose pack (different types of medications per compartment).
Drug Recall		A drug recall involves the removal of the prescription or over-the-counter medication from supply on the Australian market for reasons relating to the product's quality, safety, or efficacy.

Word	Acronym	Definition
Drug Register / Controlled Drug Book		The Drug Register (NSW) and Controlled Drugs Book (QLD) and accurately maintains all records involving Schedule 8 medications, including dispensing, receiving, administration, transferring, discarding and allocation for destruction.
Drug Safe		A locked safe or cabinet securely attached to the premises inside a locked room for the specific storage of Schedule 8 (S8) medicines. S8 Medications stored in the Drug Safe are accounted for in a Controlled Drugs Book / Drug Register.
Emergency Stock		Renamed -see Urgent use medications .
Enrolled Nurse	EN	An enrolled nurse is a nurse who has completed a Diploma of Enrolled Nursing through TAFE or another training institution, who may facilitate and contribute to the care of a Resident.
High Risk Medication		High risk medicines have a heightened risk of causing injury or harm even when used as intended and especially if they are misused or used in error.
Hospital Leave		Where a Resident is on leave to receive hospital treatment. The reason for non-administration of medications during a Resident's hospitalisation is Ⓗ and this must be documented on the medication signing sheet.
Immunisation		The action of making a person immune to infection, typically by inoculation.
Imprest Stock		Imprest stock is a term that describes medicines that may be supplied to a residential aged care service for administration to unspecified residents.
Intramuscular injection	IM	Route for medication - an injection given into the body of a muscle.
Intravenous injection	IV	Route for medication - an injection into the vein.
Medical Practitioner	MP	A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Medical Board of Australia to practise as a Medical Practitioner, under the *Health Practitioner Regulation National Law Act 2009, and its Regulations*.
Medication		A substance given with the intention of preventing, diagnosing, curing, controlling, or alleviating disease or otherwise enhancing the physical or mental welfare of people. Includes prescription and non-prescription medicines, including complementary and alternative medicines irrespective of the administered route.
Medication Advisory Committee	MAC	A group of advisors to the Residential Aged Care Home who provide medication management leadership and governance, and assist in the development, promotion, monitoring, review and evaluation of medication management policies and procedures that will have a positive impact on health and quality of life for Residents.
Medication Audit		A prescribed and systematic examination of medication data, such as medication assessments, medication charts, signing sheets and Schedule 8 drug registers, as well as operational processes such as storage and disposal. The aim of the audits is to identify areas for improvement and to promote safe and effective medication management.

Word	Acronym	Definition
Medication Chart		Refer to Prescriber Order Sheet.
Medication Incident/Error		Events that could have or did cause the Resident harm, and where medicine is likely to have been a contributing or causal factor. Medication incidents may be the result of error or system failure in the processes for prescribing, dispensing, storage and administration or disposal of medicines. Most do not cause any harm; those resulting in harm are called Adverse Medicine Events.
Medication Management		Medication management occurs at both individual and Home levels: It includes: • How medicines are selected, ordered, received, and supplied • How Residents take medicines or assisted to take them • How medicine use is recorded and reviewed • How medicines are stored and disposed of safely and • How medicines use is supported, monitored, and evaluated.
Medication Order		A medication order is a written direction provided by an Authorised Prescriber for a specific medication to be administered to an individual. This may include a Medical Discharge summary.
Medication Reconciliation		The formal process of obtaining and verifying a complete and accurate list of each Resident's current medicines including prescription, over the counter and complementary and alternative medicines. The list is compared with the medicines ordered to identify and resolve any discrepancies with the Authorised Prescriber/Medical Practitioner. Any changes are documented. For example, resident return from hospital.
Medication Review		A structured and collaborative examination of a Resident's medicines with the objective of reaching an agreement with the Resident about treatment, optimising the impact of medicines, minimising the number of medication-related problems, and reducing waste.
Nil by Mouth	NBM	When a Resident is required to fast for medical reasons or in preparation for a procedure or is not safe to eat or drink due to swallowing issues.
Nurse Initiated Medication	NIM	Non-prescription medications that are pre-approved by the Resident's Authorised Prescriber/Medical Practitioner and listed by Catholic Healthcare. NIMs are administered by a Registered Nurse when clinically indicated. Only Schedule 2 and Schedule 3 medication may be included as nurse initiated.
Nurse Practitioner	NP	A Registered Nurse endorsed by the Nursing and Midwifery Board of Australia to function autonomously and collaboratively in an advanced and extended clinical role as a Nurse Practitioner, under the Health Practitioner Regulation National Law Act 2009, and its Regulations. Nurse practitioners who are permitted and qualified can prescribe independently, in accordance with the relevant state and territory legislation, and take responsibility for the clinical assessment of a Resident, establishing a diagnosis and the clinical management required.

Word	Acronym	Definition
Over the Counter Medications	OTC	Medications that are not prescription medicines or Complementary and alternative medicines.
Pharmacist		A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Pharmacy Board of Australia to practise as a Pharmacist, under the Health Practitioner Regulation National Law Act 2009, and its Regulations.
Pharmacist – Accredited		An 'Accredited Pharmacist' for medication reviews in RACFs is a registered Pharmacist who has completed specified education programs or examinations approved by the Australian Association of Consultant Pharmacy or the Society of Hospital Pharmacists Australia.
Polypharmacy		The concurrent use of five or more medicines daily.
Prescription		An instruction by an Authorised Prescriber to a Pharmacist for the supply of a medicine to an individual Resident.
Prescriber Order Sheet	POS	The Prescriber Order Sheet (POS) is a record of current medication orders for each Resident and a communication tool between Authorised Prescribers, Home staff (RNs, ENs and Care Workers), Pharmacy and other Allied Health Professionals.
PRN Medications	PRN	'PRN' is a Latin term that stands for 'pro re nata' which means 'as required or as needed.' PRN medication are ordered by an Authorised Prescriber for a specific Resident, recorded on that Resident's medication chart and taken only as needed.
Psychotropic Medication		A psychotropic drug is a chemical substance that acts primarily upon the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behaviour.
Quality Use of Medicines	QUM	QUM is: • Selecting Resident management options wisely • Choosing suitable medicines if a medicine is considered necessary and • Using medicines safely and effectively.
Reason Codes		The letter/code in a circle used to identify the reason for non-administration of prescribed medications on a medication signing sheet. For example, Ⓡ for refused by resident.
Registered Nurse	RN	A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered, with no restrictions, by the Nursing and Midwifery Board of Australia to practise as a Registered Nurse, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.
Resident		Under the *Quality of Care Principles 2019*, a care recipient who is provided with care through a Residential Aged Care Home.

Word	Acronym	Definition
Residential Aged Care Home	RAC	A residential aged care home at which a person is provided with residential care, within the meaning of the Aged Care Act 1997 of the Commonwealth.
Residential Manager	RM	The person employed at the residential aged care home who is responsible for the management of that RAC Home.
Resident Cover Sheet	RCS	Provides demographic information to identify the resident, prescriber, and aged care home.
Resident Medication Management Review	RMMR	A service provided to a permanent Resident of a service where an accredited Pharmacist, upon the request of the Authorised Prescriber/Medical Practitioner, undertakes a comprehensive Resident medication management assessment.
Scheduled Medication		All medications used in CHL Homes are scheduled as follows in accordance with legislation: • Schedule 2 - 'Over the counter' medication labelled 'PHARMACY. • MEDICINE' sold in pharmacies and some authorised rural retail stores. • Schedule 3 - 'Over the counter' medication labelled 'PHARMACIST ONLY MEDICINE' available only directly from a Pharmacist. • Schedule 4 - Medication available from or on the prescription of an Authorised Prescriber, also known as a 'restricted substance', labelled PRESCRIPTION ONLY MEDICINE'. • Schedule 4 Appendix D - The subset of Schedule 4 medications liable to abuse or misuse, for example benzodiazepines (except the Schedule 8 benzodiazepines flunitrazepam and alprazolam), anabolic-androgenic steroids and ephedrine. Also known as a 'prescribed restricted substance' labelled PRESCRIPTION ONLY MEDICINE'. • Schedule 8 - Medication known to cause dependency in some people available from or on the prescription of an Authorised Prescriber, also known as a 'drug of addiction', labelled 'CONTROLLED DRUG'
Self-Administration		Where a Resident administers their own medications following a clinical assessment by a Registered Nurse and Authorised Prescriber who have deemed the Resident as capable to safely self-administer.
Social Leave		Where a Resident is away from the Home overnight for social reasons and the medications are given to the Resident or their authorised representative. The reason for non-administration of medications during a Resident's social leave is Ⓛ and this must be documented on the medication signing sheet.
Sliding Scale		A prescribed change in the pre-meal or night time insulin dose based on pre-defined blood glucose level ranges.
Stable Diabetes		A type of diabetes where a person's blood glucose (sugar) levels are well controlled with minimal fluctuations and within range for the individual Resident as defined by the Authorised Prescriber / Medical Practitioner and the resident is prescribed a fixed dose of insulin.

Word	Acronym	Definition
Subcutaneous injection	SC	Route for medication - an injection delivered into the tissue between the skin and the muscle underneath.
Sublingual	SL	Route for medication - under the tongue
Supervision - Direct		Involves the Registered Nurse (RN) being present to observe, work with and direct the person who is being supervised. Direct Supervision is required until competency is established.
Supervision - Indirect		Involves the Registered Nurse (RN) working in the same Home or organisation as the supervised person, but the RN does not constantly observe the activities of the delegate. The RN must be available for reasonable access. Indirect Supervision is appropriate in circumstances of established delegation and established competency.
Telephone Order		An Authorised Prescriber may give a medication order verbally over the telephone to a registered person such as a Pharmacist or a Registered Nurse. This telephone order must be confirmed by a second person (does not need to be a Registered Nurse).
Therapeutic Drug Monitoring		Therapeutic drug monitoring is a branch of clinical chemistry and clinical pharmacology that specializes in the measurement of medication concentrations in blood.
Toxic		**Toxicity** refers to how **poisonous** or harmful a substance can be. **Drug toxicity** occurs when a person has accumulated too much of a **drug** in his bloodstream, leading to adverse effects on the body.
Transcribing		Transcribing is the copying of an Authorised Prescriber's medication order from one source to another.
Transdermal		Route for medication – through the skin absorbed slowly into the body.
Unstable Diabetes		A type of diabetes where two or more consecutive BGLs are outside the range of the Directive the Resident is considered to be 'Unstable'.
Urgent Use Medications		The approved Schedule 4 and Schedule 8 medications may be stocked at a RAC Home for urgent treatment when the retail pharmacy which provides residents' dispensed medicines is closed.
Vaccination		A substance used to stimulate the production of antibodies and provide immunity against one or several diseases, prepared from the causative agent of a disease, its products, or a synthetic substitute, treated to act as an antigen without inducing the disease.
Witness		A witness is a qualified person who observes or hears the appropriate process or verbal order.
C		Staff need to be assessed as competent BEFORE they can perform this procedure.
✓		Staff can perform this procedure as part of their job role.
✖		Staff CANNOT perform this procedure - it is outside the scope of their job role.

REFERENCES

1. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
2. Health (Drugs and Poisons) Regulation 1996 (QLD)
3. Poisons and Therapeutic Goods Regulations 2008 (NSW)
4. Quality of Care Principles 2014
5. Reporting Adverse events to medicines and vaccines TGA May 2014, https://www.tga.gov.au/publication/reporting-adverse-drug-reactions
6. The Digital Australian Immunisation Handbook September 2018: https://immunisationhandbook.health.gov.au/
7. http://www.ahpra.gov.au/About-AHPRA.aspx
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MEDICATION MANAGEMENT FRAMEWORK

PURPOSE

This framework and manual have been developed to provide medication policy and procedural information for staff working in a Catholic Healthcare Limited (CHL) Residential Aged Care Home (RAC).

The manual has been developed considering the circumstances of the Home, consideration of Commonwealth and State (NSW and QLD) legislative requirements, guidelines, and contemporary practice within the aged and health care sectors.

OVERVIEW - SAFE AND CORRECT MEDICATION MANAGEMENT

RAC Homes support and often manage each Resident's medicine needs, while ensuring safe and correct medication management for all Residents, including those moving between the Home and other health care settings. The goal of any medicines service for older people is to promote quality of life.

Outcome

CHL RAC is committed to managing Resident's medications safely and correctly to:

1. Optimise health and quality of life outcomes for Residents.
2. Minimise health and safety risks for Residents.
3. Avoid risks of exposure to legal liability for employees and the Organisation.
4. Comply with the Aged Care Act 1997, specifically the Quality of Care Principles 2014.

Clinical Governance

The RAC Clinical Governance system operates within CHL's corporate governance framework whereby the board, managers and clinicians share responsibility and accountability for safe and effective Resident care.

Residents have a right to high quality aged care and information to support them to participate in their healthcare decisions, which includes medication management and administration. CHL's RAC clinicians play a critical role in achieving this through compliance with Organisational medication policies and procedures.

PHILOSOPHY OF MEDICATION MANAGEMENT

Goal

The goal of medication management within CHL RAC is to optimise quality of care by promoting safe medication administration processes.

Objectives

The objectives of medication management at CHL RAC Homes are:

1. Maintain and achieve a safe & high standard of medication management.
2. Promote safe administration of medications.
3. Respect the Residents' right to a quality medication system.
4. Respect the Resident's choice.
5. Acknowledge and work within the framework of Charter of Aged Care Right.

PRINCIPLES OF SAFE MEDICATION ADMINISTRATION

Resident Assessment and Request for Assistance with Medications

On admission to the Home and on return from hospital, a Resident is assessed, and a medication regimen and medication Care Plan is established or reviewed. This plan is subject to ongoing monitoring and reviews on a regular basis.

In **Queensland,** a Resident or their Authorised Representative **Must** formally request the assistance of a Care Worker to assist with taking of prescribed medications that have been supplied for the Resident as a dispensed medicine. The request must be on the *RAC_Request for Care Worker to Assist with Taking Prescribed Medications Form*.

The Care Worker is required to assist the Resident to take the dispensed medicine under the directions on the DAA or on the label attached to the dispensed medicine's container. The level of assistance required may change during the Resident's stay. The Resident or their Authorised Representative can withdraw consent at any time by providing the Home with written notification.

Competent and Qualified Staff

CHL acknowledges it is the Home responsibility to provide appropriately qualified staff to safely assist and undertake the administration of medications.

In CHL Homes the Residential Manager or Senior Delegate Registered Nurse may elect that Registered Nurses, Enrolled Nurses and Care Workers complete the following:

- CHL Medication Essentials Course.
- CHL Medication Knowledge Assessment.
- CHL Medication Competencies.

MEDICATION MANAGEMENT PROCESS

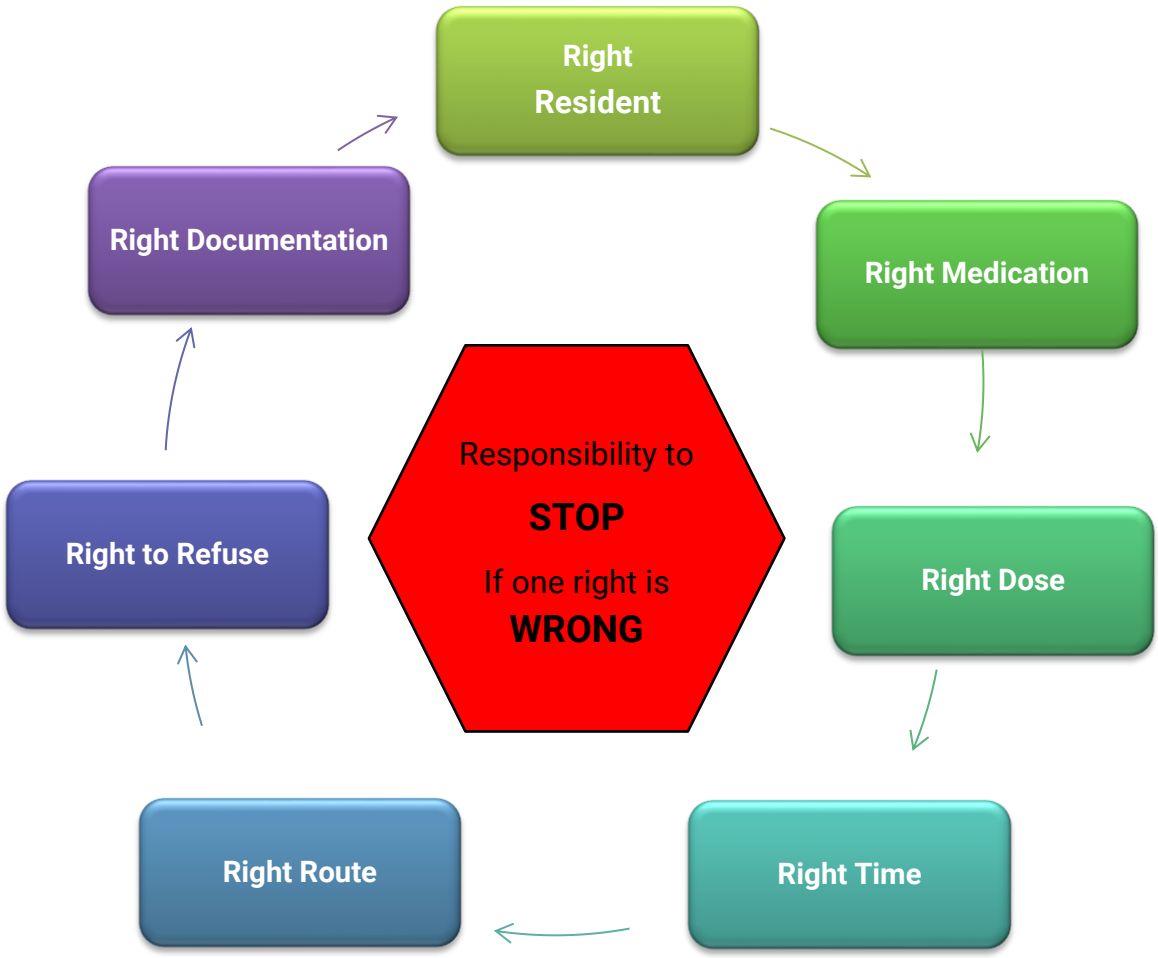
The following outlines the medication management processes and the components at the core to support quality use of medicines.

Health professionals, including Authorised Prescribers, Pharmacists, Registered and Enrolled Nurses and authorised Care Workers are involved in the RAC medication management process (as per the diagram above) to support and ensure the quality use of medicines.

RIGHTS AND RESPONSIBILITIES FOR MEDICATION ADMINISTRATION

Staff should ensure the following rights and responsibility to STOP if one right is WRONG.

When administering medications:



Clinical Considerations

Residents are to be assessed at each medication round to ensure that their condition has not changed rendering them unable to take their medication as prescribed. For example:

- If they are having difficulty swallowing.
- If their conscious state has altered and they are drowsy.

Changes in Resident clinical status should be immediately referred to the Registered Nurse for further assessment and instruction e.g. withhold the medication, contact the Authorised Prescriber / Medical Practitioner, document changes in the Progress Notes.

1. Right Resident

   Staff are to check name and photo ID a *Resident Cover Sheet, Prescriber Order Sheet, Signing Sheet*/eCase Medman and DAA to ensure they have the right Resident before giving any medications.

2. Right Medication

   Staff are to check they have the right medication by checking the label on the medication e.g. box or eye drops or DAA for the Resident against the *Prescriber Order Sheet and Signing Sheet*/eCase Medman.

3. Right Dose

   Staff are to check they have the right dose by checking the *Prescriber Order Sheet* and tablets in the DAA blister compartment against the prescribed order and number of tablets written on the *Signing Sheet*/eCase Medman for that specific time and day.

4. Right Time

   Staff are to check the *Prescriber Order Sheet, Signing Sheet*/eCase Medman and DAA blister e.g. pink for breakfast and the blister compartment for the day of the week. Staff are to make sure they have the right time Webster-Pack/Card and compartment before 'pushing' out the medication.

5. Right Route

   Staff are to check the route for administration on the *Prescriber Order Sheet.* If it is a non-packed medication, staff are to check that the medication is clearly labelled and is being administered by the prescribed route and applied to the correct place. For example, eye drops both eyes, cream to be applied to left lower leg. The *Resident Cover Sheet* also provides information on administering medications including alteration of dose form such as crushing medications.

6. Right Documentation

   Care Workers are to sign the *Signing Sheet* and number of tablets/pieces administered **after** observing the Resident swallowing the medication. Where there are half tablets, these should be included in whole numbers e.g. at breakfast the Resident has five (5) whole tablets and one (1) ½ tablet, this is documented as 6.

   Care Workers are to sign the *Signing Sheet* for each individual non-packed medication such as a cream **after** administration of the medication. The Homes with eCase Medman system, Care Workers change the status to **"Given"** then use the Multi-Sign Function.

   Registered Nurses (RN) and Enrolled Nurses (EN) are to sign for the administration of **each** individual medication, packed and non-packed.

7. Right to Refuse

   Residents have a right to refuse medication. A Resident's refusal of medication **Must** be reported to the RN and documented in the *Resident's Progress Notes* and on the *Signing Sheet* using the ® reason code. The Authorised Prescriber/Medical Practitioner should be advised as appropriate. The Homes with eCase MedMan system, Care Workers change the status to **"Refuse"** before signing in eCase MedMan or contact RN/EN for "Multi-Sign" Function.

8. Responsibility to STOP

   If any of the above rights are wrong, staff have a responsibility to **STOP** the administration of the medication and **report** to the RN and/or Residential Manager.

Medication Rounds

The procedure for administration of packed and non-packed medications should ensure that all medications are administered to the Resident at the appropriate time.

The administration of Schedule 8 medications not packed in Regular Webster-Pack/Card will be completed separately from regular medication rounds.

Medication Trolley

The following equipment should be on the Medication Trolley for each Medication Round:

- Rx Medication box with Resident Cover Sheet, Prescriber Order Sheet and Signing Sheets and any Directives e.g., Anticoagulant Directive
- Packed and non-packed medications
- Pil-Bob/s
- Disposable medicine cups, spoons, water, thickened fluid, cups
- Device to alter oral medications e.g., Rhino Crush or Silent Knight, Pill Cutter
- Suitable diluent for crushed medication e.g., Gloup
- Tissues
- Hand sanitiser and gloves
- Pen
- Sharps container
- Garbage bag
- Other equipment may also be required depending on the medications to be administered. For example, cytotoxic Pill-Bob, purple gloves etc.

Managing Refusal of Medications

Resident's Right

It is the policy of CHL to acknowledge and respect the individual's choice regarding their right of refusal to take medication prescribed for them.

Response and Reporting

If Resident refuses to take their medication:

- Staff are to report refusal to Registered Nurse and document 'Refused' on the Signing Sheet next to the medication/s or change the status to **"Refuse"** in eCase MedMan, and reason for refusal in the Resident's Progress Notes.
- Staff (RN, EN, Care Workers) are to:
    - Explain the reason for the medication.
    - Ask the Resident why they do not want to take it - any fears, concerns etc.
    - Reassure and encourage the Resident to take it.
- The RN or EN is to inform the Resident's Authorised Prescriber/Medical Practitioner/Residential Manager when medication is refused as clinically appropriate. Factors to consider include type of medication refused, frequency of refusal etc.

SELF-ADMINISTRATION OF MEDICATIONS

Applies to:

- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

Residents who have been formally assessed as being able to self-administer their medicines as part of maintaining their independence are supported to do so.

Need for Clinical Assessment

- Residents must have their cognitive ability assessed on admission through the completion of the Psychogeriatric Assessment Scale (PAS).
- Residents must have an *eCase Medication Assessment* which include Self-Medication Checklist if requesting to self-administer their medications. The Authorised Prescriber / Medical Practitioner is to sign and to review annually or as required.
- The Resident's Authorised Prescriber / Medical Practitioner will review the results of the PAS and eCase Medications Assessment giving consideration to fine motor skills, visual acuity and the suitability and applicability of dose administration aids in addition to their cognitive ability.
- If a Resident is cognitively able to administer their own medications and wishes to do so, they are to be supported by trained and competent staff.
- Residents may wish to administer some, but not all of their medications. For example, they may choose to self-administer their inhaler medication but choose to have staff administer oral medications.
- Staff administering medications are to document in the signing sheet for self-administering or change the status to "Self-Administer" in eCase MedMan. Residents to indicate that the medication has not been administered by staff due to the Resident being authorised to self-administer the medications, and that the self-administration has not been directly observed (e.g. 'S' or 'self-administered').
- The Registered Nurse is to monitor weekly or if concerned that the Resident is taking medications appropriately by checking the DAA(s)/original dispensed medication container(s).
- Regular Resident monitoring for compliance by a Registered Nurse should be undertaken as part of the Resident's Care Plan evaluation process.

Considerations

Where Residents have been formally assessed as being competent to self-administer medications, they should:

- Have a current Prescriber order Sheet.
- Inform staff of any complementary or alternative medications.
- Inform staff of any changes to the medication regime.
- Keep the medications in a locked area in their room.

RESIDENT LEAVE – SOCIAL, HOSPITAL AND DISCHARGE

Supplying Medications

If a Resident is on social leave or outing, the medications are given to the Resident or Authorised Representative in a **Webster-Pack/Card** and include **Non-Packed** medications.

When a Resident is discharged from the Home, all medications included S8 medications are returned to Resident or Authorised Representative.

Responsibility

If the medication is to be administered by an Authorised Representative, they must be willing to take the responsibility if the Resident is unable to self-administer and also should be advised of the use of the **Webster-Pack/Card** and any other medications that are not included in the **Webster-Pack/Card**. It is preferable to provide the Authorised Representative with the copy of Resident's Prescriber Order Sheet for extended social leave (that is more than one day).

Documentation

The staff member is to document the reason code for Ⓞ Outing (Medication with Resident) or Ⓛ if overnight for Social Leave or Ⓗ for Hospital Leave on the medication Signing Sheet or change the status to **"Outing"** or **"Social Leave"** or **"Hospital Leave"** in eCase MedMan, and then for each subsequent medication administration round until, they return. Document that the medications were supplied to the competent resident/Authorised Representative in the Progress Notes.

On Return from Leave

Upon the Resident's return from leave the DAA/Non-Packed medication must be checked to confirm it has not been tampered with and that medications have been administered.

Where tampering has occurred or is suspected the Registered Nurse must inform the Residential Manager.

PROCEDURES - RESIDENT RETURN FROM OUTING/LEAVE

Check Medication On Return from Outing/Leave

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Check the DAA/Non-Packed medication to confirm it has not been tampered with and that medications have been administered.
2. Where tampering has occurred or is suspected the Registered Nurse must inform the Residential Manager and if there are any concerns, refer to MP to review the Resident.
3. Document that the medications had returned from Resident/Authorised Representative in the Progress Notes.
4. If Resident/Authorised Representative did not return the DAA/Non-Packed medication, advise Supply Pharmacy, and require DAA/ Non-Packed medication as soon as possible.
5. Inform Resident/Authorised Representative that it may have additional cost for the next medication bill.

PROCEDURES - RESIDENT RETURN FROM HOSPITAL

Medication Administration on Return

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Read medical discharge summary from hospital for current medication orders.
2. Advise Authorised Prescriber/Medical Practitioner of Resident's return from hospital and need for review of discharge medications compared with pre-hospital medication regime.
3. Advise Supply Pharmacy of Resident's return from hospital and require DAA as soon as possible.
4. Photocopy the medications listed on the medical discharge summary and place them in the Resident's RxMed Chart folder.
5. Confirm if Resident returned with medications from hospital.
6. RNs and ENs are to administer medication as prescribed from the medical discharge summary which is valid for 7 days or as advised by the Resident's Authorised Prescriber /Medical Practitioner.
7. Following review by the Authorised Prescriber / Medication Practitioner the Prescriber Order Sheet is to be scanned (MedComms) to the Supply Pharmacy, if required.

PROCEDURES - RESIDENT DISCHARGE/TRANSFER

Providing Medications on Discharge/Transfer

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Advise the Supply Pharmacy **at least 48 hours prior** to discharge to ensure remaining medications and prescriptions stored at the pharmacy are given to the Home.
2. On day of discharge/transfer:
    - Select the correct Resident **Webster-Pack/Card** including non-regular pack.
    - RN Check for non-packed medications (including S8 cupboard)-RN will provide any S8s that require to be handed over.
3. Place all medications and prescriptions in a bag with the Resident's name on it.
4. Provide the Resident or their Authorised Representative with a **copy** of the current Prescriber Order Sheet.
5. Document the discharge/transfer in the Resident's Progress Notes.

Therapeutic Drug Monitoring

Why Monitoring is important?

Therapeutic drug monitoring measures drugs at specific intervals to check the concentration of the medication in a Resident's bloodstream.

Drugs that are monitored usually have a narrow therapeutic range. That is, the dosage required to be effective is close to the dosage that causes significant side effects and/or signs of toxicity.

Monitoring of drugs with a narrow therapeutic range is necessary to ensure a steady concentration of medication is maintained within the blood stream. Where the levels are higher or lower than the target range the Authorised Prescriber / Medical Practitioner can adjust the drug dosage to meet the individual needs of the Resident. The target concentration for a medication can be dependent on the condition being treated.

Note: Therapeutic monitoring is complementary to and not a substitute for clinical assessment.

Responsibilities

In consultation with Authorised Prescriber/Medical Practitioner Registered Nurses should identify Residents who may require therapeutic drug monitoring.

Note:

- Routine measurement of pulse rate before giving Digoxin medication is not necessary.
- Do not withhold the medication without direction from MP.
- If MP request regular monitoring, please document on the *RAC Observation and Oxygen Directive* and review annually or as required.

COMPLEMENTARY AND ALTERNATIVE MEDICINES (CAMS)

Reviewed by Authorised Prescriber / Medical Practitioner

All herbal medicines, vitamins and minerals, homeopathic measures, nutritional supplements, some aromatherapy products, Chinese medicines, Australian indigenous medicines and ayurvedic medicines (Indian) are to be reviewed by the Resident's Authorised Prescriber / Medical Practitioner, approved, and prescribed on the Resident's *Prescriber Order Sheet*.

Where a Resident chooses to continue to take CAMs not prescribed by their Authorised Prescriber / Medical Practitioner, they are required to complete a *RAC_Risk Acknowledgement Form* and manage these medications either themselves or with the support of their Authorised Representative or another visitor.

MEDICATIONS AND ALCOHOL

Clinical Considerations

Age-related changes in physiology affect the way the body handles alcohol resulting in alcohol remaining in the older persons' system longer and increasing health risk such as falls.

Residents are also more likely to be prescribed medications that interact with alcohol increasing the risk of adverse effects e.g. exacerbation of medical conditions.

In some cases, alcohol decreases the effectiveness of medication and in other cases enhances the effectiveness, sometimes reaching toxic levels. For example, Residents prescribed Anticoagulant Therapy who consume alcohol potentially have an increased risk of haemorrhage.

Responsibilities

Resident who consumes regular alcohol will be reviewed by their Authorised Prescriber / Medical Practitioner/Pharmacist for possible interactions.

Where clinical indicated the Resident's alcohol management may be prescribed on the *Prescriber Order Sheet* by the Authorised Prescriber / Medical Practitioner

CLASSIFICATION OF CHL HOMES

The policy supports and complements individual State and Commonwealth specific legislation and regulations. Note any applicable legislative or professional requirements takes precedence and will be applied over specific CHL policy.

CHL has the following NSW Homes classified as a 'Nursing Home':

1. Bodington	9. Macquarie Care Centre
2. Gertrude Abbott Aged Care	10. McQuoin Park
3. Holy Spirit Casula	11. Our Lady of Loreto Gardens
4. Holy Spirit Croydon	12. St Anne's Aged Care, Hunters Hill
5. Holy Spirit Dubbo	13. St Catherine's Aged Care
6. Jemalong Residential Village	14. Villa Maria Centre Unanderra
7. Lewisham Nursing Home	15. The Haven Aged Care
8. Mackillop House Norwest	16. St Hedwig Village

Note: The above list of Homes is subject to amendment.

eCase Medication Management (MedMan)

> eCase5 Medication Management
> eCase5 Medication Management Administration

eCase Medications Management (MedMan) is a module that forms part of the broader eCase suite. Please refer to **wiki** (Menu>WIKI) in eCase – Medication Management.

MedMan helps manage the distribution of medications to residents and integrates with Pharmacy systems to gather up-to-date and accurate medication information. eCase MedMan integrates to several commercial pharmacy prescribing/dispensing systems, and polls regularly for information before displaying it within the eCase environment.

In addition, MedMan is also integrated with MIMS to provide current information on all medications and interactions.

CHL has the following Homes using eCase MedMan:

1. Bethlehem House	16. St Anne's Aged Care, Hunters Hill
2. Brigidine House Randwick	17. St Bede's Home South Hurstville
3. Charles O'Neill Hostel Mayfield West	18. St Hedwig Village
4. Emmaus Village	19. St James Villa Matraville
5. George Mockler House	20. St John's Villa New Lambton
6. Gertrude Abbott Aged Care	21. St Joseph Aged Care, Hunters Hill
7. Holy Spirit Aged Care Revesby	22. St Mary's Retirement Village Berkeley
8. Holy Spirit Casula	23. St Mary's Dubbo
9. Holy Spirit Croydon	24. St Paul's Residential Aged Care
10. Holy Spirit Dubbo	25. St Peters Lane Cove North
11. Jemalong Residential Village	26. The Sister Anne Court Aged Care
12. Lewisham Nursing Home	27. Villa Maria Centre Unanderra
13. Lewisham Retirement Hostel	28. Vincentian Aged Care
14. MacKillop House Norwest	
15. Percy Miles Villa	

Note: The above list of Homes is subject to amendment.

REFERENCES

1. Aged Care Act 1997
2. CHL Clinical Governance Framework
3. CHL Privacy Policy
4. NSW Poisons & Therapeutic Goods Regulation 2008 (current version from 1 January 2019)
5. NSW Public Health Act 2010
6. ANMJ, Nursing Guidelines for the Management of Medicines in Aged Care January 2019
7. Privacy Act 1988
8. Queensland Health (Drugs and Poisons) Regulation 1996
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13. CHL Bug Control e-Manual.
14. Clinical Dosage Calculations for Australia and New Zealand, 1st Edition, Brotto & Rafferty 2012.
15. Five Moments of Hand Hygiene, Hand Hygiene Australia: www.hha.org.au
16. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
17. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
18. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
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20. Pil-Bob Brochure, Webstercare 2014.
21. Reporting Adverse events to medicines and vaccines TGA May 2014: https://www.tga.gov.au/publication/reporting-adverse-drug-reactions
22. Standard Operating Policy and Procedure: Exceptional circumstances during a routine medication round. Webstercare 2012.
23. The Digital Australian Immunisation Handbook September 2018: https://immunisationhandbook.health.gov.au/
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QUALITY SYSTEMS

APPROVED PROVIDER'S RESPONSIBILITY

Outcome

CHL through its local RAC Homes' management teams acknowledges its responsibility to provide a medication system which promotes safe, effective, and appropriate medication use and contributes overall to the quality use of medicines.

Medication Systems

CHL acknowledges its responsibility to provide a medication system which contributes to the quality use of medicines through the provision of:

- The most Senior Registered Nurse (Chief Nurse) will be employed as either the Residential Manager or Care Manager in each RAC home and will hold responsibility for ordering and maintaining the emergency S4D and S8 Imprest Stock Medications.
- An appropriately qualified and authorised person including a Registered Nurse (RN), Enrolled Nurse (EN) and Care Worker (CW) to safely undertake the administration and management of medications.
- Ongoing assessment by a regulated health professional who is qualified to assess the physical, mental, and behavioural aspects of the Resident, and the ways in which medication may affect them.
- A system by which all medication administration is documented, and medication incidents are reported, assessed and remedial action taken.
- A system of safe storage of all medications, including those self-administered by Residents, which complies with relevant legislative requirements.
- Medication reviews by regulated health professionals.
- A system which ensures continuity of medication supply.
- A system which ensures the appropriate disposal of medication.

Medication Records

CHL acknowledges its responsibility to provide medication records which contain information that supports identification of the Resident and allows for clear documentation.

Documentation includes the Authorised Prescriber medication order and requires directions associated with the medication prescribed.

CHL has a preferred medication record that is prescribed for use and negotiated as part of its pharmacy agreements.

MEDICATION ADVISORY COMMITTEE (MAC)

Outcome

All CHL Homes shall have a Medication Advisory Committee (MAC) or be an active member of a Regional MAC which provides medication management leadership and governance, and assists in the development, promotion, monitoring, review and evaluation of medication management policies and procedures that will have a positive impact on health and quality of life for Residents. The MAC will meet on a quarterly basis to benefit the Homes' needs.

Terms of Reference

The responsibilities of the MAC Committee are to:

1. Implement relevant policies, professional standards/guidelines, regulations, and legislation on medication management in the Home.
2. Make recommendations to the management of the Home on any matter relating to medication use to optimise quality use of medications.
3. Consider the review, analysis, and evaluation of:
    a. Medication usage including the use of PRN medication.
    b. Medication incidents, errors, and audit results.
    c. Adverse drug reaction reporting.
    d. Antibiotic stewardship.
    e. Psychotropic medications.
    f. Urgent medication use (NSW) & Imprest medication use (QLD).
4. Promote and facilitate multidisciplinary collaboration in promoting quality use of medicines in the Home.
5. Support and promote education programs on medication administration and management that support the quality use of medicines (QUM) in the Home.
6. Provide recommendations for improvements in medication management delivery in areas such as policy, procedure, audits, and quality indicators.

Membership

The Medication Advisory Committee will comprise of:

1. The Residential Manager or delegated Registered Nurse (where the Residential Manager is not an RN) {Chairperson}.
2. Care Manager, Registered Nurse, Care Worker.
3. An Authorised Prescriber/Medical Practitioner who attends Residents at the Home (if possible).
4. The Pharmacist or Pharmacists responsible for the supply of medication to the Home.
5. The Accredited Pharmacist is responsible for the review of medications (if possible).
6. Others co-opted by the Committee from time to time such as allied health, geriatrician.

Quorum for Meeting

A quorum will consist of at least half the members and representing a minimum of two disciplines e.g. Registered Nurse, Supply Pharmacist, Medical Practitioner etc.

Frequency of Meetings

Each Home shall hold MAC Meetings three times a year to benefit the Homes' needs, or as required such as following any incident or event which has the capacity to affect the status of medication management at the Home.

The Home may consider joining a Regional MAC Meeting as follows:

1. Join together with other CHL Homes.
2. Meet with other residential aged care providers in the local area, on the provision that prior approval is sought from the Regional Manager in regard to privacy and confidentiality of information shared as well as addressing the elements of the CHL MAC Agenda.

Agenda and Minutes

1. The Chairperson will be responsible for liaison with Committee Members and the Agenda.
2. The Chairperson will be responsible for liaison with other Sub-Committees and reporting at the Management Team or equivalent.
3. The manager or as delegated staff will be responsible for taking and distributing the Meeting Minutes to all Committee Members.
4. A copy of the Meeting Minutes will be kept on site and uploaded to Connect Hub.

Reporting

1. The Committee will provide reports to the Residential Manager, as appropriate.
2. Urgent matters will be reported to the Clinical Governance and Safe Care Team and the Regional Manager, as appropriate.

RESIDENTIAL MEDICATION MANAGEMENT REVIEW PROGRAM (RMMR) & QUALITY USE OF MEDICINES PROGRAM (QUM)

Outcome

All CHL Homes shall have their Residents' medications regularly reviewed by members of the health professional team. These reviews should be in accordance with the relevant professional standards, guidelines, regulations, and legislation.

Residential Medication Management Review Program (RMMR)

An RMMR is a service provided to a permanent Resident of a CHL Home where an Accredited Pharmacist, upon the request of the Medical Practitioner, undertakes a comprehensive Resident medication management assessment to identify, resolve and prevent medication-related problems. The accredited Pharmacist consults with the Resident and other members of the Resident's health care team.

The intent of the RMMR program is to enhance the quality use of medicines and reduce the number of adverse medicines events through a comprehensive medication review.

Service Agreements

Each CHL RAC Home will be covered by CHL Corporate RMMR Service Agreement.

Triggers for an RMMR

The following circumstances are examples that may trigger a medication review:

1. Frequent and or 'regular' use of PRN medicines
2. Discharge from a hospital in the previous four (4) weeks
3. Significant changes to medication regimen in the past three (3) months
4. A change in clinical or cognitive presentation, medical condition or physical function or abilities such as increased number of falls, inability to swallow.
5. Prescription of medicines with a narrow therapeutic index or requiring therapeutic monitoring (e.g., anticoagulants, insulin)
6. Presentation of symptoms suggestive of an adverse drug reaction
7. Sub-therapeutic response to treatment
8. Ongoing refusal of medications.

RMMR Process

The process of the RMMR (the review) must ensure that the Accredited Pharmacist works in cooperation with the Resident's Medical Practitioner to source, collate, and evaluate medication-related information with a view to identifying, preventing, and resolving medication-related problems.

The review should be undertaken in accordance with legislative requirements and relevant professional guidelines. This includes collaboration with the Medical Practitioner, Pharmacist, nursing staff, other health professionals, and the Resident or their Authorised Representative.

When required, the review team should include other health professionals including Physiotherapists and Speech Pathologists to provide expertise for specific circumstances.

Confirmation that a review has occurred at least once every 2 years or more frequently, if clinically indicated, should be documented in the Resident's progress notes.

Medication Reviews excluding RMMR

Medication reviews should also be undertaken separately to an RMMR. It is the responsibility of the Residential Manager or the Registered Nurse (where the Residential Manager is not a Registered Nurse) together with the Resident's Medical Practitioner to ensure that medication reviews are attended at least every 4 months in accordance with standards/guidelines.

Considerations for Medication Reviews

Aspects that should be considered in respect to a Resident's medication review include:

1. Monitoring of risks of adverse drug reactions and interactions, particularly if polypharmacy is combined with over-the-counter medications, or complementary and alternative medicines and alcohol.
2. Reviews of prescribed medication following changes in comorbidity and progression of disease.
3. Reviews of antibiotic medication and psychotropic medication.
4. Prescribing of PRN and Nurse Initiated Medications to cover anticipated events.
5. Use of alternative medication formulations.
6. Requirements for end of life care.

Quality Use of Medicines Program (QUM)

QUM Service means a Quality Use of Medicines Program provided to a Service through a Service-wide approach. A Registered Pharmacist or Accredited Pharmacist conducts a QUM Service in association with appropriate members of the Residential Aged Care Home. This may include:

1. Medication Advisory Activities such as participation in the MAC meetings
2. Education activities such as in-service sessions and drug information
3. Continuous improvement activities such as medication audits.

The intent of the QUM program is to improve practices and procedures as they relate to the quality use of medicines in the RAC Home.

MEDICATION RECONCILIATION

Outcome

It is the joint responsibility of the Residential Manager or the Registered Nurse (where the Residential Manager is not a Registered Nurse), the Resident's Medical Practitioner and Supply Pharmacist to ensure that medication reconciliation is attended as required to ensure a Resident receives all medications prescribed and to reduce the risk of medication omissions and duplications.

Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each Resident's current medicines including prescription, over the counter and complementary and alternative medicines. The list is compared with the medicines ordered to identify and resolve any discrepancies with the Authorised Prescriber/Medical Practitioner, any changes are documented. For example, resident return from hospital.

Triggers for Medication Reconciliation may include:

- Admission to the Home from the community, hospital, or other care setting
- Return from hospital or medical specialist appointment.
- Changes in medication orders including dose changes, ceased and new medications.
- Reprinting/rewriting of the medication chart by the Medical Practitioner.
- Following an RMMR reviewed by the Medical Practitioner.

Medication reconciliation includes:

Matching the medicines, the Resident should be prescribed to those they are actually prescribed. In the event of any discrepancies, these are discussed with the Authorised Prescriber/Medical Practitioner and reasons for changes to therapy are documented. For example, staff checking the DAA against the Prescriber Order Sheet and signing sheets/eCase MedMan system to ensure they are all the same.

MEDICATION INCIDENT MANAGEMENT

Outcome

To identify and manage medication incidents to:

- Minimise the risk to the Resident's health status.
- To facilitate analysis of causes, trends, preventative measures, and policy and procedural review.
- Provide opportunities for improvements.

Medication incidents are events that could have or did cause the Resident harm, and where medicine is likely to have been a contributing or causal factor.

Medication incidents may be the result of error or system failure in the processes of prescribing, dispensing, charting, supplying, storage, administration, or disposal of medicines. Most do not cause any harm; those resulting in harm are called Adverse Medicine Events.

Reporting of Medication Incidents

CHL promotes and encourages a culture of staff reporting of medication incidents. All medication incidents are investigated, and corrective actions taken in accordance with the CHL Incident Management Policy and relevant State (NSW and QLD) requirements.

The Medication Advisory Committee in each Home will review medication incidents and make recommendations and implement actions as required.

Medication incidents may also be reported and discussed at the CHL Clinical Risk Incidents Safety (CRIS) Meeting.

Types of Incidents to Be Reported

The following medication incidents should be reported:

- Medications given to the incorrect Resident.
- Incorrect medication being given.
- Incorrect dose being given.
- Incorrect time of medication.
- Incorrect route of administration of medicine.
- Missing medication.
- Medication found – Report on Service Impact Incident on Connect+
- Out of date medication if administered to resident.
- Lack of or error in documentation such as medication order, medication and signing chart.
- Breaches of the CHL policy and guidelines.
- Incorrect storage of medication.
- Incorrect disposal of medication.
- Incorrect supply of medication from the pharmacy.

PROCEDURES - MANAGING & REPORTING OF MEDICATION INCIDENT

Applies to:
- ✓ Residential Manager
- ✓ Registered/Enrolled Nurse
- ✓ Care Worker

Medication Incident - Registered Nurse/Enrolled Nurse or Care Worker Actions

1. Assess the Resident and provide basic first aid or call 0-000 if required.
2. Secure medication trolley.
3. Observe Resident's clinical status, e.g. variations in level of consciousness, baseline observation, nausea, or vomiting.
4. Continue regular monitoring of pulse, BP, BGL, respirations or other observations, e.g. neurological observations as clinically indicated.
5. Contact Poisons Centre (phone - 13 11 26) where clinically appropriate to identify the critical observation period.
6. Collect details about the medication incident.
7. Notify the Resident's Authorised Prescriber/Medical Practitioner and transfer to hospital if required or directed.
8. Notify Resident & Resident's Authorised Representative.
9. Notify key stakeholders as required, e.g. Residential Manager, Pharmacist.
10. Document actions taken in the Resident's Progress Notes (*Select eCase Progress Notes Type – Incident - Medication*), including what happened, time, immediate steps that were taken, the resident's clinical condition, the persons who were contacted and/or involved and the instructions that were given, as required.
11. Document on an eCase Medication Incident Register before the end of the shift with relevant staff to ensure accurate details of the event are captured in a timely manner.
12. Contact the Supply Pharmacy to maintain supply of medications if required.

Medication Incident - Follow Up Actions

1. Registered Nurse/Enrolled Nurse to complete investigation of the incident specifically:
    - Strategies in place at time of incident
    - Possible contributing factors
    - Outcomes
    - Corrective actions taken to reduce recurrence of same or similar incidents.
    - Update Resident Care Plan if required.
2. Update and complete the eCase Medication Incident Register
3. Inclusion of Medication Incident in MAC meeting discussion as required.

Medication Incident - Managers or as Delegated Actions

1. Review incident and manage any issues identified e.g. supply problem, staff education or documentation.
2. Document additional information on the eCase Medication Incident Register and select *"Managers Review"*. Document date and time if there is a need for further up.
3. Close the medication incident by putting the date on *"Date Issue Closed"* and changing the status to *"Closed* "on the eCase Medication Incident Register.

ADVERSE DRUG REACTIONS INCLUDING ANAPHYLAXIS

Outcome

To identify and manage medication adverse drug reactions and anaphylaxis to:

1. Minimise the risk to the Resident's health status.
2. Allow for analysis of cause, preventative measures, and policy and procedural review.

An adverse drug reaction (ADR) should not be confused with a medication side effect.

A side effect is a predictable effect of the medication, and it may be desirable or undesirable.

Managing Adverse Drug Reactions including Anaphylaxis

It is important to respond to adverse drug reactions and anaphylaxis urgently as they may become life threatening.

Rapid intramuscular administration of adrenaline is critical for the treatment of anaphylaxis as it is lifesaving. This can only be administered by a Registered Nurse if prescribed by the Resident's Medical Practitioner. Adrenaline is included in the CHL Urgent Use/Imprest Medication list and has been incorporated in the NIM list. This must be approved by Medical Practitioner to provide immediate access to those residents that suffer anaphylaxis.

For any anaphylaxis event - staff are to call an ambulance on 0-000 if directed.

Reporting Adverse Drug Reactions including Anaphylaxis

Any suspected adverse drug reactions including anaphylaxis should be reported to the Therapeutic Goods Administration. You do not have to be certain that the medication caused the reaction, just suspicion to report the incident.

PROCEDURES - MANAGING & REPORTING OF ADVERSE DRUG REACTIONS INCLUDING ANAPHYLAXIS

Applies to:
- ✓ Residential Manager
- ✓ Registered/Enrolled Nurse
- ✓ Care Worker

Managing an Adverse Drug Reaction

1. Ring 0-000 if ADR is life threatening or if unsure.
2. Call Registered Nurse for immediate assistance if available.
3. Suspend the administration of the drug immediately.
4. Observe symptoms, e.g. rash.
5. Commence observations, e.g. vital signs as appropriate.
6. Notify Resident's Medical Practitioner/Authorised Prescriber and commence any treatment prescribed by them.
7. Notify the Residential Manager as soon as possible following the event.
8. Withhold all medications until reviewed by a Medical Practitioner/Authorised Prescriber.
9. Document the incident, reaction, and outcome in the Resident's Progress Notes (***Select eCase Progress Notes Type – Incident - Medication***).
10. Notify the Resident's Authorised Representative of the incident.
11. Complete an ***eCase Medication Incident Register*** as soon as possible following the event and at least before the end of your shift.

Managing Anaphylaxis

1. Ring 0-000
2. Call Registered Nurse or other staff member for immediate assistance - **Never leave the Resident alone.**
3. Note symptoms, e.g. swelling of face, lips, and eyes, difficult or noisy breathing, swelling in the throat.
4. If the Resident is conscious lie them flat with their feet elevated unless this results in breathing difficulties.
5. If the Resident is unconscious and breathing regularly lay them on their left side and position to keep their airway clear.
6. Registered Nurse/Enrolled Nurse to nurse initiate oxygen by face mask at 2-4 Litres per minute flow rate unless contraindicated.
7. If there are signs of respiratory and/or cardiac symptoms and there is a medication order of Adrenaline for the Resident, the Registered Nurse is to administer Adrenaline as per directions - delaying administration can result in death. Refer to below ***Procedure – Administer EpiPen® Injection.***

8. If there is no medication order commence basic life support and/or appropriate cardiopulmonary resuscitation (CPR) unless contraindicated by the Resident's advance care directive.
9. Contact the Medical Practitioner/Authorised Prescriber where clinically appropriate to seek further instructions whilst awaiting ambulance.
10. Provide a handover to the ambulance officers.
11. Document the incident, reaction, management, and outcome in the Resident's Progress Notes including timing of each intervention.
12. Notify the Resident's Authorised Representative of the incident and/or transfer to hospital.
13. Complete an eCase Medication Incident Register as soon as possible following the event and at least before the end of your shift.

Reporting an Adverse Drug Reaction, including Anaphylaxis

1. The **Residential Manager** must report any suspected adverse drug reactions to the Therapeutic Goods Administration. Reporting can be done either:
    - Online at the TGA website https://www.tga.gov.au/reporting-problems and following the link to 'Report a problem or side effect'

      OR

    - Download and complete the **'Blue Card'** reporting form from the 'Report a Problem' area of the TGA website. Send completed Blue Cards to the TGA:
        - by email to: ADR.Reports@tga.gov.au as a Word or PDF document (preferred)
        - by mail to Office of Product Review, TGA, Reply Paid 100, Woden ACT 2606
        - by fax to 02 6232 8392.

EPIPEN® (EPINEPHRINE INJECTION)

Applies to:

- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

The EpiPen® Auto-Injector is a disposable, pre-filled automatic injection device that administers epinephrine in the event of a severe allergic reaction.

This can only be administered by a Registered Nurse if prescribed by the Resident's Medical Practitioner.

PROCEDURE – ADMINISTER EPIPEN® INJECTION

1. Identify the resident, inform them if conscious about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. Gather the required equipment (EpiPen®, sharps container, alcohol-based hand rub).
3. Select the correct EpiPen® and Resident's medication records.

   Check Resident's name on the NIM list.
4. Position the Resident comfortably.
5. Select the site for administration. Common injection site for EpiPen® is thigh.

6. Perform hand hygiene.
7. Grasp with orange tip pointing downward.
8. Remove blue safety cap by pulling straight up – do not bend or twist.
9. Place the orange tip against the middle of the outer thigh. You may give the injection directly through the clothing. Do not put your thumb over the end of the unit.

10. Swing and push the auto-injector firmly into the thigh until it "clicks".
11. Hold firmly in place for 3 seconds – count slowly, "1, 2, 3".
12. Remove EpiPen®.
13. After injection, refer to above *Procedure - Managing Anaphylaxis*.

MEDICATION MANAGEMENT AUDIT PROGRAM

Outcome

The medication management auditing program is used to identify and manage medication incidents and to monitor practice outcomes that promote safe medication administration.

Medication Auditing Program

Internal auditing of medication administration and management systems will occur in accordance with the CHL Audit Schedule.

External auditing of medication management systems by an Accredited Pharmacist will occur at least annually or as required.

Scheduled audits of medications as required may occur to support the Quality Use of Medicines.

DRUG RECALL MANAGEMENT

Applies to:

- ✓ Residential Manager
- ✓ Registered Nurse
- × EN or Care Worker

Responding to a Drug Recall

1. CHL will notify the Residential Manager when there is a drug recall.
2. Residential Manager to contact Supply Pharmacy to identify Resident prescribed the drug being recalled and to assist in the recall management including supporting the Supply Pharmacy to remove the drug from circulation at the Home ensuring all medication trolleys and storage cupboards are checked.
3. Registered Nurse to inform each Resident's Medical Practitioner/Authorized Prescriber and seek advice as to further actions to be taken.
4. Report matters to the Residential Manager for further action.
5. Residential Manager to report outcomes to the Regional Manager.
6. Residential Manager to table the drug recall and any actions taken at the next Medication Advisory Committee meeting.

REFERENCES

1. *6th Community Pharmacy Agreement:* http://6cpa.com.au
2. *6th Community Pharmacy Agreement: Programme Specific Guidelines Residential Medication Management Review Programme (RMMR) and Quality Use of Medicines Programme (QUM), July 2017, Australian Government Department of Health*
3. *Aged Care Act 1997*
4. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
5. *Medical care of older persons in residential aged care facilities, 4th Edition, The Royal College of General Practitioners April 2006*
6. *Quality of Care Principles 2014*
7. *Reporting Adverse events to medicines and vaccines TGA online:* https://aems.tga.gov.au/
8. *The Digital Australian Immunisation Handbook September 2018:* https://immunisationhandbook.health.gov.au/

ROLES AND RESPONSIBILITIES FOR MEDICATION ADMINISTRATION

ROLE OF THE RESIDENT'S AUTHORISED PRESCRIBER / MEDICAL PRACTITIONER

Outcome

Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW & QLD) legislation and clinical best practice guidelines.

Legislative requirements and Professional Standards

The Authorised Prescriber/Medical Practitioner is responsible for appropriate clinical assessment and management of the Residents under their care, including that medication orders are written and managed in accordance with the medication systems in place within CHL and in accordance with legislation and regulations.

Specific Responsibilities

1. For new admissions and admission from hospital, the Authorised Prescriber/Medical Practitioner should review and prescribe as soon as possible.
2. The Authorised Prescriber / Medical Practitioner is to ensure legal pharmaceutical prescriptions are provided in a timely manner to ensure the ongoing supply of medications intended for use by their Residents.
3. The Authorised Prescriber/Medical Practitioner is responsible for obtaining consent, verbal or written from a Resident or their Authorised Representative for medical intervention including medication as per medical profession guidelines.
4. The Authorised Prescriber/Medical Practitioner is responsible for assessing and authorising the self-administration of medication by their Residents as requested.

ROLE OF THE SUPPLY PHARMACIST

Outcome

Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW & QLD) legislation and clinical best practice guidelines.

Legislative requirements and Professional Standards

The Supply Pharmacy must dispense and supply medication and/or QUM services according to legislative requirements. It is the expectation of CHL that the Pharmacy Board of Australia's guidelines and professional standards be followed by the Supply Pharmacist.

Specific Responsibilities

1. The Supply Pharmacy has a contract within CHL to supply medications to Homes that outlines their responsibilities.
2. Responsibilities of a Supply Pharmacy apply equally regardless of the number of Supply Pharmacies servicing a CHL Home or if a formal contract is in place.
3. The Supply Pharmacy attends the RAC Home MAC meeting as needed.
4. The Supply Pharmacy attends the RAC Home as needed for the destruction of S8 medication (NSW Home only).
5. The Supply Pharmacy will include alerts for those medications not suitable for crushing on the Prescriber Order Sheet and/or on the dispensed container/ Webster-Pack/Card.
    a. The Prescriber Order Sheet will indicate how medication is to be altered and administered to individual Residents (e.g., crushed or dispersed in water prior to administration).
    b. Advice is sought from the Supply Pharmacy and/or Accredited Pharmacist if a medication is suitable for alteration when ordered.
    c. In most cases, multiple medications may be crushed together. However, there are some exceptions, and the Supply/Accredited Pharmacist is to be consulted.
    d. The Supply Pharmacy or accredited pharmacist will provide CHL Homes with a regularly updated list of common medications that cannot be crushed.
6. The Supply Pharmacy is responsible to provide monthly reports on:
    a. Antibiotic medication usage (Historical Medication Usage -Antibiotic).
    b. Psychotropic medication usage (Psychotropic Drug Usage Report) & Psychotropic Drug Totals Date Range.
    c. S8 medication usage (S8 Clients Medication per RAC Home).
    d. Cytotoxic medication usage.

ROLE OF THE ACCREDITED PHARMACIST

Outcome

Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW & QLD) legislation and clinical best practice guidelines.

Legislative requirements and Professional Standards

The Accredited Pharmacist must provide RMMR and/or QUM services according to legislative requirements. It is the expectation of CHL that the Pharmacy Board of Australia and professional standards will be followed by the Accredited Pharmacist.

CHL highly recommends that the Accredited Pharmacist is independent of the Supply Pharmacy.

Specific Responsibilities

1. The Accredited Pharmacist must enter into an RMMR Service Agreement to conduct residential medication management reviews for permanent Residents on a regular basis in accordance with accreditation and legislative requirements and professional guidelines. The contract may also require them to provide QUM services.
2. The Accredited Pharmacist must ensure they maintain their approval as a Service Provider.
3. The Accredited Pharmacist must ensure that the RMMR is undertaken in cooperation and consultation with the Resident's Medical Practitioner, nursing staff or other health professionals and the Resident to source, collate, and evaluate medication-related information with a view to identifying, preventing, and resolving medication-related problems.
4. The Accredited Pharmacist will provide a full report of the medication review to the Resident's Medical Practitioner and consult directly with the relevant personnel about the findings of the review.
5. The Accredited Pharmacist will notify the Residential Manager if any issues have arisen in the review process including any medication errors identified to enable appropriate action to be taken.
6. The Accredited Pharmacist will undertake RMMRs for each resident this can be utilised every 2 years, or if as clinically indicated.
7. The Accredited Pharmacist attends the RAC Home MAC meeting as needed.
8. The Accredited Pharmacist will conduct auditing of medication management at least annually or as required.

ROLE OF THE RESIDENTIAL MANAGER AND/OR DELEGATED SENIOR REGISTERED NURSE

Outcome

The Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW and QLD) legislation and clinical best practice guidelines.

Specific Responsibilities

1. To ensure the greatest benefit and best outcomes for individual Residents in the use and management of medications by facilitating and promoting consultation and collaboration with the health care tea
2. To ensure the safety and well-being of every Resident, by ensuring that medication management practices within the Home reflect current knowledge, applicable laws, standards, and codes of professional practice, and Organisational policies and procedures as determined by CHL.
3. To provide a safe and therapeutic environment in which CHL staff are able to competently assist and support or administer medications for every Resident.
4. To maintain CHL minimum standards and provide clear direction and guidelines to minimise the risk of medication errors.
5. To ensure those involved in the assistance and support or administration of medications know their rights, roles, and responsibilities under the CHL policies and procedures and relevant legislation for managing medication safely and correctly.
6. To oversee and evaluate the effectiveness of the medication management system which contributes to the quality use of medicines at the Home and make improvements in line with CHL's continuous improvement program.
7. To ensure that there is timely and accurate communication between the Home, Authorised Prescriber, Supply Pharmacy and Accredited Pharmacist.
8. To ensure that medication management system is completed in accordance with legislative and CHL policy requirements.
9. To order and maintain the Emergency Imprest S4D and S8 Stock Medications.

Consideration

At CHL, the Residential Manager who is registered with AHPRA and has current authority to practice without restrictions, is assigned the most senior clinical position when on duty (whether on site or on call) and has responsibility for the purposes of representing CHL regarding medication management and any subsequent delegation of authority, supervision, and direction of less senior Registered and Enrolled Nurses and Care Workers.

Where the Residential Manager is not a Registered Nurse the Residential Manager must nominate a Registered Nurse as the senior clinician who will hold responsibility for medication and any subsequent delegation of authority, supervision, and direction of less senior Registered and Enrolled Nurses and Care Workers.

In addition to the above responsibilities the Residential Manager or their delegated Senior Registered Nurse, where they are not a Registered Nurse, have the following delegation authority and roles and responsibilities:

1. The Residential Manager or Senior RN can delegate the responsibility for the management of administration of medications to a Registered Nurse only.
2. When assessed as appropriate, the Residential Manager or Senior RN can delegate the assistance and support or administration of medication to other staff members who are appropriately qualified to **assist and support** or **administer** medications, and who have been assessed and deemed competent to do so. When any aspect of care is delegated, the Residential Manager or Senior RN must ensure the delegation does not compromise the safety or quality of care for the Resident.

ROLE OF THE REGISTERED NURSE (RN) AND RN IN CHARGE

Outcome

Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW and QLD) legislation and clinical best practice guidelines.

Specific Responsibilities

The RN and RN in charge takes responsibility for the day-to-day management of medication. This includes:

1. Confirmation of consent for a Care Worker to assist a Resident with taking prescribed medication in **Queensland** Residential Aged Care Homes.
2. Delegation to and either direct or indirect supervision of Enrolled Nurses and Care Workers who are suitably qualified and deemed competent to assist and support or administer medications.
3. **A RN will complete the CHL Medication Essentials and identify competency as the new employee and there is compulsory requirement to reassess annually, and any issues or concerns are identified.**

Registered Nurses are required to follow the Code of Professional Conduct for Nurses in Australia (Nursing & Midwifery Board of Australia) and relevant State and Commonwealth legislation.

Based on clinical assessment, the Registered Nurse has the professional responsibility to withhold medications or doses if clinically indicated or if part of an overall care plan by the Authorised Prescriber /Medical Practitioner or in the case of an emergency.

The RN and RN in Charge of a Home must ensure that:

1. The Drug Safe, locked medication room and/or receptacle is kept securely locked when not in immediate use.
2. Any key or other device by means of which the Schedule 8 Drug Safe may be unlocked is kept on the person of the Registered Nurse in Charge. In the absence of 24/7 RN, the key to the Drug Safe is to be placed in a keypad locked box which only the RNs have access to.

Delegated Authority of the RN and RN in Charge

1. The RN and RN in Charge may administer medication when a lawfully written or verbal order to do so has been received from an Authorised Prescriber/Medical Practitioner
2. The RN and RN in Charge may delegate the assistance and support or administration of certain medications to an appropriately qualified Enrolled Nurse (EN) or Care Worker provided they believe at the time of the delegation that the EN or Care Worker:
    - Is suitably qualified and competent to undertake the task safely.
    - Is willing to accept and understands the delegated task and degree of accountability.
    - Communicates with the most senior Registered Nurse on duty at the time, in a timely manner about concerns with medication administration.
    - Knows the acceptable time frame for completion of the activity.
    - Has been provided authorisation and consent by the Resident or their Authorised Representative to assist with their medications where they are residing in a Queensland RAC Home (Care Worker only).
3. The RN and RN in Charge Should not:
    - Delegate medication assistance and support or administration to any staff member who has not obtained the necessary qualifications required by State (NSW or QLD) legislation and/or CHL to administer medication, under these delegated conditions.
    - Delegate medication assistance and support or administration unless the necessary level of supervision can be provided.
4. The RN and RN in Charge is responsible for monitoring Residents' therapeutic regimes and responding to the changing needs of Residents in relation to their medication.
5. The RN and RN in Charge, in delegating medication assistance and support or administration tasks, should be available to carry out complete and ongoing clinical assessment, Resident care planning and evaluation of the care delivery.
6. Where a RN is supervising undergraduate nursing students the RN is to:
    - Confirm the undergraduate nursing student is in second or third year of the course.
    - Confirm the medication administration competency assessments have been successfully completed at university prior to the clinical placement.
    - Provide Direct Supervision to the undergraduate nursing student when undertaking any aspect of medication management.
    - Report any concerns or issues to the Residential Manager.

ROLE OF THE ENROLLED NURSE (EN)

Outcome

Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW and QLD) legislation and clinical best practice guidelines.

Specific Responsibilities

1. Enrolled Nurses are required to follow the Code of Professional Conduct for Nurses in Australia (NMBA) and relevant State and Commonwealth legislation.
2. The EN must act at all times within their scope of practice.
3. The EN who accepts delegation to administer medications is:
    - Responsible for ensuring that they are safely administered.
    - Accountable for safe and competent practice when performing this activity.
    - Suitably qualified and competent to undertake the task safely.
    - Willing to accept and understands the delegated task and degree of accountability.
    - To accurately collect, document and communicate information regarding the Resident's health to the RN to assist them to conduct a clinical assessment of the Resident and evaluation of medication administration.
    - Understanding of the acceptable time frame for completion of the activity.
4. A EN will complete the CHL Medication Essentials and identify competency as the new employee and there is compulsory requirement to reassess annually, and any issues or concerns are identified.

ROLE OF THE CARE WORKER

Outcome

Residents of CHL Homes receive the best possible standard of medication management in accordance with relevant Commonwealth and State (NSW and QLD) legislation and clinical best practice guidelines.

Specific Responsibilities

1. The role of the Care Worker in relation to the quality use of medications is one of assist and support or administration, monitoring, and evaluation to support the wellbeing of all Residents.
2. The Care Worker has a duty of care to the Resident and is responsible to ensure they follow the direction of the Registered Nurse and Medical Practitioner/Authorised Prescriber.
3. A Care Worker will complete the CHL Medication Essentials and identify competency prior to being delegated the task of medication assistance and support or administration. There is a compulsory requirement to reassess annually, and any issues or concerns are identified.
4. A Care Worker who accepts the delegation to assist and support or administer medication must have:
    - Undertaken appropriate education and training.
    - Be assessed as competent by successfully completing CHL medication competency assessment as relevant to the Care Worker.
    - Accept the delegation and understand their responsibilities and accountabilities regarding medication assistance and support or administration.
    - Understand the acceptable time frame for completion of the activity.

Queensland

In **Queensland,** a Resident or their Authorised Representative **Must** formally request the assistance of a Care Worker to assist with taking of prescribed medications that have been supplied for the Resident as a dispensed medicine. The request must be on the ***RAC_Request for Care Worker to Assist with Taking Prescribed Medications Form***. The signed *Request for Care Worker to Assist with Taking Prescribed Medications Form* should be scanned and uploaded to ***eCase Gallery***.

The Care Worker must assist the Resident to take the dispensed medicine under the directions on the Prescriber Order Sheet. The level of assistance required may change during the Resident's stay. The Resident or their Authorised Representative can withdraw consent at any time by providing the Home with written notification.

DELEGATIONS MATRIX FOR MEDICATION MANAGEMENT

	Registered Nurse (RN) **A RN whose professional registration is unrestricted**	**Enrolled Nurse (EN)** **An EN whose professional registration allows for the administration of medication**	**Care Worker** **A Care Worker who has completed the CHL education and has been assessed as competent**
You Can	Administer: • Schedule **2, 3, 4 & 8** medications in all forms • Intramuscular and subcutaneous injections • Enemas • Suppositories, pessaries, and vaginal creams • Nasogastric, PEG or jejunostomy medications or feeds • Nutritional supplements • Oxygen therapy • **Influenza Vaccines (Authorised Nurse Immuniser)** **Administer** & make **clinical decision** regarding: • As Required **(PRN) Medication** • Nurse Initiated Medication **(NIM)** Undertake **Drug Calculations**	Under the direction and delegation of the RN only: **Administer** prescribed medication delivered by the following routes: • **Oral - tablets, liquids, and suspensions** • **Eye, Nose or Ear - drops, sprays, and ointments** • **Topical - creams and ointments** • **Inhalation - puffers, inhalers, nebulisers, and oxygen therapy** • **Transdermal Patches** • **Sublingual** • **Per Vaginal e.g. Pessaries** • **Per Rectum e.g. Suppositories** • **Subcutaneous Injection** • **Intramuscular Injection** • **PEG** • **Variable dose of anticoagulants** • **Sub-cutaneous injections of insulin for Residents with stable and unstable IDDM.** Prior to administering, the dose must be **double checked** with an RN, EN or Care Worker (as defined in this manual) **Administer:** • Nutritional supplements	Under the direction and delegation of the RN only: **Assist and support** residents and **Administer** prescribed medication from a **Dose Administration Aid (DAA),** application of patches and application of non-scheduled/non-medicated creams, ointments, and lotions. **Administer** prescribed medication delivered by the following routes: • **Oral - tablets, liquids, and suspensions** • **Eye, Nose or Ear - drops, sprays, or ointments** • **Topical - creams and ointments** • **Inhalation - puffers, inhalers, nebulisers, and oxygen therapy** • **Transdermal Patches** • **Sublingual** • **Sub-cutaneous injections of insulin via an Insulin Pen Device for residents with stable insulin dependent diabetes.** Prior to administering, the dose must be **double checked** with an RN, EN or Care Worker (as defined in this manual) **Administer:** • Nutritional supplements

	Registered Nurse (RN) A RN whose professional registration is unrestricted	Enrolled Nurse (EN) An EN whose professional registration allows for the administration of medication	Care Worker A Care Worker who has completed the CHL education and has been assessed as competent
You Can	**Assess, authorise,** and **direct** ENs and Care Workers to administer: • **S2** and **S3 PRN Medications** • **S4 PRN Medications** **Administer S8 PRN Medications** Receive, securely store and record restricted and controlled drugs into the Drug Safe and Drug Register/Controlled Drugs Book. **Check** Schedule 8 balances in conjunction with another RN, with competent EN or Care Worker. **Witness** • Schedule 8 medication preparation and administrations with another RN. • The telephone order from a Medical Practitioner/Authorised Prescriber with another RN. • The preparation of medication deliverable by a subcutaneous or intramuscular injection route undertaken by another RN or competent EN. • The preparation of insulin to be administered via an **Insulin Pen Device** for residents with insulin dependent diabetes. • **Influenza Vaccines.** **Take** a telephone order from a Medical Practitioner/Authorised Prescriber.	**Enrolled Nurses** may administer the following PRN medications: • **S2**, **S3** and **S4 PRN Medications** for a Resident following the explicit directions by the Authorised Prescriber/Medical Practitioner on the Prescriber Order Sheet. • **Must contact and consult the Registered Nurse on duty and receive a directive for S4D PRN Medications for Residents.** **Administer** • **Oxygen** to a Resident in the event of an **emergency** following clinical advice and direction from the Registered Nurse • **Nurse Initiated Medications (NIM)** from the CHL approved NIM list **only** following **verbal confirmation** with an RN. **Where the Enrolled Nurse is unsure or has concerns, they MUST contact the Registered Nurse for clinical advice.** **Check** Schedule 8 Balances in conjunction with an RN. **Witness** • Schedule 8 medication preparation and administrations with an RN. • The preparation of insulin to be administered via an Insulin Pen Device for residents with insulin dependent diabetes. • The preparation and administration of subcutaneous or intramuscular medication by an RN/EN. • The telephone order from a Medical Practitioner/Authorised Prescriber with an RN. • **Influenza Vaccines.**	**Care Workers** may **ONLY** assist and support or administer PRN medications as directed by the RN. • **Must contact and consult the Registered Nurse on duty or on call and receive a directive for All PRN Medications for Residents.** Where directed by the RN: the direction can be **verbalised** and **documented in the Resident's progress notes.** **Administer oxygen** to a Resident in the event of an **emergency** following clinical advice and direction from the Registered Nurse. **Where the Care Worker is unsure or has concerns, they MUST contact the Registered Nurse for clinical advice.** **Check** Schedule 8 Balances in conjunction with an RN. **Witness** • Schedule 8 medication preparation and administrations with an RN. • The preparation of insulin to be administered via an **Insulin Pen Device** for residents with insulin dependent diabetes. • The preparation and administration of subcutaneous or intramuscular medication by an RN/EN. • The telephone order from a Medical Practitioner/Authorised Prescriber with an RN. • **Influenza Vaccines.**

	Registered Nurse (RN) A RN whose professional registration is unrestricted	Enrolled Nurse (EN) An EN whose professional registration allows for the administration of medication and who has completed CHL education and training and assessed as competent	Care Worker A Care Worker who has completed the CHL education and training and has been assessed as competent
You CAN NOT	**Transcribe** medication orders. **Repackage** medications. The RN has the delegation to remove medications from a DAA but not the authority to add medication to a DAA. This is a requirement for the Pharmacist. **Relabel** medications. **Administer** any schedule of medication that is not prescribed by an Authorised Practitioner / Medical Practitioner. **Administer:** • Intravenous (IV), Epidural, Intrathecal or Intraperitoneal medications. • All Vaccines except **Authorised Nurse Immuniser** can provide vaccination without direct medical authorization. **Order Emergency Imprest S4D or S8 Drugs,** the order must be signed dated and in writing only by the Chief Nurse of the RACF (RM or CM).	**Transcribe** medication orders. **Delegate** medication activities to another staff member. **Repackage** medications. The EN has the delegation to remove medications from a DAA but not the authority to add medication to a DAA. This is a requirement for the Pharmacist. **Relabel** medications. **Administration of** any schedule of medication that is not prescribed by an Authorised Practitioner. **Administer:** • **Schedule 8 medication** which are recorded in the Home's Drug Register. • **S4D PRN** medications without prior consultation with the RN. • **S2, S3 and S4 PRN** Medications if the symptoms do not match the explicit directions on the PMC. • **Nurse Initiated Medication** without prior consultation and directive from an RN. • Intravenous (IV), Epidural, Intrathecal or Intraperitoneal medications. • The Home's Urgent Use Medication/Imprest Medication Stock. • Vaccines.	**Transcribe** medication orders. **Delegate** medication activities to another staff member. **Repackage and Relabel** medications. **Administer:** • Any schedule of medication that is not prescribed by an Authorised Practitioner. • **Schedule 8 medication** which are recorded in the Home's Drug Register. • **Non-packed S8** medications including liquids, transdermal, gels and injectables **or PRN S8** medications. • **All PRN** medications without prior consultation with the RN • **Nurse Initiated Medication.** • The Home's **Urgent Use Medication/Imprest Medication** Stock. • Anticoagulants not packed in regular DAAs. • Sub-cutaneous injections of insulin for Residents with **unstable IDDM**. • Sub-cutaneous injections, with the exception of insulin via an insulin pen device for Resident's with stable IDDM. • Vaccines. • Intramuscular (IM) injections. • Intravenous (IV), Epidural, Intrathecal or Intraperitoneal medications. • NG, PEG or jejunostomy medication or feeds. • Suppositories/enemas. • Vaginal creams or pessaries.

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia
3. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014
4. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
5. *Health (Drugs and Poisons) Regulation 1996* (QLD)
6. Medical care of older persons in residential aged care facilities, 4th Edition, The Royal College of General Practitioners April 2006
7. Medication Management in Residential Aged Care Facilities, A Guide for Health Care Workers, Australian General Practice Network, 2009
8. Nursing Practice Decision Flowchart, Nursing and Midwifery Board of Australia
9. *Poisons and Therapeutic Goods Regulations 2008* (NSW)
10. *Quality of Care Principles 2014*, Schedule 1 – Care & Services for Residential Care Services (Part 2 Care & Services, Item 2.4 Treatments & procedures), The Aged Care Act 1997: http://www.comlaw.gov.au/Details/F2014L00830/Html/Text#_Toc390951215
11. What Nurses Need to Know, Environmental Health Unit, QLD Health, 2008

PRESCRIBING & CHARTING

PRESCRIBING AND VALID MEDICATION ORDERS

Outcome

Valid medication orders must be in place before medications are administered. The Authorised Prescriber / Medical Practitioner must prescribe and order medications in accordance with State (NSW and QLD) and Commonwealth legislative requirements.

No Medication Order, No Medication Administration

No medication is to be administered without a legible, signed, and dated instruction/prescription from an Authorised Prescriber including a registered Medical Practitioner, Registered Nurse Practitioner, registered Ophthalmologist, registered Podiatrist, or registered Dental Practitioner on the Service's designated medication record and in accordance with State (NSW and QLD) or Commonwealth legislation.

For Telephone orders refer to Charting Medications- Receiving a Telephone Order for Medication.

Valid and Compliant Medication Orders

Prior to administering medications that have been ordered (or delegating the administration to an EN or Care Worker), the RN must ensure that the medication orders on the Prescriber Order Sheet contains and/or complies with the following details:

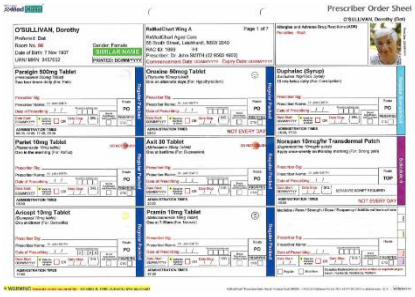
1. Each order is legible.
2. The Resident's full name and identifying information, (e.g., date of birth, photo ID).
3. Allergies/adverse drug reactions reported by the Resident and/or their Authorised Representative that have not been entered by the Registered Nurse or Pharmacist.
4. The name of the medication.
5. The strength of the medication.
6. The form of the medication - if eye/ear drop or ointment should include the eyes/ears and if a cream must specify the area for it to be applied.
7. The dose, route, and frequency of the medication.
8. Any medication ordered as 'PRN' should have an accompanying maximum dose per 24-hour period, e.g., prn every four (4) hours; and specify the maximum dose if applicable.
9. Any medication ordered as 'PRN' should have the specific reason for administration identified on the drug order itself e.g., for left shoulder pain.

10. The date of cessation, or total number of doses, where applicable (e.g., antibiotics - one course, cease when course completed, or Prednisolone - 5 mgs for two (2) days, 2.5 mgs for two days then cease).
11. Each individual medication order should be written in a separate box on the Prescriber Order Sheet and signed by the Authorised Prescriber / Medical Practitioner for each individual medication.
12. The Authorised Prescriber / Medical Practitioner writes the medications orders on the Prescriber Order Sheet ensuring all the required documentation is completed.
13. The Prescriber Order Sheet is sent (MedsComm) to the Supply Pharmacy along with any other required documentation e.g., Pharmacy Admission Form.
14. A computer-generated Prescriber Order Sheet and Signing Sheet/s are provided by the Supply Pharmacy and placed in the individual Resident RxMed Folder (See below photo).
15. Computer Signing Sheets are updated by the Supply Pharmacist as required.

Triangulation of Medication Information

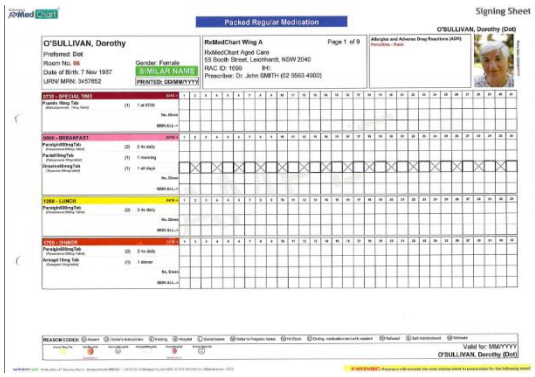
Triangulation of all medication information is essential to support safe and correct medication administration.

Triangulation includes confirming for each Resident that the Prescriber Order Sheet medication orders match the medications in the **Webster-Pack/Card** DAA, the non-packed medications, and the signing sheets/eCase MedMan system.



Prescriber Order Sheet

Webster-Pack/Card & Non-Packed Medications



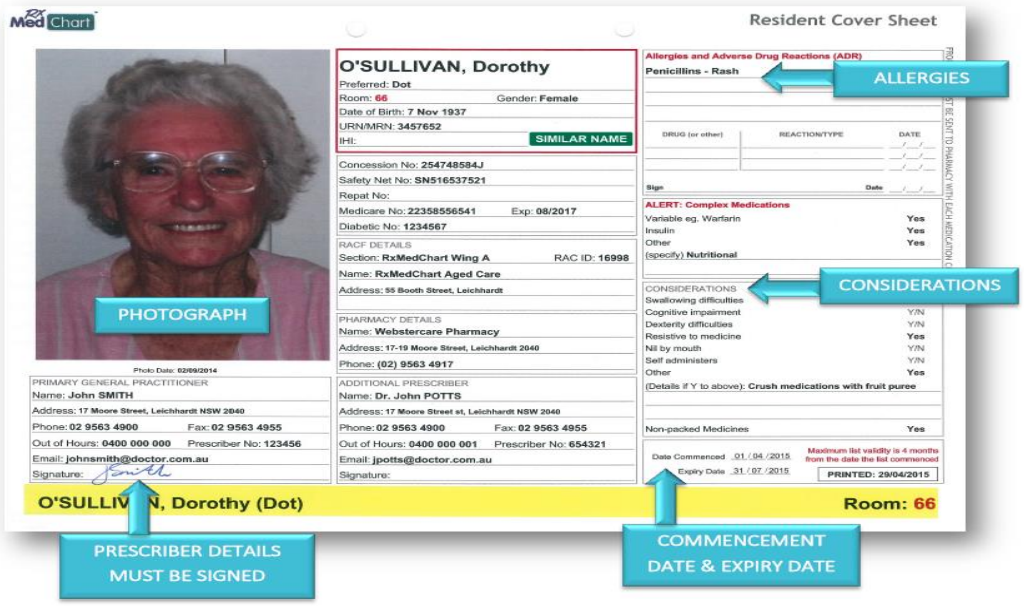
Signing Sheets/ eCase MedMan system

RxMED CHART FOLDER

- A current and dated photograph of the Resident is present on all Resident Cover Sheet, *Prescriber Order Sheets*, *Signing Sheets* and **Webster-Pack/Card**.
- Photographs of Residents are to be updated at least **every12 months** or more frequently if there has been a significant change in appearance. However, a Resident has the right to refuse a photograph.
- All **Webster-Pack/Card** should have the correct image of the tablet / capsule packed as do the *Prescriber Order Sheets* and *Signing Sheets*.

RESIDENT COVER SHEET (RCS)

The Resident Cover Sheet provides demographic information to identify the resident, prescriber, and aged care home. A copy of the Resident Cover Sheet (RCS) must accompany all medication orders and changes.



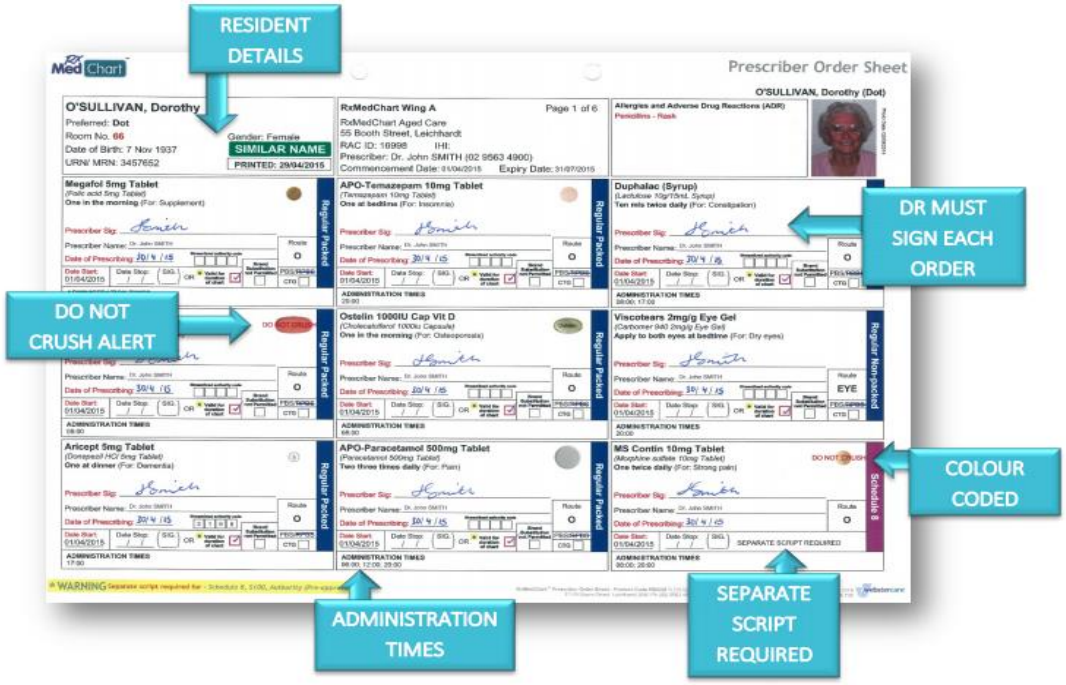
- Home to provide Resident information details to the Supply Pharmacy on admission.
- Supply Pharmacy to provide on admission and reprint at least **annually.**
- EN, RN or Competent Care Worker to document in the considerations section any specific requirements e.g., crush medications and mix with Gloup.
- MP signature.

PRESCRIBER ORDER SHEET (POS)

- The Prescriber Order Sheet (POS) records the resident's medication profile and 'prescription' information. The details are similar to the information required for a regular prescription. Prescribers make changes and additions to a resident's medication profile on the POS. A copy **MUST** be provided to the pharmacy for all medication orders and changes.
- Medications are administered to each Resident in accordance with the directions on the *Prescriber Order Sheet (POS)*, their *Care Plan* and the *Resident Cover Sheet* for specific instructions on the administration of medications for the individual Resident e.g., cut all large tablets in half; will only take medications with food.
- All Residents are positively identified prior to administration of medication. If there is any doubt of the identity of the Resident, confirmation with a second person is required.

Medicines are separated into specific categories which are identified by **coloured bands**:

- Regular packed and non-packed medications
- S8 medications
- Antibiotics and short-term medicines
- Nutritional supplements
- PRN or 'when necessary' medicines
- Insulin
- Warfarin and variable dose medicine



Prescriber Order Sheet (POS)

The Prescriber Oder Sheet are included:

Part 1	The following categories are included: • Regular Packed • Regular Non-packed • Antibiotic • Schedule 8
Part 2	Separate page for PRN medications
Part 3	Separate page for Nutritional Supplement Including weight monitoring and Complex Medication Information
Part 4	Separate page for Insulin and Insulin PRN Includes Complex Medication Information for BGL monitoring
Part 5	Separate page for Variable medication eg. Warfarin Includes Complex Medication Information for pathology
Part 6	Spare page for additional prescriber orders throughout the 4 months

Part 2

Part 3

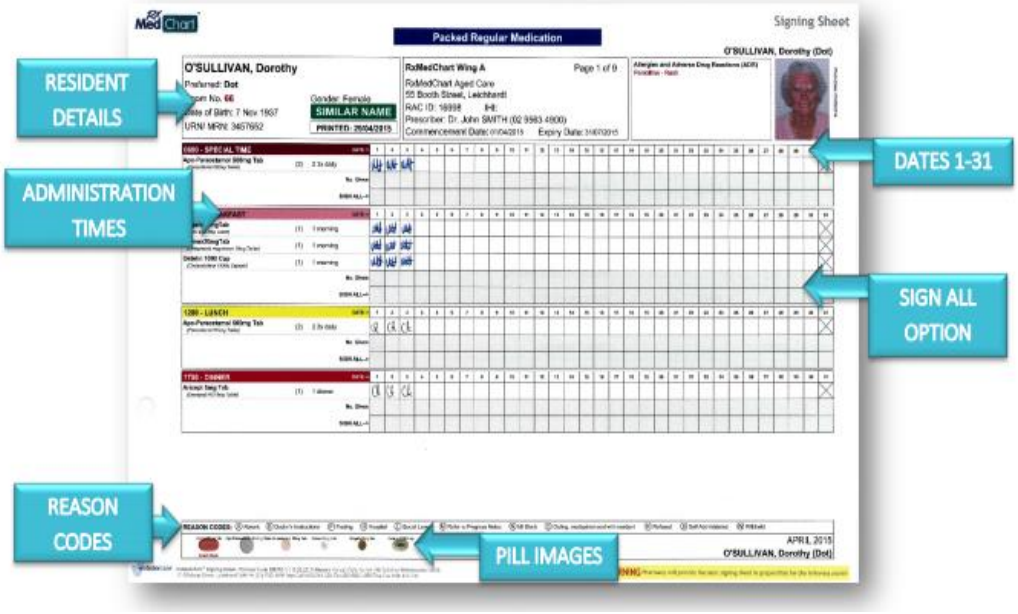
Part 4

Part 5

Part 6

SIGNING SHEETS

- Provided in a specified format to allow registered nurses, enrolled nurses, and care staff to document administration of all medicines for the duration of the RxMedChart cycle (**four months**).
- The Signing Sheets should be signed in the correct date and time corresponding with the medication order.
- Medications ordered and not administered must be recorded as such, and this record must include the reason for non-administration by inserting and circling the relevant reason code letter on the medication *Signing Sheets* and documenting the reason in the *Resident's Progress Notes*.
- For short term medications, an *Interim Signing Sheet* is to be used which is computer generated by the Supply Pharmacy and kept in the medication folder with the regular Signing Sheets.
- The administration times are clear, and colour coded according to the main dosage times of the day. Medication to be administered at a time outside of breakfast (pink), lunch (yellow), dinner (orange) or bedtime (blue), are highlighted in burgundy as Special Times.

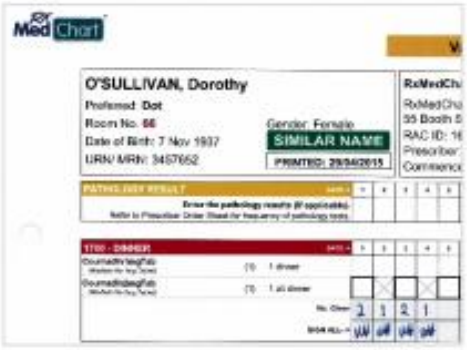


The RxMedChart signing sheets have the option to sign for medications individually or as a quantity.

Sign Individually

Sign All

Signing Sheets



The administration boxes are large to make the signing process easy for staff. To aid in administration, boxes are marked with an **"X"** on days where a medication is not due to be administered e.g., non-daily medications, short course, or antibiotic medications etc.

The signing sheets **last for one month** after which point, they will be filed in the pocket on **the back of the resident folder**. The pharmacy will provide the next month's supply of signing sheets. At the end of the four-month RxMedChart system cycle, all documentation will be retained in the resident's clinical file.

CHARTING MEDICATIONS

Outcome

Practices are supported which ensure that a medication order is correctly charted and that compliance with State (NSW and QLD) and Commonwealth legislative requirements is met.

Prescriber Order sheet

All Residents living in a CHL Home should have a hard copy Prescriber Order Sheet that reflects the current prescribed medications to be taken by the Resident for their identified medical conditions. This includes regular, when needed (PRN) and short-term medications.

Telephone Orders and Nurse Initiated Medication administrations are recorded separately on the reverse side of the Signing Sheet marked Telephone Orders / Nurse Initiated Medication.

Information Documented on Prescriber Order Sheets (POS)

Prescriber Order Sheet (POS) should have the following information documented in a legible manner:

1. Full name of Resident.
2. Identifying information e.g., date of birth.
3. Clear and recent colour photograph of Resident (within 12 months and updated when there are significant changes in the Resident's appearance) if consent obtained.
4. Known allergies and adverse drug reactions.
5. Name, Strength, Form, and Dose of medication.
6. Route and Frequency of administration.
7. As needed (PRN) medications, in addition to the above requirements an indication for use and maximum dose per 24hours.
8. Date medication commenced and ceased.
9. Time frame for use (if appropriate), cease date or number of doses to be administered.
10. Authorised Prescriber's name (printed), signature and date.
11. The dosage of oral liquid preparations should be expressed as '…mg (…mL)' e.g., Morphine mixture 5mg/mL give 10mg (2mL) twice a day.
12. Alert for Residents with same or similar names. 

New Prescriber Order Sheets

Periodically, the Supply Pharmacist may supply a new Prescriber Order Sheet in response to at least the following:

1. Multiple hand - written changes on a current Prescriber Order Sheet.
2. Medication changes post hospitalisation.
3. Medication chart reconciliations every 4 months.

The new Prescriber Order Sheet is effective immediately as long as there is a previous chart reflecting the same medications and dosages signed by the Authorised Prescriber / Medical Practitioner.

The new Prescriber Order Sheet sits on top of the existing Prescriber Order Sheet until the Authorised Prescriber / Medical Practitioner has signed the new chart.

The Authorised Prescriber / Medical Practitioner should sign the new chart at their next visit.

Once signed by the Authorised Prescriber / Medical Practitioner the previous chart is filed in the Resident's Clinical Record.

Refer to procedure for Communication to Pharmacy.

MEDICATIONS CHANGES-NEW, CEASED OR DOSE CHANGED

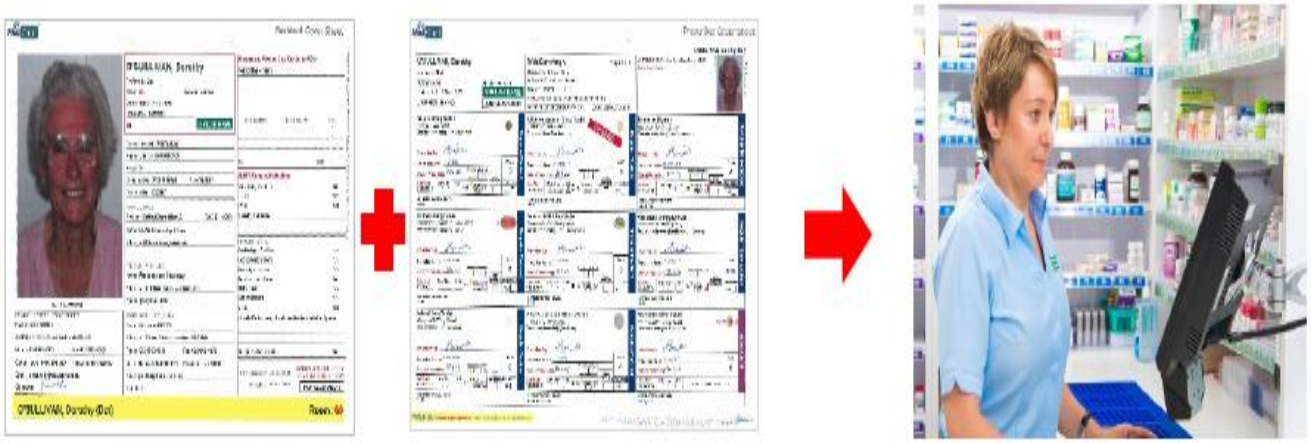
The Authorised Prescriber / Medical Practitioner should sign and date in the allocated section of the Prescriber Order Sheet, against the relevant order, that an order has been changed.

Refer to procedures for New Medication, Ceased Medication or Dose Changed.

PROCEDURES – COMMUNICATION TO PHARMACY

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

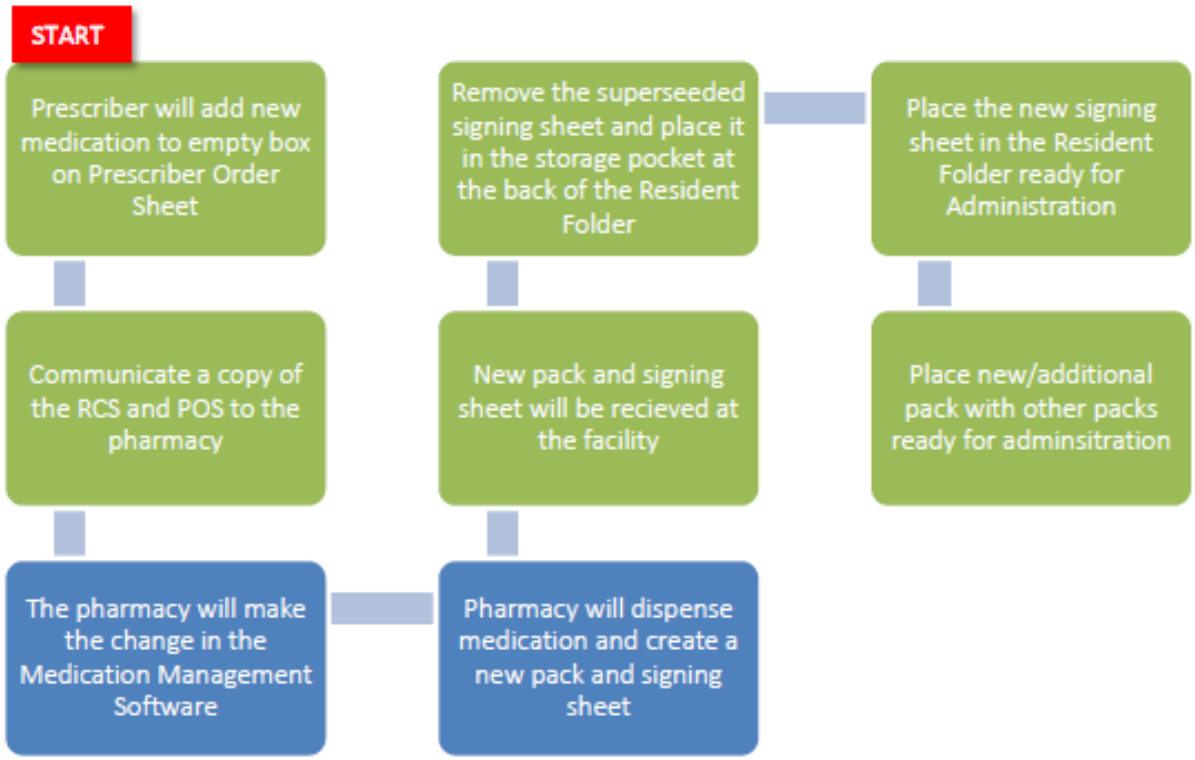
1. The *Resident Cover Sheet* and *Prescriber Order Sheet (All Pages)* Must be communicated (MedsComm) to the supply pharmacy when any change is made to a Resident's medication.
2. The supply pharmacy will make the required change and return the relevant paperwork and medication.



PROCEDURE – NEW MEDICATION (REGULAR OR SHORT-TERM)

1. Staff are required to document in eCase Progress Note.
2. The following procedure should be followed when a new medication is added to a Resident's medication.

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker



Green=Home Action

Blue=Supply Pharmacy Action

PROCEDURES – CEASED MEDICATION

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Staff are required to document in eCase Progress Notes.
2. The following process should be followed when a medication is ceased.

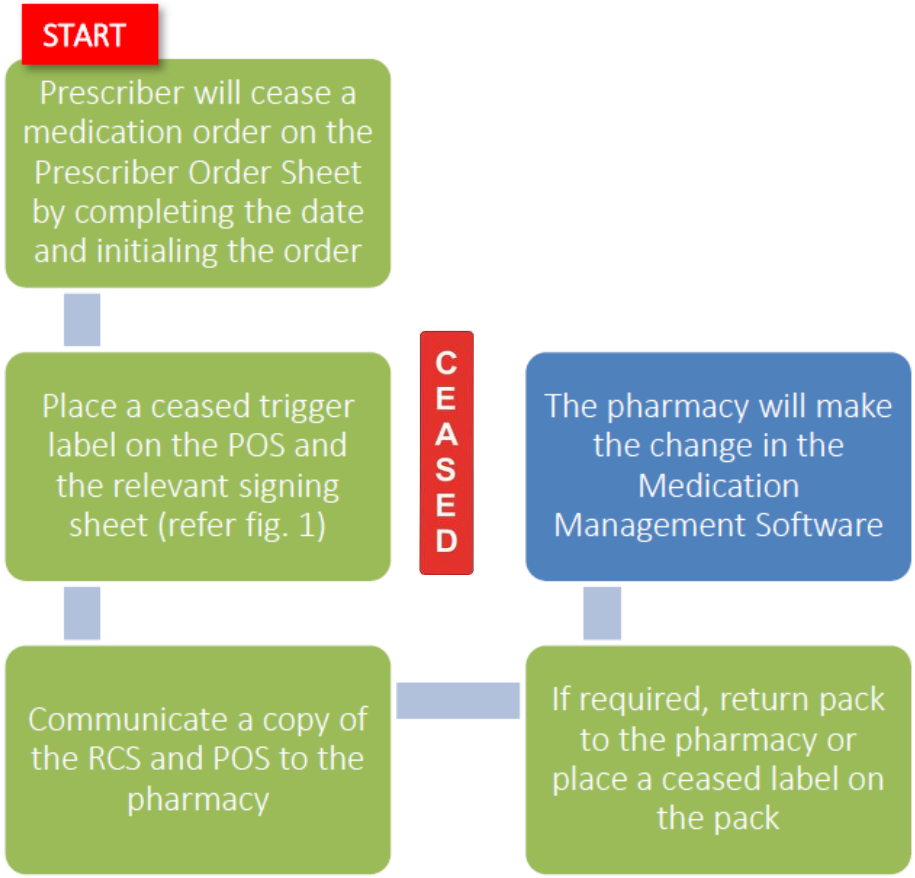
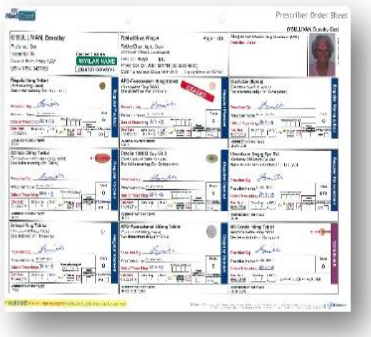


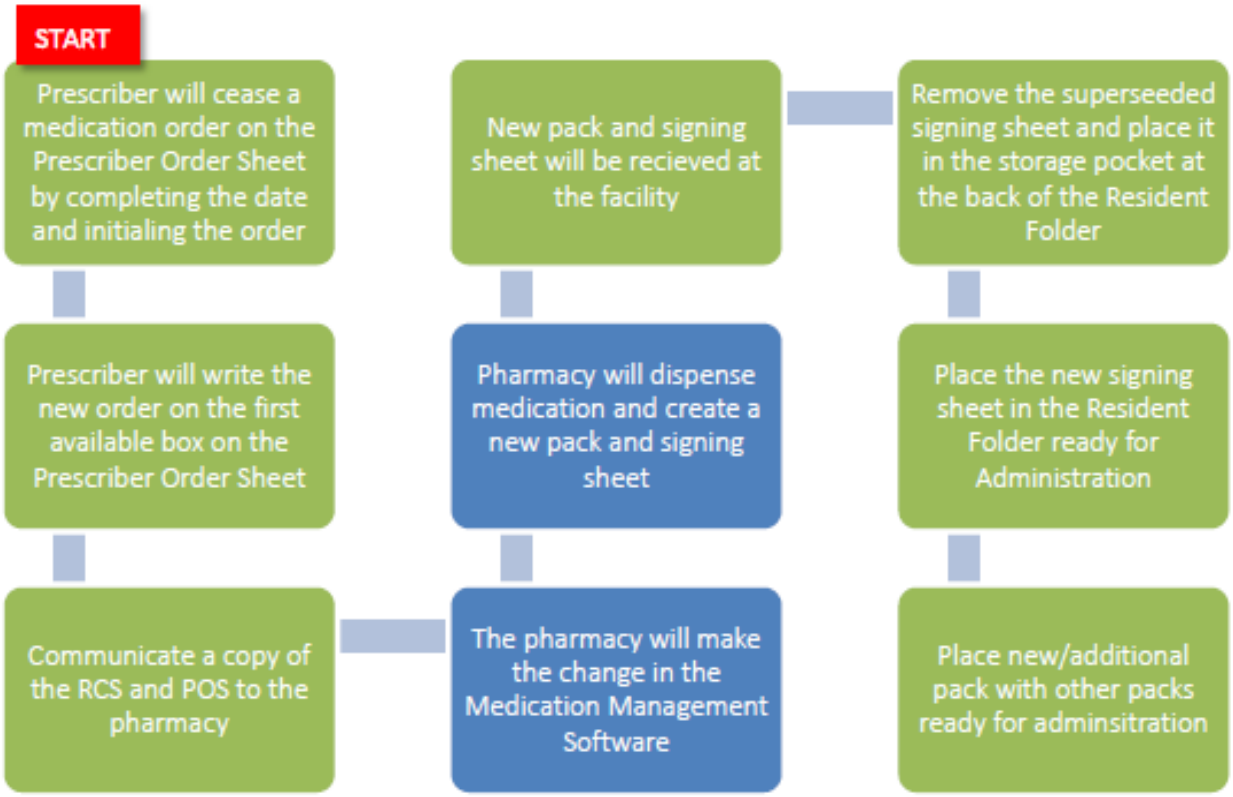
Figure 1



PROCEDURES – DOSE CHANGE

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Staff are required to document in eCase Progress Notes.
2. The following process should be followed when a dose is changed.



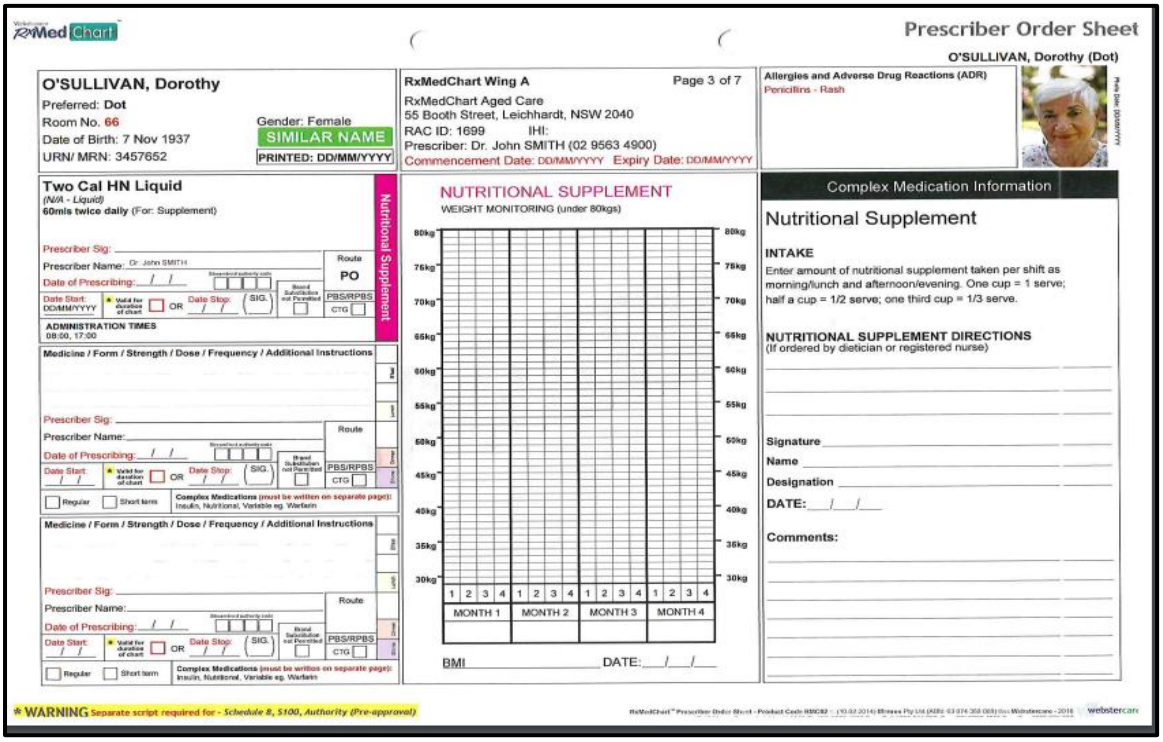
Green=Home Action

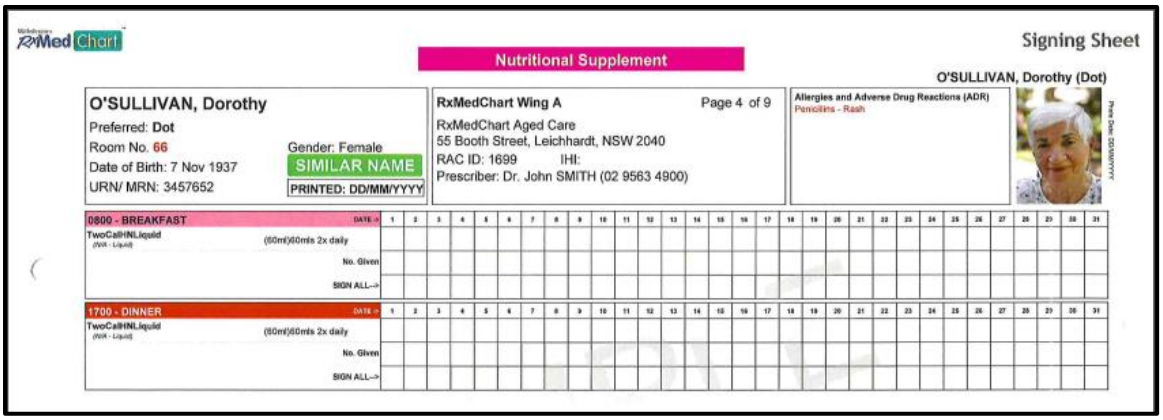
Blue=Supply Pharmacy Action

CHARTING OF NUTRITIONAL SUPPLEMENTS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

- The Authorised Prescriber / Medical Practitioner orders Nutritional Supplement on the Prescriber Order Sheet.
- The Prescriber Order Sheet is sent (MedsComm) to the Supply Pharmacy.
- A computer-generated Signing Sheets is provided by the Supply Pharmacy and placed in the RxMedChart folder.





RECEIVING A TELEPHONE ORDER FOR MEDICATION

An RN can receive a telephone order from an authorised prescriber/ medical practitioner.

Applies to:

- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

1. The RN documents the telephone order on the back of the Signing Sheet in the area allocated for Telephone Orders **including** documenting the name of Authorised Prescriber/ Medical Practitioner giving the telephone order. For the Homes use eCase MedMan, RN need to add the Medication in the MedMan system.
2. The medication order is read back to the Authorised Prescriber / Medical Practitioner in figures and words (e.g., fifty milligrams, five-zero milligrams).
3. A competent **second person**, who does not have to be an RN, **confirms** the telephone order with the Authorised Prescriber / Medical Practitioner and signs the written order or in eCase MedMan system.
4. RN, EN or competent Care Worker to send (MedsComm) the Telephone Order to the Supply Pharmacy for supply if required.
5. If the Telephone Order includes ceasing a medication an RN is to place a red 'ceased' sticker on the Prescriber Order Sheet and Signing Sheet, draw a line across the remaining days on the signing sheet and place a red 'ceased' sticker down the column of the ceased medication in the Unit Dose 7 **Webster-Pack/Card**. The Homes use eCase MedMan, staff change the status to **"Doctor Instructions"** during drug round and write **"Medication Ceased"** in notes box.
6. The instructions of the Authorised Prescriber / Medical Practitioner should be documented in the *Resident's Progress Notes*. **Note:** The Homes use eCase MedMan, RN use add medication function and eCase Progress Notes will automatically generate.
7. The Authorised Prescriber / Medical Practitioner **must sign** the telephone order **within 24 hours,** by
   a. Counter-signing the Registered Nurse's record of administration **within 24 hours** of the *Telephone Order* **OR**
   b. Sending written confirmation of the telephone order to the Home by fax or email **within 24 hours** which is then stored behind the *Telephone Order*

   Note: The order is not valid if it is not signed within 24 hours.
8. The RN must include the details of any Telephone Orders in their nursing handover to the oncoming shift.

REASON CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICATIONS INCLUDE:

Reason Code	Explanation	Reason Code	Explanation
A	Absent	N	Nil Stock
D	Doctors Instructions	O	Outing - Medication sent with Resident
F	Fasting	R	Refused
	Hospital	S	Self-administered
L	Social Leave	W	Withheld
M	Refer to Progress Notes		

It may not be possible to administer all medications during a routine medication round. The reason code for non-administration is to be documented by all staff on the Signing Sheet against the specific medication and the medication **must** remain in the DAA or original packaging.

ACCEPTABLE ABBREVIATIONS

The following table lists the abbreviations commonly used, understood, and considered acceptable for use in **Medication Ordering, Charting and Documentation** within CHL RAC Homes.

Abbreviation	Definition	Abbreviation	Definition
Timing or Frequency		**Route**	
before food	Before food	Topical	Topical
after food	After food	IM	Intramuscular
with food	With food	Inhalation	Inhalation
mane	Morning	IV	Intravenous
nocte	Night	Neb	Nebuliser
daily	Once per day	NG	Nasogastric
bd	Twice a day	PO	Oral
tds	Three times a day	PEG	Percutaneous Enteral Gastrostomy
qid	Four times a day	PV	Per vagina
4/24	Every 4 hours	PR	Per rectum
prn	When required	S/C	Subcutaneous
stat	Immediately, but only once	S/L	Sublingual
Form		**Measurement**	
Cap	Capsule	kg	kilogram
Tab	Tablet	g	gram
Elix	Elixir	mg	milligram
Eye drops	Eye drops	mcg	microgram
Eye oint	Eye ointment	iu/IU	International Unit(s)
Lin	Liniment	Ltr	Litre
Mist/Mixt	Mixture	mL, ml	Millilitre
Oint	Ointment	mmol	Millimole
Cream	Cream		
Ear drops	Ear drops		
Ear oint	Ear ointment		
Pess	Pessary		
Supp	Suppository		

REFERENCES

1. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
2. *Medical care of older persons in residential aged care facilities, 4th Edition, The Royal College of General Practitioners April 2006.*
3. *NSW Poisons & Therapeutic Goods Regulation 2008.*
4. *Queensland Health (Drugs and Poisons) Regulation 1996.*
5. *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines, Australian Commission on Safety & Quality in Healthcare, 2011.*
6. *Webster Rx Medication Charts Guideline, Webstercare.*

REGULAR DOSE ADMINISTRATION AIDS (DAA)

ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering Regular DAA

- There is no requirement to place an order for the weekly supply.
- Each week a new supply will automatically be delivered by the Supply Pharmacy and the previous week's Webster-Pack/Card collected.
- However, in the event a dose is dropped or missing from the pack, the last day's dose in the Webster-Pack/Card is to be used after confirming it is the correct dose to be given and an order sent to the Supply Pharmacy for a replacement dose. A Medication Incident is to be logged on eCase Med Incident Register.

Receipt & Storage

- The Supply Pharmacy will indicate the preferred time each day they require all medications changes to be communicated to them, to ensure same day delivery.
- Medication storage rooms, cabinets and trolleys must always be locked, inclusive of times when not in use, and the keys held by the person authorized to do so.
- The storage conditions must always protect residents' safety and privacy, and staff safety.
- Storage temperature and security are the responsibility of authorized staff. Items must be kept according to manufacturer's instruction.
- Residents, visitors to the Home and staff other than the authorized person must not have access to the medication cupboards or trolleys.
- Keys, cash, documents, or other goods MUST NOT be kept in a medication cupboard/drug safe.
- Receipt of weekly Webster-Pack/Card from the Supply Pharmacy should be signed by an authorised person (RN / EN /Medication Competent Care Worker)
- Weekly Webster-Pack/Card are to be stored on a pharma file in a locked medication room, or within a locked cupboard.

Refrigerated Medications

For Medications ONLY

- ONLY medications requiring refrigeration are to be kept in the Medication Fridge. A sign stating, **'For Medications Only'** should be placed on the fridge.
- The Medication Fridge is to be kept in a secure medication room and accessed by authorized staff only.
- The temperature of the fridge must be checked at least daily, or more often if required. Record the minimum and maximum temperature on the CHL *Medication/Vaccine/Pathology Refrigerator Temperature Record* form.
- The temperature range must be maintained between **2 - 8° Celsius.**
- Corrective actions to address fluctuations in temperature must be taken in a timely manner, including contacting the Supply Pharmacist and/or local Public Health Unit for advice before using or discarding the medications.
- Keep fridge door openings to a minimum.

Return to Pharmacy

Circumstances when medications should be returned to the Supply Pharmacy include where:

- A Resident's medication is ceased or changed by the Authorized Prescriber / Medical Practitioner.
- A Resident is deceased - no medication is to be relabelled for another Resident or used as urgent use under any circumstances.
- A medication has expired, is contaminated or damaged.
- Medications currently not charted on a Prescriber Order Sheet including regular, non-packed and PRN medications (including all forms of medication e.g. tablets, creams, lotions, and liquids etc.).
- *A Resident's own medication brought into the RAC Home on admission that is determined to be unsuitable for use.*

Disposal

- All weekly regular DAAs requiring disposal are to be placed in the secure Pharmacy Returns Box or locked room for medications for collection by the Supply Pharmacy.
- The Supply Pharmacy is required to destroy them appropriately to ensure the privacy and confidentiality of each Resident's health information is maintained as well as appropriate disposal of any remaining medications.
- Where the Supply Pharmacy uses DAAs with barcoding the returned packs should be scanned by the pharmacy and any medications remaining in the packs recorded and the Home notified. For this reason, the Home is to leave any missed doses in the DAA rather than discard them. This also supports the audit trail of medications not administered.

ADMINISTRATION DAA

Registered Nurses, Enrolled Nurses, and Care Service Employees (who completed CHL Medication Essentials and been assessed competent) can administer medications packed in DAAs.

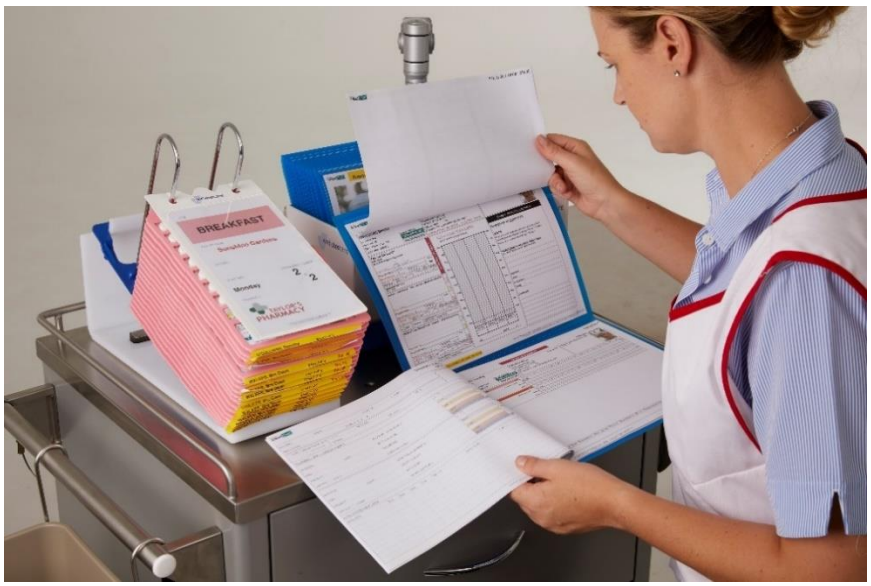
Unit Dose 7 Webster-Pack/Card (UD7)

The Unit Dose 7 Webster system is based on the premise that there are usually four medication rounds per day, with different coloured pharmafiles used for each round.

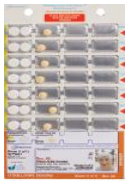
Unit Dose 7 **Webster-Pack/Card** have just one type of medication per column which makes it easier to identify, cease or withhold medication.

Each Unit Dose 7 **Webster-Pack/Card** is comprehensively labelled with the contained medications, including a colour image of the tablet or capsule, Resident information (including a colour photograph) and other alerts such as "Do Not Crush". This supports staff as they have all the information they need at the time of administration.

The packs are packaged and formatted to contain descriptions of the medicines in a way that complies with State and Territory Regulations to allow the safe administration of medicines by Registered Nurses, Enrolled Nurses, and Care Workers in accordance with their professional responsibilities and obligations.



Webster-Pack/Card DAAs are colour coded according to the dosage time or type of medications they contain.

Colour Codes	Medication Round / Type of Medication	Pack	Card
Pink	Breakfast - routine medications		
Yellow	Lunch - routine medications		
Orange	Dinner - routine medications		
Blue	Bedtime - routine medications OR Multi Dose - routine		
Green	Antibiotics OR Short-term medications e.g. Prednisone		
Purple	Cytotoxic drugs Schedule 8 (Regular)		
Mustard	Anti-coagulants - a medication used to eliminate or reduce the risk of blood clots e.g. Warfarin		

Colour Codes	Medication Round / Type of Medication	Pack	Card
Burgundy	Time specific such as pre- breakfast e.g. Fosamax.		
White or Black	PRN - when required medications e.g. Panamax. Schedule 8 (PRN only)		
Fuchsia	Parkinson's medications	N/A	

Photo Identification

All Residents must be identified before being given medication. For this purpose, a dated photo of the Resident should be attached to their DAA and Signing Sheet. This photo must have the Resident's name on it and reviewed at least **annually** or when there is a change in resident's appearance.

Staff are to check the Resident photograph against the Resident's appearance and if required, verify the Resident's identity with other Service personnel.

In some circumstances there may be no photo available. In this instance, staff must take additional measures to verify the identity of the Resident.

Homes are responsible for providing the Supply Pharmacy with current photos of Residents for use on **Webster-Pack/Card** DAAs and documentation.

Checking Medications for Administration

Before administering medications from DAAs, Care Workers need to complete a minimum of 3 checks of the medication against a valid medication order in addition checking the number of medications on the Signing Sheet or eCase MedMan System equals the number of medications in the DAA and prescribed on the Prescriber Order Sheet for the dose time.

Registered Nurses and Enrolled Nurses must complete a minimum of 3 checks of the medication against a valid medication order in addition to checking Signing Sheets or eCase MedMan System to confirm accuracy prior to administration.

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Registered Nurses and Enrolled Nurses must complete a minimum of 3 checks of the medication against a valid medication order in addition to checking Signing Sheets or eCase MedMan System to confirm accuracy prior to administration.

No Pre-Removal of Medications

Medications must not be removed from DAAs or other packaging prior to the scheduled time of administration.

No Leaving Medications Administration with a Resident

Medications **must never** be left on lockers or food trays for later self-administration by a Resident or administration by another staff member.

Altering Dose Form - Crushing or Cutting Medications

Medications may only be crushed on advice from an Authorised Prescriber / Medical Practitioner or Pharmacist or Registered Nurse.

Residents are to be assessed at each medication round to ensure that their condition has not changed rendering them unable to take their medication as prescribed. For example, if they are having difficulty swallowing.

Any 'gagging,' choking, or coughing experienced by the Resident when swallowing medication is to be reported to the Registered Nurse.

All staff administering medications may only cut a tablet in half if it has scoring (a line across it). In many cases, this may have already been done by the Pharmacist before being packed in the DAA.

Dropped or Missing Dose

Medications are administered as directed on the Prescriber Order Sheet as ordered by the Authorised Prescriber / Medical Practitioner. In the event a dose is dropped or missing from the pack, the last day's dose is administered after consultation with the Registered Nurse. The Supply Pharmacy should be informed when replacement medication is required.

Tampered or Contaminated Medication

If a DAA blister compartment is broken or opened the medication could have been tampered with or contaminated. If the medication appears to be sweaty and discoloured the medication could be contaminated as well. If that is the case:

- Do not give the medications.
- Notify the Registered Nurse and await their instructions.
- Report the medication incident in the Resident's Progress Notes and complete an eCase Medication Incident Register.
- Arrange for the medications to be replaced by the Supply Pharmacy if required.

Medication Expiry Dates

- Medications are not to be used beyond their expiry dates.
- Monitoring medication expiry dates is the responsibility of authorised staff. Expired medications are to be returned to Supply Pharmacy for correct disposal, as per current State (NSW and QLD) regulations and guidelines.
- If expired medication is given, report the medication incident in the Resident's Progress Notes and complete an eCase Medication Incident Register.

Individual Resident Needs for Safe Medication Administration

Staff must check if the Resident has any special medication needs such as difficulties with swallowing or is resistive to taking medication or Resident's allergies before administering the medication.

Adequate Fluids

Staff must be aware of a Resident's need for thickened fluids and provide the required consistency of fluids to assist the Resident to take the medications safely.

Mixing Medications with Meals

Staff MUST NOT mix medications in with a Resident's meal or food under any circumstance.

Observing the Resident

The staff member administering the medication is responsible to stay and observe that the Resident has ingested all of the oral medications administered.

Staff Signature - Signing Sheet

Staff member confirms that the Resident has swallowed the tablets and then signs the Signing Sheet or eCase MedMan System following administration.

PROCEDURE - ADMINISTERING MEDICATION FROM DAA

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Select** the correct DAAs for that dosage time and Resident's medication records.

   Check:
   - Resident's name and photo identification on the DAA.
   - Prescriber Order Sheet - name and photo identification.
   - Signing Sheet or eCase MedMan system - name and photo identification.
3. **Check** the Prescriber Order Sheet confirming a legal medication order and check against the medications listed on the Signing Sheet or eCase MedMan system and packed in the DAA to ensure consistency. This includes the drug name, dose, strength, route, time, and Resident's allergies.
4. **Check** the Expiry Date on the DAA.
5. **Perform** hand hygiene.
6. **Remove** the contents of the correct blister(s) using a Pil-Bob or place tablets directly into a medication cup for that time and day using a non-touch technique and re-check the DAA against the Prescriber Order Sheet.
7. **Count** the number of tablets/capsules in the cup and check the number of tablets/capsules listed on the Signing Sheet. If count is not correct, inform the RN.
8. **Provide** the Resident with assistance to take medications. This may include:
   - Guiding medication cup or spoon to their mouth - using a 'no touch' technique.
   - Crushing medication and placing it in **Gloup** if required as documented on the Resident Cover Sheet or Prescriber Order Sheet or DAA or care plan.
   - Providing adequate fluid to swallow medication - guiding cup to their mouth if needed.
9. **Observe** the Resident swallow the tablets/capsules:
   - DO NOT leave medications with Resident to take later.
   - DO NOT place medication in food to administer.

Clean Up and Documentation

10. **Return** medication and equipment to storage and dispose of waste appropriately.
11. **Perform** hand hygiene.
12. **Check** Prescriber Order Sheet against medications administered and record the number of tablets/capsules given and sign on the Signing Sheet: The Homes with eCase MedMan system, staff change the status to **"Given"** and sign.
    - **Note:** RNs and ENs to individually sign for each medication.
    - **Document** in the Resident's eCase Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

REFERENCES

1. *Australian Medicines Handbook, 2012.*
2. CHL Bug Control e-Manual.
3. *Five Moments of Hand Hygiene, Hand Hygiene Australia: www.hha.org.au*
4. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
5. *'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf*
6. *Medical care of older persons in residential aged care facilities, 4th Edition, The Royal College of General Practitioners April 2006.*
7. *NSW Poisons & Therapeutic Goods Regulation 2008.*
8. *Pil-Bob Brochure, Webstercare 2014.*
9. *Queensland Health (Drugs and Poisons) Regulation 1996.*
10. *Standard Operating Policy and Procedure: Exceptional circumstances during a routine medication round. Webstercare 2012.*
11. *Webster Rx Medication Charts Guideline, Webstercare.*

NON-PACKED & PRN MEDICATIONS (EXCL. S8)

ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering of Non-Packed and PRN Medications (excluding Schedule 8)

- Non-packed and PRN medications are not included in the automatic weekly packed medications orders as they may require replenishing at any time.
- The non-packed and PRN checklist, available from the Supply Pharmacy (printed on the Webstercare Medication Management Software), can be used to assist the ordering of these medications.

Receipt and Storage of Non-Packed and PRN Medications (excluding Schedule 8)

- Receipt of non-packed and PRN medications (excluding S8) from the Supply Pharmacy should be signed by an authorized person (RN / EN /Medication Competent Care Worker) confirming the medications ordered are the same as the medications delivered.
- Non-packed medications are to be stored in a locked medication room, preferably within a locked cupboard or medication trolley.
- PRN packed medications are to be stored on a pharma file and stored in a locked medication room, preferably within a locked cupboard or medication trolley.
- Non-packed medications with a short shelf life, after opening **MUST** have **'date opened' stickers** and/or expiry date noted on the primary container (not on the packaging) when in use.
- PRN Medication packed in a DAA **expires 6 months** from the date of receiving from pharmacy.
- **PRN Paracetamol** packed in a DAA **expires 12 months** from the date of receiving from pharmacy. Pharmacy is responsible for placing the expiry date on the DAA pack.
- Regular checking of non-packed and when necessary (PRN) medication will occur to monitor expiry dates.
- Medication that has reached its expiry date is to be removed from storage and returned to the Supply Pharmacy for destruction with the exception S8 medications in NSW.

Disposal of Non-Packed and PRN Medications (excluding Schedule 8)

- All non-packed and PRN medications should be disposed of appropriately and **according to CHL Medication Manual, safe work practices and as per manufacturer's instruction**. All non-packed medications, including regular or PRN and PRN medications requiring disposal, are to be placed in the secure Pharmacy Returns Box or locked room for collection by the Supply Pharmacy.

ADMINISTRATION PRN MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Practice Limitations

Identified Need

The need to administer PRN Medications may be identified by:

- Request of the Resident or Authorised Representative.
- Registered Nurse, Enrolled Nurse, or Care Worker assessment.

Registered Nurses

Can administer ALL PRN medications.

Enrolled Nurses

- **S2, S3 and S4 PRN Medications** for a Resident following the explicit directions by the Authorised Prescriber/Medical Practitioner on the Prescriber Order Sheet.
- **Must contact and consult the Registered Nurse on duty and receive a directive for S4D PRN Medications for Residents.**

Care Workers

Care Workers may ONLY assist and support or administer PRN medications as directed by **Registered Nurse on duty or on call**. The direction can be verbalised and documented in the Resident's progress notes *(Select eCase Progress Notes Type: Medication Management – Medication – PRN with RN authorisation).*

Clinical Considerations Before Administering a PRN Medication

Medications which are to be administered on a PRN basis should be given in accordance with the individual order for that medication.

The individual Prescriber Order Sheet order must contain the following detailed instructions for use:

- Name of the medication
- Strength of the medication
- Form of the medication
- Dosage of medication
- Route of administration
- Indication for use
- Frequency of administration.

Evaluation Following the Administration of a PRN Medication included S8 Medications

Each time a PRN medication is administered a notation should be made in the Resident's Progress Notes (eCase Progress Notes Type – Medication Management – Medication - PRN) stating:

1. The reasons for the PRN being given.
2. Evaluation of the effectiveness of the medication.

Assessing and Reviewing the Frequency of PRN Medication Administration

The Registered Nurse should request the Authorised Prescriber / Medical Practitioner to review PRN medications if:

1. A pattern of use is identified.
2. Clinically indicated.

If PRN medication has not been used for the past four months, it should be reviewed by the Authorised Prescriber / Medical Practitioner and ceased if appropriate.

Monitoring for Adverse Reactions

After administering medications, the Resident should be monitored for any adverse reactions, such as:

- Discomfort (pain or itchiness)
- Skin inflammation or irritation
- No improvement to the condition of the affected area

If staff notice any of these symptoms, notify the RN immediately and document in the Resident's Progress Notes.

PROCEDURE - ADMINISTERING PRN MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. **Identify** the need for PRN Medication by Resident request.

   OR observed signs and symptoms e.g. grimacing from pain.
2. **Gather** equipment required.
3. **Select** the correct PRN medication (DAA or non-packed) and the Resident's Medication Records. **Check:**
   - Resident's name and photo identification.
   - Prescriber Order Sheet - name and photo identification.
   - Signing Sheet or eCase MedMan system - name and photo identification.
4. **Check** the Resident's Medication Records for PRN Medications specifically:
   - Prescriber Order Sheet confirming a legal medication order this includes the drug name, dose, strength, route, time, Resident's allergies and checking indications and directions for use.
   - Signing Sheet or eCase MedMan system will show the last 7 days administration history - check when it was last administered and if maximum daily dose has been reached.
5. **Seek** authorisation and direction from the RN to administer the PRN medications for all medications:
   - PRN Medications where Resident's symptoms DO NOT match the directive on the Prescriber Order Sheet.
   - PRN Medications where maximum daily dose has been reached.
6. **Check** the Expiry Date of the medication.
7. **Perform** hand hygiene.
8. If DAA - follow steps for administration of medications from DAA.
9. If Non-packed follow steps for relevant administration procedure.
10. **Observe** the Resident swallow the tablets/capsules or administration of non-packed medication.

Evaluation and Documentation

11. **Perform** hand hygiene.
12. **Record** and sign on the Signing Sheet:
    - Date and time of administration.
    - Dose administered.
    - Signature of the person administering the medication.
    - Effective (Y / N)

    Note:
    - RNs and ENs to individually sign for each medication.
    - The Homes with eCase MedMan system, staff need to write in the notes box reason for giving and then change the status to **"Given"** and sign.
13. **Check** on the efficacy of the PRN Medication after approx. 30 minutes e.g. did the medication relieve or resolve the symptoms?
14. **Document** in the Resident's Progress Notes:
    - *Medication administered as per medication chart.*
    - Date and time medication administered.
    - Reasons for the PRN medication being given and its effectiveness.
    - Explicit directions from the Authorised Prescribed / Medical Practitioner.
    - RN/EN documents in in eCase Resident's Progress Notes *(Select Progress notes type **Medication Management – Medication –PRN and PRN Medication Evaluation**)*

      Note: For the Homes with eCase MedMan system, the eCase Progress Notes will automatically generate from the record of administration step. Staff need to document evaluation in eCase Resident's Progress Notes (Select Progress notes type ***Medication Management – PRN Medication Evaluation***)
    - Care worker after the directive is given by the RN, records in eCase Resident's Progress Notes *(Select Progress notes type **Medication Management - Medication - PRN with RN authorisation**)*

ADMINISTRATION EYE MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Eye drops and ointments may be administered by **Registered Nurses, Enrolled Nurses or Care Workers** as ordered by the Authorised Prescribed / Medical Practitioner.

Clinical Considerations

- Eye drops in use should not be stored in the refrigerator.
- Xalatan, Xalacom, chloramphenicol, chloromycetin eye drops are to be refrigerated prior to opening.
- Eye drops should be stored and discarded as per manufacturer's instructions.
- The date of opening should be noted on the tube or bottle.
- The eye can only normally accommodate one drop. Multiple eye drops are administered **at five (5) minutes intervals** between each drop to ensure the previous drop is absorbed. If multiple drops are administered and one is more irritant than the others, that drop is administered last.
- **Eye ointments and gels are applied after eye drops** to allow time for absorption into the eye.

PROCEDURE - ADMINISTERING EYE DROPS AND OINTMENTS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (gloves, tissues).
3. **Select** the correct eye drop/ointment and the Resident's medication records. **Check:**
    - Resident's name on the bottle/tube.
    - Prescriber Order Sheet and Signing Sheet/eCase MedMan System.
4. **Check** the Prescriber Order Sheet confirming a legal medication order and check against the medications listed on the Signing Sheet/eCase MedMan system and eye drops/ointment to ensure consistency. This includes the drug name, dose, strength, route, time, and allergies.
5. **Check** expiry and opening dates and ensure the eye drop is at room temperature unless otherwise specified on the bottle/tube.
6. **Perform** hand hygiene and apply gloves.
7. If there is discharge from the eye/s complete an eye toilet first.
8. **Request** Resident to tilt their head backwards and look upwards.
9. **Remove** the cap and place inverted on a clean surface.
10. **Using** a tissue gently pull down the lower lid to form a pouch (conjunctival pouch).

If Instilling Eye Drops:

11. **Approach** the eye from the side and hold the dropper/bottle approx. 1.5cm from the eye, **do not touch** the eye lids or lashes.
12. **Squeeze** the bottle and instil one drop in the middle of the lower lid (conjunctival pouch). If more than one drop is required, allow **five-minutes** intervals between each drop.
13. **Ask** the resident to close their eyes and advise them to avoid blinking or rubbing eyes for a few moments. If appropriate, ask the Resident to apply gentle pressure for a few minutes to the bridge of the nose, to prevent the drops draining from the eye.
14. Blot excess drops around the eye with a tissue from the inner to the outer eye, using a separate tissue for each eye.

If Applying Eye Ointment:

15. **Squeeze** out a small amount of ointment and discard it prior to use.
16. **Squeeze** the tube to apply ointment as a ribbon along the eye pocket of the lower lid from the inner to outer eyelid.
17. **Ask** the Resident to close their eyes and advise them to avoid rubbing or blinking eyes for a few moments.

Clean up and Documentation

18. **Replace** cap/lid to eye drops/ointment.
19. **Remove** gloves.
20. **Return** eye drops/ointment to storage and dispose of equipment appropriately.
21. **Perform** hand hygiene.
22. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
23. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

ADMINISTRATION EAR MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

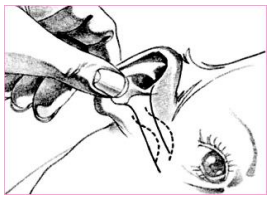
Ear drops and ointments may be administered by **a Registered Nurse, Enrolled Nurses, or Care Workers** at the direction of the Authorised Prescribed / Medical Practitioner.

Clinical Considerations

- Ear drops should be administered **at room temperature**, if possible.
- Chloromycetin ear drops **are to be refrigerated prior to opening.**
- Kenacomb and Otocomb ear drops **are to be refrigerated at all times** (before and during use).
- Ear drops should be discarded **as per manufacturer's instructions**.
- The date of opening should be noted on the tube or bottle.

PROCEDURE - ADMINISTERING EAR DROPS AND OINTMENTS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (tissue, disposable sheet, gloves).
3. **Select** the correct ear drop/ointment and the Resident's medication records. **Check:**
    - Resident's name on the bottle/tube.
    - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Check** the Expiry Date on the label.
5. **Ensures** ear drops are at room temperature prior to instillation unless otherwise specified.
6. **Perform** hand hygiene and apply gloves.
7. **Position** the Resident comfortably on his/her side opposite to affected ear, placing towelling or disposable sheet under their head.



If instilling ear drops:

8. **Gently** tips bottle from side to side to mix contents.
9. **Remove** the cap from the dropper bottle and hold above the ear canal, explain procedure to resident then gently pull the outside of the ear up and back to straighten the ear canal.
10. **Administer** the correct number of ear drops prescribed, aiming for the drops to fall against the sides of the ear canal.
11. **Wipe** away excess drops with a tissue.
12. **Keep** the treated ear facing up for approx. 5 minutes to allow the medication to reach the affected area.

If applying ear ointments:

13. **Remove** the cap, squeeze tube, and apply a ribbon of ointment in the ear canal.

Clean Up and Documentation

14. **Replace** cap/lid to ear drops or ointment.
15. **Remove** gloves.
16. **Return** ear drops/ointment to storage and dispose of equipment appropriately.
17. **Perform** hand hygiene.
18. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
19. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

ADMINISTRATION NASAL DROPS AND SPRAYS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Nasal drops and sprays may be administered by **Registered Nurses, Enrolled Nurses or Care Staff** as ordered by the Authorised Prescribed / Medical Practitioner.

Clinical Considerations

- Nasal drops and sprays should be administered **at room temperature**, if possible.
- Nasal drops and sprays should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the tube or bottle.
- It is important that the Resident's nostrils are clear prior to instillation of drops or sprays to ensure the medication can go deep inside the nose. Resident should be asked to blow their nose prior to instillation of medication.

PROCEDURE – ADMINISTERING NASAL DROPS OR SPRAYS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (gloves, tissues).
3. **Select** the correct nasal drops/spray and the Resident's medication records.

   Check:
   - Resident's name on the bottle
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Check** expiry date.
5. **Perform** hand hygiene and apply gloves.
6. **Request** the Resident to clear their nose by gently blowing into a tissue.

For Nasal Drop Application:

7. **Sit** the Resident down and tilt their head backward or if possible (and clinically appropriate), ask the Resident to lie down with a pillow under their shoulders positioning their head lower than their shoulders.
8. **Insert** the dropper one (1) centimeter into the nostril, inserting the correct number of drops.
9. Immediately afterward tilt their head forward as much as is comfortable.
10. **Assist** the Resident to sit up after a few seconds, to allow the drops to drip into the pharynx.

For Nasal Spray Application (Pump Bottle):

11. **Gently** tip the bottles from side to side to mix contents before each use.
12. **Prime** the nasal spray before first use and if required. Follow manufacturer's instruction for advice.
13. **Ask** Resident to tilt their head slightly forward and to breathe out slowly.
14. **Ask** Resident to block the nostril not requiring medication.
15. **Insert** spray nozzle into the nostril holding the bottle with your thumb at the bottom and the first two fingers at the top on either side of the nozzle.
16. **Ask** the Resident to breathe in slowly through the nostril as you squeeze the pump bottle to administer the medication at the same time.
17. **Repeat** the procedure for the other nostril, if ordered.

Clean Up and Documentation

18. **Wipe** away excess drop with a clean tissue.
19. **Clean** the applicator with another clean tissue, apply the cap.
20. **Remove** gloves.
21. **Return** nose drops/spray to storage and dispose of equipment appropriately.
22. **Perform** hand hygiene.
23. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
24. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

ADMINISTRATION LIQUID MIXTURES AND SUSPENSIONS

Liquid mixtures and suspensions may be administered by **Registered Nurse, Enrolled Nurses, or Care Workers** at the direction of the Authorised Prescribed / Medical Practitioner.

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Clinical Considerations

- Mylanta (liquid formulations) are to be refrigerated only after opening.
- Liquid mixtures and suspensions should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the bottle.
- When measuring liquid medications use a graduated medicine cup place on the flat surface while pouring the medicine to the prescribed volume (mL).
- If excess medication is removed from the bottle discard the excess, **DO NOT** return to the bottle.

PROCEDURE - ADMINISTERING LIQUID MIXTURES & SUSPENSIONS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (measuring cup, tissue).
3. **Select** the correct liquid or suspension and the Resident's medication records. **Check:**
    - Resident's name on the bottle.
    - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Perform** hand hygiene.
5. **Position** the Resident ensuring they are in an upright position.
6. **Mix** contents by tipping the bottle from side to side and check the expiry date.
7. **Remove** the cap/lid maintaining sterility of cap/lid.
8. **Pour** the liquid into the measuring cup on the flat surface and confirm the prescribed volume.
9. **Replace** cap/lid on the bottle. Use a tissue to wipe drips from around neck of bottle if required.
10. **Administer** the liquid medication to the Resident.
11. **Confirm** that the Resident has swallowed the medication and offer the Resident appropriate fluids if required.

Clean Up and Documentation

12. **Return** liquid medication to storage and dispose of equipment appropriately.
13. **Perform** hand hygiene.
14. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
15. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

ADMINISTRATION SUBLINGUAL MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

A Registered Nurses, Enrolled Nurse or Care Worker may administer sublingual sprays, tablets, lozenges, or wafers as ordered by the Authorised Prescribed / Medical Practitioner.

Clinical Considerations

- Sublingual medications should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the bottle.
- Sublingual medications are administered under the tongue and therefore not absorbed through the gastro-intestinal system. This method allows for rapid absorption into the blood stream and does not require water for ingestion. Advise Residents not to swallow immediately following administration, particularly Glyceryl Trinitrate spray to allow for absorption through the oral mucosa.
- Most sublingual wafers and lozenges medications are wrapped in foil because they are sensitive to moisture. Staff should wear gloves when removing from packaging.

PROCEDURE - ADMINISTERING SUBLINGUAL MEDICATIONS

Administering Sublingual Tablets, Wafers, Lozenges or Sprays

1. Identify the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. Select the correct sublingual medication and the Resident's medication records.

   Check:

   - Resident's name on the medication.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
3. Check the Expiry Date of medication and opening date on Anginine (for Angina) tablets. Tablets expire 90 days after opening. The date of opening should be noted on the bottle.
4. Remove the medication from the original packaging using a 'no touch' technique or gloves if necessary.
5. Count the number of tablets, wafers, lozenges and/or number of sprays to be administered against the Signing Sheet/eCase MedMan system.
6. Perform hand hygiene and apply gloves.
7. Position the Resident into a comfortable upright position.

   If medication is Glyceryl Trinitrate check Blood Pressure prior to administering.
8. Request Resident open mouth and move tongue to roof of mouth.

9. **Using** gloved hand if wafer or lozenge place medication under resident's tongue.
    - For **tablets or wafers:** Advise Resident to close mouth and not swallow the tablet or wafer.
    - For **lozenges**: Advise Resident to suck on lozenge and to not chew or swallow the lozenge.
    - For **sprays**: Advise Resident to close mouth following administration and avoid swallowing for as long as is comfortable.
10. If medication is Glyceryl Trinitrate (for Angina) **check after 3-4 minutes** that pain is relieved.
    - If pain is NOT resolved re-check Blood Pressure and administer second tablet/spray if ordered.
    - Recheck and record Vital Signs.
    - Do not administer more than the maximum dose ordered during an angina attack.
    - If no relief is achieved after the two doses (or the maximum prescribed dose) call an ambulance for immediate transfer to hospital after checking Advance Care Directive.
    - Notify Authorised Prescriber /Medical Practitioner re the incident and effect of treatment.
    - Notify the Resident's Authorised Representative of the incident and transfer to hospital.

Clean up and Documentation

11. **Return** medication to storage and dispose of equipment appropriately.
12. **Perform** hand hygiene.
13. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
14. **Document** in the Resident's Progress Notes and escalate to RN/ Authorised Prescriber /Medical Practitioner if the Resident has refused medication, missed medication, for any medication error or medical emergency.

ADMINISTRATION TOPICAL CREAMS AND OINTMENTS

Creams, ointments, and other topical preparations may be administered by **Registered Nurses, Enrolled Nurses, or Care Workers** at the direction of the Authorised Prescribed / Medical Practitioner.

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Clinical Considerations

- Topical creams and ointments should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the tube or bottle.
- When a medicated preparation is prescribed for a Resident, the order must state the site for application, strength of the preparation, frequency of the application and the order must be reviewed at regular intervals.
- Creams should not be applied to open skin e.g. skin tear or exudating wound unless specifically prescribed for management of the condition.

PROCEDURE - ADMINISTERING TOPICAL CREAMS & OINTMENTS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (gloves, spatula if required).
3. **Select** the correct cream or ointment and the Resident's medication records.

   Check:
   - Resident's name on the bottle/tube.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Perform** hand hygiene and apply gloves.
5. **Position** the Resident comfortably and prepare area for application ensuring only area of skin for application of cream is exposed.

Applying Topical Cream or Ointment:

6. **Assesses** the condition of the skin prior to application of cream.
7. **Determine** amount of cream/ointment required.
8. **Remove** the cap/lid and place inverted on a clean surface.
9. **Remove** cream or ointment and place onto your fingertip/spatula and gently apply to the affected area.

Clean Up and Documentation

10. **Remove** gloves.
11. **Replace** the cap/lid.
12. **Return** creams or ointment to storage and dispose of equipment appropriately.
13. **Perform** hand hygiene.
14. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
15. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

ADMINISTRATION TRANSDERMAL PATCHES

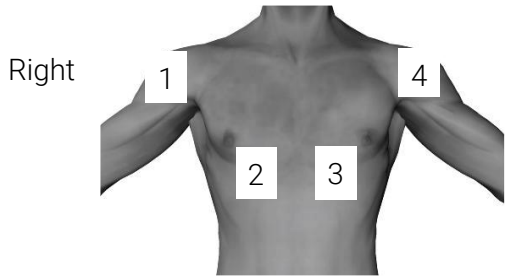
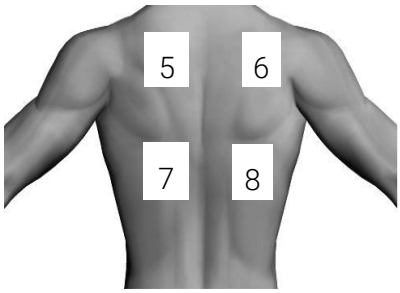
Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Transdermal Patches may be administered by **Registered Nurses, Enrolled Nurses or Care Staff** as ordered by the Authorised Prescribed / Medical Practitioner.

Clinical Considerations

- Transdermal patches should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the box.
- Patches are applied according to directions for a particular period of time.
- Staff are to ensure patches remain in place for the required period of time and are removed at the required time: this may vary between a number of hours in the case of **nitrate patches**, to a number of days for analgesic/pain medication.
- Applications sites should be **regularly rotated** to avoid local skin irritation or reaction.

Sites for Application

FRONT VIEW	BACK VIEW
	

- **NEVER** cut a patch or touch the sticky side of a patch.
- Once applied to the skin press with the palm of the hand for **about 30 second**.
- Patch application and sites as well as removal must be documented on *eCase Patch Chart*.
- **Occlusive dressings** must not be applied over a patch unless specifically approved by the manufacturer.
- Not all skin will bond with the patch's adhesive. Secondary adhesive support may be required. Please refer to manufacturer's instructions and consult with health professional or pharmacy before adding skin tape to the transdermal patch.
- **Heat packs and other heat sources** must not come into contact with the patch as this may alter medication release characteristics. Do not apply a patch to an area where a heat pack has recently been removed and the skin is still warm.

Monitoring Patches

- Patches should be monitored daily to ensure they are still in place and documented on eCase Patch Chart.

Missing Patches

If a patch is missing from its site of application:

- A thorough search of clothing, bedlinen, bathroom, and rooms should be carried out to locate the missing patch (particularly in the case of an S8 patch).
- Patches found to have fallen off must not be re-applied.
- A patch that has not been found is to be reported as a medication incident and procedures followed according to medication incident protocol.

  Note: where a transdermal S8 patch (fentanyl or buprenorphine) is unable to be located on the resident, it must be treated as a loss and reported (as soon as possible) in line with policy, 'Loss or Theft of S8 Drugs'.

PROCEDURE - APPLYING TRANSDERMAL PATCHES

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Identify the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. Gather equipment required (gloves, sharps container, pen).
3. Select the correct Transdermal patch and the Resident's medication records.

   Check:

   - Resident's name on the packaging.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. Check expiry date.
5. Check eCase Patch Chart to determine where the patch is to be applied and location of patch to be removed if applicable.

To apply a new patch

6. Perform hand hygiene.
7. Adjust Resident clothing to access a clean, dry, and hairless area of skin to apply patch which preferably has not had a patch applied to it for 3 to 4 weeks prior.
8. Check skin condition of the Resident and confirm that the Resident has not had a heat pack recently applied to the area proposed for patch application.
9. Open the packaging, remove the patch, and carefully peel off the smaller portion of the plastic/foil backing being careful not to touch the sticky medicated area of the patch.
10. Apply the new patch to the chosen site.
11. Gently press on the patch with palm of hand for 30 seconds. Ensure the entire patch is in contact with the skin, especially around the edges.
12. Readjust the Resident's clothing and ensure they are comfortable.

To remove a used patch

13. **Remove** the used patch by peeling it from the skin gently, folding the patch on itself to avoid contact with your skin.
14. Dispose of used patch in **the sharps container**.

Clean Up and Documentation

15. **Perform** hand hygiene.
16. **Sign** Signing Sheet/eCase MedMan system at correct date & time.
17. **Record** the new site application in ***eCase Patch chart.***
18. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

ADMINISTRATION INHALATION MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Inhalation medications may be administered by **Registered Nurses, Enrolled Nurses or Care Workers** as ordered by the Authorised Prescribed / Medical Practitioner.

Clinical Considerations when Using Metered Dose Inhalers (MDI)

- Inhalation medications should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the box, tube, or bottle.
- If using **multiple inhalers**, Residents are to be administered **short-acting bronchodilators (e.g. Salbutamol) first** and **corticosteroids last** to assist with inhalation of medication in the airways.
- For **steroid inhalers** Residents must rinse their mouth out with water to reduce the risk of steroid powder absorption in the mouth which can lead to oral thrush.

PROCEDURES - ADMINISTERING INHALATION MEDICATIONS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (e.g. cup of water and bowl for rinsing mouth).
3. **Select** the correct inhaler and the Resident's medication records.

   Check:

   - Resident's name on the inhaler.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Perform** hand hygiene.
5. **Position** the Resident comfortably in an upright position.
6. **Administer inhalation medications according to specific manufacturer's instructions.**

Clean Up and Documentation

7. **Return** inhalation medication to storage and dispose of equipment appropriately.
8. **Perform** hand hygiene.
9. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
10. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

PROCEDURES - USING A SPACER (MDI & RAPIHALER)

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Clinical Considerations when Using Spacer

- Residents who have trouble using a puffer should use a spacer.
- The puffer is released into one end of the spacer and the Resident breaths in and out of the other end. Spacers avoid the need to co-ordinate dose release with inhalation.
- Spacers **MUST NOT** be shared between Residents.
- Spacers are to be washed in neutral detergent and allowed to air dry. **DO NOT** rinse as the detergent prevents static electricity which can make the medication stick to the sides of the spacer instead of travelling through it.
- Spacers should be washed prior to first use.

Note: Spacers require **'priming'** before first use and after every wash

Priming

1. **Assemble** spacer (if Volumatic device).
2. **Attach** Metered Dose Inhalers (MDI) to mouthpiece of spacer.
3. **Press** down on metal canister and release 2-4 puffs of medication into spacer.
4. **Administer** medication as directed.

Single Breath Technique or Four Breath Technique

1. **Check** dose counter if available.
2. **Remove** MDI cap, hold inhaler upright and shake well.
3. **Insert** inhaler upright into spacer.
4. **Put** mouthpiece between teeth without biting and ask resident to close lips to form a good seal.
5. **Ask** Resident to breath out gently into the spacer.
6. **Keep** spacer horizontal and press down firmly on inhaler canister once.
7. **Ask** the resident to breathe in slowly and deeply.
8. Resident to hold breath for **5-10 seconds** or as long as comfortable **OR**

   For residents unable to manage the single breath technique, they can instead **breathe in and out normally for 3-4 breaths**.
9. While holding breath, remove spacer from mouth and ask Resident to breathe out gently.
10. **Remove** inhaler from spacer.
11. If more than one dose is needed, repeat all steps starting from step 4.
12. **Replace** inhaler cap.

    Note: A tightly fitting face mask can be used for people who cannot form a close seal around the mouthpiece.

ADMINISTRATION NEBULISER MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Clinical Considerations when Using Nebulisers (including T-mouthpiece)

- Nebuliser medications should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the box.
- Nebulisers convert liquid medication into a fine mist inhaler through a mouthpiece or mask.
- The air flow and pressure of nebuliser should be checked **at least once a year** by the equipment service provider.
- Nebules are only to be removed from original packaging immediately prior to administration and the remainder stored out of direct light.
- A T-mouthpiece is preferred to be used when administering certain medications such as corticosteroid, via nebulisers to direct flow of drug away from the eyes.
- Nebuliser masks should be washed in neutral detergent, rinsed, and allowed to air dry prior following each use.
- Nebuliser masks and tubing should be replaced at least every month or more frequently dependent upon individual Resident use.

PROCEDURES - ADMINISTERING NEBULISER MEDICATIONS

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (appropriate mask or T-mouthpiece, tubing, tissues, damp cloth, water, and bowl for rinsing mouth out if applicable).
3. **Select** the correct nebules and the Resident's medication records.

   Check:
   - Resident's name on the nebules box.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Check** the expiry date of the nebule/s ensuring they are in original packaging and have not been exposed to light. The date of opening should be noted on the foil packaging.
5. **Perform** hand hygiene.
6. **Ensure** the Resident is seated in an upright position.
7. **Open** the bowl & place the solution of the nebule(s) into the bowl, screw top onto bowl & mask/mouthpiece.

8. Attach the tubing to the nebuliser.
9. If using a mask: attach the tubing to the mask and place mask on the Resident's face ensuring a secure fit.
10. If using a mouthpiece: attach the tubing to the T- mouthpiece and instruct the Resident to close their mouth firmly over the mouthpiece.
11. Switch nebuliser machine **"on",** the solution to be nebulised should begin to 'mist'; if the mist escapes from around the face mask, adjust the fit of the mask by gently pressing the face mask over the bridge of the Resident's nose and gently tighten strap behind their head.
12. Remind the Resident that it is important to breathe through the mouth and not to talk during the procedure if possible.
13. Switch nebuliser machine **"off"** when all the medication in the bowl has been nebulised and the mist has ceased, approximately 5-10 minutes.
14. Assist the Resident to remove the mask or mouthpiece.
15. Assist the Resident to wipe their face with a damp cloth if required.
16. If steroid medication is nebulised encourage the Resident to rinse their mouth with water and to spit out into a bowl.
17. Take the mask or mouthpiece and bowl, and clean the equipment with neutral detergent, rinse and allow to dry.

Clean Up and Documentation

18. Return nebuliser equipment to storage and dispose of rubbish appropriately.
19. Perform hand hygiene.
20. Sign Signing Sheet/eCase MedMan system at correct date and time.
21. Document in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

OXYGEN THERAPY

The **Authorised Prescriber / Medical Practitioner** is responsible for ordering continuous, intermittent, PRN or NIM oxygen therapy for Residents in accordance with their individual medical needs. This is recorded on the *RAC Observation and Oxygen Directive* and/or Prescriber Order Sheet in litres per minute (L/min) and/or on the NIM form.

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

RAC Observation and Oxygen Directive should be reviewed by the Authorised Prescriber / Medical Practitioner **annually** or as required.

RAC Observation and Oxygen Directive is to be kept with the Resident's RxMed Chart Folder and **uploaded** to eCase Gallery.

Practice Limitations

Registered Nurses

Responsible for:

- Assessing Resident needs regarding emergency or intermittent oxygen usage.
- Ensuring oxygen therapy is administered as medically prescribed.
- Documented in the Resident's Progress Notes and carefully monitored.

Documentation should include:

- The reason for administering the oxygen.
- The flow rate administered.
- The effectiveness of oxygen delivery.
- Actions initiated to facilitate review of the Resident by their Authorised Prescriber / Medical Practitioner.
- Condition of the Resident including vital signs.

Enrolled Nurses and Care Workers

- May administer prescribed Oxygen Therapy at the direction of the Authorised Prescribed / Medical Practitioner.
- May administer oxygen to a Resident in an emergency situation following clinical advice and direction from a Registered Nurse and/or call an ambulance 0-000.
- CHL's preference is for each resident with COPD to be reviewed by the Authorised Prescribed / Medical Practitioner regarding their need for oxygen. If required, the prescribed dose and frequency is to be documented on the medication chart.

Oxygen Therapy - Delivery Options

Oxygen therapy can be delivered via a portable oxygen cylinder, or via an oxygen concentrator.

Portable oxygen cylinders must be secured to a trolley when in use and must be replaced when fill level reaches 25%. They last a few hours and can be used in emergency situations. Oxygen therapy delivered via this method is usually via a face mask and tubing (single use).

An oxygen concentrator is an electrical device which draws on room air and pumps out a low flow of continuous oxygen. Oxygen tubing is connected to the concentrator that delivers oxygen via nasal prongs. This therapy is generally used for Residents requiring long term oxygen therapy.

An Oxygen Concentrator:

- Plugs into a regular power point.
- Removes gases from the air which increases the concentration of oxygen available to the Resident.
- Is suitable for Residents who require regular administration of oxygen at low flow levels.
- Is not suitable for emergency situations e.g. treatment of chest pain.
- MUST NOT be used as a nebuliser unit.
- MUST NOT be covered or obstructed whilst in operation to ensure adequate ventilation.
- Requires cleaning as per manufacturer's instructions where the concentrator has a filter.

PROCEDURE - ADMINISTERING OXYGEN THERAPY

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

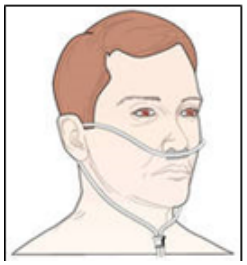
1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** the required equipment (Oxygen Cylinder or Oxygen Concentrator) ensuring it is clean and ready for use.
3. **Check** the Resident's Medication Records.
    - Prescriber Order Sheet - Resident's name and photo identification
    - Signing Sheet/eCase MedMan system - name and photo identification (for PRN order only, not continuous Oxygen) OR
    - Administer oxygen to a Resident in the event of an emergency following clinical advice and direction from the Registered Nurse.
4. **Ensure** appropriate signage is in place e.g. "No Smoking Oxygen in Use"

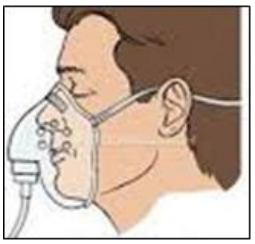
<u>For Oxygen Cylinder with Oxygen Flow Meter OR Oxygen Concentrator</u>

5. **Check** the expiry date on cylinder and ensure adequate supply of Oxygen is available (must be replaced when fill level reaches 25%) and transport it to the resident.

    OR

    Plug the Oxygen Concentrator into a power point and ensure there is adequate ventilation around the concentrator.
6. **Perform** hand hygiene.
7. **Attach** nasal prongs or mask, (and extension tubing if required), to the Oxygen Flow Meter or Oxygen Concentrator.





8. **Turn** the oxygen ON at the Flow Meter to the correct flow rate indicated on the Prescriber Order Sheet (L/min).

    OR

    Turn the Oxygen Concentrator ON. A temporary alarm will sound for a few seconds to alert you that the alarm is functioning. Set the flow rate to the appropriate level between 0-4 as prescribed on the Prescriber Order Sheet.

9. **Gently** insert the nasal prongs into the nostrils of the resident and secure tubing behind ears.

   OR

   Place the mask over the nose and mouth of the resident and secure the mask in place by placing the elastic strap at the back of resident's head and moulding the mask over the bridge of the nose.

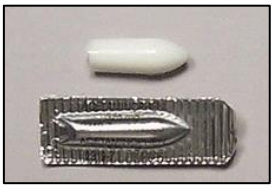
   Note: Check the resident's skin for points of pressure from the equipment to prevent pressure injury. For example, behind the ears for nasal prongs or on bridge of the nose for masks.

10. When oxygen is no longer required, turn oxygen OFF at Flow Meter or Concentrator and remove mask/nasal prongs.

Clean Up and Documentation

11. **Clean**, replace and dispose of equipment appropriately.
12. **Perform** hand hygiene.
13. **Sign** Signing Sheet/eCase MedMan system at correct date and time if required.
14. **Document** in the Resident's eCase Progress Notes and escalate to RN if required.

RECTAL SUPPOSITORIES, ENEMAS, VAGINAL PESSARIES AND CREAMS



Care Worker must **NOT** administer rectal suppositories, vaginal pessaries or enemas and internal creams.

Clinical Considerations

- Rectal suppositories, vaginal pessaries or enemas and internal creams should be discarded as per manufacturer's instructions.
- The date of opening should be noted on the box, tube, or bottle.
- Proctosedyl and Scheriproct suppositories are to be refrigerated at all times (before and during use).
- Such preparations are available for use in the event a Resident is unable to swallow medication or local action is required (e.g. for constipation).
- Rectal preparations include suppositories and enemas.
- Suppositories are stored at the temperature indicated by the manufacturer to help maintain the shape of the suppository.

PROCEDURE – ADMINISTERING SUPPOSITORIES AND ENEMAS

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (gloves, disposable under sheet, water-based lubricant, tissues).
3. **Select** the suppository/enema and the Resident's medication records.

   Check:

   - Resident's name on the box.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Check** the expiry date for the medication.
5. **Perform** hand hygiene and apply gloves.
6. **Position** the Resident so that they are lying down on their left side with upper leg flexed.
7. **Ensure** they are covered with a sheet with only the buttocks exposed.

Suppository

8. **Suppository** - Remove wrapper and apply water soluble lubricant to the tip of the suppository / enema tip and a gloved finger.
9. **Suppository** - Ask the Resident to take deep breaths through their mouth to relax their anal sphincter muscles. Gently insert the suppository by directing it with the finger through the anus approximately 3.5 cm into the rectum, this is to ensure it is placed beyond the internal sphincter.

Enema

10. **Twist** the and pull the seal off the nozzle.
11. **Squeeze** the tube slightly so that a drop of the medication smears the tip which makes insertion easier.
12. **Insert** the nozzle fully into the rectum.
13. **Squeeze** the contents out fully by squeezing the shoulder of the tube.
14. Withdraw the nozzle while keeping the tube squeezed tightly and place on disposable sheet.
15. **Ensure** anal area is wiped clean and dry.
16. **Encourage** the Resident to retain the suppository/enema for as long as they can.

Clean Up and Documentation

17. **Remove** gloves and dispose of equipment appropriately.
18. **Perform** hand hygiene.
19. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
20. **Document** in the Resident's Progress Notes including effect of medication and escalate to Authorising Prescriber /Medical Practitioner if appropriate.

PROCEDURE – ADMINISTERING VAGINAL PESSARIES & CREAM

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Gather** equipment required (gloves, applicator, and lubricant if applicable, tissues, disposable under sheet).
3. **Select** the correct vaginal pessary/creams and the Resident's medication records.

   Check:
   - Resident's name on the box.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Check** the Expiry Date of the medication.
5. **Perform** hand hygiene and apply gloves.
6. **Position** the Resident so that they are lying on their back with the legs slightly drawn up or on their side and ensure they are covered with a sheet with only the vulvar area exposed.

Pessaries

7. **Remove** wrapper from the pessary and insert into applicator (if required).
8. **Lubricate** the applicator or finger and gently insert the applicator or finger with the pessary into the vagina.
9. During insertion, **ask** the Resident to take deep breaths through their mouth to relax their muscles.
10. **Hold** the applicator in position and slowly push the plunger until it stops to place the pessary in the vagina.
11. **Remove** the applicator/finger from the vagina.

Cream

12. **Remove** cap from the cream tube ensuring sterility of the cap.
13. If using an applicator fill with the required amount of cream.
14. **Lubricate** the applicator and gently insert the applicator with the cream into the vagina.
15. During insertion, **ask** the Resident to take deep breaths through their mouth to relax their muscles.
16. **Hold** the applicator in position and slowly push the plunger until it stops to place the cream in the vagina.
17. **Remove** the applicator from the vagina and place on disposable sheet.
18. **Ensure** labia area is wiped clean and dry.
19. **Encourage** the Resident to remain lying on their back for 10 minutes.

Clean Up and Documentation

20. **Disposes** of equipment appropriately.
21. **Cleans** applicator in accordance with the manufacturer's instructions if required.
22. **Remove** gloves.
23. **Performs** hand hygiene.
24. **Sign** Signing Sheet/eCase MedMan system at correct date and time.
25. **Document** in the Resident's Progress Notes and escalate to Authorised Prescriber / Medical Practitioner if appropriate.

INTRAMUSCULAR MEDICATION

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

Practice Limitations

Registered Nurse and Enrolled Nurses

Intramuscular injections of medications are administered deep into the muscle tissues of appropriate sites to provide rapid systemic action and the absorption of relatively large doses of up to 5 ml.

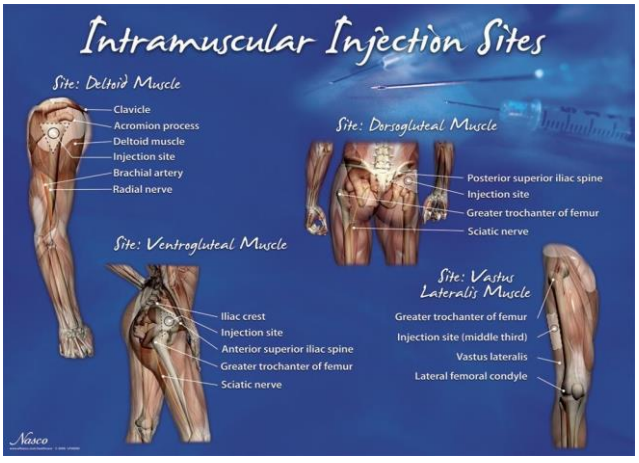
ONLY Registered Nurses and Enrolled Nurses are permitted to administer intramuscular injections in CHL RAC Homes.

Clinical Considerations

- Intramuscular injections of medications should be discarded as per manufacturer's instructions.
- Intramuscular injections should not be administered at inflamed, oedematous, or irritated sites or sites that contain moles, birthmarks, scar tissue or other lesions.
- Size 21 or 23 gauge needle should be used to ensure the medication is injected into the muscle.
- IM injections require a sterile technique.
- Injectable medications should be stored in accordance with the manufacturer's instructions.

Injection Sites

Intramuscular injections can be administered into the thigh, buttocks, and upper arm or above the buttocks.



http://www.frontmed.co.nz/products/product-details/_cat2_/120/Emergency--Medical-Training/Anatomical-Models-Charts/_prod_/Intramuscular-Injection-Sites-Poster

PROCEDURES – ADMINISTERING INTRAMUSCULAR MEDICATION

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Clean** the preparation surfaces with neutral detergent.
3. **Gather** equipment required (gloves, syringe, needle, alcohol wipe, kidney dish, sharps container).
4. **Select** the correct medication and Resident's medication records.

   Check:

   - Resident's name on the box.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
5. **Check** the Expiry Date for the medication.
6. **Perform** hand hygiene.
7. **Connect** the needle and syringe maintaining an aseptic technique. If required remove the soft metal or plastic cap protecting the rubber stopper of the vial and inject air equal to the medication volume into the vial).
8. **Draw** up the required liquid medication from the ampoule/vial into the syringe.

   If the entire volume of the ampoule/vial is not required, discard excess medications into sharps container.

   If **reconstitution** is required:

   - Using a sterile single-use syringe and needle withdraw the reconstitution solution from the ampoule or vial.
   - Insert the needle into the rubber stopper in medication vial and inject the reconstitution fluid.
   - Mix the contents of the vial thoroughly until all visible particles have dissolved.
   - After reconstituting the contents withdraw the prescribed amount of medication into syringe.
9. **Place** the ampoule, syringe, and alcohol swab in a Kidney dish/ injection tray to take to the Resident.
10. **Recheck** the order on the prescriber order sheet against the medication orders with a witness (RN, EN or Care Worker).
11. **Perform** hand hygiene and apply gloves.
12. **Remove** the cap from the needle.
13. **Using** index finger and thumb of non-dominant hand spread skin around site.

14. **Hold** the syringe in a dart fashion and insert the needle into the muscle at a 90º angle leaving 0.5cm of the needle exposed.
15. **Draw** back gently on the syringe plunger (If blood appears in the syringe, remove, select a new site and repeat).
16. **Slowly** depress the plunger until the entire dose of medication is administered.
17. **Withdraw** needle and press an alcohol swab against site for up to 5 seconds and then release. **Do not massage immediately** dispose of needle and syringe in sharps - **Never** re-sheath a needle if not using a safety needle.
18. **Remove** gloves.
19. **Readjust** Resident's clothing and ensure they are comfortable.

Clean Up and Documentation

20. **Ensure** all equipment is cleaned and returned to correct storage area.
21. **Performs** hand hygiene.
22. **Sign** the Signing Sheet/eCase MedMan system at correct medication, date, and time.
23. **Document** any exceptions to administration such as Resident refusal or for any medication incident e.g. reaction. Escalate to Authorised Prescriber / Medical Practitioner if appropriate.

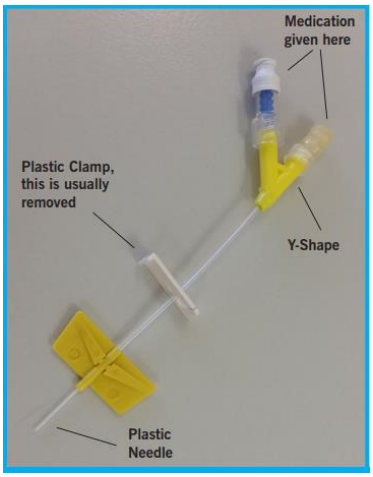
SUBCUTANEOUS CANNULA AND INJECTION

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

A subcutaneous cannula, also known as a 'Saf-T-Intima™,' is a little plastic tube designed to carry medication into a person's body.

Subcutaneous means 'just below the skin;' a subcutaneous injection means giving an injection just under the skin. There is good blood supply under the skin, and this carries the drug into the rest of the body.



Subcutaneous injections are normally less painful than an injection into the muscle and are easier to give than an intravenous or intramuscular injection.

Practice Limitations

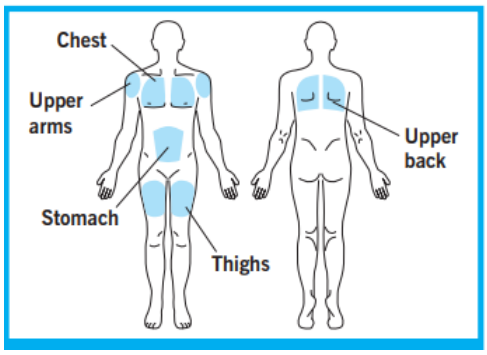
ONLY Registered Nurses and Enrolled Nurses are permitted to administer subcutaneous injections in CHL RAC Homes.

Clinical Considerations

- Subcutaneous injections of medications should be discarded as per manufacturer's instructions.
- Prolia injection are to be refrigerated at all times in original carton.
- The subcutaneous method is a safe and effective way of giving medications, especially when a Resident is experiencing swallowing problems or has nausea and/or vomiting.
- Subcutaneous injections require a sterile technique.
- Check the insertion site before and after give an injection into the cannula and the site should be assessed for redness, bruising, swelling, tenderness, leakage, or discharge. Re-site if any of these are present.
- The cannula needs to be changed and the site must be changed **every 7 days** or sooner to maintain patency and sites rotated to avoid tissue damage.

Injection Sites

- The cannula can be inserted into the Resident's abdomen or chest, upper thigh, or upper arm. If the resident is experiencing some confusion and is likely to remove the cannula, it can be placed in the upper back.
- Oedematous areas, bony prominences, skin creases, scars and distended abdomens should be avoided.

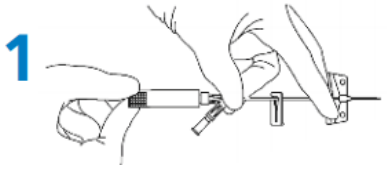


PROCEDURES – INSERT SUBCUTANEOUS CANNULA

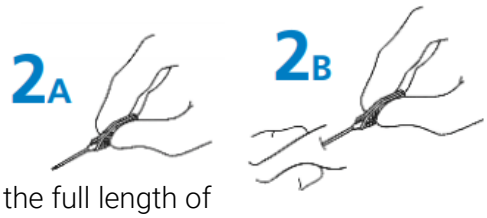
Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

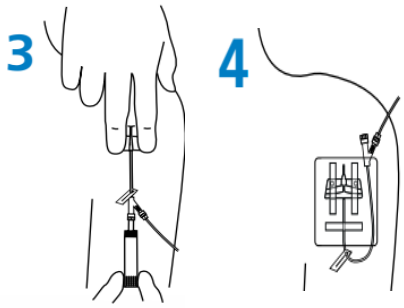
1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Clean** the preparation surfaces with neutral detergent.
3. **Gather** equipment required (gloves, needleless syringe with luer lock, #24-gauge butterfly needle, Sodium Chloride 0.9% solution, alcohol wipe, transparent dressing (e.g. Opsite or Tegaderm), tape, kidney dish, sharps container).
4. **Perform** hand hygiene and apply gloves.
5. **Select** the subcutaneous site.
6. **Cleanse** site (circular area 5-8cm) with alcohol swab and allow to dry. Remove slide clamp if preferred.
7. **Rotate** the white safety shield 360 to loosen the needle. Ensure the bevel is up and catheter is not extended over the needle tip/bevel.



8. **Remove** the vent plug and Attach a needleless connector/luer lock to the side Y port.
9. **Pinch** the textured (pebbles side down) yellow wings together.



10. **Gently** pinch the skin fold. Insert at a 30-45 degree angle to the full length of the needle.
11. **Hold** the wings flat on the skin firmly (do not hold the centre bar). Pull back on the white safety shield in a straight continuous motion until the safety shield separates leaving the cap.
12. **Discard** the needle immediately in the sharps container.
13. **Apply** sterile transparent dressing (e.g. Opsite or Tegaderm). Loop the extension set and secure in place. (Optional: can place gauze under the port to protect the skin).



14. **Flush** the set with Sodium Chloride 0.9% solution (additional **0.4ml** for priming the set including the luer lock).
15. **Remove** gloves.
16. **Label** the dressing: Record the date and time of insertion.

Clean Up and Documentation

17. **Ensure** all equipment is cleaned and returned to correct storage area.
18. **Perform** hand hygiene.
19. **Document** in Resident's Progress Notes - Injection site, catheter size, site assessment and any other pertinent actions or observations.

PROCEDURES – ADMINISTERING SUBCUTANEOUS MEDICATION VIA SUBCUTANEOUS CANNULA

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

1. **Identify** the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. **Clean** the preparation surfaces with neutral detergent.
3. **Gather** equipment required (gloves, syringe, needle, alcohol wipe, Sodium Chloride 0.9% solution, kidney dish, sharps container).
4. **Select** the correct medication and Resident's medication records.

   Check:

   - Resident's name on the box.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
5. **Check** the Expiry Date for the medication.
6. **Perform** hand hygiene.
7. **Connect** the needle and syringe maintaining an aseptic technique. If required remove the soft metal or plastic cap protecting the rubber stopper of the vial and inject air equal to the medication volume into the vial).
8. **Draw** up the required liquid medication from the ampoule/vial into the syringe.

   If the entire volume of the ampoule/vial is not required, discard excess medications into sharps container.

   If **reconstitution** is required:

   - Using a sterile single-use syringe and needle withdraw the reconstitution solution from the ampoule or vial.
   - Insert the needle into the rubber stopper in medication vial and inject the reconstitution fluid.
   - Mix the contents of the vial thoroughly until all visible particles have dissolved.
   - After reconstituting the contents withdraw the prescribed amount of medication into syringe.
9. **Draw** up Sodium Chloride 0.9% solution and leave the syringe attached to the ampoule until ready to give.
10. **Place** the ampoule, syringe, and alcohol swab in a Kidney dish/ injection tray to take to the Resident.
11. **Recheck** the order on the prescriber order sheet against the medication orders with a witness (RN, EN or Care Worker).

12. **Perform** hand hygiene and apply gloves.
13. **Using** alcohol wipe clean the end of bionector for at least 30 seconds and allow to dry.
14. **Push** the syringe straight into the bionector and twist to lock.
15. **Slowly** push down on the plunger to give the medication.
16. After administration of prescribed medication, **flush** the cannula with Sodium Chloride 0.9% solution (*additional **0.4ml** for flushing the set including the luer lock*).
17. **Remove** the syringe.
18. **Dispose** of sharps directly into a sharps container.
19. **Remove** gloves.
20. **Readjust** Resident's clothing and ensure they are comfortable.

Clean Up and Documentation

21. **Ensure** all equipment is cleaned and returned to correct storage area.
22. **Performs** hand hygiene.
23. **Sign** the Signing Sheet/eCase MedMan system at correct medication, date, and time.
24. **Document** any exceptions to administration such as Resident refusal or for any medication incident e.g. reaction. Escalate to Authorised Prescriber / Medical Practitioner if appropriate.

SUBCUTANEOUS MEDICATION VIA A SYRINGE DRIVER - NIKI T34

Indications for Use

Subcutaneous infusion of medications delivered via syringe drivers may be used for the relief of acute pain, chronic pain and symptom management including for Residents in the terminal phase of palliation or for when the oral route is no longer clinically appropriate.

Syringe drivers deliver a stable dose of subcutaneous drugs over period of time, usually 24 hours and often two to four medications are mixed as well as a diluent. Certain combinations of medications may not be compatible, and a Pharmacist or Palliative Care Team should be consulted regarding the most effective mechanism of medication delivery.

Applies to:

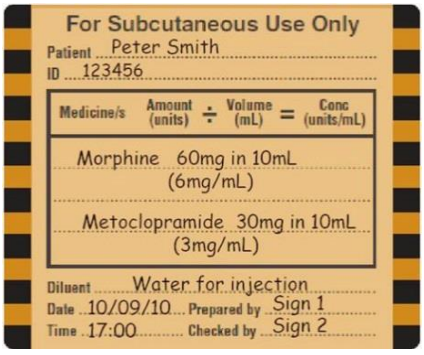
- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

Practice Limitations

- In CHL the use of syringe drivers is to be managed by **Registered Nurses** only under the instruction of a Medical Practitioner / Authorised Prescriber or other suitably qualified person.
- Syringe drivers are to be prepared by a **Registered Nurse** and checked by another staff member who has been assessed as competent to **witness** the loading of the medication and setting the pump to the prescribed amount for administration.
- The key to the Niki T34 lock box is to be kept with the syringe driver when not in use. When in use, the key is to be kept on the person of a **Registered Nurse**.
- **Enrolled Nurses and Care Workers** can report any beeps that indicates changes in the pump's operations to the RN, for assessment by the RN.

Clinical Considerations

- Labelling of each prepared syringe is a national requirement.
- Labelling should include:
    1. The Resident's name and date of birth/ID.
    2. Each medication includes the amount and volume of syringe to calculate concentration.
    3. Type of diluent.
    4. Date and time of preparation.
    5. Who prepared the syringe driver?
    6. Who witnessed and checked the preparation of the syringe driver?



Commonly Used Syringe Driver Medications

- Haloperidol (antipsychotic/antiemetic)
- Metoclopramide (antiemetic)
- Glycopyrrolate (anticholinergic)
- Hysocine Hydrobromide (nausea & vomiting)
- Hyoscine Butylbromide (GI motility)
- Midazolam (benzodiazepine)
- Hydromorphone (opioid analgesic)
- Clonazepam (benzodiazepine)
- Morphine (opioid analgesic)
- Fentanyl (opioid analgesic)
- Cyclizine (sedating antihistamine)

Combination of Medications to be Avoided

- Metoclopramide and Cyclizine - forms crystals
- Cyclizine and Hyoscine - forms crystals
- Dexamethasone and Midazolam - forms precipitates
- Clonazepam and PVC - adsorption resulting in decreased concentration.

Diluents

- Sodium Chloride 0.9% solution is most commonly used as the diluent in syringe drivers. It produces a solution closer to the isotonicity with body fluids than water for injection. However not all drugs are compatible with Sodium Chloride such as Cyclizine which is to be diluted in water for injection as it crystalises when added to Sodium Chloride 0.9% solution.
- Check the prescribed diluent with the Medical Practitioner/Authorised Prescriber or Pharmacist.
- NOTE: Breakthrough doses of analgesia are NOT to be administered via the Saf-T intima™ side port of the infusion set as it will significantly interrupt the 24hr dose administration.

PROCEDURE - ADMINISTERING MEDICATION VIA A SYRINGE DRIVER NIKI T34

Applies to:

- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

1. Identify the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. Gather equipment required:
    - Niki T34 with lock box and 9-volt battery in situ with key.
    - BD Plastipak luer lock syringe for loading (largest syringe fitting is 30ml with the use of the lock box) - determined by the volume of drugs.
    - 1ml/2ml syringes (for accurate drawing up).
    - Needles for drawing up medications.
    - Safe-T-Intima.
    - Extension tubing: 75cm luer lock tubing.
    - Sodium Chloride 0.9% ampoule, 10ml ampoule/s as diluent, unless H_20 ordered.
    - Alcowipe swabs syringe, tubing.
3. Select the correct medication and Resident's medication records.

    Check:

    - Resident's name on the box.
    - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
4. **Check** the Prescriber Order Sheet with the witness confirming a legal medication order and check against the medications listed on the Signing Sheet and medication to ensure consistency. This includes the drug name, dose, strength, route, time, and Resident's allergies.
5. **Check** expiry date of medication.
6. **Check** the syringe driver is clean and ready for use.
7. **Perform** hand hygiene.

Prepare the Syringe

8. **Use** the prescribed luer lock syringe BD-Plastipak.
9. **Draw** up medication and mix with diluent to prescribed volume.
10. **Place** completed label on the infusion set by wrapping it around tubing.

Connect Infusion Set to the Syringe

11. **Select** the appropriate infusion set.
12. **Connect** the infusion set securely to the syringe and prime the tubing (if new infusion) with the prescribed medication.

Check the NIKI T34 Syringe Pump

13. Preloading and Syringe Placement:
    - Raise clamp.
    - Ensure that the barrel clamp arm of the NIKI T34 is down. Close clamp.
    - Turn on the NIKI T34; press and hold the "ON / OFF" button. The pump will beep once and the software version of the NIKI T34 will appear on the screen.
    - The LCD display will show 'PRE-LOADING' and the actuator will start to move. Wait until it stops moving. The pump is calibrating itself during this process. The NIKI T34 will prompt you to load the syringe.

    Check the Battery by pressing 'INFO' key repeatedly until the battery level appears on the screen and then press 'YES' key to confirm.

    Note: Discard the battery if less than 20% of the life remaining. The average battery life, starting at 100%, is approximately 3-4 days depending on use.

Fitting the Syringe to the NIKI T34

14. If the actuator is not in the correct position to accommodate the syringe leave the barrel clamp down and use the FF or BACK buttons on the keypad to move the actuator to the required position.

    Forward movement of the actuator is limited, therefore repeated presses of the FF key may be required when moving the actuator forward. Backwards movement is not restricted. The actuator can only be moved as described above. DO NOT use force to try and move the actuator manually as it could damage the device.

15. Lift the barrel clamp arm and load the syringe into the NIKI 34 Pump.
16. Seat the filled syringe collar / ear and plunger so the back of the collar / ear sits against the back of the central slot (ensure correct placement). The syringe collar / ears should be vertical.
17. Lower the barrel clamp arm.

Confirm the Syringe Size and Brand

The NIKI T34 will detect the syringe size and brand once loaded. You must ensure the correct brand of syringe is selected as the NIKI T34 reads the volume digitally and the incorrect choice of syringe brand could result in an incorrect volume being detected.

18. If the NIKI T34 has selected the correct brand and size of the syringe press the 'YES' key to confirm

    OR

19. Use the ▲▼ arrows to scroll up or down to view other syringe brand choices, select your correct syringe brand and then press 'YES' key to confirm.

Setting the Infusion Parameters (New Resident) & Review the Infusion Parameters (Same Resident)

After the syringe has been confirmed the next screen shows the volume of the content of the syringe, default duration and rate. The NIKI T34 calculates and displays the deliverable volume, duration of an infusion. The Pump will be locked into a 24-hour default duration for palliative care program.

If using 20ml syringe, infusion volume in 18ml (usually over a 24-hour period)

If using 30ml syringe, volume of 23ml (usually over a 24-hour period)

20. When the screen shows YES to resume or NO for the new syringe **select**:
    - **YES,** key to RESUME only if that syringe has been interrupted.

      OR
    - **NO,** key for a NEW syringe.

Connect to the Resident

The pump screen will then prompt 'START INFUSION'

21. **After** the syringe confirmation, the first screen that appears below:
    - Press **'YES'** key OR
    - Press **'NO'** key for a new syringe

      Note: The LED light flashes green whilst working.
22. **Lock** the box and RN only to carry the key.

Clean Up and Documentation

23. **Clean**, replace and dispose of equipment appropriately.
24. **Perform** hand hygiene.
25. **Both** staff including witness sign Signing Sheet/eCase MedMan system at correct date and time.
26. **Commence** eCase Subcutaneous Syringe Driver Observation Chart.
27. **Document** in the Resident's Progress Notes and escalate to Residential Manager or Authorised Prescriber/Medical Practitioner if the Resident has refused medication, missed medication or for any medication error.

Safety Alert - all Nikki T34 pumps and pump housings manufactured from 2013 onwards.

These pumps should not be used in sunlight or, if it is necessary for the Resident to go outdoors, protect the pump from exposure (by placing it in a pouch or a bag).

Issued by REM SYSTEMS in April 2016

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SCHEDULE 8 (S8) & S4D MEDICATION

ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering of Schedule 8 (S8) & S4D Medications

Regular S8 & S4D Packed in a DAA

- There is no requirement to place an order for the weekly supply.
- Each week a new supply will automatically be delivered by the Supply Pharmacy and the previous week's **Webster-Pack/Card** collected.

Non-Packed & PRN S8 and S4D

- Order for Schedule 8 & S4D medication will be sent (MedsComm) by the **Registered Nurse**.

Note:

- ALL Schedule 8 medications **SHOULD** be packed in Purple S8 **Webster-Pack/Card** or original packaging.
- ALL regular S4D medication **SHOULD** be packed in the **Unit Dose 7 Webster-Pack/Card DAA.**
- A full list of all S4D medicines is available at https://www.health.nsw.gov.au/pharmaceutical/Pages/sch4d.aspx

Receipt and Storage of S4D Medications

NSW RAC 'Nursing Homes'

- **Only Registered Nurse** should accept delivery and sign for receipt of S4D drugs (DAA, non-packed, PRN).
- Homes should ensure the Supply Pharmacy delivers S4D medications at a time when there is a Registered Nurse available to accept delivery.
- S4D medications, whether in original packaging or in a DAA, **must be securely stored in a separate lockable cupboard apart from all other medications.**
- Securely stored includes:
  - Being securely locked in a cupboard which is securely attached to the premises.
  - The key to the lockable cupboard must be kept separate to all other keys and on the person of the Registered Nurse
  - Where there is no Registered Nurse on the premises 24/7, the key to the lockable cupboard is to be secured in a separate safe/lock box accessed by a combination lock or keypad upon the conclusion of their shift. This safe/lock box can then be accessed by the RN on-call if needed.
  - In NSW nursing homes, **all** S4Ds must be stored separately to other medications and kept in a lockable cupboard, whether packed or not, however if packed they must be packed separately in the Unit Dose 7 **Webster-Pack/Card** DAA.

Receipt and Storage of S4D Medications

NSW Non 'Nursing Home' RAC Homes

a. Regular UD7 Webster-Pack/Card

- Receipt from the Supply pharmacy should be signed by an authorized person (RN, EN or Medication Competent Care Worker).
- S4D medications which are packed in Regular UD7 Webster-Pack/Card DO NOT need to be stored separately to all other drugs.
- Regular weekly Unit Dose 7 Webster-Pack/Card are to be stored on a pharma file and out of Resident or visitor access in either a:
    - Locked medication cupboard securely attached to the premises.
    - Locked medication room
    - Locked medication trolley
    - A locked drawer/cupboard in a Resident's room for Resident's self-administering medication.

b. Non-Packed, PRN and Urgent Use/Imprest S4D medications

- A receipt from the Supply Pharmacy should be signed by a Registered Nurse confirming the medications ordered are the same as the medications delivered.
- Homes should ensure the Supply Pharmacy delivers at a time when there is a Registered Nurse available to accept delivery.
- Must be securely stored in a separate lockable cupboard apart from all other medications. Securely stored includes:
    - Being securely locked in a cupboard which is securely attached to the premises.
    - The key to the lockable cupboard must be kept separate to all other keys and on the person of the Registered Nurse
    - Where there is no Registered Nurse on the premises 24/7, the key to the lockable cupboard is to be secured in a separate safe/lock box accessed by a combination lock or keypad upon the conclusion of their shift. This safe/lock box can then be accessed by the RN on-call if needed.

Receipt and Storage of Schedule 8 (S8) Medications

NSW RAC 'Nursing Homes' and QLD RAC Homes

- Only a **Registered Nurse** should accept delivery and sign for receipt of S8 drugs (DAA, non-packed, PRN).
- Homes should ensure the Supply Pharmacy delivers S8 medications at a time when there is a Registered Nurse available to accept delivery.
- S8 medications, whether in original packaging or in a DAA, must be securely stored in a drug safe apart from all other medications and recorded in the Drug Register or Controlled Drugs Book by a Registered Nurse and appropriate witness.
- Securely stored includes:
    - Being securely locked in a Drug Safe which is securely attached to the premises.
    - The key to the Drug Safe must be kept separate to all other keys and on the person of the Registered Nurse
    - If a code or combination is used to lock and unlock the Drug Safe, only the Registered Nurses at the Home has access.
    - Where there is no Registered Nurse on the premises 24/7, the key to the Drug Safe is to be secured in a separate safe/lock box accessed by a combination lock or keypad upon the conclusion of their shift. This safe/lock box can then be accessed by the RN on-call if needed.
    - In NSW nursing homes, all S8s must be stored separately to other medications and kept in an S8 safe, whether packed or not, however if packed they must be packed separately in DAA.
    - In QLD, regular S8s can be packed either multi-dose or unit dose and the pack must be stored in safe, it is permissible that other multi-dose packed medications to be in the safe with the S8s.

Receipt and Storage of Schedule 8 (S8) Medications

NSW Non 'Nursing Home' RAC Homes

a. Regular UD7 Webster-Pack/Card

- Receipt from the Supply pharmacy should be signed by an authorized person (RN, EN or Medication Competent Care Worker).
- S8 medications which are packed in Regular UD7 **Webster-Pack/Card DO NOT** need to be stored separately to all other drugs or recorded in a Drug Register.
- Regular weekly Unit Dose 7 **Webster-Pack/Card** are to be stored on a pharma file and out of Resident or visitor access in either a:
    - Locked medication cupboard securely attached to the premises.
    - Locked medication room
    - Locked medication trolley
    - A locked drawer/cupboard in a Resident's room for Resident's self-administering medication.

b. Non-Packed, PRN and Urgent Use/Imprest S8 medications

- A receipt from the Supply Pharmacy should be signed by a **Registered Nurse** confirming the medications ordered are the same as the medications delivered.
- Homes should ensure the Supply Pharmacy delivers at a time when there is a Registered Nurse available to accept delivery.
- Must be securely stored in a drug safe apart from all other medications and recorded in the Drug Register or Controlled Drugs Book by a Registered Nurse and appropriate witness. Securely stored includes:
    - Being securely locked in a Drug Safe which is securely attached to the premises.
    - The key to the Drug Safe must be kept separate from all other keys and only the Registered Nurses at Home has access.
    - Where there is no Registered Nurse on the premises 24/7, the key to the Drug Safe is to be secured in a separate safe/lock box accessed by a combination lock or keypad. This safe/lock box can then be accessed by the RN if needed.

Disposal of Schedule 8 (S8) Medications

Persons who are NOT authorised to Destroy S8 Medications

An Accredited Pharmacist who is carrying out medication reviews in a Home, but who is not supplying medication to the Home, is **NOT** authorised to destroy or receive unwanted drugs of addiction for destruction at that Home.

NSW RAC 'Nursing Homes'

I. Ceased or Expired S8 Medications and Discharged Resident

- Schedule 8 medication identified for destruction is to be destroyed **on the premises** - it **MUST NOT** be returned to the Supply Pharmacy.
- Schedule 8 medication must be destroyed by the Supply Pharmacist in the presence of the Residential Manager or a Senior Delegated Registered Nurse of the Home.

  Note: Other persons who are authorised to supervise the destruction of S8 drugs are NSW Police Officers or NSW Health appointed inspector.
- Whatever form of destruction is used, it must render the S8 medication unrecoverable and must not constitute a risk to the community. For example,
  a. Shake out contents of vial into sharps container and dispose in sharps container followed by detergent/ liquid soap in sharps container.
  b. Draw up the contents of the ampoule in a syringe and expel contents in sharps container.
- An entry is made in the Drugs Register by the Supply Pharmacist, marked as *Destroyed by Pharmacist* (must record **AHPRA number**) and the amount destroyed recorded in the 'Amount Given' column and a balance recorded in the 'Balance' column. The transaction must be co-signed by the Residential Manager or the Senior Delegated Registered Nurse as the witness.

II. A portion of an S8 medication (Tablet, Vial, Syringe Driver)

- The unused portion must be rendered unrecoverable and discarded by a **Registered Nurse** in the presence of a witness and **recorded in the drug register on the same line as the record of administration.**
- The unused portion of tablets must be crushed between paper towel, mixed with liquid soap and contents disposed of in the sharps container in the presence of a witness.
- The unused portion of vial must be crushed underfoot, between two sheets of absorbent paper, so that the drug is rendered indistinguishable from the crushed glass and the paper containing the crushed glass and liquid is disposed of into the sharps container or draw up the contents of the ampoule in a syringe and expel contents in sharps container.
- For partially used S8 infusions and syringe drivers the unused portion must be expelled in a sharps container in the presence of a witness. The volume discarded must be documented in the Resident's *eCase Progress Notes – (eCase Progress Notes Type - **Medication Management – Disposal of medications**)* by the Registered Nurse and then another entry by the witness stating they witnessed the discarding of drug type and amount.

III. Used S8 transdermal patches

- Used patched must be folded in half so that the medication is trapped within the adhesive surface, then disposed of in a sharps container.
- Used patched must be removed in the presence of a witness, even if the patch is not to be replaced.
- The date and time of the discarding must be recorded on the eCase Progress Notes – *(eCase Progress Notes Type - **Medication Management – Disposal of medications**)* by the Registered Nurse and then another entry by the witness stating they witnessed the discarding of drug type and amount.

IV. Missing S8 Transdermal Patch

- A transdermal S8 patch is missing from the Resident, it must be treated as a loss and reported immediately in line with Policy Loss or Theft of S8 Drug
- Record on the eCase Progress Notes – (select ***eCase Progress Notes Type - Incident – Medication***)
- Record in eCase as a medication incident (select ***Incident Type – S8 medication missing (CAS 2)***
- Replace the patch and report to the Residential Manager and RM report to Regional Manager.

V. S8 Transdermal Patch off Resident

- Transdermal S8 patch is found to have come off the resident, the Registered Nurse must be informed and record the findings on the resident's ***eCase Patch Chart*** and in the **comment section** of the chart add the name of the witness (staff member who found the patch) and location of found S8 patch.
- The RN must ensure the patch is replaced and report to the Residential Manager if they are any issues.
- Record on the eCase Progress Notes – (select ***eCase Progress Notes Type - Incident – Medication***)
- Record in eCase as a medication incident (select ***Incident Type – Staff related-dropped/damaged medication***)
- In the absence of a Registered Nurse, the S8 patch in the presence of a witness must be placed in a specimen jar and labelled with the Resident's details. This should then be secured in a locked medication cupboard and documented on the eCase Med Incident Register, Resident's Progress Notes and reported and communicated at handover.

NSW Non 'Nursing Home' RAC Homes

- Regular DAAs requiring disposal are to be placed in the secure Pharmacy Returns Box or locked room for collection by the Supply Pharmacy.
- The Supply Pharmacy is required to arrange their destruction at the pharmacy by an authorised person.
- Non-packed, PRN S8 medications and Urgent use morphine must be destroyed on the premises as described above for NSW RAC 'Nursing Homes'.

QLD RAC Homes

- Schedule 8 medications identified for destruction may be returned to the Supply Pharmacy.
- An entry is made in the Controlled Drugs Book by the Senior Registered Nurse and Supply Pharmacist, marked as Returned to Pharmacy (including name and address) for destruction and the amount removed from the drug safe recorded as 'Amount Given' and the balance recorded in the 'No. Remaining' column.
- The Supply Pharmacist removes the unwanted S8 medications from the RAC Home and packages them and forwards to Queensland Health.

URGENT USE AND IMPREST S8 MEDICATIONS

Urgent Use S8 Medications (NSW RAC Homes)

- To be maintained for use for Residents as clinically indicated and on the order of a Medical Practitioner/Authorised Prescriber.
- Supply should be used only until receipt of the Resident's dispensed supply of the medication (if continued).
- Must be obtained from the Supply Pharmacy on the signed written order of the Residential Manager or Care Manager. This order should be on the *RAC Urgent Use Stock Medication Order form (NSW)*.
- **Monthly** checks are to be carried out using the *RAC Urgent Use Stock Medication Checklist (NSW)* to ensure stock is maintained and expiry dates are checked.
- CHL Homes can hold a maximum of thirty (30) ampoules of Morphine Sulphate containing 30mg or less per ampoule or as approved by the Director General of the Health Pharmaceutical Services Unit. **Note:** ***For the individual Resident, there is no limit stock to hold. The S8 medications supply will be according to script.***

Imprest S8 Medications (QLD RAC Homes)

- Director of Nursing, Medical Superintendent, or Registered Nurse in charge, is authorised to obtain an S8 medicine for use in the nursing home on a purchase order (see notes below for link to purchase order template).
- **Medicines are not restricted to a defined list.** QLD sites can have access to other oral medications authorised if approved and any other medications considered important to keep.
- Purchase Order Template: *Medicines and Poisons Act 2019 – Purchase order template*.

Urgent Use/Imprest S8 Medication Stock - All CHL RAC Homes

- Must be supplied in original packaging.
- Must be stored in the Drug Safe which is securely attached to the premises.
- Must be recorded and accounted for in a Drug Register or Controlled Drugs Book by a Registered Nurse and appropriate witness.
- Must only be administered by the Registered Nurse accompanied by an appropriate witness.
- Must only be administered to one Resident at a time.
- Must only be ordered by the Residential Manager or delegated Senior Registered Nurse.

ADMINISTRATION OF SCHEDULE 8 MEDICATIONS

Applies to:

- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

Schedule 8 medications are classified as dangerous drugs of addiction and as such risk mitigation strategies are in place to ensure safe practice and regulatory compliance. All aspect of S8 drugs including the possession, supply, prescribing, administration, and use are strictly regulated.

In NSW, there are legislative requirements associated with the management of Schedule 8 medication that apply to **'Nursing Homes' only**.

In QLD, there are legislative requirements associated with the management of Schedule 8 medication that apply to **all Residential Care Homes**.

While there is no requirement in the Health (Drugs & Poisons) Regulation 1996 for a Registered Nurse to have a witness when administering or recording S8 drugs in Queensland RAC Homes, it is CHL policy that the entire procedure is witnessed.

Schedule 8 medications may be referred to as Controlled Drugs in Queensland.

Practice Limitations

Registered Nurses

Registered Nurses are permitted to administer and witness all S8 medications including packed in **Webster-Pack/Card**, Non-Packed, PRN and Urgent Use/Imprest medication stock as long as they have been prescribed by an Authorised Prescriber / Medical Practitioner. The S8 key **ONLY** to be carried by Registered Nurse and the S8 key to be separated from other keys.

Enrolled Nurses & Care Workers

- NSW RAC 'Nursing Homes' and Queensland RAC Homes

  In NSW CHL RAC Homes classified as a 'Nursing Home' and in all QLD RAC Homes Enrolled Nurses and Care Workers are **NOT** permitted to administer S8 medications in any form or packaging, however, may act as **a witness** for the preparation and administration of an S8 drug with a Registered Nurse.

- NSW Non 'Nursing Home' RAC Homes

  In NSW CHL RAC Homes **Not** classified as a 'Nursing Home' Enrolled Nurses and Care Workers **MAY** administer S8 medications packed in **Regular DAA** under the supervision and direction of a Registered Nurse.

Witnessing of S8 Medications - PRN, Non-Packed and Urgent Use/Imprest Medication Stock in all CHL RAC Homes

- The witness can preferably be another Registered Nurse, but if unavailable, an Enrolled Nurse or Care Worker who has completed Witness S8 Medications competency.
- The witness MUST be present for the duration of the entire procedure including:
    - Unlocking of the Drug Safe
    - Removal of the required medication from the Drug Safe
    - Checking the medication order, dose, balance, and expiry date
    - Administration
    - Witnessing
    - Recording/Signing in the Drug Register or Controlled Drugs Book
    - Signing on medication signing sheet

S8 MEDICATION ROUNDS - REGULAR PACKED AND NON-PACKED

Administration Directly from Drug Safe

Where S8 medications are administered directly from the Drug Safe then the Schedule 8 medications shall only be removed from the Drug Safe, entered into the Drug Register or Controlled Drugs Book and administered to one Resident at a time.

Administration from a Lockable Mobile Medication Trolley

If the administration of S8 medications is required for a number of Residents during a certain time of the day or day of the week, and it is preferable to do this as a S8 round, a locked mobile medication trolley should be used for the temporary transportation of the S8 medications in their original packaging or DAA from the Drug Safe as opposed to removing an individual dose specific to each Resident requiring S8 medications at that time.

Medication administration is recorded in the Drug Register or Controlled Drug Register, signed by both the Registered Nurse and the witness following the application, injection, or ingestion of the medication by the Resident.

Where the Registered Nurse responsible for the administration of S8 medication is interrupted during a round e.g., for a medical emergency, the trolley must be locked, and Registered Nurse MUST hold the key.

After the S8 Medication Round both staff members are to return all the S8 medication to Drug Safe.

Where a S8 medication round is being undertaken it is preferable that this is at a different time to other regular medication rounds.

MAINTAINING AND RECORDING IN THE S8 DRUG REGISTER OR CONTROLLED DRUGS BOOK

Drug Register or Controlled Drugs Book

The Drug Register (NSW) and Controlled Drugs Book (QLD) accurately maintain all records involving Schedule 8 medications, including receiving, transferring, administering, discarding and allocation for destruction.

Recording in the Drug Register or Controlled Drugs Book

All entries in the Drug Register (NSW) and Controlled Drugs Book (QLD) are to be in the following coloured ink. Blue pen **MUST NOT** be used.

	Pen Colour
Administration	Black
Resident medication received	Red
Urgent Use/Imprest Medication Stock received	Red
Footnote asterisk and notation	Red
Balance check by Registered Nurse	Red
Destruction/Returns	Red
Balance check by Residential Manager/as delegated	Green

Staff Signature Register for S8 Medication Administration & Witnessing - All CHL RAC Homes

All CHL Homes are to maintain the Staff Signature and Witness Register – S8 Medication which includes names and signatures of the authorised RNs, ENs, medication competent Care Workers and supply Pharmacist. This should be updated **annually** and as required.

Retention of Drug Register or Controlled Drug Register - All CHL RAC Homes

The Drug Register or Controlled Drug Register is to be archived for a minimum of **seven (7) years** from the date of the last entry made in it and then destroyed.

Refer to CHL RAC_Resident Information Management Policy for further information.

Maintaining the Drug Register - NSW

- A record of all Schedule 8 medication is to be kept in a Drug Register.

  Note: Excludes Schedule 8 medications packed in Regular DAA in CHL RAC Homes NOT deemed as a 'Nursing Home'.

- The Drug Register must be in the form of a bound book with consecutively numbered pages that cannot be removed or replaced without a trace.
- A record of all inward (receipt) and outward (destroyed by Supply Pharmacist) transactions relating to Schedule 8 medication must be recorded in the Drug Register in indelible red pen.
- For receipt of Schedule 8 medications from the Supply Pharmacy the entry should state *Received from Pharmacy* and the amount recorded in the 'Amount Received' column in indelible red pen.
- A separate page in the Drug Register must be kept for each drug, each form of the drug, and each strength of the drug supplied for each Resident or for Urgent Use.
- Where Resident medication is provided in a DAA e.g. 40 x 0.5 tablets of Endone 5mg tablets these are to be recorded as 40 tablets in the amount received column and upon administration to the resident "1" is to be entered in the amount given column.
- When there are no more pages to enter medication delivery or administration, the balances of the Schedule 8 medication stored in the Drug Safe (either currently prescribed or ceased) are transferred to a new Drug Register. The index must be updated to reflect all medications entered and carried forward (C/F) with the balance recorded at the top of each page for each medication.
- No entry in the Drug Register may be altered, obliterated, erased, or cancelled. That is, no lines may be drawn through entries, no entries scribbled out or crossed out in any way, nor numerals altered.
- If an error is made it must be left as it is, marked with an asterisk, rewritten correctly on the next line, and countersigned by a witness. An asterisk and notation MUST be made at the footer of the page explaining the error with the date, time, and signature of both staff in indelible red pen.

- Balance checks of all Schedule 8 medication must be conducted and recorded in the Drug Register at least ***weekly*** *or* ***more often*** *as directive from the Home Managers* by a Registered Nurse and a competent witness to the procedure in indelible red pen or red ink stamp.
    - The entry in the Drug Register should state *Balance Check* and the actual balance recorded in the 'Balance' column.
    - It is sufficient to use the volume gradations provided on most proprietary bottles of Morphine mixture to check the balance remaining.
- Any discrepancy in a balance must be reported to the Residential Manager (or delegated Senior Registered Nurse where the Residential Manager is not an RN) immediately. Service Impact Incident-Medication in Connect+ to be completed.
- Destruction of all Schedule 8 medications are to be recorded in the Drug Register and should state *Destroyed by Pharmacist'* in indelible red pen.
- The Drug Register balance must be checked by the Residential Manager (or delegated Senior Registered Nurse where the Residential Manager is not an RN) on every ***March*** *and* ***September*** using indelible green pen.

Maintaining the Controlled Drugs Book - QLD

- A record of all non-packed, PRN and Imprest stock Schedule 8 medication is to be kept in a Controlled Drugs Book.
- The Controlled Drugs Book must be in the form of a bound book with consecutively numbered pages that cannot be removed or replaced without a trace.
- A record of all inward (receipt) and outward (returns to QLD Health) transactions relating to controlled drugs must be recorded in indelible red pen.
- For receipt of Schedule 8 medications from the Supply Pharmacy the entry should state *Received from* ***Pharmacy, address*** and the amount recorded in the 'Amount Given or Received' column in indelible red pen. New boxes of Schedule 8 medications received should remain sealed.
- A separate page in the Controlled Drug Register must be kept for each drug, each form of the drug, and each strength of the drug supplied for each Resident or for Imprest Medication stock.

- Where Resident medication is provided in a DAA e.g. 40 x 0.5 tablets of Endone 5mg tablets these are to be recorded as 40 tablets.
- When there are no more pages to enter medication delivery or administration, the balances of the Schedule 8 medication stored in the Drug Safe (either currently prescribed or ceased) are transferred to a new Controlled Drug Register. The index must be updated to reflect all medications entered and carried forward (C/F) with the balance recorded at the top of each page for each medication.
- No entry in the Controlled Drug Register may be altered, obliterated, erased, or cancelled. That is, no lines may be drawn through entries, no entries scribbled out or crossed out in any way, nor numerals altered.
- If an error is made it must be left as it is, marked with an asterisk, rewritten correctly on the next line, and countersigned by a witness. An asterisk and notation SHOULD be made at the footer of the page explaining the error with the date, time, and signature of both staff in indelible red pen.
- Balance checks of all Controlled Drugs (S8) must be conducted and recorded in the Controlled Drug Register every shift by the Registered Nurse delegated that task for that day and witnessed by another person in indelible red pen or red ink stamp.
- The entry in the Controlled Drug Register must include a signature in the 'Shift Change Check' section.
- It is sufficient to use the volume gradations provided on most proprietary bottles of Morphine or Oxycodone mixture to check the balance remaining.
- Any discrepancy in a balance must be reported to the Residential Manager immediately. Service Impact Incident-Medication in Connect+ to be completed.
- Destruction of all Schedule 8 medications are to be recorded in the Drug Register in indelible red pen.
- The Controlled Drug Register balance must be checked by the Residential Manager and Supply Pharmacist at least once per month using indelible green pen.

PROCEDURE FOR RECORDING ENTRIES INTO THE DRUG REGISTER (NSW)

Applies to:

- ✓ Residential Manager
- ✓ Registered/Enrolled Nurse
- ✓ Care Worker

The entry must be legible, in the required pen colour and made on the day and time of the transaction and show the following details:

1. Date.
2. Time using 24-hour clock.
3. Resident's name.
4. Amount (or volume) administered in the "Amount given" column:
   - For liquids, in millilitres (mL)
   - For solid dosage forms record whole or part tablets e.g. 1 or 0.5 tablet
   - For ampoules, the dose e.g. 7.5mg
5. Balance of medication remaining in the 'Balance' column.
6. The name of the prescribing Authorised Prescriber / Medical Practitioner.
7. Print name and signature of the administered or supplying person.
8. Print name and signature of the person witnessing the transaction.

Example of NSW S8 Drug Register

2

WARD REGISTER OF DRUGS OF ADDICTION – POISONS AND THERAPEUTIC GOODS ACT 1966

Drug (name strength form) ENDONE 5mg TABLETS (40 half tabs as packed by Pharmacy) **Ward** MR JONES

Date (/_/_)	Time received or given	Patient's name/Received from	Amount received	Amount given	Discard	Balance	Name of prescriber	Print name of administering or supplying person	Signature of administering or supplying person	Print name of person witnessing, supervising or directing	Signature of person witnessing, supervising or directing	Comments/ Professional Registration number if applicable
13.6.16	Transferred Balance from Page: 11					40		JOY RYOE	Joy Ryde	DEE BUNK	Dee Bunk	
18.6.16	14 00	MR JONES		1		39	Dr. HUBER	JOY RYOE	Joy Ryde	DEE BUNK	Dee Bunk	
	Transferred Balance to Page:											

Footnotes:

PROCEDURE FOR RECORDING ENTRIES INTO THE CONTROLLED DRUG REGISTER (QLD)

Applies to:
- ✓ Residential Manager
- ✓ Registered/Enrolled Nurse
- ✓ Care Worker

The entry must be legible, in the required pen colour and made.

on the day and time of the transaction and show the following

details:

1. Date.
2. Resident's name.
3. Amount (or volume) administered in the "Amount given" column:
    - For liquids record in millilitres (mL)
    - For solid dosage forms record the dosage e.g. 5mg
    - For ampoules record the dose e.g. 7.5mg
    - Number used in the 'No. Used' column in QLD using whole numbers e.g. 1.
4. Time using 24-hour clock.
5. Signature of the person who has given or received.
6. Signature of the person witnessing the transaction
7. Balance of medication remaining in the 'No. Remaining' column
8. The name of the prescribing Authorised Prescriber / Medical Practitioner (for QLD add their name in the comments section).

    Example of QLD Controlled Drug Register

CH28 Each page must refer to one form and strength of drug only D.D. No: – PAGE No.

DRUG BUPRENORPHINE (NORSPAN) **FORM** Patch **STRENGTH** 5mg 4937202

DATE DRUG GIVEN OR RECEIVED	PATIENT'S NAME OR SUPPLIER		AMOUNT GIVEN OR RECEIVED	No. USED	TIME GIVEN	BY WHOM GIVEN OR RECEIVED	CHECKED BY (SIGNATURE)	No. REMAINING	WEEKLY CHECK AND COMMENT (INITIALLED)
	SURNAME	GIVEN NAME/S							
10/03/2015	Received Med Pharmacy 10 Rob St, Ipswich		2			CBlack	A Tompsett	2	
11/03/2015	Brown	Robert	5mg	1	800	B Wright	A Tompsett	1	Dr Grey
11/03/2015	Balance Check					B Wright	A Tompsett	1	

RECORDING REFUSALS OF S8 MEDICATIONS IN THE DRUG REGISTER (NSW) OR CONTROLLED DRUG REGISTER (QLD)

If a Resident refuse to take their S8 medication the refusal must be documented on the signing sheet and in the Drug Register or Controlled Drug Register. The two staff that removed the S8 medication from the drug safe / trolley must make a second entry in the drug register noting *'Refused and discarded'*. An asterisk and notation MUST also be made at the footer of the page, with the date, time, and signature of both staff in indelible red pen.

RECORDING S8 LIQUID MEDICATIONS BALANCES - VARIATIONS

If the balance in the Drug Register or Controlled Drug Register is NIL, but there is still some liquid left in the bottle, the Registered Nurse should:

- Record the sequential balance as NIL for the purpose of recording the administration of the drug to the Resident.
- Measure the true balance of liquid remaining using a sterile syringe.
- Adjust the drug register to read **'Balance on hand'** and record the amount of the liquid as an additional entry on the next available line on the drug register page.
- Any deficit must be treated as a loss and reported as soon as possible.

  Example:

  1. The Morphine mixture balance in the Drug Register or Controlled Drug Register for a Resident is 'NIL' however there is some remaining medication in the bottle.
  2. After measuring the remaining liquid (using a syringe for accuracy) it is noted that 20mls of liquid remains in the bottle.
  3. Confirm the amount remaining with the witness and record the amount as ***Balance on hand*** i.e., 20mLs.
  4. When the new 200mL bottle of morphine mixture arrives from the pharmacy for the same Resident it must be recorded in the Drug Register or Controlled Drug Register as 200mLs, and the balance recorded as 220mLs.

PROVIDING SCHEDULE 8 MEDICATIONS FOR RESIDENTS ON SOCIAL LEAVE OR OUTINGS

- Where a resident is going on leave the S8 medication, either regular or PRN as an individual medication or box /DAA of S8 medications can be provided to a competent Resident/Authorised Representative as for other medications.
- For Schedule 8 medications stored in the Drug Safe and recorded in the Drug Register/Controlled Drugs Book the individual medication or box/DAA of S8 medication is to be removed from the Drug Safe in accordance with the Schedule 8 management policy.
- The removal of the medication must state the Resident's name - Provided for Leave and the total amount removed in the 'Amount Given' column.
- The Registered Nurse must document the reason code Ⓞ for Outing (Medication with Resident) or if overnight Ⓛ for Social Leave on the medication Signing Sheet or change the status to "Outing" or "Social Leave" in eCase MedMan and document the supply of the medications to the competent resident/Authorised Representative in the Progress Notes.
- Upon the Resident's return from leave the box/DAA Schedule 8 medication **must** be checked by the RN to confirm and entered back into the Schedule 8 Drug Register/Controlled Drugs Book. Where tampering has occurred or is suspected the Registered Nurse must inform the Residential Manager.

LOSS OF A S8 DRUG REGISTER (NSW) OR CONTROLLED DRUG REGISTER (QLD)

Any loss or destruction of a Drug Register or Controlled Drug Register is to be reported as soon as possible to the Residential Manager, who must then notify their Regional Manager.

A Service Impact Incident in Connect+ MUST be completed and an initial investigation conducted before the end of the shift.

Applies to:

- ✓ Residential Manager
- ✓ Registered Nurse
- × EN or Care Worker

PROCEDURE FOR LOSS OF S8 DRUG REGISTER (NSW) OR CONTROLLED DRUGS BOOK (QLD)

Legislative Reporting Obligations – NSW

In addition to the above, the **Residential Manager** must notify NSW Ministry of Health Pharmaceutical Services Unit using the website *Notifying the loss or theft of drugs under Poisons and Therapeutic Goods legislation*.

Legislative Reporting Obligations - QLD

In addition to the above, the **Residential Manager** must also notify in writing via email:

The Chief Executive of Medicines Regulation and Quality Unit - mrq@health.qld.gov.au

AND the Local Public Health Unit

Villa Maria Eastern Heights	Villa Maria Fortitude Valley
West Moreton Public Health Unit	Metro North Public Health Unit
eh.westmoreton@health.qld.gov.au	eh.brisbanenorth@health.qld.gov.au
Phone (07) 3818 4700	Phone (07) 3624 1111

Assistance or advice can be obtained during business hours by contacting the Medicines Regulation and Quality Unit on telephone (07) 3328 9890.

The Registered Nurse must carry out a balance check of all Schedule 8 medications held and enter the particulars in a new Drug Register or Controlled Drug Register as soon as possible.

An exercise book with consecutively numbered pages may be used at that point, if a new, official Drug Register or Controlled Drug Register is not available.

The Registered Nurse in Charge at the time the Drug Register or Controlled Drug Register was deemed as missing or lost **MUST** complete a CHL Service Impact Incident (CAS 2) in Connect+.

LOSS OF S8 OR S4D MEDICATIONS

Applies to:

- ✓ Regional Manager
- ✓ Residential Manager
- × RN, EN or Care Worker

Any loss or suspected misappropriation of an S8 or S4D **is required to** be reported as soon as possible to the Residential Manager, who must then notify their Regional Manager.

Similarly, where there is no apparent loss of drugs, but concern exists of possible or admitted misappropriation of S4D or S8 drugs by a staff member, this **is required to** also be reported to the Residential Manager as soon as possible, who must then notify their Regional Manager.

Regional Manager to investigate reporting to Governing bodies, e.g. APHRA.

A Service Impact Incident (CAS 2) in Connect+ **should be completed** and an initial investigation conducted before the end of the shift.

PROCEDURE FOR LOSS OF S8 AND S4D MEDICATIONS

Legislative Reporting Obligations – NSW

In addition to the above, the **Residential Manager** must:

- **Notify** NSW Ministry of Health Pharmaceutical Services Unit using the website *Notifying the loss or theft of drugs under Poisons and Therapeutic Goods legislation*
- The words "Initial Notification" should be noted on the form.
- Assistance or advice can be obtained during business hours by contacting the Duty Pharmaceutical Officer at Pharmaceutical Services on telephone (02) 9391 9944.
- Maintain a copy of the submitted form for record keeping purposes.
- Notify the local police where **theft is confirmed.**

Legislative Reporting Obligations - QLD

Applies to:
- ✓ Regional Manager
- ✓ Residential Manager
- × RN, EN or Care Worker

In addition to the above, the **Residential Manager** must:

- **Notify** the Chief Executive of the Medicines Regulation and Quality Unit of any loss (either accountable or unaccountable) or theft of these drugs via email mrq@health.qld.gov.au

  AND the Local Public Health Unit

Villa Maria Eastern Heights	Villa Maria Fortitude Valley
West Moreton Public Health Unit	Metro North Public Health Unit
eh.westmoreton@health.qld.gov.au	eh.brisbanenorth@health.qld.gov.au
Phone (07) 3818 4700	Phone (07) 3624 1111

- Assistance or advice can be obtained during business hours by contacting the Medicines Regulation and Quality Unit on telephone (07) 3328 9890.
- Maintain a copy of any information submitted for record keeping purposes.
- Notify the local police where **theft is confirmed.**

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Australian Medicines Handbook, 2012.
3. CHL Bug Control e-Manual.
4. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia
5. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
6. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
7. High-Risk Medicines Management, 2013 NSW Health.
8. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
9. NSW Poisons & Therapeutic Goods Regulation 2008.
10. Queensland Health (Drugs and Poisons) Regulation 1996.

ANTICOAGULANT MEDICATION - WARFARIN

CHARTING OF WARFARIN

1. The Authorised Prescriber / Medical Practitioner writes the medications orders on the Prescriber Order Sheet ensuring all the required documentation is completed.
2. The Prescriber Order Sheet is sent (MedsComm) to the Supply Pharmacy
3. A computer-generated Prescriber Order Sheet and Signing Sheet is provided by the Supply Pharmacy and placed in the RxMedChart Folder.

In addition to the charting of Warfarin the Authorised Prescriber / Medical Practitioner should complete and maintain a current individualised *Anticoagulant Directive* for each Resident requiring anticoagulant therapy. *Anticoagulant Directive* should be reviewed by the Authorised Prescriber / Medical Practitioner **annually** or as required.

The *Anticoagulant Directive* (for use with the RxMed Chart) is to be kept with the Resident's RxMed Chart Folder and **uploaded** to eCase Gallery.

The Authorised Prescriber / Medical Practitioner will review the INR result, RxMed Chart Variable Dose Medication and *Anticoagulant Directive* (For use with the RxMed Chart) for any variation.

In NSW where a Resident's warfarin dosing is stable the medication should be packed in a mustard coloured **Webster-Pack/Card** and reviewed by the Authorised Prescriber / Medical Practitioner on a regular basis.

Practice Limitations

Registered and Enrolled Nurses can **administer** a prescribed dose of warfarin according to the written order or telephone order (as received by RN) from the Authorised Prescriber / Medical Practitioner or delegated body (pathology). This can be either from a DAA or from the original packaging/bottle.

Registered Nurses may adjust Warfarin doses according to an *Anticoagulant Directive* determined by the Authorised Prescriber / Medical Practitioner. The Directive **MUST** include the Resident's target International Normalised Results (INR), frequency of INR monitoring and completed medication change orders.

Prior to administration of Warfarin the dose **MUST** be checked and confirmed by a **witness** who could be an **RN, EN or Care Worker**, against the medication order. **Refer to Procedure – Variable Dose Medication Signing Sheet.**

Care Workers can **ONLY** administer Warfarin **packed** in a DAA by the Supply Pharmacist.

Clinical Considerations

It is important that Residents prescribed Warfarin stay on the same brand (currently Coumadin or Marevan in Australia) over the course of therapy as the two brands are not bioequivalent.

Warfarin should be given **at the same time every day, in the afternoon**.

If a dose of Warfarin is missed the staff member responsible for medication administration should contact the Supply Pharmacist and Authorised Prescriber / Medical Practitioner for instruction.

The **Registered Nurse or Enrolled Nurse** has the responsibility for coordinating **pathology results** with the Authorised Prescriber / Medical Practitioner / Pathologist in regard to variable dose Warfarin therapy.

When the INR is outside the range documented on the *Anticoagulant Directive* (for use with the RxMed Chart)

- The *Anticoagulant Directive* (for use with the RxMed Chart) is to be sent to the Authorised Prescriber / Medical Practitioner for confirmation of administration of the next dose.

  OR

- Contact Authorised Prescriber / Medical Practitioner and follow phone order procedure.

Where the Warfarin is in a DAA and the dose is different to the dose packed the **RN must** check and confirm the dose with a **witness**, who could be an RN, EN or Care Worker, against the medication order prior to administration. This must be documented by **both staff** members on the Signing Sheet.

Managing International Normalised Results (INR)

CHL RAC Homes that use the pathologist to manage the INR result will be notified by the pathologist of Warfarin dose to be administered.

PROCEDURE – VARIABLE DOSE MEDICATION SIGNING SHEET

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

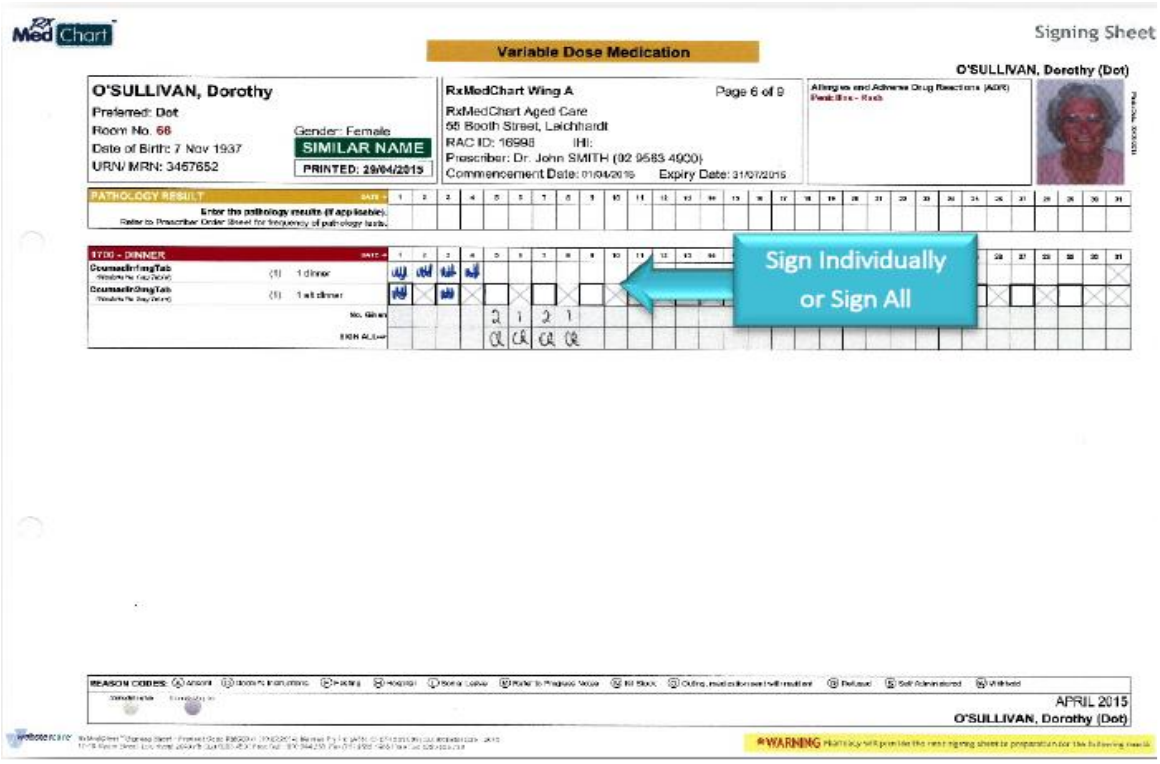
There are two options when signing for variable medication.

Option 1: Variable dose medication is setup with specific doses

The Variable medication is prescribed at a specific dose for a set administration time. For example, Warfarin is prescribed as *1 at dinner*.

In this case the medication is signed for using the standard regular medication administration process. The pathology results can be recorded throughout the month on the required date.

The **Prescriber Order Sheet – Variable** should be referenced throughout the administration process. Record the administration of medication either next to each dose or as a quantity.



Option 2: Variable medication is administered based on pathology results

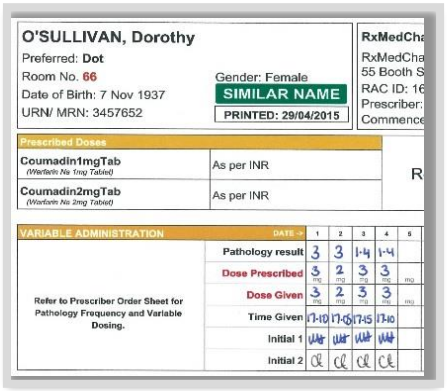
Variable medication may be administered with a dose dependent on the outcome of a pathological result. For example, Warfarin prescribed 'As per INR.'

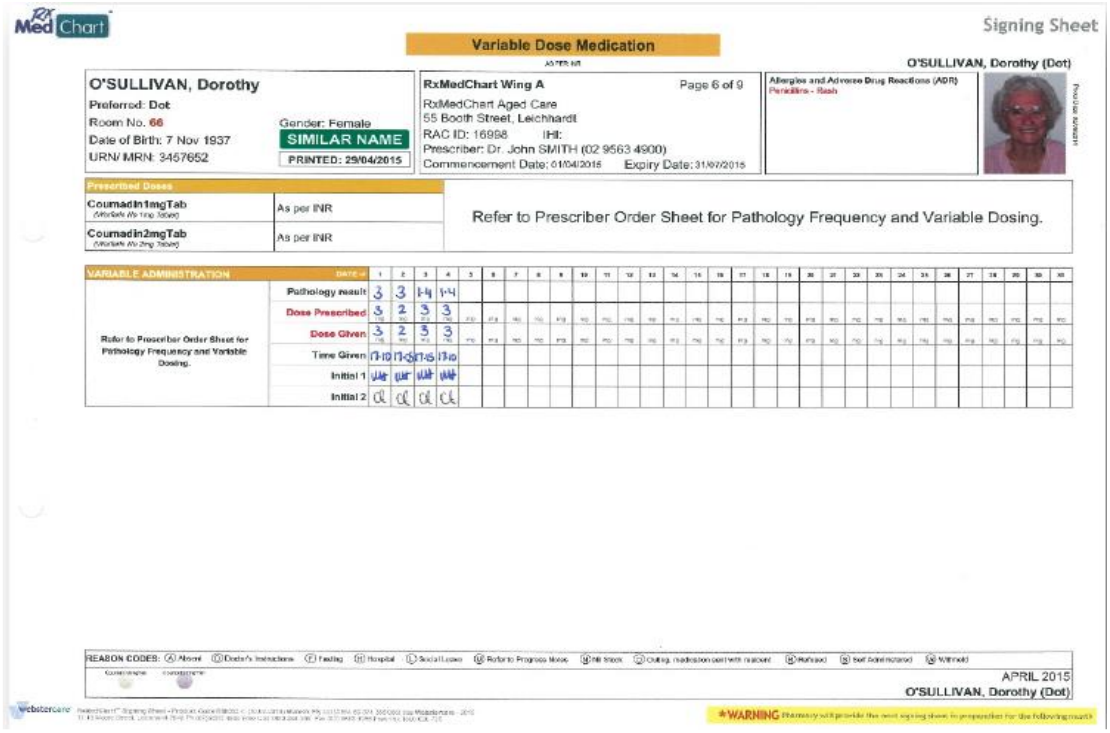
In this case the medication is signed for using the Variable Dose Medication – As per INR signing sheet. You will be required to enter the Pathology Result, Dose Prescribed, Dose Given, Time given, and two staff can verify the administration. The **Prescriber Order Sheet – Variable** should be referenced throughout the administration process.

The medication strength and form are listed at the top of the signing sheet.

Enter the following information when administering medication.

- Pathology Result
- Dose Prescribed
- Dose Given
- Time Given
- Initial 1
- Initial 2





REFERENCES

1. A Guide to Therapeutic Drug Monitoring Version 2, Meditrax 2009.
2. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
3. Australian Medicines Handbook, 2012.
4. CHL Bug Control e-Manual.
5. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia.
6. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
7. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
8. High-Risk Medicines Management, 2013 NSW Health.
9. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
10. NSW Poisons & Therapeutic Goods Regulation 2008.
11. Queensland Health (Drugs and Poisons) Regulation 1996.
12. The Australian Immunisation Handbook 2019, https://immunisationhandbook.health.gov.au/.
13. Warfarin Risk Management Manual for Aged Care Homes, Meditrax 2009.

INSULIN & GLUCOMETER

ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering

Insulin that is identified as requiring ordering will be sent (MedsComm) by the Registered Nurse.

Receipt

Receipt of insulin/s from the Supply Pharmacy should be signed by an authorized person (RN / EN /Medication Competent Care Worker) confirming the insulin/s ordered are the same as the insulin/s delivered.

Storage

Insulin is to be stored as follows:

- Unopened insulin stored in the Medication Fridge is safe to use until the expiry date printed on the box/vial/cartridge.
- Record date of opening
- Opened insulin stored at room temperature **expires 4 weeks** from the date of opening and/or as per manufacturer's instructions.

Monitoring insulin expiry dates is the responsibility of all staff involved in the administration.

Disposal

All used or empty insulin cartridges or vials should be disposed of in a sharps container.

All unopened insulin cartridges or vials requiring disposal are to be placed in the secure Pharmacy Returns Box or locked room for collection by the Supply Pharmacy.

GLUCOMETER

Glucometer Calibration

To calibrate the glucometer each time when opening a new box of test strips.

To calibrate the glucometer **every month** and record on the *RAC_Glucometer Calibration & Quality Control Log.*

Cleaning and disinfection Glucometer

To clean and disinfect the glucometer **as per manufacturer's instructions**.

ADMINISTRATION OF INSULIN

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Insulin is considered a high-risk medication because of the potential impact on the health and safety of Residents who are prescribed the medication and staff who manages and administers it.

Stable Diabetes

A type of diabetes where a person's blood glucose (sugar) levels are well controlled and within range for the individual Resident as defined by the Authorised Prescriber / Medical Practitioner and the Resident is prescribed a fixed dose of insulin.

Unstable Diabetes

Where two consecutive BGLs are outside the range of the Directive the Resident is considered to be 'Unstable' and this must be escalated to the Registered Nurse. At this point the Care Worker is no longer able to administer the insulin until the BGLs are stable.

Practice Limitations

Registered Nurse/Enrolled Nurse

- Insert new insulin cartridges according to the manufacturer's specific instructions.
- label new insulin pen device with Residents' names.
- Adjust Insulin doses according to order on the Prescriber Order Sheet and in accordance with the *Diabetic Directive* determined by the Authorised Prescriber / Medical Practitioner.
- The Registered Nurse may delegate insulin administration to a Care Worker who has been assessed as competent to administer insulin via an Insulin Pen device.

Care Worker

- Administer insulin via a delivery device for Residents with stable BGLs ONLY.
- Witness the preparation of an Insulin Pen Device.

Clinical Considerations

In addition to the charting of Insulin the Authorised Prescriber / Medical Practitioner should complete and maintain a current individualised *Diabetic Directive* for each Resident which includes a range of acceptable blood glucose levels and action required if levels are outside this range.

Diabetic Directive should be reviewed by the Authorised Prescriber / Medical Practitioner **annually** or as required.

Diabetic Directive is to be kept with the Resident's RxMed Chart Folder and **uploaded** to eCase Gallery.

If possible, Residents may **self-administer** insulin in accordance with procedure for "Self-Administration." Some Residents are assessed as able to self-administer but may require staff to assist them, for example, to dial or draw up (prepare) the dose.

Insulin may be administered via **disposable pens** and also **reusable pens** that may be reloaded with disposable insulin cartridges.

Each Home should have a **hypoglycaemic kit** available including the following:

- Small packet of Jellybeans.
- Small container of fruit juice / can of non-diet soft drink.
- Glucose tablets or Glucose Gel 15g.
- Sachets of honey.
- A copy of the Management of a Hypoglycaemic and Hyperglycaemic Episode flow chart *(Diabetic Directive Page 2-3)*

A hypoglycaemic kit should be monitored for the **expiry date and replaced** and the *RAC_Hypoglycaemic Kit Checklist* should be completed Monthly by RN or as delegate.

NOTE: Glucagon may only be administered as per *Diabetic Directive* and as order by an Authorised Prescriber/Medical Practitioner. The Glucagon order may be written on the Prescriber Order Sheet or via telephone order to a Registered Nurse and a competent witness.

PROCEDURES - ADMINISTERING INSULIN VIA INSULIN PEN DEVICE

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Identify the Resident, inform them about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. Gather the required equipment (glucometer, Resident's *Diabetic Directive form*, retractable lancet, insulin pen device, retractable needle, sharps container etc.)

Retractable Lancet

Retractable Needle

Check BGL

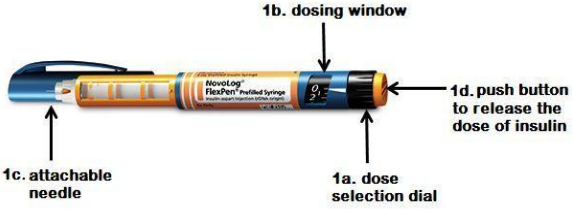
3. **Measure** the Resident's BGL **prior to administer insulin.**
4. **Check** the Residents BGL levels are within the prescribed parameters documented on the Resident's *Diabetic Directive*.
5. **Select** the correct insulin and the Resident's medication records.

   Check:

   - Resident's name on the insulin pen device box/pen.
   - Prescriber Order Sheet and Signing Sheet/eCase MedMan system.
   - Check and witness when loading new cartridge.

Prepare Medication

6. If giving "cloudy" (mixed) insulin roll the pen 10 times between the palms of your hands and then invert the pen 10 times to evenly mix the insulin.
7. **Remove** the cap from the pen.
8. **Remove** the paper tab from the retractable needle.
9. **Attach** the needle - screw the needle straight onto the cartridge holder.
10. **Remove** the outer cap from the needle.
11. **Prime** the pen if a new cartridge:
    - Dialup two (2) units.
    - Point the pen up.
    - Tap cartridge to collect air at the top of the vial for removal.
    - Push the injection button and look for a stream of insulin.

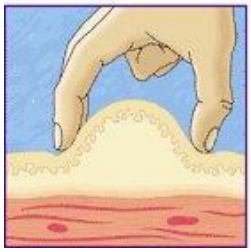


12. If no stream is seen repeat the priming process.
13. **Dial** the required dose of insulin.
14. **Witness** (RN, EN or Care Worker) the dose of insulin dialled against the medication orders.
15. If the dose of insulin has been over dialled expel the contents into a sharps container and redial the correct amount.

Prepare the Resident

16. **Position** the Resident comfortably.
17. Palpate the skin and select the site for sub-cutaneous administration, taking into account appropriate rotation of sites.

Inject the Insulin

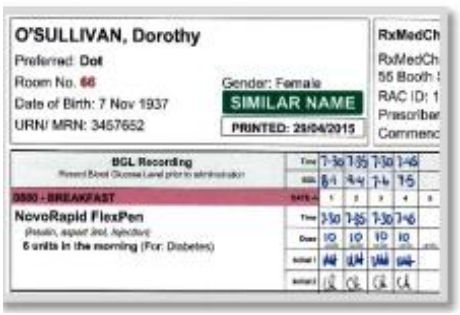


18. **Perform** hand hygiene and apply gloves.
19. **Make** a lifted skin fold (if appropriate) using the thumb and index finger to gently lift the subcutaneous tissue away from the muscle layer to reduce the risk of administering the medicine intramuscularly.
20. **Insert** the needle into the skin at 90 degree angle to its full depth and listen for a "click" sound. Place your thumb on the injection button and slowly press for 5-10 seconds until the button stops moving.
21. **Wait** 10 secs. then withdraw the needle and confirm the Resident has received the required dose by checking the dial has returned to zero (0).
22. **Readjust** Resident's clothing and ensure they are comfortable.

Remove Needle and Dispose of Sharp

23. **Remove** the retractable needle.
24. **Dispose** of retractable needle in sharps container.

Clean Up and Documentation



25. **Ensure** all equipment is cleaned and returned to correct storage area.
26. **Perform** hand hygiene.
27. **Both staff** to sign Signing Sheet/eCase MedMan system at correct date and time as per photo.
28. **Document** in the Resident's Progress Notes and escalate to RN if the Resident has refused medication, missed medication or for any medication error.

PROCEDURES - ADMINISTER GLUCAGEN® HYPOKIT

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

1. Identify the resident, inform them if conscious about the procedure, gain consent and ensure they are positioned comfortably with consideration for privacy.
2. Gather the required equipment (glucometer & strips, retractable lancet, retractable needle, GlucaGen® HypoKit, sharps container, *Diabetic Directive form*, alcohol-based hand rub, tissue, pen, and paper)

Check Diabetic Directive and Medication Record

3. Check the Resident's *Diabetic Directive*.
4. Select the correct GlucaGen® HypoKit.and Resident's medication records.

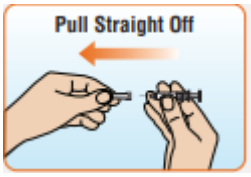
   Check:

   - Resident's name on the GlucaGen® HypoKit.
   - Prescriber Order Sheet - name and photo identification.
   - Signing Sheet/eCase MedMan system - name and photo identification.
5. Check that the orange plastic cap on the vial of GlucaGen® is firmly attached.

   Do not use if the cap is loose or missing.
6. Check the Prescriber Order Sheet confirming a legal medication order and check against the medication listed on the Signing Sheet and the medication to ensure consistency.

   This includes the drug name, dose, strength, route, time, and allergies.

Preparing the GlucaGen® Dose



7. With your thumb, flip the cap off the GlucaGen® vial.
8. Pick up the prefilled syringe containing sterile water.

   Do not use any other liquid to mix the medicine.
9. Hold the syringe with 1 hand. With your other hand, pull the needle cover off the syringe.

   Do not remove the plastic backstop from the syringe.
10. Pick up the GlucaGen® vial of dry powder. Hold the vial with 1 hand. With your other hand, push the needle of the prefilled syringe through the center of the rubber stopper.
11. Hold the vial and syringe together, with the needle still inserted into the vial.

    Carefully turn the vial and syringe together right side up. Slowly push the plunger down until the syringe is empty. Do not take the syringe out of the vial.

12. Firmly hold both the vial and syringe together in one hand, and gently shake until the powder is completely dissolved. Do not use if a gel has formed, or if you see particles in the solution. **Do not take** the syringe out of the vial.

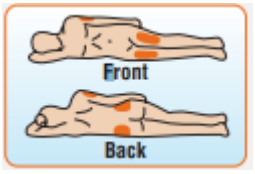
13. With the needle still inserted into the vial, carefully turn the vial and syringe together upside down. Gently pull down on the plunger and slowly withdraw all of the liquid into the syringe. **Do not pull** the plunger out of the syringe.
14. Keep the needle inside the vial. Check the syringe for air bubbles. If you see bubbles, tap the syringe until the bubbles rise to the top of the syringe. Gently push on the plunger to move only the air bubbles back into the vial.

15. Check the medication orders with a witness (RN, EN or Care Worker).

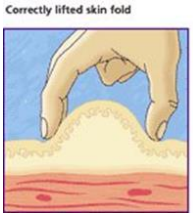
    The usual dose for adults who weigh more than 25 kg is 1 mg (1 mL). Use the content of the full syringe (1 mL).
16. Take the syringe and needle out of the vial when the correct dose of GlucaGen® is in the syringe.

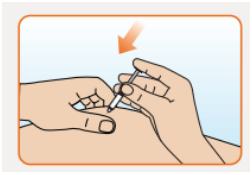
Giving the GlucaGen® injection

17. Position the Resident comfortably.
18. Select the site for administration. Common injection sites for GlucaGen® are upper arms, thighs, or buttocks.



19. Perform hand hygiene and put on gloves.
20. With one hand gently pinch the skin at the injection site. With your other hand insert the needle into the skin and push the plunger down until the syringe is empty.





Remove Needle and Dispose of Sharp

21. Pull the needle out of the skin and press on the injection site. Disposes of used syringe with the needle attached immediately in sharps container.
22. Turn the person on their side. When an unconscious person awakens, they may vomit. Turning the person on their side will lessen the chance of choking.
23. Remove gloves and perform hand hygiene.
24. Feed the person as soon as they are awake and able to swallow.

Re-Check BGL

25. Measure the Resident's BGL
26. Check the Residents BGL levels are within the prescribed parameters documented on the Resident's *Diabetic Directive*.

    If the BGL is continued outside the prescribed BGL parameters report to the RN and may require transferring to hospital for further interventions.

Clean Up and Documentation

27. Ensure all equipment is cleaned and returned to correct storage area.
28. **Both staff** to sign Signing Sheet/eCase MedMan system at correct date and time.
29. Document in the Resident's eCase Progress Notes and inform Medical Practitioner to review Resident.

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Australian Medicines Handbook, 2012.
3. CHL Bug Control e-Manual.
4. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia
5. Diabetes Australia, https://www.diabetesaustralia.com.au/.
6. GlucaGen® HypoKit, Instructions for Use, https://www.glucagenhypokit.com/instructions.html.
7. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
8. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
9. High-Risk Medicines Management, 2013 NSW Health.
10. Insulin Risk Management in Aged Care Homes, Meditrax 2008, NPS 2011: http://www.nps.org.au/conditions/hormones-metabolism-and-nutritional-problems/diabetes-type-2/for-individuals/medicines-and-treatments/insulin/types-and-forms-available-in-australia
11. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
12. NSW Poisons & Therapeutic Goods Regulation 2008.
13. Queensland Health (Drugs and Poisons) Regulation 1996.

NURSE INITIATED MEDICATIONS (NIMs)

APPROVAL OF THE CHL NURSE INITIATED MEDICATION LIST

- CHL has an approved list of non-prescription (unscheduled, S2 or S3) Nurse-Initiated Medications (NIMs) with indications for use and precautionary information.
- This list is reviewed by CHL as required.

AUTHORISATION OF NURSE INITIATED MEDICATION BY AUTHORISED PRESCRIBER / MEDICAL PRACTITIONER

- On admission the Authorised Prescriber / Medical Practitioner is to sign and date a *Nurse Initiated Medication Form* for each individual Resident, as well as signs against any medications not authorised for administration for an individual Resident.
- The signed NIM form is to be kept with the Resident's RxMed Chart Folder for reference.
- Approval for *Nurse Initiated Medication* is to be reviewed by the Authorised Prescriber / Medical Practitioner **Annually**

ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering

1. Identify the NIM to be ordered.
2. RN to complete a CHL *RAC Nurse Initiated Medication Order Form*.
3. Send (MedsComm) the form to the Supply Pharmacy.

Receipt & Storage

1. Upon delivery check medication supplies off against the medication order.
2. Sign the delivery receipt from the Pharmacy.
3. If medication is not accounted for, document on the Pharmacy receipt and advise the respective Home area/staff.
4. NIM are to be stored in a locked medication room, preferably within a locked cupboard or medication trolley.
5. Monitoring NIM is the responsibility of Registered Nurses. **Monthly** checks of NIM stock are to be carried out using the CHL *Nurse Initiated Medication Checklist* to ensure stock is maintained and expiry dates are checked.

Disposal

1. Expired NIM are to be returned to Supply Pharmacy for correct disposal as per current State (NSW and QLD) regulations and guidelines.

ADMINISTRATION OF NURSE INITIATED MEDICATIONS (NIMS)

General Considerations

Applies to:

- ✓ Registered Nurse
- ✓ Enrolled Nurse
- × Care Worker

NIMs are appropriate for one off or occasional medications. Any Residents with an ongoing need for this type of medication should be referred to their Authorised Prescriber / Medical Practitioner for assessment.

The NIM list consists of non-prescription medications intended for short term use for conditions that may require simple treatment with medication.

Prior to administration, the RN or EN is to confirm there are no potential contraindications with prescribed regular and/or PRN medications and previously administered NIMs.

Nurse Initiated Medication/s must be recorded on the back of the Signing Sheet with the administration and outcome documented in the Resident's Progress Notes.

Practice Limitations

Registered Nurses are permitted to initiate the administration of a NIM.

The Registered Nurse is accountable for their clinical knowledge in administering NIM and for monitoring and reporting the effect of the medication.

Enrolled Nurses may administer Nurse Initiated Medications (NIM) from the CHL approved NIM list, only following verbal confirmation with a RN.

Where the Enrolled Nurse is unsure or has concerns, they MUST contact the Registered Nurse for clinical advice.

Care Workers CANNOT administer nurse-initiated medication.

FORM

RAC - Nurse Initiated Medication Form (Registered Nurses Only)

catholic healthcare

In circumstances when any of the medications listed below are required by my resident, I give permission for the Registered Nurse (RN) to administer them as clinically indicated. If a clinical problem for which medication is given persists, I will be informed.

Attach Addressograph Here

Medical Practitioner Name: _____ **Signature:** _____ **Date:** _____

- The signed NIM list is to be kept with the Resident's Primary Medication Chart for reference. **Note:** Check regular and PRN medication orders for potential contraindications
- This document is to be reviewed by the Medical Practitioner (MP) **Annually**
- All Nurse Initiated Medication/s must be recorded on the back of the PRN Medication Signing Sheet or eCase MedMan with the administration and outcome documented in the Resident's Progress Notes

MP to tick individual boxes below, OR ☐ this box to authorise all medications

Tick	Indication	Medication	Dose	Route	Notes
☐	**Acute Asthmatic symptoms** – Bronchospasm/ Shortness of Breath	Salbutamol 100 mcg/ dose MDI	**1-2** oral inhalations	**Inhalation**	Shake well before use. Prime MDI device (discard 2 activations) before first use or if unused for > 5 days. Administer **via spacer** (note disposable spacers available). Prime Spacer by activating 3 puffs into the spacer before use. **If symptoms persist, call an ambulance (0-000).**
☐	**Anaphylaxis**	Adrenaline Vial 1: 1000 = 1mg in 1 mL	Draw **0.5 mL** (=500 mcg) from ampoule. Inject IMI into outer mid-thigh.	**Intramuscular**	**Call an ambulance (0-000).** Do not give I.V. For severe reactions or if symptoms recur, dose may be repeated after 5-15 minutes as per guidelines and training* *RNs are required to be familiar with the "Acute Management of Anaphylaxis" and are recommended to complete Health Professional e-training course.
☐	**Chest Pain**	Glyceryl trinitrate spray 400 mcg/ dose (e.g., Nitrolingual Pumpspray)	Check Blood Pressure prior to administering each dose. **1** spray **every 5 minutes (max. 2 doses).**	**Sublingual**	Prime spray (1 spray if not used > 7 days or 5 sprays if not used > 4 months). Resident should be seated. **Call ambulance (0-000) if chest pain persists after 2 doses or systolic BP < 90 mmHg before use.** Monitor for hypotension after use. Pumpspray bottles are recommended for single-consumer use only.
☐		Glyceryl trinitrate tablet 300 mcg (e.g., Nitrostat)	Check Blood Pressure prior to administering each dose. **1** tablet **every 5 minutes (max. 3 doses).**		Ensure resident is seated prior to dosing. **No more than three tablets are recommended within a 15-minute period. Call ambulance (0-000) if chest pain persists after a total of 3 tablets in a 15-minute period or systolic BP < 90 mmHg before use.** Monitor for hypotension after use.
☐	**Cough (chesty)**	Senega and Ammonia mixture	**10 mL every 6 hours**	**Oral**	Contact MP if symptoms persist **after 2 doses.**
☐	**Constipation** - if more than three (3) days pass between bowel movements or if there is difficulty or pain when passing a hardened stool	Docusate with sennosides	**2** at night	**Oral**	Contact MP if constipation persists, or symptoms of faecal impaction.
☐		Macrogol 3350 sachet	**1-3** sachets daily		
☐		Glycerol suppository	**1** daily	**Rectal**	
☐		Sodium citrate enema (e.g., Microlax)	**1** dose only		

approver	owner	date approved	version number	page
Organisation Clinical Systems Governance and Compliance Manager	Reporting, Policy, and Data Analysis Manager	11 March 2022	V16	1 of 2

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Australian Medicines Handbook, 2012.
3. CHL Bug Control e-Manual.
4. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia
5. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
6. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
7. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
8. NSW Poisons & Therapeutic Goods Regulation 2008.
9. Queensland Health (Drugs and Poisons) Regulation 1996.

URGENT USE/IMPREST MEDICATIONS

URGENT USE MEDICATIONS (NSW)

Applies to:

- ✓ Residential Manager
- ✓ Registered Nurse
- × EN or Care Worker

CHL RAC NSW Homes may store approved Urgent use medications from the approved list for urgent treatment when the retail pharmacy which provides Residents' dispensed medicines is closed.

Protocols approved by the RAC Home Medication Advisory Committee (MAC) must determine which of the available medications are needed for urgent treatment from the approved list (see below).

The MAC committee will be responsible for the decision of which antibiotics (limit {5} Five) will be stocked and where there is no maximum stock limit stated the committee members will determine the stock amounts to reflect the requirements of the Home.

The Home will provide information for registered nurses on the handling, administration and recording of the medications.

Approved Urgent Use List for Use in CHL NSW Homes

Adrenaline (Epinephrine) injection 1 mg/1 mL (1:1000)
Antibiotics in oral form, no more than 5 (Five) different antibiotic substances
Atropine Sulfate Monohydrate injection
Clonazepam oral liquid 2.5 mg/mL, no more than 20 mL
Diazepam injection, no more than 5 (five) ampoules of 10 mg/2 mL
Furosemide (Frusemide) injection
Glycopyrronium Bromide (Glycopyrrolate) injection
Hyoscine Butylbromide injection
Metoclopramide Hydrochloride Monohydrate injection
Midazolam injection, no more than 10 (ten) ampoules of 5 mg/5 mL
Morphine Sulfate Pentahydrate injection, no more than a total of 30 (thirty) ampoules {5 mg/1 mL, 10 mg/1 mL, 15 mg/1 mL or 30 mg/1 mL}
Prochlorperazine Mesilate injection

ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering - excluding S8s in CHL NSW Homes

Urgent use medications are to be maintained for use for Residents as clinically indicated and on the order of a Medical Practitioner/Authorized Prescriber.

Urgent use medication **MUST** be obtained from the Supply Pharmacy on the signed written order of the Residential Manager or Care Manager using the Urgent Use Stock Medication Order form (NSW).

The cost of urgent use medication is borne by the Home.

Urgent use medication **MUST** be supplied by the Supply Pharmacist manufacturer's original pack.

Receipt - excluding S8s in CHL NSW Homes

Receipt of urgent use medications from the Supply Pharmacy should be signed by a Registered Nurse confirming the medications ordered are the same as the medications delivered.

Receipt of urgent use must be recorded in the *Urgent Use Stock Medication Register – Usage (NSW)* form documenting the name of the urgent use medication/s, date received and Registered Nurse receiver's signature.

On receipt of the resident's labelled supply, the urgent use medication pack must be withdrawn from use and placed back in stock for future use. Residents' dispensed supplies of medication **must not be used to replace emergency stocks**.

Storage - excluding S8s in CHL NSW Homes

Urgent use medications are to be stored in a locked cupboard within the medication room or when in use stored in the locked medication trolley.

The urgent use medication is to be removed from storage **as a whole pack** and doses **administered to residents directly from that pack**. Single blister strips **should not be removed** due to the risk of medication error.

Monitoring for urgent use medication and their expiry dates is the responsibility of Registered Nurses. This is to be undertaken at least **Monthly** using the *Urgent Use Stock Medication Checklist (NSW)*.

Disposal - excluding S8s in CHL NSW Homes

Urgent use medication should be disposed of appropriately and according to CHL Medication Manual and safe work practices.

Urgent use requiring disposal, excluding S8s, is to be placed in the secure *Pharmacy Returns Box* or locked room for collection by the Supply Pharmacy.

Record return to pharmacy in the *Urgent Use Stock Medication Replacement Record (NSW),* including the date, name of medication/s, reason for return and the Registered Nurse's signature.

IMPREST MEDICATIONS (QLD)

CHL RAC QLD Homes may store approved *Imprest Medications* for urgent treatment when the retail pharmacy which provides residents' dispensed medicines is closed. The list of *Imprest Medications* will be agreed on with the Supply Pharmacist & RAC MAC Committee.

The Supply Pharmacy must hold a wholesaler's license to be able to supply Imprest Medications. Alternatively, the Residential Manager can issue a *purchase order* to the wholesaler directly for the supply of Imprest Medications.

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Australian Medicines Handbook, 2012.
3. CHL Bug Control e-Manual.
4. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia
5. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
6. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
7. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
8. NSW Poisons & Therapeutic Goods Regulation 2008.
9. Queensland Health (Drugs and Poisons) Regulation 1996.

CYTOTOXIC AND OTHER HAZARDOUS MEDICATION

CYTOTOCIX MEDICATION - ORDERING, RECEIPT, STORAGE & DISPOSAL

Ordering

There is usually no requirement to place an order for regular cytotoxic medications as they are provided in purple weekly Unit Dose 7 pack and labelled with the required cautionary warning label.
Note: Non-cytotoxic hazardous medications should NOT be labelled as "cytotoxic."

Each week a new supply will automatically be delivered by the Supply Pharmacy and the previous week's folder/s collected.

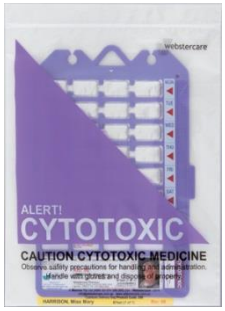
Receipt

Cytotoxic medicines SHOULD be delivered to the Home in a sealed container or bag e.g., Webstercare *Cytotoxic Delivery Bag*, separate from any other medication or items.

Cytotoxic medicines SHOULD be appropriately packaged and labelled with the required cautionary label by the Supply Pharmacy to alert staff of the requirement for special administration and handling requirements. The labelling should be a purple "CYTOTOXIC" sticker or other cytotoxic wording highlighted in purple.

If there is any evidence the medication is damaged, or packaging broken in any way, the medication must be returned to the Supply Pharmacy in a sealed container or bag.

Storage



Cytotoxic medicines, whether in a DAA or original packaging must be stored in a sealed container or bag with cautionary warning labels e.g., Cytotoxic - Handle with care. These labels should be provided by the Supplying Pharmacy.

The weekly Webster-Pack/Card or original packaged medication is to be stored in a locked medication room.

If there is any evidence the medication is damaged, or packaging broken in any way, the medication must be returned to the Supply Pharmacy in a sealed container or bag.

Disposal

Cytotoxic medications should be disposed of appropriately and according to CHL Medication Manual and safe work practices.

Unused cytotoxic medications or empty DAA requiring disposal are to be placed in a sealed container or bag e.g., Webstercare *Cytotoxic Delivery Bag* and placed in the secure Pharmacy Returns Box or locked room for collection by the Supply Pharmacy.

All cytotoxic medication **waste** including any residual cytotoxic drug following a Resident's treatment and the materials or equipment associated with the preparation, transport, or administration of the drug therapy e.g., spatulas, medication cups, gloves are to be disposed of in a purple cytotoxic waste container or double waste bag (i.e., into waste bag, tie off, place into second waste bag, tie off) which is in turn placed into a purple contaminated waste bin.

Sharps associated with cytotoxic drug administration must be disposed of into purple cytotoxic sharps containers. Refer to *CHL Bug Control e-Manual* – Management of Cytotoxic Drugs and Waste.

ADMINISTRATION OF CYTOTOXIC OR OTHER HAZARDOUS MEDICATIONS

Applies to:
- ✓ Registered Nurse
- ✓ Enrolled Nurse
- ✓ Care Worker

Practice Limitations

Care Workers are **NOT** authorised to administer injectable cytotoxic or other hazardous medications.

Staff who are pregnant, breastfeeding, or planning pregnancy should notify their Residential Manager. Staff should indicate if they do not want to administer cytotoxic or other hazardous medications or risk exposure to waste products or spills.

Clinical Considerations

The Prescribed order sheet and signing sheet for cytotoxic medication is highlighted with a purple "CYTOTOXIC" sticker or notated as cytotoxic drug and/or highlighted with purple. **Note:** an alert sticker may be generated by the supplying pharmacy for non-cytotoxic hazardous medications, depending on specific precautions recommended.

Staff are to monitor Residents taking cytotoxic medications for signs of infection or fever; anaemia or bleeding or bruising, indicating a severe fall in platelet count.

DO NOT CRUSH, divide, or alter the cytotoxic or other hazardous medicine in any way. If a Resident is unable to swallow an oral medication, the medication should be withheld, and the Authorised Prescriber / Medical Practitioner contacted for instruction.

Documentation and Care Planning

Resident's prescribed cytotoxic or other hazardous medications should have an **'Alert'** in eCase.

According to WHS Regulation, the CHL RAC Homes are required to maintain:

- Hazardous Chemical & Cytotoxic Drugs Register
- Risk assessment for cytotoxic drugs
- Safety data sheet for each cytotoxic or other hazardous drug (To be obtain from pharmacy)
- Historical Medication Usage - Cytotoxic Drug (To be obtain from pharmacy)

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Australian Medicines Handbook, 2012.
3. CHL Bug Control e-Manual.
4. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia.
5. Cytotoxic Drugs and Related Waste – Risk Management, SafeWork NSW, July 2017: http://www.safework.nsw.gov.au/__data/assets/pdf_file/0005/287042/SW08559-Cytotoxic-drugs-and-related-risk-management-guide.pdf
6. Guide to cytotoxic and other hazardous medication in aged care, Meditrax 2018.
7. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
8. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
9. High-Risk Medicines Management, 2013 NSW Health.
10. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
11. NSW Poisons & Therapeutic Goods Regulation 2008.
12. Queensland Health (Drugs and Poisons) Regulation 1996.

VACCINES

ORDERING, RECEIPT, STORAGE & DISPOSAL

Applies to:

- ✓ Registered Nurse
- × Enrolled Nurse
- × Care Worker

Ordering

- In NSW, NSW Health advises Homes when vaccines are available to be ordered.
- CHL Homes ordering vaccines for Residents must use the order form provided by NSW Health ordering may be undertaken by a Registered Nurse in consultation with the Residential Manager.
- In QLD, the Authorized Prescriber / Medical Practitioner brings the vaccines to the Home for administration to his/her Residents.

Receipt

- In NSW, receipt of Vaccines from NSW Health should be signed by an authorized person (RN) confirming the vaccines ordered are the same as the vaccines delivered.
- The Supply Pharmacy or General Practice may agree to store vaccines until vaccination clinics are held.
- The entity receiving the vaccines from NSW Health will be responsible for cold chain monitoring and advising the Home of any breaches.

Storage

- Appropriate storage of vaccine is essential to ensure Residents receive effective vaccines.
- Vaccines are easily impacted by changes in temperature resulting in loss of potency or destruction.
- Vaccines in CHL Homes should be stored in a purpose-built vaccine fridge with the temperature maintained between 2-8° Celsius and the vaccine fridge must be placed in a secure room where only appropriate staff have access.
- The Supply Pharmacy or General Practice may agree to store vaccines for Homes if there is no vaccination fridge.
- Upon receipt of vaccines at the RAC Home the Registered Nurse must IMMEDIATELY place the vaccines in the Vaccine Fridge to ensure vaccines are maintained appropriately.
- When storing vaccines, the refrigeration temperature MUST be monitored twice daily recording minimum and maximum temperatures.

Disposal

- Used vaccines are to be disposed of in a sharps container. When disposal of vaccines is required, such as unused, past their expiry date or they have been exposed to temperatures outside the recommended range of **2° Celsius to 8° Celsius** (Cold Chain Breach), the Residential Manager is to contact the relevant State (NSW and QLD) Health Department for advice.
- Where a **Cold Chain Breach** has occurred (this excludes fluctuations up to +12°C, lasting no longer than 15 minutes, as may occur when stock taking or restocking refrigerators), the vaccinations **MUST** be immediately isolated and labelled **'Do Not Use'**.
- The vaccines should remain in the fridge between **2°C and 8°C**.

REFER TO RAC POLICIES & PROTOCOL RELATED TO INFLUENZA/COVID-19 VACCINATION

1. RAC_Vaccination Management Policy - Residents
2. RAC - COVID-19 Post Vaccine Protocol for Resident

REFER TO AUSTRALIAN GOVERNMENT WEBSITE RELATED TO COVID-19 VACCINATION

1. DOH - COVID-19 Vaccines Home Page
2. DOH - COVID-19 Vaccine Aged Care Readiness Toolkit
3. DOH - COVID-19 Vaccination – Resource Pack for Residential Aged Care
4. DOH - Australian COVID-19 Vaccination Policy
5. ATAGI Clinical Guidance on COVID-19 Vaccine in Australia in 2021

REFERENCES

1. Australian Health Practitioner Regulation Agency: Pharmacy Board of Australia, Codes and Guidelines
2. Australian Medicines Handbook, 2012.
3. CHL Bug Control e-Manual.
4. Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia.
5. Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014.
6. Guiding Principles for Medication Management in Residential Aged Care Facilities, Commonwealth Department of Health & Aged Care 2022.
7. National Vaccine Storage Guidelines Strive for 5, 3rd Edition; Commonwealth of Australia 2020. https://www.health.gov.au/sites/default/files/documents/2020/04/national-vaccine-storage-guidelines-strive-for-5.pdf
8. 'Just a repeat' - When drug monitoring is indicated, Catherine Lucas and Peter Donovan 2013: http://www.racgp.org.au/download/Documents/AFP/2013/January/February/201301lucas.pdf
9. NSW Poisons & Therapeutic Goods Regulation 2008.
10. Queensland Health (Drugs and Poisons) Regulation 1996.
11. The Australian Immunisation Handbook 2019, https://immunisationhandbook.health.gov.au/.

MEDICATION MANAGEMENT FORMS LIST IN CONNECT+

TABLES

Form Name	Updated Date & Version
Report any Loss of S8 Medication or Destruction of a Drug Register or Controlled Drug Register	
Controlled Drugs Loss or Theft Notification (QLD)	External Form
Controlled Drugs Destruction (QLD)	External Form
Notification of Loss or Theft of Accountable Drugs (NSW)	External Form
Abbreviation	
RAC_Approved Abbreviations	Aug 19/V2
RAC_Medication Manual_Acceptable Abbreviations	Aug 19/V2
Cytotoxic and other Hazardous Medication	
RAC_Cytotoxic Drug Spill Kit Checklist	Apr 21/V4
RAC_Hazardous Chemical & Cytotoxic Drugs Register	Dec 19/V2
RAC_Risk Assessment for Cytotoxic Drugs	Dec 19/V1
Directive (SOM – Clinical Directives Folder Index)	
RAC_Anticoagulant Directive RxMed Chart	Nov 19/V2
RAC_Diabetic Directive	Nov 19/V5
RAC Observation and Oxygen Directive	Mar 22/V1
Insulin and Glucometer	
RAC_Glucometer Calibration & Quality Control Log	May 21/V1
RAC_Hypoglycaemic Kit Checklist	May 21/V2
MAC Meeting	
RAC_MAC Terms of Reference	Jul 2022/V5
RAC_MAC Meeting_Agenda & Minutes TEMPLATE	Jul 2022/V13

Form Name	Updated Date & Version
Medication Management	
RAC_Facsimile to Pharmacy for Medication Orders	Dec 19/V3
RAC_Medical Practitioner Communication Form	May 21/V5
RAC_Staff Signature and Witness Register_Medication	Dec 19/V4
RAC_Staff Signature and Witness Register_S8 Medication	Dec 19/V5
Request for Care Worker to Assist with Taking of Prescribed Medications (Queensland only)	Dec 19/V4
Subcutaneous or Intravenous Therapy Record	Aug 17/V2
Nurse Initiated Medication (NIM)	
Nurse Initiated Medication Checklist	Mar 22/V5
Nurse Initiated Medication Form	Mar 22/V16
Nurse Initiated Medication Order Form	Mar 22/V6
Urgent Use Stock Medication (NSW) and Imprest Medication (QLD)	
Urgent Use Stock Medication Checklist (NSW)	Jul 22/V12
Urgent Use Stock Medication Order Form (NSW)	Jul 22/V9
Urgent Use Stock Medication Register – Usage (NSW)	Jul 22/V10
Imprest S8 Medications (QLD) - Purchase Order Template	External Form
Imprest System (OLQ)	Sep 12/V1
Vaccination	
Medication/Vaccine/Pathology Refrigerator Temperature Record	Nov 18/V6