Medication Administration Self Directed Learning Package 2010 EEN/RN.

AIM: To ensure nursing staff are proficient and safe in administering medication for optimal patient outcome, by assessing their knowledge in relation to medication administration and medication calculation's.

Definitions: Drugs of dependence: Drugs which are subject to special legal provisions, storage and recording requirements as per controlled substance Act 1984.

Medication Calculations: see attached document for Formulae.

Medication administration:

Medication Administration - the 8 rights.

1. Right medication
2. Right dose
3. Right time
4. Right patient
5. Right route
6. Right Frequency
7. Right to refuse
8. Right documentation

6 additional checks.

1. Check for allergy/sensitivity status.
2. Check expiry date on medication.
3. Be aware of the indications/contraindications of the medication.
4. Is aware of the normal dosage for each drug.
5. Ensure the order is legible(not ambiguous) and clearly written.
6. States the relevant patient required.

Alert: If you are unfamiliar with a drug check the MIMS for clarification. if you cannot read the medication order, do not administer.

Oral medication procedure.

- Adhere to the 8 rights and 6 checks of medication administration.
- Assess if the patient is capable of swallowing. If in doubt refer to CNC and Medical Practitioner or GP.
- Adhere to infection control principles.

Subcutaneous Injection Procedure.

Adhere to the 8 rights and 6 checks of medication administration, infection control policy and:

- Select correct site: anterior aspect of upper arms, fat pads on the abdomen, upper hips, upper back and lateral upper arms and thighs.
- Maintain patient's privacy;
- Wipe with alcohol in a circular motion to cleanse area and then allow to dry.
- Pinch up a fold of skin and insert needle at a 45-90 degree angle.
- Slowly inject solution without aspirating prior to injection.
- Observe sites, and ensure patient comfort.
- Rotate sites for subsequent injections for resident comfort and to reduce risk of bruising.
- Adheres to infection control principles and transports and disposes of needles in appropriate sharps safe containers.

Intramuscular Injection - Procedure:

Adhere to the 8 rights and 6 checks of medication administration, infection control policy and:

- Select correct intramuscular site - Deltoid (upper arm), Dorsogluteal(upper outer quadrant of buttocks), vastus lateralis (anterior lateral thigh)
- Maintain patient's privacy;
- Wipe with alcohol in a circular motion to cleanse;
- Spread skin taut and insert needle at 90 degree angle.
- Aspirate and observe for blood, if blood appears, remove and discard needle.
- Inject medication slowly, remove needle quickly, gently apply pressure to site.
- Observe site and ensure patient comfort.
- Adhere to infection control principles transport, and dispose of needles in appropriate sharps safe containers.

Intravenous injection - Procedure.

Adhere to the 8 rights and 6 checks of medication administration, (including knowledge of the length of time over which the medication must be administered) infection control policy and:

- Maintain patient's privacy;
- Ensure patency of intravenous site, line and compatibility of fluids.
- Wipe port with alcohol.
- Clamp off IV tubing above the port site.
- Insert fluid.
- Inject medication slowly according to drug and manufacturers instructions.
- Observe IV site, and ensure patient comfort.
- Adhere to infection control policies throughout including the transport and disposal of needles in appropriate sharps containers.

NB: If a drawing up needle is used, then it must be changed to the interlink system for IV administration.

Checking and Administration of Schedule 8 Drugs - Procedure.
All schedule 8 drugs (drugs of dependence) must be checked (adhere to 8 rights and 6 checks) and administered by two staff members, and the entire procedure witnessed by the same two staff members, one of whom must be a Registered Nurse.

- Check medication for drug name, quantity remaining in cupboard, expiry date and that all ampoules are intact. In residential facilities you may also have to ensure that it is the right residents medication package, as they are ordered individually.
- Check drug against written order, adhere to the 8 rights and 6 checks.
- Check time drug was last given and exact mode of administration. This check is attended three times, when the drug is removed from the locked cupboard, on preparing drug and before administration.
- Check that the correct dosage is withdrawn from the ampoule, and any discarded medication is observed by the two staff members and recorded in the DD book. Any calculations must be checked by the two staff members.
- The two staff members are accountable for the Schedule 8 or S4D from the start of the process and must both witness ingestion or administration or any discarding of medication.

Medication Adverse Event Reporting Mechanism:

A medication incident is to be documented for any of the following:

- Omission of a drug dose
- Incorrect drug given
- Incorrect dose given
- Incorrect patient
- Expired stock used

- Additional dose given
- Incorrect route of administration
- Drug given at wrong time
- Incorrect drug preparation type
- Illegible or ambiguous medication order

In the event of a medication adverse event, the patient is managed according to the error that has occurred and the patient outcomes from that error. This may require close monitoring of the patient. The Nurse Unit Manager, or nurse in charge of shift and admitting doctor must also be notified, if in the Aged Care sector resident/patient GP must be notified. Family will also be notified by the In Charge.

All medication adverse events are recorded on medication incident forms and sent to the unit manager.

In the event of serious harm or injury to the patient the hospital co-ordinator or facility manager, CNC must be notified. And a sentinel event form completed.

Medication Administration Hospital/Facility Policies and Legislation.

Every staff member must be aware of the Hospital/Facility Policy in regard to:

- Phone orders
- Nurse initiated medications
- Patient self administration of medications
- Ambiguous, unclear Medication orders.

Refer to the facility Policy and consult In Charge.

Phone Orders:

- Phone orders must be written in ink in the correct section of the medication chart.
- The nurse is to inform the doctor of the patient's allergy status.
- The generic name. dosage, frequency and the route is to be written, whilst the order is repeated back to the doctor. S8 medication orders must also include maximum daily dosage.
- The doctor must sign the order within 24 hours.
- A second nurse is to verify orders for S8, IV infusions, anticoagulant therapy, insulin and hazardous substances.

*Check facility policy in relation to this issue as some facilities require a second nurse to verify **all orders.***

Nurse Initiated Medication:

- Nurse initiated medication may be administered to adults only according to the established list at each facility, however the patient's doctor must be notified and the order written by the doctor within 24 hours.

- Nurse initiated medications must be documented in the once only section of the medication chart with the code N/I entered as well as the signature.
- If the patient requires the medication more than twice in a 24 hour period, a written order must be obtained.
- The effectiveness of the medication must be recorded as a variance in the patient's progress notes.

Points to note:

- Over the counter medications are not nurse initiated medications.
- Nurse initiated paracetamol is to be given for analgesia *only* and only given for pyrexia on doctors orders.
- Check that drugs can be crushed
- Glyceryl Trinitrate administered as per facility chest pain policy and doctors orders. All chest pain patients are to be reviewed by the facility Doctor or the patient's own GP.
- Antacids are contra-indicated in patients with renal insufficiency.
- Nurses must never administer a medication that has been prepared by someone else.
- Medications must not be left unattended.
- The nurse must ensure the patient/resident ingests the medication before leaving that patient/resident.

Patient Self Administration.

- Patients can only self administer on the direction of the doctor and documentation of same by the doctor in the patients progress notes/medication chart.
- The patient must be assessed as physically and cognitively capable.
- The medication must be in a prescribed medication container, labelled as per State Health Legislation.

Unclear, Ambiguous Medication Orders.

- The nurse can only administer medications written by a medical practitioner approved by the facility and on an approved chart. Refer to facility policy.
- The order must be written legibly in the correct section of the medication chart,

with the name of the medication, the strength and dose, administration route, frequency and the date.

- The nurse must never alter an order to improve the legibility of the order.
- Illegible unclear medication orders are to be rewritten by the Doctor prior to administration.