MEDICATION MANAGEMENT

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Medication Management:

Is this document a:

Policy [√] Procedure [ ] Protocol [ ] Guideline [ ]

Insert Service Name(s), Directorate and applicable Location(s):

The Village Residence

Title of Policy Development Group:	Medication management
Approved by:	Michael McCaul
Reference Number:	FPM 1
Version Number:	001 – Final 01.05.2022, Revised September 2023
Publication Date:	03.12.2019, 01052023, 08102023
Date for revision:	May 2024 or earlier
Electronic Location:	HIQA SCHEDULE 5 ORDERING OF MEDICINES FOLDER

Version	Date Approved	List section numbers changed	Author
1	03/12/2019 01.05.2022		Michael McCaul
	29.04.2023		Jolly Varghese/Michael McCaul
	08102023		Michael McCaul

POLICY AND PROCEDURES

TABLE OF CONTENTS.

1.0 Policy Statement

It is the policy of Boyne View House that all aspects of medication management be aimed at promoting the maximum benefit for each resident, while at the same time minimising any potential harm in accordance with the resident's informed decision making and consent. Medication management practices will be based on legal, best evidence and professional requirements.

2.0 Purpose

To outline the processes and procedures for medication management in Boyne View House

Objectives

2.1.1 To ensure that all nursing staff in Boyne View House are fully aware of their legal and professional responsibilities with regard to medication management.

To promote a person Centred approach to medication management for each resident so as ensure that each resident, in accordance with their wishes receives the maximum benefit from their medications.

2.1.2 To ensure that all medication management practices comply with appropriate legislative and professional requirements.

2.1.3 To promote safe medication management in Boyne View House

2.1.4 Scope

This policy applies to all registered nurses, registered prescribers and healthcare assistants involved in any aspect of medication management for residents in Boyne View House

Definitions

2.1.5 Adverse reaction: "…a response to a medicinal product which is noxious and unintended" (p 74 European Directive 2010, cited in NMBI, 2015).

2.1.6 Exempt medicine: is an unauthorized medicine which is supplied on foot of a prescription or order from a registered doctor or dentist, for use by individual patients under their care in order to fulfil the special needs of those patients. (HPRA 2014).

2.1.7 High-Alert medications: are medications that bear a heightened risk of causing significant patient harm when they are used in error. (Institute of Safe Medication Practices, 2014).

2.1.8 Medication Management: The facilitation of safe and effective use of medicines (Nursing and Midwifery Board of Ireland, NMBI 2015).

2.1.9 Medicine reconciliation: the process of creating and maintaining the most accurate list possible of all medications a person is taking – including drug name, dosage, frequency and route – in order to identify any discrepancies, deletions, omissions, additions and to ensure any changes are documented and communicated, thus resulting in a complete list of medications (NMBI, 2015).

2.1.10 Medicines review: a structured critical examination of a patient's medicines with the objective of reaching an agreement with the patient about maximising the impact of medicines and minimising the number of medication-related problems and reducing waste (NMBI, 2015).

2.1.11 Medication Errors: refer to preventable events that may cause or lead to inappropriate medication use or resident/service user harm while the medication is in the control of the healthcare professional or resident/service user (An Bord Altranais, 2007).

2.1.12 Near miss event: refers to a situation where the error does not reach the resident/service user and no injury results (An Bord Altranais, 2007).

2.1.13 Transcribing: is the act of transferring a medication order from the original prescription to the current medication administration record/prescription sheet (An Bord Altranais, 2007).

Actions	***Michael McCaul.***

3.0

This policy will be disseminated to all staff in The Village Residence who are involved in medication management for residents and a record will be kept of all those who have signed the policy acknowledgement forms.	*Person in Charge*
Where a new version of this policy is produced, the previous version will be removed and filed away.	*Person in Charge*
On induction, all new nursing staff will be given an explanation of this policy.	*Person in Charge*
Nurses must comply with legal and professional requirements for medication management for residents.	*All registered nurses in this centre*
Nurses will report to *The Person in Charge* any concerns that they have regarding the safety of medication management in the home.	*All registered nurses in this centre*
Residents will receive information about their medicines in a language and format appropriate to his/her individual needs.	*All registered nurses in this centre*
Nurses will comply with the procedures and practices outlined in this policy.	*All registered nurses in in this centre*
Healthcare assistants will assist residents with taking their medicines only under the direction and supervision of a registered nurse in accordance with this policy.	*All healthcare assistants.*
Each resident will have an assessment of their medication management needs as part of their comprehensive assessment, which will be reviewed routinely every four months or where there is a significant change to their care and / or condition. A care plan to meet these needs will be developed as per the assessment and care planning protocol outlined in this policy.	*All registered nurses in in this centre*
Nurses will maintain their competence in medication management and inform the person in charge if they have any knowledge deficits or training needs related to medication management in The Village Residence.	*All registered nurses.*
Nurses will attend training /updates on medication management annually or where there is a significant change to practice in this area.	*Person in Charge.*
Nurses will have the required knowledge of legislation, practice standards and codes as outlined in An Bord Altranais Guidelines for Medication Management, 2007.	*All registered nurses.*
Nurses will report and manage any medication incidents according to the guides and procedure outlined in this policy	*All registered nurses.*
Nurses will have knowledge of all medicines being administered, including benefits, risks and side effects.	*All registered nurses.*
Medication management audits will be conducted as part of the clinical governance framework for The Village Residence	*Person in Charge*

3.1 Prescribing Modalities

3.1.1 Medicines for residents of The Village Residence are prescribed by a registered medical practitioner or registered dental practitioner on a GMS or private prescription sheet.

3.1.2 Prescriptions are then transcribed onto The Village Residence prescription Kardex by the registered nurses in accordance with the standard procedure for transcribing, outlined under **section 8.6.**

3.1.3 Medicine orders can also be received as remote (Verbal) orders, where there is an immediate an unplanned need, but must comply with the requirements for same outlined under **section *8.4.***

3.1.4 Medicine orders can be received via facsimile, but must comply with the requirements for same outlined under **section 8.5** facsimile orders.

3.2 Requirements for Prescriptions.

3.2.1 Prescriptions must take into account the views of the resident and /or representative as appropriate as well as the resident's needs HIQA, 2015, p.9 and 12)).

3.2.2 Prescribers must ensure that the resident for whom they are prescribing has been given an explanation of the rationale for the prescribed medicines and have agreed to same, unless there is evidence that the resident is unable to be involved in making decisions related to their medicines (HIQA, 2015, p..9).

3.2.3 Handwritten prescriptions must be written legibly in black ink or otherwise so as to be indelible.

3.2.4 All prescriptions for residents in The Village Residence must:

- Be dated.
- State the resident's General Medical Services (GMS) number /unit number (if applicable)
- State the prescriber's registration or PIN number.
- State the resident's full name, age, date of birth, room number and unit or have the resident's address label affixed.
- State any known allergies, or if none, this must be stated.
- Have directions written in English, using only approved abbreviations
- Use the generic name of the medicine and preparations, *except* in circumstances where a specific preparation is indicated by the resident's clinical condition. In this situation, the original prescription should state the brand name and 'Do Not Substitute' to ensure that the specific brand medicine is dispensed from the pharmacy.
- State the form, dosage and frequency and times of each medicine.
- State the names of medicines and preparations in full, using approved titles only
- any specific instructions including instruction to change the form (for example, crush) where indicated for each medicine
- State the duration of prescription.
- Be signed by the prescriber.

- Date of discontinuation of each medicine *– a line must be drawn through each medicine discontinued (HIQA, 2015, p.13).*

3.2.5 If amending or correcting an original prescription, the prescriber should rewrite the prescription in full.

3.2.6 The prescriber should never use a decimal point before a trailing zero – for example, 5mg is correct, not 5.0mg. Always use a whole zero before a decimal when the dose is less than a whole unit – for example, 0.5ml is correct, not .5ml. The use of the decimal is only otherwise acceptable to express a range – for example, 0.5 to 1mg.

3.2.7 For *Pro re nata* (PRN), 'as required' medications, the prescription must state the initial dose, timing of respective doses; the circumstances in which the medicine should be administered and the total dose that can be administered in a 24 hour period.

3.2.8 'As required' medications should have a review date identified.

3.2.9 Where a medicine is ordered to be administered in a crushed format, the order to crush must be written on the prescription sheet for each individual medicine that needs to be crushed. The rationale for same should be recorded in the resident's medical notes and nursing care plan.

(Note: A record of allergies or adverse reactions should be maintained on the prescription and administration records. Any routine periodic tests to monitor certain medicines (for example, Warfarin – INR monitoring) should be recorded on the prescription and administration records (HIQA, 2015, p.14)

3.3 MDA Scheduled Controlled Drugs.

3.3.1 Prescriptions for MDA schedule 2 and 3 controlled drugs must be handwritten and must:

- Be legible, written in indelible ink.
- Be signed and dated by the registered prescriber.
- Specify the address of the person issuing the prescription (except for GMS prescriptions)
- Specify the name and address of the resident for whom the prescription is being issued.

3.3.2 Prescriptions for MDA schedule 2 and 3 controlled drugs must specify the following in capital letters

- The brand name of the drug.
- The dose to be taken in both words and figures.
- The form of the drug.
- The strength where appropriate.
- In both words and figures, the total quantity of the drug or preparation or number of dosage units to be supplied.

- In the case of a prescription for a total quantity intended to be dispensed in installments; the prescription should specify the quantity, the number of installments and the intervals between installments to be observed.

NB: MDA prescriptions must be dispensed within 14 days of the issue date, except where the drug is being dispensed in installments, in which case, no installment should be dispensed after two months of the date of the prescription.

3.4 Remote (Verbal) Orders.

3.4.1 In The Village Residence, a nurse may accept a remote (verbal or telephone order) order from a general practitioner (G.P.) in exceptional situations where there is an immediate/unplanned need and the G.P. is unable to issue a new prescription in person at the time (ABA, 2007; NMBI, 2015).

3.4.2 Remote orders cannot be accepted for controlled drugs or from registered nurse prescribers.

3.4.3 The following procedure must be followed when taking a verbal order from a resident's G.P.:

- The nurse must provide and document the G.P. with the context for the need for the medication order using the SBAR (Situation-Background-Assessment-Recommendation) acronym (NMBI, 2015).
- Listen to the order.
- Document the order on the designated verbal order sheet so that it can be used for nurses who are administering the medicine.
- Repeat the order back to the G.P. for verification.
- The G.P. must repeat the order to a second nurse or healthcare assistant.
- The second person must confirm the order with the original nurse.

It is preferable that a second nurse verifies the verbal order, however where a second nurse is not on duty i.e. night duty, a healthcare assistant may verify the order.

3.4.4 A record of the remote order must be made in the resident's nursing narrative notes and include:

- The date and time of the order.
- The prescriber's full name and his/her confirmation of the order.
- The reason for accepting the verbal order.

3.4.5 Any nurse who accepts a verbal order must ensure that he/she knows the purpose of the medicine prescribed as well as the indications and

contraindications for administration, monitoring and reporting the resident's condition.

3.4.6 The resident's GP must prescribe the medicine on the resident's prescription sheet at his/her next visit to The Village Residence.

3.5 Transcription of Medication Orders/Prescriptions. See Policy on Nurse Transcribing.

3.5.1 Transcription is carried out by the registered nurses of The Village Residence .The nurse who transcribes is professionally accountable for the decision to transcribe and the accuracy of the transcription.

3.5.2 When a registered nurse is required to transcribe a medication order, the nurse must follow the standard procedure for transcribing outlined in ***8.7***

3.5.3 Transcribing must be carried out by a registered nurse and a second registered nurse must separately check the prescription transcribed.

3.5.4 The transcribed prescription sheet must be signed by the transcribing nurse and co-signed both by the second nurse and by the general practitioner before use.

3.5.5 Where a nurse is unsure about a transcribed prescription, he/she should check the prescription with the prescriber or pharmacist.

3.5.6 Nurses must not transcribe scheduled controlled drugs.

3.5.7 Nurses must not amend any treatments/prescriptions.

3.5.8 Transcriptions must be written IN CAPITALS using black ink.

3.5.9 The nurse should ensure to write drug strengths in full, with the exception of the following.

G = Gram
MG = Milligram
ML = Millilitre

3.5.10 All other drug strengths should be written in full, for example: nanogram, units, micrograms, etc.

3.6 Transcribing Procedure

3.6.1 The nurse who is transcribing must always carry out the procedure in a quiet area that is free from distraction.

3.6.2 The nurse must bring the original or faxed prescription and transcribe onto the resident's prescription sheet.

3.6.3 The nurse must read through the original prescription and ensure that it is legible and check the following.

- Date

- The resident's General Medical Services (GMS) number /unit number (if applicable)
- The resident's full name, age, date of birth, room number and unit or have the resident's address label affixed.
- Medicine name, (generic, unless otherwise specified by the prescriber as a brand that must not be substituted)
- State the names of medicines and preparations in full, using approved titles only
- The form, including if the medicine will need to be crushed
- State the duration of the prescription.
- The prescriber has signed the prescription.
- The dose and frequency.
- Any additional directions

3.6.4 The nurse must also check that the resident's allergy status has been documented.

3.6.5 Where the nurse is unsure or has any concerns about any content of the original prescription, he/she should clarify the prescription with the prescriber.

3.6.6 Having satisfied him/herself that the original prescription is clear and correct, the nurse should transcribe the following details using block capitals from the original/faxed prescription onto the resident's prescription Kardex.

- Medication name
- Form. e.g. tablet, capsule, liquid
- Strength
- Dose
- Route
- Frequency
- Start date
- Duration or review date
- Any additional directions

3.6.7 Having completed the transcription the nurse must re-check the transcribed information against the original/faxed prescription.

3.6.8 The independent/second nurse must then complete the following steps:

- Read through the original/faxed prescription and ensure that it is legible and that the contents are correct.
- Compare the original prescription with the transcribed prescription to ensure that the resident's personal details are correct.
- Compare each medicine on the original prescription with the transcribed prescription to ensure each has the correct name, dose, form and route of administration and frequency of administration transcribed.
- Where the nurse is unsure about any content of the original/faxed prescription, he/she should clarify the prescription with the transcribing nurse.

The original prescription must be attached to the transcribed record

(HIQA, 2015, p.15).

3.6.1 The resident's general practitioner must sign the transcribed prescription before it is used for drug administration.

4.0 Medication Management for New Admissions

4.1 Medication Reconciliation for Residents on Admission.

4.1.1 The medication reconciliation process for any resident will commence prior to admission, through the pre-admission assessment. The nurse manager who conducts the pre-admission assessment will gather the following information about the prospective resident's medication history:

- Name, dose, route, frequency of all current prescription medicines.
- How the prospective resident usually takes their medicines, including whether or not the prospective resident self- administers and his/her preference for same.
- Any discrepancies between the prescription and how the prospective resident takes his/her medicines.
- The name, dose, route and frequency of any non-prescription medicines that the prospective resident has been taking.
- Any known adverse drug reactions that the prospective resident has previously experienced with medicines, including allergies.
- Any recent changes to the prospective resident's medicines regime, such as medicines added, discontinued or alterations to dose, frequency or route of existing medicines.

4.1.2 The nurse manager will use at least two sources of information to complete the medication history and where there is any ambiguity, a

third source of information will be used to clarify any ambiguity or conflicting information.

4.1.3 Sources of information that may be used for conducting a medication history may include:

- The prospective resident.
- Family member.
- Current prescription/prescription Kardex if coming from hospital or another healthcare facility.
- Referring professional or member of nursing staff if coming from hospital or another healthcare facility.
- The Common Summary Assessment Record (CSAR) for the prospective resident, if available.
- The prospective resident's pharmacist is recognised as the best source of information, where there is any ambiguity.

4.1.4 The nurse manager will also review the prospective resident's medical history and current diagnoses/ conditions in order to reconcile the list of medicines with the prospective resident's medical profile.

4.1.5 The nurse manager will ascertain the prospective resident's preferences for choice of pharmacy services and general practitioner.

4.1.6 Where the prospective resident chooses to use the pharmacy services of The Village Residence and / or the services of the Medical Officer attending The Village Residence, where able, he/she will be asked to document their consent to same. Where the prospective resident is unable to provide consent, discussions about these services with his/her representative and the outcome of these discussions will be recorded on the consent form and signed and dated by the nurse manager and the representative.

4.2 Medication reconciliation on Re-admission to Boyne View House.

4.2.1 Medication reconciliation must also be carried out for any resident re-admitted to The Village Residence following transfer to hospital or discharge home which can occur

4.3 Preparation for Admission

4.3.1 Two days, prior to the admission of a new resident, the nurse manager will contact the referring facility/hospital or the resident's general practitioner (if coming from home) and request a faxed copy of the resident's current prescription.

4.3.2 The nurse manager will compare the faxed prescription against the pre-admission assessment medication history and against the resident's CSAR if available.

4.3.3 Where there are any discrepancies between the medication history on pre-admission assessment and the emailed prescription, the nurse in charge will contact the referring hospital/facility to verify any changes or the resident's general practitioner, if coming from home.

4.3.4 The nurse manager and staff nurse on duty will transcribe the medicines from the emailed prescription onto a prescription Kardex.

4.3.5 Transcription of medicines must be carried out according to the transcription procedure outlined in **Section 8.6** of this policy.

4.3.6 Emailed prescriptions will then be emailed on to Stack's Pharmacy or the resident's pharmacy. In order to prepare medications for the day of admission.

4.4 Medication Management on Admission of a Resident

4.4.1 Medication reconciliation is again carried out on admission using the following procedure:

- The admitting nurse will check the prescription accompanying the resident against any emailed prescription received prior to admission to identify any discrepancies between both prescriptions.
- The nurse will then check the transcribed prescription against the prescription accompanying the resident to identify any discrepancies between the two.
- The nurse will review the resident's medication history and current conditions to ensure that the medicines prescribed correspond with the resident's medical diagnoses and health conditions.

4.4.2 Having reviewed the above documentation, the nurse will check the following with the resident and / or representative:

- Known previous adverse drug reactions/allergies
- Preferences and needs for medication administration, including the need for any medicines to be crushed and any preference for self-administration of medicines.
- If coming from home, the nurse will check for any discrepancy between the medicine orders and how the resident has been taking his/her medicines.
- Whether or not the resident is taking any over the counter medicines.
- If the resident is returning from a hospital admission, the nurse should identify any changes to the medication regime by comparing the new prescription against the prescription sheet that was in use for the resident prior to going out to hospital.

4.4.3 Where there are any discrepancies noted or where there is ambiguity about the resident's medicine regime, the nurse should liaise with the referring hospital or the resident's own pharmacist and G.P. for clarification. Any concerns arising from the medication reconciliation must be brought to the attention of the admitting G.P/medical officer, who will be signing the prescription sheet.

4.4.4 Any changes to medication orders that have been made subsequent to receipt of the faxed prescription must be updated on the resident's transcribed prescription Kardex.

4.4.5 The transcribed prescription kardex should be reviewed by the admitting G.P/medical officer prior to signing same.

4.4.6 The nurse must inform Stack's Pharmacy or the residents chosen pharmacy of any changes to the prescription via e mail and a follow-up phone call.

4.4.7 The resident's additional medications will be delivered to the nursing home on the afternoon of the resident's admission.

4.4.8 Where the resident requires a prescribed medication prior to the delivery of same by the pharmacy, the nurse may administer the medicine from the resident's own supply only where the medicine is clearly labelled, in its original container and not past the expiry date.

5.0 Ordering and Supply of Medications in Boyne View House.

5.1.1 Medicines in The Village Residence can only be ordered by a registered nurse.

5.1.2 *Stack's pharmacy in Laytown supply all medications to* The Village Residence *, they can be contacted on 0419827163 Monday to Friday 9 am to 7pm. email on stacks.laytown@healthmail.ie. Outside of these hours a pharmacist can be contacted on the following emergency numbers 0861726969.Lusk Pharmacy is also available as an emergency pharmacist on the following number 018430140*

5.1.3 *Stack's pharmacy is available on site on a regular monthly basis and should a resident wish to speak to them they will make themselves available outside of these times.*

5.1.4 **Daily Orders**

Every time there is a change in medications, or commencing antibiotics the following steps will have to be followed

- A pharmacy requisition form will have to complete along with updated kardex and prescription if available and email to Stack's pharmacy.
- Please note that pharmacy will not dispense medications if the original prescription not with us.
- Requisition form will have to be kept in the pharmacy folder for future receipt and reference
- When the order is delivered to the unit, each item has to be checked off and signed against the requisition.
- Medications returned to pharmacy will have to be entered on IN&OUT book(Receipt book is known as IN&OUT book

5.1.5 **Monthly Orders**

- Requisition form and all kardexes will have to be scanned to Stack's on the 3rd Monday of the medication cycle before 6 pm
- Inform pharmacy of all changes including discharged or deceased residents.

Daily, monthly, regular and PRN medications orders are also completed electronically through the epic care system. Instructions can be followed on the video below, also on the home page on the tablet used for medication administration.

004.mp4

PRN medications must only be prescribed, ordered and labelled on a named resident basis and must only be used for the named resident.

5.7 Delivery of Medications.

5.7.1 On delivery of weekly medicines, the nurse on duty and pharmacy staff member will check the contents of the delivery against the order sheet and each resident's prescription sheet.

5.7.2 The pharmacy supplied information print outs should also be checked at this time to ensure the information contained is accurate for each medicine.

5.7.3 The nurse and pharmacy staff member must record that the delivery has been checked and is correct. Both persons must sign the record.

5.7.4 Where there are any discrepancies in the contents of the delivery and residents' medication prescription kardex, these must be recorded as well as any remedial actions taken.

5.7.5 Errors in dispensing, such as wrong drug or strength must be recorded as a medication incident form on the NIMS.

5.7.6 The medications are stored in the designated lockable storage area in the relevant Unit

5.8 Order and Delivery of Stock Medicines

*Please refer **section 9.0** of this policy for further details.*

5.1 ***A record of all medicines ordered must be maintained. Nurses must record every order on The Village Residence order sheet (HIQA, 2015. P. 12)***

5.2 ***Delivery of medicines must be checked against the records of orders (HIQA, 2015. P. 12).***

5.3 Changes to Residents Medicines Outside of weekly Orders.

5.3.1 Where the resident's medications are altered during the week, the Pharmacy will provide a same day delivery of new medications.

5.3.2 The medical practitioner will update the resident's prescription kardex by handwriting the new prescription order on the kardex. The medical practitioner will also generate a GMS script that is required by the pharmacy. Two registered nurses will transcribe the kardex ready for GP to sign on next visit. See transcription policy.

5.3.3 Both of these should then be emailed via health mail to the dispensing Pharmacy and a follow-up phone call made. The medication(s) will be

delivered on the same day and the GMS script furnished to the pharmacy on delivery of the medication.

5.3.4 Where the resident's medical practitioner makes changes to prescriptions from their own surgery, the GMS Script will be faxed to the nursing home and comply with **section 8.5 Faxed Prescriptions.** Additionally, the nurse on duty will email the resident's current prescription sheet to the medical practitioner who will amend same and email it back to the nursing home.

5.3.5 Where the resident has been prescribed a new medicine or there has been an increase in the dose of medication, the Pharmacy will supply these in additional medication cassettes until the next weekly order is due.

5.3.6 Where medication has been discontinued or the dose reduced, the Pharmacy will dispense entirely new *cassettes / roll/ blister pack* and the current one must be returned to the Pharmacy on delivery of the new ones.

5.3.7 Where a resident has been prescribed a medication outside of normal working hours e.g. an antibiotic prescribed for a resident during the night, the nurse can check the emergency stock of medication and use same for the resident in keeping with **sections 10.5.3 to 10.5.5** as outlined above.

5.1 Prescribing and Administration of Warfarin.

5.1.1 Warfarin is prescribed on a designated anti-coagulant prescription sheet.

5.1.2 Orders for warfarin are based on the resident's INR results, the frequency of which is determined by the resident's medical practitioner.

5.1.3 Blood samples for INR (International Normalized Ratio) are taken as required / requested by the residents GP or a member of nursing staff in the mornings. The bloods are taken to Our Lady of Lourdes Hospital warfarin clinic *for* testing.

5.1.4 The nurse on duty and a second member of nursing staff must phone the laboratory in the afternoon to check the INR results. Once the order has been received and confirmed by the second nurse this information is documented on the resident's anticoagulant order sheet, warfarin clinic send an email to the ward generic email and nurse on duty email the resident's GP.

5.1.5 The resident's GP/medical officer completes the relevant section of the resident's anticoagulant order sheet, including the warfarin order and emails same back to The Village Residence.

5.1.6 On receipt of the warfarin order, two nurses must transcribe the order onto the anticoagulant prescription sheet using the appropriate transcribing procedure.

5.1.7 Two nurses check and administer warfarin to residents.

5.1.8 Where a resident is on Warfarin, his/her medication needs care plan must include interventions to meet any needs arising from the use of warfarin.

5.2 Supplying Medicines to a Resident on Leave/ Discharge from The Village Residence

5.2.1 Nurses must ensure that residents on temporary leave from The Village Residence have access to an adequate supply of prescribed medications.

5.2.2 Prior to supplying any medicines to a resident on temporary leave, the nurse should document the resident's ability to self- administer medications while on leave.

5.2.3 Where any resident is unable to self- administer medications, the nurse must ensure that the supply of medicines is given to a responsible person accompanying the resident.

5.2.4 Where a resident is unable to self- administer medications while on leave, the nurse should ensure and that a nominated responsible person is available to administer / assist the resident with taking his/her medicines.

5.2.5 The nurse will liaise with the Pharmacy to arrange for dispensing medicines to a resident on temporary leave for an extended period of time.

5.2.6 Where the resident will not be away for more than a few hours, the nurse will place the resident's medications into a tablet container(s) and provide the resident/representative with written information on what medicines are in the container and what time they should be administered. Any additional information/instructions required regarding the administration of the medicines should also be recorded.

5.2.7 Where the resident will be absent for an extended period, the nurse will ask the pharmacy to dispense a supply of medicines for the resident.

5.2.8 The nurse who gives the resident / representative medications for temporary leave must document in the resident's progress notes, the name and amount of each medicine given; the name of the person to whom they were given; the arrangements for the resident to receive their medicines while on leave (i.e. self-medicating or the name of the person responsible for administration); and any instructions given.

5.2.9 Where the resident will be on leave for an extended period of time, and is receiving variable dose drugs such as warfarin, the nurse should liaise with the resident's prescriber and pharmacist regarding any special arrangements that would be needed to support the safe administration of medications and monitoring of the resident. These arrangements must be documented in the resident's progress notes.

5.2.10 Where a resident is being discharged from The Village Residence, the nurse must ensure that the resident will have access to a supply of medicines when leaving.

5.2.10.1 Where there will be a delay in a resident receiving medication from his / her pharmacist, the pharmacist will be asked to dispense an appropriate supply of medicines for the resident on discharge.

5.2.11 Details of drugs and information given and to whom these were given should be documented in the resident's narrative notes.

6.0 Storage of Medicines.

6.1.1 Medicines must be stored in the appropriate storage area as indicated on the label or packaging of the product or as advised by the dispensing pharmacist.

6.1.2 Storage areas for medicines in The Village Residence are:

- The Resident's individualized medicine storage press in their own room.
- Medicines Store cupboard treatment room .
- Medicine Store room located at treatment room .
- Medicine fridge located at treatment room.
- The MDA locked cupboard located at treatment room.

6.1.3 Medicines trolleys must be locked and secured to the wall at all times, when not in use.

6.1.4 Medicine keys must be kept on the person of the nurse in charge.

6.1.5 All MDA controlled drugs must be stored in the MDA cupboard in the treatment room .

6.1.6 MDA Schedule 2 drugs must be checked and recorded by two nurses at every change over of shift.

6.1.1 All MDA Schedule 2 drugs must be entered into the Controlled Drugs Register recording the resident's name, amount of stock, batch number and expiry date.

6.1.2 Preparations for oral use must be separated from those for topical use to avoid confusion.

6.2 General Storage Principles.

6.2.1 Medicinal products must always be stored separately from antiseptics, disinfectants and cleaning products.

6.2.2 Stability: some preparations may require storage under well-defined conditions, e.g. ‘below 10˚c or ‘store in a refrigerator’. The nurse receiving the medicine must check for any specific instructions on the packaging of the medicine.

6.2.3 Labeling: the wording of labels is chosen carefully to convey clearly all essential information. Printed labels should always be used.

6.2.4 Medicinal preparations should never be decanted / transferred (in bulk) from one container to another except by a pharmacist.

6.2.5 The label on the pack should in most cases give guidance about storage conditions for individual prescriptions. The term ‘a cool place’ is normally interpreted as meaning between 1˚c and 15˚c for which a refrigerator (between 2˚c and 8˚c) will normally suffice. ‘Room temperature’ allows a range of approximately 15˚c to 25˚c. If in any doubt about storage requirements for any preparation nurses should check with the pharmacist.

6.2.6 All drugs should be protected from light, heat (generally not above 25C) and moisture.

6.2.7 Medicines requiring refrigeration to ensure stability (as noted on package labeling) should be stored in the medicines refrigerator.

6.2.8 The nurse in charge must check the temperature of the medicines refrigerator daily and record same in the medicines refrigerator checklist.

6.2.9 All MDA controlled drugs must be stored in the MDA cupboards.

6.2.10 All MDA Schedule 2 drugs must be checked and recorded by two nurses at every change of shift and recorded in the Controlled Drugs Register.

6.2.1 All MDA Schedule 2 drugs must be entered into the Controlled Drugs Register recording the resident’s name, amount of stock, batch number and expiry date.

6.2.2 Medicinal preparations should never be decanted / transferred (in bulk) from one container to another except by a pharmacist.

6.3 Stock Control.

6.3.1 Only medicines currently prescribed for residents are kept in the Village Residence (HIQA, 2015, p. 12).

6.3.2 The Village Residence operates a system of stock checking every *Month*. This involves checking all areas where medicines are stored, including trolleys, cupboards and medicines fridges.

6.3.3 The nurse completing the stock control, checks for any out of date medicines or those no longer in use.

6.3.4 Medicines that have exceeded their expiry date or are no longer in use are stored in the designated area in the medicine cupboard while awaiting return to the pharmacy.

6.3.5 The nurse who completes the stock check must record same and outcomes/actions taken on the appropriate form

6.4 Disposal of Medicines.

6.4.1 Medicines no longer in use or those that have expired must be returned to the pharmacy.

6.4.2 Any medicines being returned must be recorded on the 'Pharmacy Returns Form and signed and dated by the nurse who has prepared the medicines for return.

6.4.3 Medicines for return must be stored in the designated area of the medicine cupboards while waiting to be returned.

6.4.4 Where a tablet has been dropped, spit out or regurgitated, this should be collected using a tissue and disposed of in the sharps box with purple lid, which is designated for medicines.

6.4.5 A record of the medicine being 'spit out' or regurgitated should be documented in the resident's medication administration sheet (MARS) and the appropriate form.

7.0 Assessment and Care Planning for Medication Needs.

7.1.1 Each resident has an assessment of their medication needs as part of the admission assessment.

7.1.2 An initial care plan to meet the resident's medication needs must be completed by a nurse within 48 or earlier if indicated by the admission assessment. The care plan must include:

- The resident's abilities for medication management and taking medicines.
- Any preferences the resident has regarding the management and administration of his/her medicines.
- Any specific needs the resident may have for taking their medicines e.g. the need for crushing, assistance, via PEG tube and so on.

- Any risks related to their medicines management and how these will be addressed, e.g. falls, hypoglycemia from insulin therapy and so on.
- Any specialist healthcare professionals involved in meeting the resident's medication needs and any instructions relevant to nursing, for example, psychiatry of old age or diabetic clinic.
- Any needs for monitoring related to the resident's medication needs, eg any vital signs that must be taken prior to administration as applicable or laboratory values that need to be monitored e.g. INR tests.

7.1.3 As with all other aspects of the resident's care plan, the nurse should seek the views of the resident and / or representative as appropriate when completing the resident's medication needs care plan. The nurse should check that the resident has information about their medicines as required.

7.1.4 Changes to a residents' condition resulting from medicines should be recorded on the residents' nursing narrative notes, such as noted improvements or concerns.

7.1.5 Omission of a medicine and the reason for same must be recorded in the nursing narrative notes.

7.1.6 Refusal of medicines and actions taken must be recorded in nursing narrative notes.

7.1.7 Administration of a 'PRN' / as required medicine, including the reason for administration and effect must be recorded in nursing narrative notes.

7.1.8 Each resident must have a documented review of medicines every three months.

7.2 Monitoring

Monitoring the efficacy of any medication is an integral part of the nurse or midwife's role. If the medicine does not achieve the desired effect, or results in the onset of adverse events or reactions, the nurse or midwife must:

- maintain a record of the patient's clinical status to ensure that their safety has not been or will not be compromised;
- record the adverse events or reactions in the patient's care plan;
- report to the authorised prescriber;
- ensure that the patient is fully informed about their progress and are involved in making decisions regarding their ongoing care;

- Report suspected adverse reactions to the Health Products Regulatory Authority (HPRA). www.**hpra**.ie

8.0 Medication Review.

8.1 Frequency of Reviews.

8.1.1 A review of residents' medication is undertaken every three months by the resident's general practitioner and the pharmacist.

8.1.2 Nurses should also request a review of a resident's medication

- Where there is a significant change in the resident's condition or treatment regimen.
- Where the nurse suspects an adverse effect or drug interaction based on clinical signs and symptoms.

8.1.3 Nursing staff should liaise with residents' general practitioners/medical officer regarding medication reviews. A medication review should involve the nurse and the resident's general practitioner/medical officer and where possible the pharmacist

NB: Any history of an adverse event, whether mild or severe such as allergic reaction should be documented as a warning / allergy in the first page of the resident's records and the medication prescription sheet.

9.0 Administration of Medicines in The Village Residence.

9.1 Ten Rights of Medicines Administration (NMBI, 2015).

There are 10 rights of medicines administration referred to in HIQA (2015) as those outlined in NMBI (2015). These are:

1. Be certain of the identity of the resident to whom the medicine is being administered by verifying the, photograph or name and date of birth on the medicine chart **(Right patient).**
2. Understand the intended purpose of the medicines to be administered **(Right reason).**
3. Confirm that the name of the dispensed medicine to be administered corresponds with the generic or brand name of the prescribed medicine and they must only administer a viable medicinal product – that is, properly packaged and within its expiry date. The nurse or midwife must also check, both by asking the patient and checking the allergy status box on the chart, whether the patient has a known and recorded allergy to the prescribed drug **(Right Drug).**
4. Administer the medicine via the prescribed anatomical route and site **(Right route).**

5. Administer the medicine at the prescribed time and prescribed intervals **(Right time).**
6. Confirm, through arithmetical calculation that the dose of the medicine being administered concurs exactly with the dose prescribed. Where the local PPPGs identify this process for high risk medicines, the dose must be independently verified. (See section on double checking) **(Right dose).**
7. Confirm that the form of medicine that has been dispensed matches with the specified route of administration **(Right form).**
8. Ensure the medicine is prescribed for the appropriate reason and state to the patient the action of the medication and why it is prescribed **(Right action).**
9. Sign, date and retain all documentation recording the administration of each medicine in the medicines administration chart (or other document directing the administration of a medicine). The chart must only be signed to record a medicine has been administered once the medicine administration has been witnessed **(Right documentation).**
10. Observe the patient for adverse effects, and assess the patient to determine that the desired effect of the medicines has been achieved **(Right response).**

9.1.1 Nurses are not permitted to give any medicine, including an 'over the counter' preparation unless it has been prescribed by the resident's general practitioner/medical officer. In the event that a written prescription is not available and there is an unforeseen / unplanned need, verbal orders and faxed prescriptions can be used in accordance with the requirements for both outlined in this policy under the relevant headings.

9.1.2 The same nurse must prepare and administer medicines.

9.1.3 The principles of aseptic 'non touch' technique and appropriate precautions for specific drugs should be adhered to during the preparation and administration of medicines.

9.1.4 In The Village Residence medication administration is a 'protected' activity. That means that the nurse administering medications must not be disturbed during the medication round.

9.1.5 Healthcare assistants or another competent person such as a relative may assist a resident taking oral medications only under the direction and supervision of a registered nurse.

9.1.6 The registered nurse, when delegating a particular role/function must take account of the principles outlined in the scope of practice, particularly, that the primary motivation for delegation is the best interests of the resident (An Bord Altranais, 2015).

9.1.7 A nursing or midwifery student should only administer a medicine to a patient:

- Under the supervision of a registered nurse or midwife;
- When they the student, agree to undertake the administration;
- On gaining the patient's consent.

9.1.8 Except in the case of scheduled and 'high alert' drugs, medicines may usually be administered by a nurse on his/her own.

9.1.9 For 'high alert' drugs such as warfarin; insulin and those requiring complex calculations, another nurse or healthcare assistant should independently double check the 'ten rights' with the nurse administering the medicine.

9.2 Procedure for Administration of Medicines.

9.2.1 The nurse administrating medication must check that the information on the resident's prescription sheet is complete, correct and legible.

9.2.2 Every nurse must complete the 'ten rights' prior to administering medication.

9.2.3 Where there is any ambiguity regarding a prescribed medicine, clarification must be sought from the appropriate healthcare professional such as the prescriber or the pharmacy prior to administration.

9.2.4 The nurse must clean her hands before the medication round and between each resident.

9.2.5 Prior to administration, the nurse must check the ***resident's prescription kardex.*** The prescription kardex must be checked for the following:

- Name, date of birth, room number and resident unique identifier number or photo identification of the resident
- Name of medication.
- Medication dose and administration route.
- Date and time(s) that the medication is to be administered.
- Indication for use.
- Any specific instructions given on the label /packaging / prescription sheet for preparation and / or administration of the prescribed medication eg diluents as appropriate
- Prescribed medication is dated and signed by the prescriber.
- Any known allergies.
- Check that the medication has not already been administered.
- The nurse should check the description of the drugs on the sachet.

9.2.6 Using a 'non touch' technique, the nurse places the resident's medication from the medicine box/bottle into a medicine cup and completes the following steps:

- Go to the resident and check the five rights with the resident.
- Provide any information or explanation the resident may need.
- Perform and record any relevant vital signs specific to the drug being administered in the medication prescription sheet prior to administration of the drug and continue with administration if vital signs are within the required range.
- Medicines must be given as soon as they are prepared or opened.

- Administer drug as prescribed and according to any instructions from the prescriber and / or pharmacist.
- Stay with the resident, until the medicine has been taken.

9.2.7 Where a liquid form of medication or patches are being administered, the date of opening of the bottle /package must be recorded on the label. ***<u>This includes oral nutritional supplements.</u>***

- Internal Liquids (eye drops, oral liquids) – 30 days
- External Preparations (creams and ointments) – 90 days
- Record dose given in prescription chart and in any other place as per legal requirements e.g., Scheduled drugs.
- Ensure the resident is safe and comfortable.
- The nurse must return to the medicine trolley and immediately sign the appropriate MAR sheets after administering the medication.

9.3 Covert Administration of Medication.

9.3.1 Decisions to administer medications in food may be made in situations where a resident finds medication unpalatable or has difficulty swallowing tablets or because the resident is unsure what to do when presented with a tablet or syrup. In these situations, the resident has difficulty complying with treatment rather than refusing treatment (United Kingdom Psychiatric Pharmacy Group, 2001). Such decisions should involve the resident as far as he or she is able, the nursing team, general practitioner, pharmacist and the views and observations of the resident's representative and should be documented by the general practitioner/medical officer in the resident's records.

9.3.2 Disguising medication in food should not be usual practice, but used only as a last resort in a situation where the resident lacks the capacity to understand the purpose of the treatment and risks associated with not taking treatment and the treatment is necessary to preserve life or prevent deterioration of the resident (Nursing and Midwifery Council, 2007; Commission for Social Care and Inspection UK, 2007)). Such decisions should involve the resident as far as he or she is able, the nursing team, general practitioner/medical officer, pharmacist and the views and observations of the resident's representative and should be documented by the medical practitioner in the resident's notes and prescription sheet (HIQA, 2015). As with other all care planning, this

decision should be reviewed on a regular basis and particularly where there is a significant change to the resident's care and /or condition (HIQA, 2015).

9.3.3 A full written assessment of the resident is performed prior to the administration of medicines covertly. The assessment should identify the following:

- The medicines being administered
- The indications for these medicines,
- Alternative measures that have been taken
- The rationale for the use of covert administration.

(Health Information and Quality Authority, 2015)

9.3.4 Where medicines are covertly administered, nursing staff will observe for and document side effects (in the residents medication needs care plan).

9.3.5 As with all other medications, where the nurse has concerns regarding adverse effects of covert medication administration, he/she should inform *Clinical Nurse Manager* who will liaise with the resident's general practitioner/medical officer. Appropriate action should be taken to reduce and eliminate side effects

9.4 Crushing Medications

9.4.1 Nurses must not administer medicines in a crushed format unless this has been prescribed by the resident's prescriber.

9.4.2 If a nurse feels that a change in the form of a drug (e.g. crushing) may be necessary for its safe administration, he/she should consult with the resident and / or the resident's representative as appropriate; the resident's general practitioner and pharmacist to discuss alternative preparations or forms of administration that will meet the needs and wishes of the resident.

9.4.3 If it is deemed necessary to administer the medication in an unlicensed form, this should be prescribed by the general practitioner in the resident's prescription kardex (An Bord Altranais 2007). The reason for crushing the medicine must be recorded in the resident's medication needs care plan.

9.5 Procedure for Administering Crushed Medications ***(Amend according to equipment in use).***

9.5.1 Equipment

- silent knight

9.6 Crushing technique

9.6.1 Disposable crushing bag should be used for each resident.

9.6.2 Wherever possible administer to residents when upright.

9.6.3 To avoid medicine degradation and inadvertent administration to the wrong resident, the crushed tablets and capsules should be administered as soon as possible after altering/mixing.

9.6.4 Don't use the residents' meal to administer their medication as this may effect their appetite. Always use a separate item such as yoghurt or custard etc…

9.6.5 To minimise the risk of oesophageal irritation always administer the medicine with sufficient water or other suitable liquid.

9.6.6 Crushing tablets or opening capsules should only be considered as a last resort (Griffith & Davies, 2003).

9.6.7 The following formulations have special release mechanisms that make them unsuitable for crushing:

- Sublingual tablets
- Buccal tablets
- Melt tablets
- Chewable tablets
- Proton pump inhibitors.

9.6.8 Calcium or iron tablets should not be crushed with any other medication.

9.6.9 Slow release tablets or capsules are specifically designed to release the drug over a long period of time. Crushing these will cause the entire drug to be released at once and may cause toxic side effects.

9.6.10 Where a nurse is in any doubt about any aspect of crushing a medicine, she must contact the pharmacist for instructions.

9.7 Administration, Recording and Monitoring of 'As Required' Medications.

9.7.1 Prior to administration of a required drug, the nurse must check the MARs to see how much of the drug has been administered previously so as to ensure that the resident does not receive more than the maximum dose in a 24 hour period.

9.7.2 When administering 'as required' medications, the nurse should record the drug administered as well as the reason for drug administered and the effects of the medication in the nursing narrative notes.

9.7.3 Where a resident has continued requirement for an 'as required' medication, this should be reviewed with the resident's prescriber.

9.8 Administration of Vaccinations.

9.8.1 Influenza and /or pneumococcal vaccinations are prescribed, ordered, stored and administered by the resident's general practitioner/medical officer.

9.8.2 The resident's consent for vaccination must be sought prior to administration of the vaccine, unless he/she is unable to give consent, in which case the decision to administer the vaccine is made by the general practitioner/medical officer, in consultation with the resident's next of kin/representative.

9.8.3 A record of the vaccine and its batch number must be kept in the medical records following administration of any vaccine.

9.9 Withholding Medication

9.9.1 It is appropriate to exercise professional judgment to withhold a drug if relevant in a specific resident case. However, the reason for withholding the medicine and any follow up actions taken or required must be recorded in the nursing narrative notes.

9.9.2 Where a nurse considers that it may be necessary to withhold a medicine, he/she should consult with the resident's prescriber and / or pharmacist for advice.

9.9.3 The nurse must record that the medicine has been withheld on the MARs sheet. A note must also be made in the resident's narrative notes that the medicine was withheld and the reason for same, including any other person that was consulted.

9.9.4 The resident should be informed by the nurse of the decision to withhold the medicine and the reason for same.

9.10 Procedure for when a resident refuses a medicine.

9.10.1 Where a resident refuses a medication, the nurse should respect his/her right to refuse. However, the nurse should ensure that:

- The resident is provided with and understands the reasons why the medication has been prescribed and any risks associated with not taking the medication.
- The nurse understands why the resident is refusing the medication and that this is discussed with the resident's prescriber so as to identify the appropriate action/alternatives that can be agreed. The nurse must use his/her judgment as to the urgency of contacting the prescriber, which will depend on the nature of the medication prescribed.

9.10.2 Accurate and timely documentation should be made for any drug withheld or refused. The nurse must record same in the comments section of the medication administration sheet and the resident's progress notes.

9.10.3 Any information or advice given to a resident about the possible consequences of such a refusal must be documented in the nursing narrative notes.

9.10.4 If a medicine is given at a later time than prescribed, the prescriber should be contacted to ensure that there are no contra-indications. If

there is a pattern where a resident often refuses a medicine, the nurse must ensure that a plan is put in place to address the resident's needs. This must be done with involvement of the staff, multidisciplinary team, the resident and their representatives, if appropriate.

9.10.5 This plan must be reviewed on a regular basis, in line with the relevant legislation or more often if circumstances change

9.10.6 Omitting to give a drug ***without a documented rationale*** for withholding the drug should be treated as an 'omission' error and must be recorded as such on a medication error form.

9.11 Procedure for Administration of Controlled Medicines.

9.11.1 The nurse administering a controlled drug must ensure that a valid prescription is available and adheres to the requirements for prescribing controlled drugs.

9.11.2 Select the correct drug from the controlled drugs cupboard in the presence of another nurse or care assistant, where another nurse is not on duty.

9.11.3 Go to the resident's page in the controlled drugs register.

9.11.4 The nurse must count the drug to be administered making sure that the balance is correct as per the last count recorded.

9.11.5 Enter the residents name, the drug to be administered, the dose and the balance of the remaining drug into the controlled drug register.

9.11.6 The 'ten rights' considerations of medication administration must be adhered to.

9.11.7 Entry must be signed by the nurse administering the medication as well as the second nurse or healthcare assistant who also checked the medicine prescription, the medicine and the balance.

9.11.8 Return remaining stock to MDA cupboard and lock the cupboard.

9.11.9 Take the prepared dose to the resident, once again checking the chart for the drugs and dose.

9.11.10 Check the resident's name, date of birth and drug allergy history prior to administration.

9.11.11 The nurse administering the drug must stay with the resident while drug is taken.

9.11.12 The nurse who administered the drug should sign the medication chart after drug is administered.

9.11.13 Administration of a controlled medicine must comply with the general procedure for administration of medicines with the following additional precautions:

- Liquid controlled drugs should be measured with a syringe.

- Where a discrepancy in the amount of a controlled drug is noted, the nurse must report this immediately to the *CNM 2*

- A Medication Incident/ Error form must be completed and an investigation of the incident will be carried out by *CNM1 or 2*

- In the event that a controlled drug cannot be accounted for, the person in charge or deputizing nurse manager must inform An Garda Siochana.

9.11.14 Residents who have been prescribed a medicine patch must be checked by the nurse / care assistant providing personal care every morning to ensure that the patch is in situ.

9.11.15 Where a resident's medicine has accidently been removed by either the resident or from the resident's movement, the nurse on duty must be informed and the patch disposed of in accordance with this policy.

9.12 Self-Administration of Medication

9.12.1 Residents of The Village Residence are encouraged and facilitated to self-administer their medications in accordance with their needs and wishes.

9.12.2 A resident may self-administer medications following assessment resulting in a decision made that the resident is competent and agrees to self-administration of medication (An Bord Altranais, 2007; NMBI 2015). This assessment will be undertaken by a nurse in collaboration with the resident, the resident's medical practitioner, pharmacist and the resident's representative if as appropriate. The assessment should consider:

- The resident's choice
- The amount of support a resident needs to self-administer medicines
- The resident's ability to understand the process
- The resident's knowledge of their medicines and treatment plan
- The resident's literacy and ability to read labels
- The resident's dexterity and ability to open bottles and containers
- If the resident can take the correct dose of their own medicines at the right time in the right way
- Where the resident's medicines will be stored
- The responsibilities of residential care staff.

(Health Information and Quality Authority, 2015)

9.12.3 The resident's designated nurse is responsible for the initial assessment, while all nurses are responsible for continual assessment of a resident who is self-administering.

9.12.4 With their consent and following assessment and documentation of the agreed decision, residents who are self-administering share responsibility for their actions relating to self-administration of their medications.

9.12.5 The resident's consent must be obtained before self-administration of medications is commenced.

9.12.6 Any change to the initial assessment must be recorded and arrangements for self–administration of medicines reviewed (An Bord Altranais 2007). There are four levels of self-administration of medicines in

- Level 0: Resident is not self-administrating.
- Level 1a: Resident self-administers with full supervision.
- Level 1b: Resident requests medication from the nurse at the appropriate time.
- Level 2: The resident administers the medicines without the supervision of the nurse.

9.12.7 For residents on level 2; the medicines must be stored in a cupboard / locker in the resident's room. This must be locked and a key kept both by the resident and on the main drug keys.

9.12.8 The resident has responsibility for the safe storage of the medicines. The resident records the medication taken in his/her own self-administration reminder chart.

9.12.9 The nurse checks verbally or on the resident's self-administration form that the drug has been taken at the time it was due.

9.12.10 Any comments/concerns/problems noted by the nurse are recorded by the nurse in the resident's on going assessment record.

9.12.11 Variable (e.g. Warfarin), once only, short course treatments and PRN medications are administered by the nurse at the usual drug round times.

9.12.12 As with all other medicines, medications that are being self-administered must be prescribed by the resident's general practitioner/medical officer on the medication prescription sheet.

9.12.13 As with all care planning, the appropriateness of self-administration of medication for a resident should be continually monitored and reviewed at an agreed schedule for each resident and reassessments made where any problems are noted and where there is any significant change in the resident's care and condition.

9.12.14 For those residents self-administering medication(s), the medication needs care plan should include the following information:

- Where the medications are being stored
- The level of support the resident requires and resulting responsibility of the staff
- How to monitor whether the resident is still able to self-administer medicines
- Detail the ongoing supervision to ensure adherence with the treatment plan
- Who will be recording that the medicines have been taken by the resident and how this will be recorded.

9.12.15 The resident's on-going progress must be noted daily in the progress notes.

9.12.16 The nurse initiating self-administration must provide the resident with written information about the medications they are self-administering. This may be obtained from the Pharmacy.

9.13 Self-Administration of Controlled Drugs.

Designated Centres will ensure that their process for self-administration of Schedule 2 and 3 controlled drugs includes additional specific information about:

- *Obtaining or ordering Schedule 2 and 3 controlled drugs*
- *Storing Schedule 2 and 3 controlled drugs*
- *Recording supply of Schedule 2 and 3 controlled drugs to resident's*
- *Disposal of unused or expired Schedule 2 and 3 controlled drugs.*

(Health Information and Quality Authority, 2015)

In essence this means that if residents are self-administering controlled drugs, staff will need to provide a risk assessment; include the practice on the risk register and identify measures to address risks associated with this activity. For example, this will include secure lockable storage area; documentation of receipt of controlled drugs by the resident, which is witnessed and signed; signed consent; checking balances with the

resident and perhaps another witness at scheduled intervals and disposal of controlled drugs kept by the resident for self-administration.

9.14 Resident and medication factors unsuitable for self- administration of medications.

- Acute confusion.
- Cognitive impairment affecting capacity.
- History of alcohol/drug abuse.
- Mental health conditions affecting the resident's ability.
- Unstable medication regime.
- Variable medications such as warfarin, reducing dosages.
- Short term courses eg. Antibiotics.
- Items requiring refrigeration.
- Once only doses.

9.15 Storage of medications for self-administration:

9.15.1 Medicines for level 2 self- administration must be stored in the resident's locked locker in his/her room. Exceptions include any medication that needs to be kept in the refrigerator, Warfarin, MDAs *(See note above)* short term courses e.g. antibiotics, once only doses.

9.15.2 Medications no longer in use should be removed from the resident's medication cupboard / locker and sent back to pharmacy.

9.15.3 Where a key is lost, all efforts should be made to locate the key. If the key cannot be found after all reasonable efforts have been exhausted, an incident form should be completed and the resident's lock should be changed.

9.15.4 Medications should be supplied on a named resident basis from the pharmacy for the resident.

9.16 Use of Medications for Seizure management.

9.16.1 Each resident who experiences seizures must have an individualized seizure management care plan in place. This plan must include a medication protocol for the management of seizures individualized to the resident.

9.16.2 Seizure management plans and protocols must be developed which outline the following: *(also see The Village Residence Management of Seizures / Epilepsy Policy for further information)*

- The circumstances when it is to be used and the time to wait before administering the medicine
- Dose interval
- The timing of respective doses
- The maximum dosage in a 24-hour period
- Action to be taken if symptoms persist.

9.16.3 If a second dose of medicine is prescribed, then the prescription must state the period of time after administration of the first dose in which the second dose can be administered. The protocol and plan should form part of the resident's care plan.

9.16.4 All nursing staff in The Village Residence receives additional training in the administration of seizure medication during an emergency. (Note Epilepsy Ireland provides training courses for healthcare professionals on the use of emergency seizure medications.)

9.16.5 Medicines used for the management of seizures should be reviewed and evaluated on a regular basis.

(Health Information and Quality Authority, 2015)

9.17 Use of Complimentary Medicines

9.17.1 The Person in Charge will receive written confirmation of qualifications from any person intending to provide complimentary therapy to a resident in The Village Residence.

9.17.2 A registered nurse must contact the resident's general practitioner/medical officer and pharmacist to verify that the therapy is safe for the resident. The nurse must record the details of the verification in the resident's progress notes.

9.17.3 The provision of complimentary therapy for any resident must comply with the requirements for informed consent.

9.18 Use of Oral Nutritional Supplements

9.18.1 Oral nutritional supplements can be considered however the MUST tool assessment should be completed prior to the use of nutritional supplements. The decision to use nutritional supplements should be made in collaboration with the resident's general practitioner/medical officer and /or a dietician and prescribed by the resident's general practitioner/medical officer.

9.18.2 Oral nutritional supplements should not be used as a sole treatment for malnutrition and should always be given in combination with dietary advice and advice on food fortification (HIQA, 2013).

9.18.3 Oral nutritional supplements should not be used as first line treatment. A 'Food First' approach should be used initially.Oral nutritional supplements should only be initiated if first line dietary measures have failed despite adequate duration (4 weeks).

9.18.4 The timing of when oral nutritional supplements are offered to a resident is key. Offering too near to a mealtime may displace a person's natural eating pattern due to feeling satisfied form the oral nutritional supplement. Conversely, offering the supplements too soon after a meal may result in poor compliance, as the resident may be full from their meal (HIQA, 2013).

Please refer to the policy on Appropriate use of Oral Nutritional Supplements

9.19 Management of Adverse Events.

9.19.1 An adverse event is defined as:

'a response to a drug that is noxious and unintended reaction at doses normally used in man for prophylaxis, diagnosis of therapy of disease or for the restoration, correction or modification of physiological function (EEC Directive, 2001 cited in An Bord Altranais, 2007).

9.19.2 Possible indicators of adverse effects of medications include:

- Change in Vital signs
- Lethargy
- Drowsiness
- Rash
- Unsteady gait
- Aggression
- Falls
- Behaviour change
- Blood results.
- Change in resident's condition.

- Bleeding

This list is not exhaustive.

9.19.3 Where an adverse event is suspected, the well-being of the resident should be paramount and the nurse must take appropriate action to remedy any harm caused by reaction.

9.19.4 The nurse should notify the resident's prescriber/general practitioner/medical officer about any adverse event / reaction to any medicine.

9.19.5 All suspected reactions to new products and serious suspected reactions to established medicines should be notified to the Health Products Regulatory Authority on their report forms, which can be downloaded from www.hpra.ie

9.19.6 The nurse noting the reaction should liaise with the resident's prescriber/general practitioner/medical officer about submission of any report to the Health Products Regulatory Authority.

9.19.7 Reactions to any medicine and measures taken to remedy any harm caused by the reaction should be recorded in the resident's notes.

9.19.8 If reaction to a medicine is confirmed, a 'warning' should be placed in the appropriate space provided on the first page of the resident's record.

9.20 Management of Medication Errors.

9.20.1 The nurse should establish that a medication error has occurred and assess the level of error so as to determine the action required, which may be one or more of the following:

- Emergency action involving resuscitation and possible transfer to the acute hospital.
- Continuing monitoring of the resident's clinical condition.
- Remedial action to avoid further error.
- Single or ongoing documentation.
- Error defined and corrected.

9.20.2 All medication errors, omissions and near miss events should be reported to *the medical officer* as soon as is reasonably practical and a Medication Incident / Error Form should be completed and signed by the person who noted the error.

9.21 For all medication errors that have reached the resident and require measures to prevent, monitor or treat harm, the following procedure must be followed:

- Upon noticing the medication error the resident's clinical condition must be assessed.
- The person who detected the error must inform the person in charge or his/her Deputy on duty in her absence.

- Based on the resident's clinical condition, the nurse in charge will decide on the appropriate course of action.
- The resident's general practitioner/medical officer should be notified. The timing of notification of the GP will depend on the seriousness of the error and the resident's condition.

9.21.1 The poisons unit in Beaumont Hospital /National Medicines Information Centre, St. James Hospital can be contacted for any advice or guidance that may be required.

9.21.2 Errors should be recorded on a Medication Incident /Error form (NIMS) by the nurse who noted the error. Details of the error and effect if any, to the resident and any resultant treatment should be recorded in the resident's progress notes.

9.21.3 Where the resident required emergency treatment and transfer to the acute hospital, the resident's family / next of kin should be informed.

9.21.4 The completed incident report form must be reviewed by the person in charge

9.21.5 All medication errors that resulted in harm to a resident should be investigated by the *CNM 2. The in*vestigation should identify:

- The circumstances and context of the error.
- The stage at which the error took place.
- Review of documentation.
- Environmental factors.
- Resident factors.
- Organisational factors such as policies/procedures/training.
- Human factors

9.21.6 The findings and outcomes of the investigation should be documented.

9.21.7 Medication errors will be reviewed by the *clinical governance committee* at each meeting.

9.21.8 Medication errors that do not result in harm but occur frequently must also be investigated using root cause analysis by the *clinical governance committee.*

10.0 Audit of medication Management.

10.1.1 Audit of medication management practices are carried out on a scheduled basis. These include prescribing; administration and audit of medication needs care plans.

10.1.2 Use of psychotropic and antibiotic usage are audited monthly.

10.2 Procedure for Administration of Subcutaneous Injections

10.2.1 The subcutaneous route is preferred for a slow, sustained release of medication, with up to 1-2ml being injected into the subcutaneous tissue (RCN, 1999)

10.2.2 Prepare clean tray/ receiver with subcutaneous needle and syringe, alcohol swabs and drug vial. The preparation and administration of drugs should be performed by the same nurse.

10.2.3 Check that the packaging of all equipment is intact.

10.2.4 Wash hands as per hand washing procedure.

10.2.5 Check the '10 Rights' of Drug Administration and verify with another nurse

10.2.6 Inspect vial/ solution for cloudiness or particle matter and expiry date and verify with another nurse.

10.2.7 Clean the rubber cap with alcohol swab and draw up the prescribed amount of solution.

10.2.8 Change the needle (correct needle size for the drug) and tap the syringe to dislodge any air bubbles. Expel air.

10.2.9 Dispose of used needle in appropriate sharps container.

10.2.10 Explain and discuss procedure with resident.

10.2.11 Assist resident into required position and remove appropriate clothing to expose site.

10.2.12 Clean chosen site with an alcohol swab for 30 seconds and allow to dry for at least 30 seconds.

10.2.13 Gently pinch skin up into a fold so as to lift the adipose tissue away from muscle.

10.2.14 Insert needle into skin at an angle of 45 degrees and release the grasped skin. Inject the drug slowly.

10.2.15 Insulin should be administered at an angle of 90 degrees.

10.2.16 The site for insulin injections should be systematically rotated, that is using upper arms or abdomen for several months before there is a planned move elsewhere in the body (Burden, 1994 cited in RCN, 1999).

10.2.17 Withdraw needle rapidly and apply pressure to any bleeding point.

10.2.18 Make the resident comfortable.

10.2.19 Do not re-sheath the used needle.

10.2.20 Record the administration on appropriate drug administration record sheet.

10.2.21 Dispose of sharps safely in appropriate sharps container.

11.0 Procedure for Administration of Intramuscular Injections.

11.1 Prepare the injection in a clean area, free from interruptions and distractions.

11.2 Collect equipment:

- Resident's Medication Prescription Kardex.
- Medicine Ampoule and diluent if required.

- Appropriate size syringe.
- 21G needle for drawing up medicine or reconstitution (wide bore blunt fill needle may be required for more viscous preparations).
- Appropriate size needle, in accordance with the resident's needs. The needle should be long enough to penetrate the muscle and still leave at least one third of its length exposed to facilitate its removal should it snap from the hub - 21 (green) and 23 (blue) gauge needles are most commonly used.
- Injection tray.
- Non sterile gloves.
- Plasters (check allergy status of resident).
- Ampoule snapper or gauze.
- Alcohol swab (for deep intramuscular injections or where required by local policy).
- Sharps container.

11.2.1 Check the 5 rights against the resident's prescription with a second nurse or healthcare assistant.

11.2.2 Check the expiry date, check for damage to containers including, contamination and that the medication has been stored in line with manufacturer's guidance (e.g. in the refrigerator).

11.2.3 Inspect vial/ solution for cloudiness or particle matter and expiry date and verify with another nurse.

11.2.4 Clean hands and put on gloves.

11.2.5 Tap the ampoule gently to dislodge any medicine in the neck.

11.2.6 Snap open the neck of glass ampoules using an ampoule snapper or placing a sterile topical swab over the score line. Hold the ampoule at the base and placing thumb over the score line, and then apply gentle pressure away from the body to snap the top of the ampoule off.

11.2.7 Using the needle, draw the required volume of solution into the syringe. For highly viscous preparations it is may be necessary to draw up using a wide-bore blunt fill needle (e.g. red BD Blunt Fill, 18g (1.2mm) and then carefully swap this for administration needle.

11.2.8 Invert the syringe and tap lightly to aggregate the air bubbles at the needle end. Expel the air carefully.

11.2.9 Replace the needle with the needle to be used for administration and discard the used needle in the sharps container.

11.2.10 When labelling a prepared syringe take care not to obscure the volume graduation markings on the syringe

11.2.11 Keep the ampoule and any unused medicine in the injection tray, until administration is complete to enable further checking procedures to be undertaken.

11.3 For withdrawing solutions or suspensions or for reconstitution, follow manufacturer's instruction.

11.3.1 Having prepared the medicine for injection, place in in the tray / receiver and prepare the resident.

11.3.2 Provide an explanation to the resident and obtain the resident's consent.

11.3.3 Choose an appropriate IM. Injection site according to the resident's needs and preferences.

11.3.4 Assist the resident into the required position and ensure he/she is comfortable.

11.3.5 Inspect the proposed injection site for signs of inflammation, swelling, infection and / or skin lesions. If any of these are present, choose an alternative site.

11.3.6 If site is not dirty, there is no need to clean. If site needs to be cleaned, soap and water can be used.

11.3.7 If using an alcohol swab, swab for 30 seconds and allow drying for a further 30 seconds

11.3.8 For emaciated residents, it may be necessary to 'bunch up' the muscle before injecting.

11.3.9 Pull the skin downwards or to one site at the intended site (Z track technique).

11.3.10 Holding the needle at a 90 degree angle, Commence the injection with the heel of your palm resting on the thumb of the non dominant hand, and by holding the syringe between the thumb and forefinger.

11.3.11 Thrust the needle into the skin.

11.3.12 Pull back the plunger. If no blood is aspirated, depress the plunger and inject the drug slowly at approximately 1ml per ten seconds unless instructions on the medicine specify differently.

11.3.13 Wait for 10 seconds before withdrawing the needle

11.3.14 Withdraw needle rapidly and apply pressure to any bleeding point.

11.3.15 Assist the resident into a comfortable position.

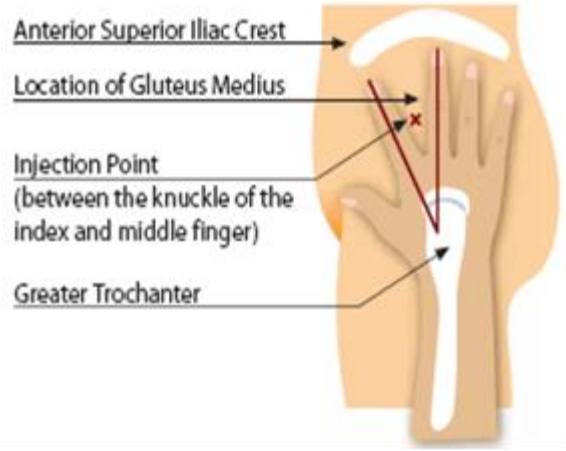
11.3.16 Do not re-sheath the used needle.

11.3.17 Record the administration on drug administration record sheet including the site used. Rotate injection site where injections are repeated frequently.

11.3.18 Dispose of sharps safely in sharps container

11.3.19 If blood is aspirated at stage 15.3.12, withdraw the needle completely, replace it and recommence procedure. Explain to the resident what has happened.

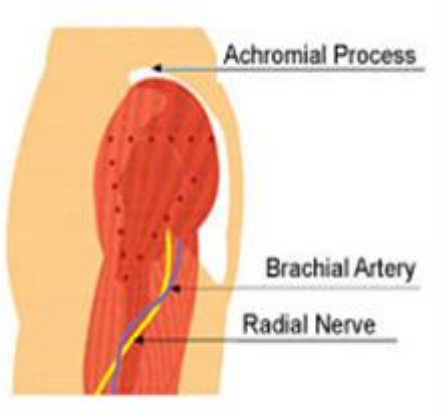
Fig 2: Choosing an Appropriate Intramuscular Injection Site (Cocoman, A. and Murray, J. 2008 and 2010; Greenway 2004).



Ventrogluteal Site:

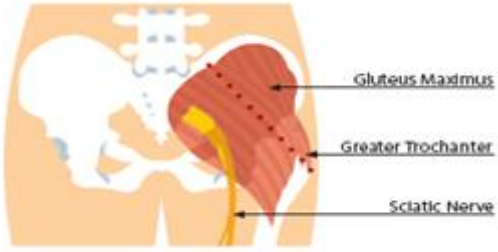
This is now the Preferred Location for IM injections. According to Cocoman, A and Murray, J (2008) 'The contemporary evidence-based literature on IM injection sites highlights the Ventrogluteal Site as the site of choice for IM injections'. This site is relatively free of large penetrating nerves and blood vessels.

- Find the trochanter. It is the knobbly top portion of the long bone in the upper leg (femur). It is about the size of a golf ball.
- Find the anterior iliac crest (the thick curved upper border of the pelvic bone).
- Now place the heel of your opposing hand (i.e. right hand for left hip) on the client's greater trochanter (the bump of bone on the outside of the hip bone).
- The index (second) finger of the hand is placed on the client's anterior superior iliac spine and the middle finger stretched dorsally towards but below the iliac crest.
- The triangle formed by the index finger, the third finger and the crest of the ilium is the injection site ('V')
- The thumb should always be pointed toward the front of the leg. Always use the index finger and middle finger to make the 'V'
- Give the injection between the knuckles on your index and middle fingers.
- Up to 3-4ml of fluid may be given in this site.
- *A standard 21 gauge (1.25) 0.6/30 mm or a 23 gauge (1.5) 0.8/40 mm needle will penetrate muscle at the ventrogluteal site (Greenwood, 2004).*



The Deltoid Site

- Find the knobbly top of the arm (acromion process)
- The top border of an inverted triangle is two finger widths down from the acromion process
- Stretch the skin and then bunch up the muscle
- Insert the needle at a right angle to the skin in of the inverted triangle
- **Caution:** This is a small site – give only 1-2ml or less of fluid in this site.



Least favoured site because of potential injuries to sciatic nerve.

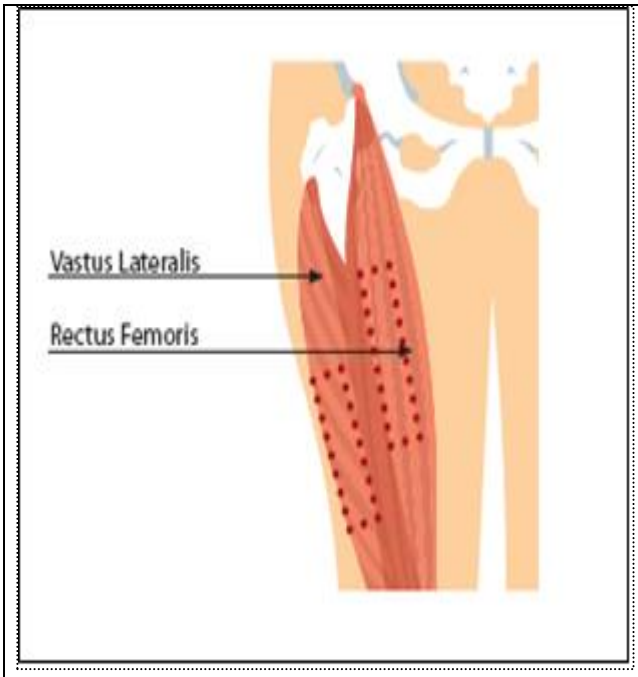
Now recommended that a double cross land-marking be used upper outer quadrant be divided

into quadrants and that the injection be given in

the upper outer quadrant of the upper outer quadrant (Small, 2004 in Cocoman and Murray, 2008).

Dorsogluteal Site (buttock)

- Find the trochanter. It is the knobbly top portion of the long bone in the upper leg (femur). It is the size of a golf ball
- Find the posterior iliac crest. Many people have ‘dimples’ over this bone
- Draw an imaginary line between the two bones
- After locating Boyne View House of the imaginary line, find a point one inch toward the head. This is where (X) to insert the needle
- Stretch the skin tight
- Hold the syringe like a pencil or dart. Insert the needle at a right angle to the skin
- Needle length will depend on the resident’s size – studies have found that drug may not always reach muscle because of varying amount of adipose tissue in this site.
- Up to 3ml of fluid can be given in this site



Vastus lateralis Site

- To find the thigh injection site, make an imaginary box on the upper leg. Find the groin.
- One hand's width below the groin becomes the upper border of the box
- Find the top of knee. One hand's width above the top of the knee becomes the lower border of the box
- Up to 1-5ml of fluid may be given into this site

12.0 Administration of Subcutaneous Fluids (hypodermoclysis)

12.1.1 Subcutaneous fluids are usually prescribed for mild to moderate dehydration, during palliative care or following CVA and any other condition making oral administration difficult. Hypodermoclysis can only be performed by registered nurses who have completed the required training.

12.1.2 Contra- indications for the use of subcutaneous fluids are as follows:

- Fluid overload e.g. cardiac failure
- Marked tissue oedema
- Moderate to severe renal disease
- Severe dehydration, severe electrolyte imbalance
- Shock, circulatory failure
- Phlebitis/ cellulites at the infusion site
- Residents with coagulation disorder.

12.1.3 Prior to the administration of subcutaneous fluids, a full explanation of the reason for same should be discussed with the resident /resident's representative as appropriate by the resident's general practitioner.

12.1.4 Where the resident is unable because of illness to give consent, the decision to administer S.C. fluids will be made by the resident's general

practitioner in consultation with the resident's representative, the person in charge or his/her Deputy on duty.

12.1.5 **Procedure for Hypodermoclysis**

12.1.6 Collect equipment and prepare environment.

- Prescribed fluid
- Administration set
- Small (21g) butterfly cannula
- Transparent occlusive dressing

12.1.7 Explain the procedure to the resident and/or representative, allowing time for any questions.

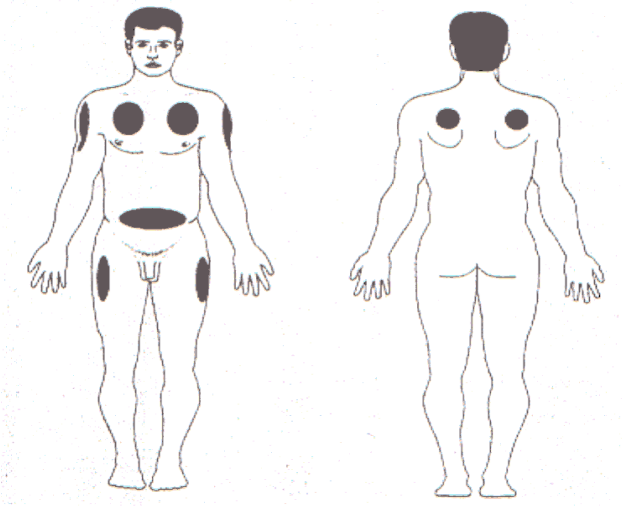
12.1.8 Check the fluid against the prescription chart with another registered nurse. Both nurse should check :

- The prescription is valid
- The fluid name, strength and volume.
- The batch number and expiry date
- The infusion route and rate

12.1.9 Wash and dry hands to minimise the risk of cross infection

12.1.10 Attach the giving set to the infusion fluid and prime giving set and butterfly needle to prevent air bubble formation in the line.

12.1.11 Assess the resident for a suitable site to provide a comfortable and safe area for fluid absorption. The site should be chosen in consultation with the resident. Examples of commonly used sites are:



12.1.12 Subcutaneous fluids should not be sited on:

- Lymphoedematous tissue
- Skin recently irradiated
- Area already with a rash of any type
- Peripheral limbs (below knee or below elbow)

12.1.13 Clean the injection with an alcohol swab for 15 – 30 seconds and allow to dry to reduce the risk of site contamination.

12.1.14 Introduce the butterfly needle at a 45 º angle to provide a comfortable and safe method of fluid administration.

12.1.15 If blood appears in the line on insertion of the needle, withdraw immediately and repeat the process in a different site.

12.1.16 Coil the tubing and secure with a semi permeable film dressing.

12.1.17 Set the infusion at the prescribed rate to ensure the fluid is infused correctly.

12.1.18 Monitor as frequently as possible

12.1.19 Record details of infusion to include:

- Date and time commenced
- Observations of infusion site
- Signature
- Date & time discontinued.

12.2 Care of the Resident Undergoing Hypodermoclysis

12.2.1 As there is a very small risk of abscess formation at the infusion site, at each visit the site and surrounding tissues should be observed for signs of:

- Reddening and inflammation around the site
- Obvious signs of infection
- Excessive oedema
- Hard and/or white skin
- Abscess
- Any signs of blood in the administration set.
- Blood in the butterfly needle.
- Signs of resident discomfort.

12.2.2 The giving set should be changed every 48 hrs.

12.2.3 The infusion should be checked for correctness of rate to reduce the risk of over – infusion. If the fluid has infused too quickly, slow or temporarily stop the infusion to achieve the prescribed rate.

12.2.4 The cannula should be changed at least every 72 hrs. The infusion site should be reviewed regularly for evidence of inflammation or poor absorption. The time taken for this to occur can vary from hours to over 3 weeks. If skin breaks down rapidly, suggestions include:

- Change the infusion device
- Use a different site cleanser
- Change the site dressing

(Marsden, 2006)

12.2.5 If the resident is also receiving subcutaneous medication via a syringe driver, it is advisable to mark the lines to differentiate between the two infusions.

12.3 Procedure for Needle Stick Injury.

12.3.1 Encourage the area to bleed freely by washing under warm running water.

12.3.2 Do not suck the puncture site

12.3.3 Wash the site thoroughly

12.3.4 Apply waterproof dressing.

12.3.5 Where possible the source (resident) should be identified.

12.3.6 Report the incident to the person in charge or his/her Deputy on duty, who will arrange for the staff member to attend hospital.

12.3.7 Blood tests may be obtained from the source where possible (only with the sources consent) and checked for hepatitis B, Hepatitis C, and HIV.

12.3.8 An incident form should be completed at the earliest opportunity.

12.4 Procedure for Administration of Medication via PEG tube.

12.4.1 Check that all medicines to be administered have been verified by the general practitioner/medical officer and/or pharmacist as appropriate for administration via an enteral feeding tube.

12.4.2 If medication is associated with incompatibility, turn off the pump to stop continuous feeding 1-2 hours prior to administration as per the specific medicines being administered.

12.4.3 Check the ‘10 rights’ considerations.

12.4.4 Wash hands and wear gloves prior to administering medication.

12.4.5 Explain the procedure to the resident.

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

- Soluble tablets: dissolve in 10-15mls water.
- Liquids: Shake well. For thick liquids mix with an equal volume of water.
- Tablets: Crush and mix with 10-15mls water.

12.4.7 Volumes less than 10mls can be measured with a 10ml syringe and left aside until the resident is in the correct position. This should then be administered into the barrel of the 50-60ml syringe, the 10ml syringe rinsed with water, which should also be administered into the barrel.

12.4.8 Check for correct tube placement by visually checking the position of the tube.

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

12.4.10 If a pump is being used for continuous feeding, turn it off and clamp the tube. Remove plunger from 60ml syringe and connect it to damp tubing. Follow manufacturer’s instructions for cleaning or use a new syringe each time if the syringe is single use only.

12.4.11 Pour 15-30mls of cooled boiled or sterile water into syringe, open clamp and flush tubing using gravity flow. Clamp tubing once syringe is empty, allowing water to remain in the tube.

12.4.12 Both cooled boiled water and sterile water should be labelled and dated, kept refrigerated and discarded 24hrs after opening.

12.4.13 Put dissolved/diluted/liquid medication into syringe and unclamp tubing, allowing medication to flow by gravity.

12.4.14 Flush tubing with 15-30mls of water or prescribed amount.

12.4.15 If administering more than one medication, flush with 5ml or prescribed amount between each medicine administered.

12.4.16 Clamp tubing and detach syringe.

12.4.17 Check that a break is not needed before recommencing feed

12.4.18 Recommence feed.

12.4.19 Record medications given.

12.5 Procedure for Installation of Eye Drops.

12.5.1 Gather the following equipment:

- Sterile dressing pack and sterile water for irrigation if the resident has an eye infection with discharge.
- Appropriate eye drops
- Low linting swab / moist gauze swab.

12.5.2 Explain and discuss the procedure with the resident.

12.5.3 Consult the resident's prescription sheet and drops and check the following:

- Drug
- Dose
- Date and time
- Expiry date.
- Route and method of administration
- Validity of prescription
- Signature of doctor
- Correct resident
- Correct eye

12.5.4 Ask the resident to look up immediately before instilling the drop.

12.5.5 Hold the inverted dropper in the other hand as close as possible to the eye but ensuring that contact of the dropper with the eyelid will not occur if the resident blinks.

12.5.6 Allow one drop to fall into the outer 1/3 of the conjunctival sac behind the lower lid.

12.5.7 Ask the resident to close eyes for one minute and remove excess drops from beneath the eye with a tissue.

12.5.8 Make the resident comfortable

12.5.9 Discard any used articles.

12.5.10 Replace cap on eye drop container.

12.5.11 Wash hands with bactericidal soap and water or bactericidal alcohol hand rub

12.5.12 Complete the residents recording chart in relevant documentation

12.5.13 Where more than one eye medicine is ordered, allow five minutes between for proper absorption.

12.5.14 If drops and ointment / gel are prescribed, leave administration of ointment gel to last.

12.5.15 Remove the cap from the eye drop container.

12.5.16 Assist the resident into the correct position i.e. head well supported and tilted back

12.5.17 Wash hands with bactericidal soap and water or bactericidal alcohol hand rub

12.5.18 With one finger, draw the lower eyelid down.

12.5.19 For administration of eye ointment, follow the same procedure and apply the ointment by gently squeezing the tube and with the nozzle approx. 2.5cm above the lower lid apply along the inner edge of the lower lid from the nasal corner outward. Warn the resident that there will be a transient blurring of vision for a few minutes.

12.6 Administration of Ear Drops.

12.6.1 Ear drops should only be administered as prescribed by the resident's doctor.

12.6.2 Each step of the procedure should be explained to the resident and their verbal consent obtained.

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

12.6.4 The top of the resident's ear should be extended upwards and outwards to straighten the ear canal.

12.6.5 The filled dropper of oil should be placed over the entrance to the resident's ear canal and squeezed until one drop is instilled. The resident should be instructed to maintain that position for five minutes. Excess drops that pool outside the ear should be wiped off when the resident sits up.

12.6.6 Cotton wool should not be inserted into the entrance of the ear canal as this will absorb the drops. The exception to this is where the manufacturers instruct the use of cotton wool.

12.6.7 If the drops are to be inserted into both ears, steps two to four should be repeated on the opposite side.

In The Village Residence, two staff members must be in attendance when any medicine is being given per rectum or per vagina.

12.7 Procedure for Administration of a Rectal Enema.

12.7.1 Gather the following equipment:

- Disposable protective covering.

- Disposable gloves
- Topical swabs
- Lubricating jelly
- Solution required or commercially prepared enema.

12.7.2 Explain the procedure with the resident ensuring that the resident understands the purpose and nature of the procedure and gives his/her consent to proceed as far as he/she is able.

12.7.3 Check the enema against the resident's prescription sheet

12.7.4 Assemble and prepare the equipment

12.7.5 Warm the enema to body temperature in a container of tepid water

12.7.6 Wash Hands

12.7.7 Ensure that the resident has privacy.

12.7.8 Assist the resident to lie in a left lateral position

12.7.9 Place protective covering under the resident's left side

12.7.10 Put on disposable gloves.

12.7.11 Lubricate the enema tube

12.7.12 Expel the air from the enema tube by squeezing a small amount of fluid up from the reservoir bag containing the enema fluid.

12.7.13 Insert the enema tube in to the rectum in an upward and slightly backward direction for 7.5cm approximately

12.7.14 Administer the warmed enema slowly and gently.

12.7.15 Observe the resident for any signs of discomfort throughout the procedure.

12.7.16 Dry the anal area

12.7.17 Assist the resident into a comfortable position and ensure the resident has access to a toilet or commode.

12.7.18 Observe and record the nature of bowel motion

12.7.19 Dispose /clean equipment.

12.7.20 Remove gloves and wash and dry hands

12.7.21 Record the administration of the medication, its effects on the prescription sheet and in the nursing notes

12.7.22 Report any adverse reactions to the resident's general practitioner/medical officer.

12.8 Procedure for Administration of Suppositories.

12.8.1 Assemble the following equipment.

- Disposable pad
- Disposable gloves
- Topical swabs or tissues
- Lubricating jelly
- Suppository (ies) as per resident's prescription.

12.8.2 Explain and discuss the procedure with the resident ensuring that the resident understands the procedure and gives his/her consent to proceed.

12.8.3 When administering a medicated suppository the nurse should wait until after the resident has emptied his/her bowels.

12.8.4 Check the preparation against the resident's prescription sheet

12.8.5 Ensure the resident's privacy and that the bedpan, commode or toilet is readily available.

12.8.6 Assist the resident to lie in the required position, i.e. on the left side, with the knees flexed, the upper higher than the lower one, with the buttocks near the edge of the bed. This allows for ease of passage of the suppository into the rectum by following the natural anatomy of the colon.

12.8.7 Place a disposable protective covering beneath the resident's hips and buttocks.

12.8.8 Wash hands with bactericidal soap and water or bactericidal rub and put on disposable gloves.

12.8.9 Place some lubricating jelly on the topical swab and lubricate the end of the suppository.

12.8.10 Separate the resident's buttocks and insert the suppository into the rectum in an upward and slightly backward direction advancing it for about 2 – 4 cm.

12.8.11 Once suppository has been inserted, clean any excess lubricating jelly from resident's perineal area.

12.8.12 Ask the resident to retain the suppository for 20 minutes or until he/she is no longer able to do so.

12.8.13 If a medicated suppository is given, remind resident that its aim is not to stimulate evacuation and to retain suppository for at least 20 minutes or as long as possible.

12.8.14 Record administration of the suppository in the resident's prescription sheet and record its effect and the result in the progress notes so as to monitor the resident's bowel function.

12.9 Procedure for Administration of a Vaginal Pessary. (2 STAFF)

12.9.1 Assemble and prepare the equipment

12.9.2 Explain and discuss the procedure with the resident

12.9.3 Check the preparation against the resident's prescription sheet and '5 rights' considerations.

12.9.4 Ensure the resident's privacy.

12.9.5 Wash hands and apply protective gloves.

12.9.6 Assist the resident to lie in a lateral position with the upper knee drawn towards the chest, or into a supine position with the knees flexed, heels together and legs parted.

12.9.7 Place protective covering under the resident's side/buttock

12.9.8 Lubricate the pessary(s)

12.9.9 Insert the pessary(s) along the posterior vaginal wall and into the top of the vagina.

12.9.10 Observe the resident for any signs of discomfort and reassure as required.

12.9.11 Wipe away any excess lubrication from the resident's perineum

12.9.12 Apply a clean sanitary towel

12.9.13 Assist the resident into a comfortable position following the procedure.

12.9.14 Record the administration of the pessary on the resident's medicine administration sheet and in the nursing notes

12.9.15 Monitor for any adverse effects, and report to the resident's doctor/medical officer as required.

12.10 Procedure for Administration of Medicine via a Nebuliser.

12.10.1 Assemble all the equipment required, compressor, nebuliser chamber (cirrus), mask/mouth piece. Prescribed medication for nebulising, resident's prescription sheet, nasal oxygen cannula if required, sputum container.

12.10.2 Explain the procedure to the resident.

12.10.3 Assist the resident into the appropriate, comfortable position.

12.10.4 Provide instruction on breathing techniques during the procedure i.e. every fifth breath should be a deep breath if possible.

12.10.5 Ensure the nebuliser mask is labeled with the resident's name and date.

12.10.6 Ensure the nebuliser chambers do not contain any components that can be easily swallowed.

12.10.7 Fill the nebuliser chamber with the prescribed medication as per the '10 rights' consideration immediately before administration.

12.10.8 Nebulisation time for bronchodilators should be less than 10 minutes. Longer nebulisation may indicate that the equipment is no longer working correctly and will need maintenance.

12.10.9 Nebulisers used for bronchodilators should be disassembled, washed in warm water with weak solution of detergent at least once a week then carefully dried. The nebuliser should be run for a few moments before next use.

12.10.10 Where nebuliser chamber packs are marked by the manufacturer as "single use" they should be discarded; where they are marked "single resident" they may be reusable for that individual resident. Check manufacturer's instructions.

12.10.11 Filters are checked once a month and if discoloured, changed. A record of checking and changing filters must be kept on the unit.

12.10.12 Compressors should be wiped over with soap and water wipe after use to avoid cross infection.

12.11 Application of Transdermal Patches.

12.11.1 Explain the procedure to the resident.

12.11.2 Adhere to the five rights.

12.11.3 Ascertain any special considerations for application of the patch.

12.11.4 Wash and dry hands.

12.11.5 Select site of application, which must be dry and hairless.

12.11.6 Avoid areas where the skin is broken, inflamed or irritated or where there are skin folds, scars or calluses.

12.11.7 Preferable sites are the upper arm, upper trunk or behind the ear.

12.11.8 Sites should be rotated for each application.

12.11.9 Wash and dry the site.

12.11.10 Remove the old patch, fold in half so that adhesive sides stick together and discard in a sharps bin (with purple lid).

12.11.11 Remove the new patch, writing the date, time and initials on the patch.

12.11.12 Peel back the protective layer; apply the exposed side to the resident's skin.

12.11.13 Hold down the side that has been applied with one hand using the other hand to remove the rest of the protective liner.

12.11.14 Press the patch firmly in place with the palm of the hand for approx. 30 seconds.

12.11.15 Wash and dry hands.

12.11.16 Document the application in the resident's medication administration kardex noting also the site used.

NB: Where the resident has significant cognitive impairment and at risk of removing the patch, the patch should be placed on the residents back between the scapulae.

12.12 Procedure for Administration of Topical Medication.

12.12.1 Explain and discuss the procedure with the resident.

12.12.2 Check the resident's medication prescription sheet

12.12.3 Use aseptic technique if skin is broken.

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

12.12.5 If the preparation causes staining, advise the resident of this.

12.12.6 Record the administration in the resident's MAR sheet.

13.0 References:

1. An Bord Altranais (2007). Guidance to Nurses and Midwives on Medication Management. An Bord Altranais: Dublin.
2. Nursing and Midwifery Board of Ireland (2015) Standards for Medicines Management for Nurses and Midwives (Draft for Consultation).
3. Health Act 2007 (Care And Welfare Of Residents In Designated Cottage Hospitals For Older People) Regulations 2013
4. An Bord Altranais (2014). Review of the Scope of Practice for Nursing and Midwifery An Bord Altranais: Dublin.
5. Asperheim, M.K. (1996). Pharmacology: an introductory text 8th Edition. W.B. Saunders Company: Philadelphia.
6. Audit Commission (2001) A Spoonful of Sugar: Medicines Management in NHS Hospitals. Audit Commission: London.
7. Chan, L. (2002) Drug-Nutrient Interaction in Clinical Nutrition. Current opinion in Clinical Nutrition and Metabolic Care 5, 3, 139 – 143.
8. Cocoman, A and Murray, J. (2006) IM injections: How's Your Technique. World of Irish Nursing. April 2006 pp. 50-51
9. Department of Health, UK (2001) Medicines and Older People: Implementing medicines-related aspects of the NSF for Older People. http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle
10. Ward, D (2005) Greater Peterborough Primary Care Partnership, Guidelines for Good Practice: Eye care and Instillation of Eye Drops/Ointment.
11. Griffith, R., Davies R. (2003) Tablet Crushing and the Law: the implications for nursing. Professional Nurse, 19(1) 41-42.
12. Health Information and Quality Authority (2015) Medicines Management Guidelines
13. Health Information and Quality Authority (2009) National Standards for the Care of Older People in Residential Care
14. Health Information and Quality Authority (2014) Guidance for health and social care providers: Principles of good practice in medication reconciliation
15. Health Information and Quality Authority (2013) Provider Guidance: Food and Nutrition.
16. Health Act 2007 (Care and Welfare of Residents in Designated Cottage Hospitals for Older People) Regulations 2013.

17. Health Services Executive, Nursing Homes Ireland and Boots Care Services (2009). Medication Management Templates. Standards for Practice in Residential Care.

18. Mckenry, L. & Salerno, E. (1998). Pharmacology in Nursing 20th Edition. Mosby: St. Louis.

19. Midland Health Board, (2005) Guideline for the Administration of a Pessary accessed: http://www.mhb.ie/mhb/OurServices/PoliciesProceduresGuidelines/Appendix1/CareoftheOlderPersons/d7632.PDF

20. National Coordinating Council for Medication Error Reporting and Prevention, (1998) About Medication Errors accessed at http//www.nccmerp.org

21. National Medicines Information Cottage Hospital, (2002) Adverse Drug Reactions. NMIC publications. Vol. 8(2).

22. Nursing and Midwifery Council, United Kingdom, (2007) Guidelines on the Administration of Medicines. www.nmc-uk.org

23. POWYS NHS Wales, (2008) Procedure for Nebuliser administration in Primary Care and Community Hospital accessed http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=501&id=44548

24. Thomson, F. (2000). Managing Drug Therapy in Patients Receiving Enteral and Parenteral nutrition. Hospital Pharmacist 7, 6 155 – 164.

25. United Kingdom Central Council, (2001) position statement on the covert administration of medicines. www.ukcc.org.uk.

26. Weinstein, S.M. (2000) Plumer's Principles and Practices of Intravenous Therapy. 7th Edition. Lippincott: Philadelphia.

27. Workman, B. (1999) Safe Injection Techniques. Nursing standard 13(39) 47-52.

28. Commission for Social Care Inspection, (2007) Professional Advice: Administration of Medicines in Care Homes accessed at www.csci.org.uk

29. United Kingdom Psychiatric Pharmacy Group, (2001) The Administration of Medication in Food or Drink to People Unable to give Consent to or Refuse Treatment Administered in this way. accessed at: http://www.ukppg.org.uk/tablets-in-food.html

30. National Institute for Health and Clinical Excellence, UK (2004) Treating convulsive status epilepticus in adults.