Policy Statement:

Churchill Hospital (Churchill) will ensure medication management, including prescribing, and administration is safe and timely. Staff will work within their scope of practice in relation to medication management.

In conjunction with an accurate patient medication history, medication management will consider a patients individual and cultural requirement, their own/usual medicines including any over the counter and supplements.

Policy Applies to:

All nurses and credentialed medical practitioners working at Churchill Hospital. All nursing students are covered by a formal educational contract with Te Pukenga.

Related Standards and Legislation:

- The Medicines Act 1981, Misuse of Drugs Regulations 1977 and any amendments to these.
- Medicines (Standing Order) Regulations 2011
- Adherence to :
  - Ministry of Health Standing Order guidelines (2016).
  - Health Quality and Safety Commission guidelines including Adherence to the Medication Charting Standard version 3, 2012 and National Medication Chart toolkit 2021.
  - ACHS EQuIP6 Standard 1.5 Criterion: 1.5.1: Medications are managed to ensure safe and effective practice.
  - Nga Paerewa Health and Disability Standards NZS8134.:2021, criteria: 3.4 My medication

Objectives:

To ensure that:

- All patients' medications are managed safely and efficiently.
- All staff has access to up-to-date relevant medication information.
- Safe & appropriate practices are adhered to, for the introduction of new medications, medicines reconciliation, the prescribing, dispensing, administration, review, storage and disposal of medications.
- Every health professional recognises their responsibility to act to prevent a potential medicine error occurring.

Cultural Consideration:

Ensuring that the patient and their whanau individual needs are recognised and they are part of the medication management process, including understand their medications and the use of these. Specific health literacy, cultural needs, values, and beliefs are considered, documented and implemented as appropriate.

Evaluation:

- Medication chart audit
- Patient Journey audit
- Patient feedback
- Reportable events
- NZPSHA benchmarking data

Procedure:

Obtain Accurate Medication History

Patients are requested to provide a pharmacy or doctors printed list of current prescribed medication prior to admission, and to document these on their Health Questionnaire including any over the counter medicines and herbal medications.

Patients' allergies and sensitivities should be documented in the appropriate area of the chart, by a health professional, usually the RN.

Patients should be asked to identify any herbal/rakau rongoā or complementary and alternative medicines (CAM) that they are taking. This should be recorded on the nursing assessment form.

Medication Reconciliation

The medication reconciliation process requires the charted medication (on the 8-day chart) to be reconciled by the nurse with the below documents and the patient.

- GP medication letter/pharmacy list and interviewing the patient.
- Physical medication in labelled containers

Once reconciled the appropriate (Green) box on the front of the 8-day chart should be correctly filled out to advise users of completion or discrepancies documented in notes and prescriber notified.

Adhering to National Medication Chart Standards

The Medication Charting Standards (Health, Quality & Safety Commission New Zealand, 2012) are to be used to meet the minimum requirements for patient safety for prescribing, dispensing and administering of medications (either paper or electronic based).

Medication Prescribing

Churchill uses the eight day or day stay National Medical Chart.

Credentialed medical practitioners will chart:

- Patients own medication from the validated information ascertained on admission.
- Plus, any other medications requirements.

After medications have been prescribed on the medication chart, the nurse is to ensure the patient's own medications are correctly prescribed on the medication chart and reconcile with the prescription provided by the patient, as detailed above. Any changes to the prescribed medication should be carefully written and the changed annotated by the prescriber. The preference is to rechart the medication for legibility and clarity.

Pro Re Nata (PRN) Medications

All PRN medications must be prescribed in accordance with the Medication Charting Standard 2012. Following this requires the documentation of the indication for use and the maximum dose.

Pre-printed PRN medications sticker

Several pre-printed PRN medication stickers have been agreed with the anaesthetists working at Churchill. These stickers are placed in the appropriate page of the medication charts.

- Pre-printed medications must not be administered unless the prescriber dates and signs each medication prescribed individually.
- Pre-printed medications which are not required will not be signed or dated and should have a line drawn through them.
- Prescribers should not write over the pre-printed medicine sticker but use a new prescribing line to write their wishes.

Verbal Orders

Under NO circumstances shall a verbal order be taken for a first dose of a Controlled Drug e.g. narcotics. Verbal orders for a 'first dose' of a Controlled Drugs are NOT permitted in New Zealand legislation. Verbal orders for controlled drugs are only allowable where a Controlled Drug has ALREADY been prescribed and administered to a patient. In that case the Prescriber may change the prescription either verbally or in writing e.g. for a patient requiring an additional PRN dose, a dose increase or a change in preparation from 'Immediate Release' (IR) to 'Sustained Release' (SR) preparation of the SAME drug.

Verbal orders can only be made by a prescriber and must initially be received by a Registered Nurse, and repeated to another nurse, who confirms the order and observes it is written accurately. Charting will follow the "National Medication" charting standard.

All verbal orders must be signed, by the prescriber, within 24-hours of the verbal order being taken.

Standing Orders

A standing order is a written instruction by a prescriber to an authorised specified person or class of people, who do not have prescribing rights, to allow administration of specified medicines.

All standing orders must meet the requirements of the Ministry of Health Standing Orders Guidelines (2016).

Standing orders for Churchill patients can only be issued by a credentialed medical practitioner on a prescribed form and must be confirmed annually. Copies of these standing orders are kept in the ward.

- Administration of a standing order is dependent on the professional judgement of the registered nurse (RN) following assessment of the patient.
- The RN must have completed a competency to administer the standing order. This includes having knowledge of the medicine being administered, the indications, recommended dose range, method of administration and any contraindications and side effects.
- The RN must have access to medicine information resources: Links to NZ Formulary and enoids are on the Te Whatu Ora NM intranet home page.
- Administration of a standing order is documented in the 'once only' area of the national medication chart and should include documenting of **SO** in the pharmacy and special instructions area for each medication.
- All standing orders must be signed by the prescribing doctor within 24 hours – 7 days (refer to individual standing orders for timeframe) of administration.
- Student Nurses must not administer medicines under standing orders.

Dispensing and Storge of Medications

All hospital required medications are dispensed by a local contracted pharmacy, who also stock the medicine room and ensure all medicines provided are within current dates.

Medications that require refrigeration are stored in the medicine fridge in the locked medicines room.

Controlled drugs are stored in the controlled drug safe in the medications room.

Access to the medicine room is by security access card only which has been issued to the staff who are required to access this room. Access to the drug safe is only granted to Registered Nurses who enter their security number.

The medicine room and medicine fridge are monitored to ensure the room is below 25 degrees Celsius and the fridge is between 2 and 8 degrees Celsius. Daily temperatures are recorded on the chart in the medication room. Any discrepancies in temperature are to be reported to the General Manager or Clinical Team Leader.

Patients Own/Usual Medication

Patient's own medication should be brought into the hospital in pharmacy dispensed containers (not blister packs) and are to be used before hospital stock. Medications will be stored securely in the designated area - patient's locked draw or controlled drug safe.

Drugs requiring refrigeration will be put into the medication fridge and this will be noted on the patient's medication chart.

Patient's own controlled drugs must be locked in the controlled drug safe, recorded in the controlled drug register and noted in the patient's file.

On discharge all drugs are returned to the patient unless otherwise instructed by the surgeon or anaesthetist.

Herbal Remedies / Rakau Rongoā and Non-Pharmacological Remedies

- Patients should be asked to identify any herbal/rakau rongoā or Complementary and Alternative Medicines (CAM) that they are taking.
- The above should be recorded on the nursing assessment form.
- Preadmission staff will ask patients to discontinue taking these remedies preoperatively as they may interact with other medicines or affect bleeding. Patients will be instructed to leave herbal medicines at home.
- Where a patient insists on taking herbal medicines, this will be documented in the clinical record and the patient's Credentialed Specialist / Pharmacist notified.

Administration of Medicines

Nursing staff administer medication at Churchill via, pr, oral, subcutaneous, sublingual and IV infusions including use of patient-controlled analgesia, under prescription of a credentialled specialist. Following good practice, using the 5 R's

- right person
- right time
- right dose
- right route
- right medication

The nurse must check the patient allergies to any medication by reading the allergy section in the medication chart and checking with the patient prior to administration.

Withholding Medications

All RNs will use their clinical judgement when administering medication to a patient. Where the decision is to withhold the medication, for any reason this must be discussed with the prescribing specialist involved in the patient's care and recorded in the patient's clinical record.

Transcribing

Nurses are not permitted to transcribe, or replicate a patient's prescription on any document. The exception is the writing of the medications as guidance to the patient on discharge. This will be carried out to assist with the continuity of medications by the patient and whanau on discharge when the patient's specialist or anaesthetist is not available. This is a patient guide and not a written prescription. The RN must take every care to ensure what is written is accurate and is from the patient's medication chart. If there is any doubt about the details of the medication it should not be written and the specialist contacted.

Self-Administration of Patients Own Medication

Patients do not generally self-administer medicines at Churchill, due to the risk related to post operative alertness.

The RN can supervise a patient taking their own medication but the preference is that the nurse administers all medications. The exception to this would be use of inhalers which can be kept at the patient's bedside. The nurse must ensure the patient is alert enough to be able to administer and the patient must inform the nurse they have taken the inhaler. The nurse will then note the self-administration in the patient's chart.

Patients who are on insulin are acknowledged as the person best positioned to monitor and administer their insulin. This will be facilitated by the RN.

All adverse events/allergies experienced by a patient in relation to their medicines at Churchill should be notified to the Centre for Adverse Reaction (CARM) by the specialist.

Controlled Drug Management, Counting and Discrepancy

Controlled drugs (CD) and CD prescription pads are kept in the CD safe in the locked medication room. CD prescription pads are recorded in the CD Register by serial number.

Administering controlled drugs

Two nurses, one of whom is an RN will follow the prescription for the CD and check the medication out of the safe, recording it as per the register. Two nurses then take the medication to the patient, checking the identity of the patient and the time the last dose of CD was given. Ensure the medication is taken by the patient and complete the administration part of the medication chart.

Controlled drug register check – discrepancy process

Recording of all CDs must be documented in the CD register, all entries must be complete and legible, to allow for follow up and audit.

The Misuse of Drugs Act 2001 requires weekly checking of controlled drug records and physical quantities and six monthly quantitative and stock level checking.

If during the weekly check or on any other occasions a discrepancy is identified between the drug quantity on the shelf and the controlled drug record, the following process will apply:

The Registered Nurse must:

- keep the discrepancy confidential throughout the process.
- check the entries are the correct drug, form and strength, recount the physical stock take (with another RN).
- check the calculations in the Controlled Drug register, going back to the previous known correct balance.

- check the Controlled Drug cupboard and other medication areas, in case any unaccounted drugs have been put in an unusual place.
- if the discrepancy cannot be resolved after following the above steps then a reportable events form must be completed.

On receiving the reportable the Clinical Team Leader must:

- Review all patient notes for the period of the discrepancy and check for any drugs administered but not recorded.
- If the cause of the discrepancy can be identified, record the reasons for the discrepancy and as necessary in the Controlled Drug Register and on the reportable event form.
- If these procedures do not identify the cause of the discrepancy, then the Clinical Team Leader will inform the General Manager who will determine the best course of action for further investigation.

Witnessed disposal of controlled drugs

Witnessed disposal of CD is undertaken when not all a CD is administered and should be witnessed by two nurses one of whom should be a RN. The disposal is recorded in the CD register at the time of disposal.

Section 29 Medications “Unapproved Medicines”

It is rare that patients would be prescribed a Section 25 or Section 29 medicine at Churchill.

Section 25 of the Medicines Act permits practitioners to prescribe any medicine for a particular patient in their care. This includes the use of approved or unapproved medicines.

Section 29 of the Medicines Act enables a New Zealand company/pharmacy to legally obtain and supply an unapproved medicine to a patient when authorised by a prescriber (reporting requirements apply).

It is the responsibility of the prescribing specialist to gain consent prior to the administration of any section 29 medication.

Section 29 of the Medicines Act requires notification of sale or supply of unapproved medicines.

Section 29 of the Act permits the sale or supply to medical practitioners, of medicines that have not been approved. It also requires the "person" who sells or supplies the medicine to notify the Director-General of Health of that sale or supply in writing, naming the medical practitioner and the patient, describing the medicine and the date and place of sale or supply, and the number of packs supplied.

If a medicine is dispensed as a Section 29 the supplying pharmacy will provide the appropriate forms for completion.

- Record the patient's name and doctor prescribing the unlicensed medication on the Section 29 Recording Form for that medication.
- Send the completed form to Powsillo's Pharmacy upon completion or annually, whichever is the earlier.

Returning Expired Medication to Pharmacy

Non-CD medication can be returned to pharmacy once it has expired.

CD medication should be checked out from the drug safe and documented as returned to pharmacy in the CD register by two nurses and handed to pharmacy staff member to dispose of.

Discharge Medications

Patients requiring discharge medications receive a script from either the anaesthetist or surgeon prior to discharge. The anaesthetists /surgeons may select a:

- Specialist preference prescription form (A, B,C, D, or E)
- Specialist prescription form
- Controlled Drug prescription

A photocopy of the discharge prescription is to be kept in the patient chart.

Advise patients to fill prescription on their way home from the hospital. A list of pharmacies is available from reception and in patient compendiums, including details of opening hours.

Specialist preference Prescription and Specialist Prescription forms should only be emailed to a pharmacy prior to discharge if the patient is unable to make any other arrangements. In these instances, the original script must be posted to the pharmacy by the nurse who faxed the prescription.

CD scripts must not be emailed to Pharmacy. Patients/family must take the CD script to the pharmacy to be filled.

Churchill facilitates patients, who are unable to access a pharmacy on discharge, by supplying prescribed medications, of the two most common medications used for pain management – Paracetamol and Ibuprofen.

No other medicines will be provided by the RN to discharging patients.

The specialist will complete a discharge medication prescription form. The RN will review and ensure this is clear and complete. They will supply the commercial packs without removing or adding any tablets to the packs. The packs are supplies by the local pharmacy. A copy of the completed discharge medication prescription will be placed int the patients record.

Accessing Medications Out of Hours

If a patient is prescribed a medicine which is not in Churchill's usual stock contact the local pharmacy. If the medication is required out of hours and the local pharmacy is not available, contact the Wairau Hospital duty nurse manager (ext 9959) for assistance.

Associated Documents:

- Standing Orders
- Special Authority (For Subsidy on Community Pharmaceuticals) Procedure

References:

- The Australian Council on Healthcare Standards (ACHS), EQuIP6 Guidebook 1 – Accreditation, standards, Guidelines – Clinical Function. Standard 1.5. Criterion 1.5.1
- NZS8134.1:2008, HDSS 3.12
- Health Quality & Safety Commission New Zealand. (2012). *Medication Charting Standard.* Retrieved www.hqsc.govt.nz. As Author.
- HSQC medicine reconciliation standard, version 3, September 2012.
- Misuse of drugs act 1975, 2020 update.
- Medications Act 1981
- Nelson Marlborough Health - Standing Orders Policy –21.12.20
- Nelson Marlborough Health - Controlled Drug Policy 11.12.20
- Nelson Marlborough Health - Medication Administration. 15.12.20
- Nelson Marlborough Health - Patient's Own Medication. 05.08.17