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Medication Policy Overview

- Garden View Aged Care uses a single-dose 7 days Webster system supplied by an accredited Pharmacy in the individual Resident's name.
- Our 7 days Webster system begins **every Monday**

- Each BLISTER PACK holds the dose to be administered at:
  - Breakfast (8am)- PINK
  - Lunch Time (12noon)- YELLOW
  - Dinner Time (5pm)- ORANGE
  - Bedtime (8pm)- BLUE
  - PRN Medications are held in WHITE
  - S8 medications are held in PURPLE
  - Antibiotics are held in GREEN
  - Cytotoxic are held in PURPLE (& in special plastic bag)

- For safe practice, staff should seek consent by asking resident if they are ready to take the medication (in any form) before pressing them out of the blister packs.
- If they had been punched out and the resident refuses, the staff is to discard the medication in the yellow bin provided by pharmacy and write on medication chart as ® (refused), and same document in the progress notes. The yellow bin has to be kept in the locked treatment room and to be collected by pharmacist.
- When a resident refuses to take the S8 drug which had been checked out of the drug book, the drug should be discarded into the sharp bin by RN and witnessed by the same staff who has witnessed the entire procedure and a second entry into the drug book as refused and discarded and signed by 2 staffs. The medication chart should reflect that the resident refused to take the medication by entry of ®, and same document in the progress notes.
- Medications are prescribed by the LMO and they are dispensed by a Registered Nurse (RN), Endorsed Enrolled Nurse (EEN) or trained competent Certificate III/Certificate IV under the supervision and delegation of the RN.
- All medications are stored in locked medication room out of access from relatives/visitors/residents when not in use. Medication trolleys must be left locked if left unattended. The RN or EEN/Medication delegate is completely responsible for the security of all medication/drug.
- Garden View provides high care needs to our residents and we do not endorse self-medicating by residents. Complementary medication may be given by staffs provided they are approved and written on the medication charts.
- Webster packs are checked by the Saturday and Sunday night RNs; double checked by Monday RNs (especially the Warfarin) before administration.
• As the strength of Warfarin changes with the level of INR of residents, it is important that the residents get the correct dose prescribed by the treating doctor. Two staffs to check the medication for correct dose before giving. Any strength changes by the doctor must be faxed to Pharmacy as soon as possible.

• Incident report to be completed when staff make or find an error in any aspect of the medication management. All necessary actions to be carried out to remedy the problem that could arise from the incident and recorded on the incident report. Investigate and try to find the course of the incident, hence record possible plans to prevent recurrence.

• The completed report to be handed to DDON/DON for further monitoring/action as required and lastly, these incidents reports to be discussed at MAC meeting to analyse any trends, for further actions if needed.

• Medication Chart Codes to be used at this facility: refer to medication chart
  ➢ A = Absent
  ➢ D = Drs Instructions
  ➢ F = Fasting
  ➢ H = Hospital
  ➢ L = Social Leave
  ➢ M = refer to progress notes
  ➢ N = nil stock
  ➢ O = outing (medication with residents)
  ➢ R = refused
  ➢ W = withheld

**Understanding of Medication Policy & Procedure Agreement**

I ______________________________, hereby read on the (Date) __________________ and fully understand this facility's medication Policy and Procedure and will agree to abide them at all times.
I have also received a copy for future reference.

Signature: ________________________________ Position: ________________
STORAGE OF MEDICATION

Policy
All medications obtained from pharmacy or brought in by residents are correctly stored in accordance to legal requirements and that the correct conditions are met in relation to security, storage temperature and stock rotation. (Expiry date checking)

Storage Mandatory Requirements:
1. All medications are stored out of resident and visitor access in a locked cupboard or locked medication trolley or in a locked clinical room.
2. Medications requiring refrigeration, i.e. below 8°C, as indicated on the label should be stored in a refrigerator. All medication is stored in the same container/carton in which it was received from pharmacy. Nursing staff must not remove medication from these packs until immediately before administration to a resident. The temperature of the fridge is monitored and recorded every night by night RN.
3. Resident no longer here or in use to be destroyed/returned to pharmacy. **It should not be kept or used for other residents**
4. During routine administration of medications, the medication trolley is kept within eyesight by the authorised person. If the medication trolley is not within eyesight it should be locked and no medication left accessible.
5. All Webster blister packs are to be placed on metal loop files called Pharma files. Each resident’s medication is separated from the next resident’s medication by a white plastic divider that can carry the resident’s name and room number.
**Medication Administration**

**Policy**
Medications are prescribed and chart by the Local Medical Officer (LMO) and they are dispensed by a Registered Nurse (RN), Endorsed Enrolled Nurse (EEN) or trained competent Certificate III/Certificate IV under the supervision and delegation of the RN

**Medication Administration Mandatory Requirements:**

1. **Identification Medication Chart:**
   - Resident’s Full name
   - Date of Birth
   - Doctor’s Name
   - Allergies
   - Directive as to how the medication is to be given is current & also in NCP
   - Current photograph that clearly resembles the resident’s current appearance
   - Thickened fluid sticker if required
   - Diabetic Red dot sticker if required

2. **Nurse Initiated Chart:**
   - Resident Full Name
   - Date of Birth
   - Allergies
   - Treating Doctor’s Name
   - Doctor’s Signature
   - Valid date (reviewed within the last 12 months by the Doctor)

3. **Medication Charts & Drugs ordered:**
   - Resident’s Full name
   - Date of Birth
   - Allergies
   - Doctor’s name authorising the medication order
   - Drug order
   - Dose
   - Frequency
   - Route
   - Date authorised by Doctor
   - Doctor’s signature authorising the medication
   - PRN medications to specify the max dosage
   - Nursing times are correct with the doctor’s order
   - Medications prescribed by doctor are signed by staff according
• Correct Medication Chart Codes is recorded & documented as specified
• Telephone orders are signed with 24hrs by doctor
• Medications that are ceased is signed off by a doctor
• Medications are blistered or in the original manufacturers packaging/container/bottle/ vial according as per doctor’s medication chart order
• Medications prescribed by the LMO for the resident are not expired.
• Insulin ordered for the resident are dated when opened (valid for 30days)
• Eye drops ordered for the resident are dated when opened (valid for 30days). Eye drops to be re-ordered by the evening RN at the end of the month and the night staff of the last day of the month has to date the new eye drops ready for use and discard the old ones.
• Nurse initiated medications that are regularly initiated by staff have been reviewed by the doctor for regular medication administering

4. **Diabetic Protocol Management:**
   • Each Diabetic Resident to have a protocol
   • Resident’s Name & details (Label sticker is appropriate)
   • In the important section: Doctor’s name is visible
   • Doctor’s Signature
   • Date of authorisation
MEDICATION ADMINISTRATION- ORAL PROCEDURE:

1. Wash and dry their hands before starting and throughout the course of dispensing medications
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the blister pack/drug packaging

2.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

2.2 Right medicine
   - Including checking expiry date

2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt
4. Ask the resident if they are ready to take the medication before pressing them out of the blister directly into the medication cup.
5. Give medication as per instruction on the Medication Identification chart, (including given one by one, crushed and mix with pureed fruit or give with thickened fluids.
6. Must check and ensure residents swallowed their medications successfully
7. Wash & dry hands or use the waterless hand wash
8. Sign after administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:
9. A = Absent
10. D = Drs Instructions
11. F = Fasting
12. H = Hospital
13. L = Social Leave
14. M = refer to progress notes
15. N = nil stock
16. O = outing (medication with residents)
17. R = refused
18. W = withheld
19. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Medication Administration- PRN (as required)

Procedure:
1. Wash and dry their hands before starting of dispensing medications
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the blister pack/drug packaging:

   2.1 Right Resident:
      • By checking the Medication ID Chart for the resident's photograph and asking his/her name (if applicable)
      • Noting and checking to see the resident's allergies

   2.2 Right medicine
      • Including checking expiry date

   2.3 Right dose
   2.4 Right time
   2.5 Right route
   2.6 Right documentation
   2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt
4. Ask the resident if they are ready to take the medication before pressing them out of the blister directly into the medication cup.
5. Give medication as per instruction on the Medication Identification chart, (including given one by one, crushed and mix with pureed fruit or give with thickened fluid.
6. Must check and ensure resident swallowed their medications successfully
7. Wash & dry hands or use waterless hand wash
8. Sign off on the medication chart the PRN medication given, with the time, date and sign off
9. Document in the Residents progress notes your interventions, reason for giving the PRN medication and the outcome of your interventions. Alternatively, document on the “yellow” PRN Progress Note stickers and paste into the Residents progress notes by completing the details on the sticker.
10. Residents requiring regular administration of PRN medications, must be referred to the LMO for further review and investigation and alternatively for daily dose.
11. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Eye drop Procedure:
1. Wash and dry their hands before starting and throughout the course of dispensing medications.
2. Staff must refer to Medication chart and follow the **7 Rights, cross check with the eye drop bottle**
   2.1 Right Resident:
      • By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
      • Noting and checking to see the resident’s allergies
   2.2 Right medicine
      • Including checking expiry date
   2.3 Right dose
   2.4 Right time
   2.5 Right route
   2.6 Right documentation
   2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**
4. Sit resident in comfortable position, obtain consent, explain what you are going to do and ensure privacy.
5. Request resident open eye and look upward, tilting head backwards.
6. Gently pull down the lower lid to form a pouch.
7. Approach the eye from the side and hold the dropper bottle near the lid, but do not touch the eyelid or lashes.
8. Squeeze the bottle, placing the number of drops into pouch.
9. Ask resident to close their eyes, suggest resident does not rub the eye and try to blink for a short time.
10. Apply gentle pressure for a few minutes with a finger to the bridge of the nose to prevent the drops draining from the eye.
11. Blot excess drops around the eye with tissue.
12. Ensure resident is comfortable and vision is not altered.
13. Wash and dry hands or use waterless hand wash.
14. Return eye drops to the correct storage location.
15. Sign after administration on the medication chart at the correct date and time.

Medication Chart Codes to be used at this facility:
16. **A** = Absent
17. **D** = Drs Instructions
18. **F** = Fasting
19. **H** = Hospital
20. **L** = Social Leave
21. **M** = refer to progress notes
22. **N** = nil stock
23. **O** = outing (medication with residents)
24. **R** = refused
25. **W** = withheld
26. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before.
Administration of Eye Ointment Procedure:

1. Wash and dry their hands before starting and throughout the course of dispensing medications
2. Staff must refer to Medication chart and follow the 7 Rights, cross check with the eye ointment tube

2.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

2.2 Right medicine
   - Including checking expiry date

2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**

4. Sit resident in comfortable position, obtain consent, explain what you are going to do and ensure privacy

5. Squeeze out about 1cm of ointment onto swab & discard

6. Request resident open eye and look upward, tilting head backwards.

7. Gently pull down the lower lid to form a pouch

8. Approach the eye from the side and hold the ointment tube near the lid, but do not touch the eyelid or lashes.

9. Squeeze the tube, placing 1cm to 1.5cm into pouch

10. Close the eyelids; suggest resident does not rub the eye.

11. Wipe away any excess with a gauze swab

12. Ensure resident is comfortable and vision is not altered

13. Wash and dry hands or use waterless hand wash

14. Return eye ointment to the correct storage location

15. Sign after administration on the medication chart at the correct date and time

**Medication Chart Codes** to be used at this facility:

16. A = Absent
17. D = Drs Instructions
18. F = Fasting
19. H = Hospital
20. L = Social Leave
21. M = refer to progress notes
22. N = nil stock
23. O = outing (medication with residents)
24. R = refused
25. W = withheld

26. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
ADMINISTRATION OF EAR DROP PROCEDURE:

1. Wash and dry their hands before starting and throughout the course of dispensing medications.
2. Staff must refer to Medication chart and follow the 7 Rights, cross check with the ear drop bottle.
   2.1 Right Resident:
      - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
      - Noting and checking to see the resident’s allergies
   2.2 Right medicine:
      - Including checking expiry date
   2.3 Right dose
   2.4 Right time
   2.5 Right route
   2.6 Right documentation
   2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt.
4. Lie the resident in comfortable position on the side with a towel or blue sheet under the head, obtain consent, explain what you are going to do and ensure privacy.
5. Gently pull the outside of the ear up & back.
6. Administer the number of eardrops prescribed, trying to get drops to fall against the sides of the ear canal.
7. Gently massage, or apply pressure to the area in front of the ear on the side of the face.
8. Wipe away excess drops with a gauze.
9. If prescribed, place a cotton wool swab loosely into the ear.
10. Ensure resident is comfortable, remove towel if used.
11. Wash and dry hands or use waterless hand wash.
12. Return ear drop to the correct storage location.
13. Sign after administration on the medication chart at the correct date and time.

Medication Chart Codes to be used at this facility:

14. A = Absent
15. D = Drs Instructions
16. F = Fasting
17. H = Hospital
18. L = Social Leave
19. M = refer to progress notes
20. N = nil stock
21. O = outing (medication with residents)
22. R = refused
23. W = withheld
24. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Nasal Spray Procedure:
1. Wash and dry their hands before starting dispensing medications
2. Staff must refer to Medication chart and follow the 7 Rights, cross check with the nasal spray bottle
2.1 Right Resident:
   • By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   • Noting and checking to see the resident’s allergies
2.2 Right medicine
   • Including checking expiry date
2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**
4. Sit the resident in comfortable position, obtain consent, explain what you are going to do and ensure privacy
5. Request resident to clear nose by gently blowing on a tissue paper
6. Shake the nasal spray before each use, remove cover from nozzle
7. Insert spray nozzle into the nostril and block other nostril and while sniffing gently, tilt head slightly forward and keeping bottle upright.
8. Press firmly down on collar of bottle, requesting resident to breathe gently inwards through the nostril, inhaling the spray.
9. Repeat in the other nostril if necessary
10. Replace cap on nozzle
11. Wash and dry hands or use waterless hand wash
12. Return nasal spray to the correct storage location
13. Sign after successful administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:
14. A = Absent
15. D = Drs Instructions
16. F = Fasting
17. H = Hospital
18. L = Social Leave
19. M = refer to progress notes
20. N = nil stock
21. O = outing (medication with residents)
22. R = refused
23. W = withheld

24. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
ADMINISTRATION OF LIQUID MEDICATION PROCEDURE:

1. Wash and dry their hands before starting dispensing medications.
2. Staff must refer to Medication chart and follow the **7 Rights, cross check with the liquid bottle**
   
   2.1 Right Resident:
   
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

   2.2 Right medicine
   
   - Including checking expiry date

   2.3 Right dose

   2.4 Right time

   2.5 Right route

   2.6 Right documentation

   2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**

4. **Ask if the resident is ready to take the medication before measuring the medication.**

5. Pour the liquid into measuring cup in (mLs), check the measurement at eye level

6. Inform resident of their medications, provide fluids and encouragement

7. Must check and ensure resident has successfully swallowed their medications

8. Wash and dry hands or use waterless hand wash

9. Sign after administration on the medication chart at the correct date and time

**Medication Chart Codes** to be used at this facility:

9. A = Absent
10. D = Drs Instructions
11. F = Fasting
12. H = Hospital
13. L = Social Leave
14. M = refer to progress notes
15. N = nil stock
16. O = outing (medication with residents)
17. R = refused
18. W = withheld

19. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Inhaler/Puffer Procedure:

1. Wash and dry their hands before starting and throughout the course of dispensing medications.

2. Staff must refer to Medication chart and follow the **7 Rights, cross check with the inhaler/puffer**
   - **Right Resident:**
     - By checking the Medication ID Chart for the resident's photograph and asking his/her name (if applicable)
     - Noting and checking to see the resident’s allergies
   - **Right medicine**
     - Including checking expiry date
   - **Right dose**
   - **Right time**
   - **Right route**
   - **Right documentation**
   - **Right reason**

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**

4. Sit Resident in comfortable position, ask the resident for consent, ensuring privacy.

5. Remove the cap from the inhaler and shake the inhaler holding between thumb & first finger with the mouthpiece at the bottom

6. Ask resident to breathe out slowly & fully, don’t force the air out.

7. Place the inhaler well into the mouth, placing lips firmly around it.

8. Resident to slightly tilt head back and to start breathing in, at the same time press the canister down into the base of the inhaler.

9. Resident to breathe in deeply as spray reaches the lungs

10. Resident to hold breathe for about 10 seconds and then remove the inhaler and ask the resident to breathe out slowly

11. Repeat steps for extra doses if needed, waiting a minute or more before use of next inhaler.

12. Replace the cap on the inhaler/puffer

13. Provide oral fluids and encouragement

14. Must check and ensure residents has successful inhaled their medications

15. Wash and dry hands or use waterless hand wash

16. Sign after administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:

17. **A** = Absent

9. **D** = Drs Instructions

10. **F** = Fasting

11. **H** = Hospital

12. **L** = Social Leave

13. **M** = refer to progress notes

14. **N** = nil stock

15. **O** = outing (medication with residents)

16. **R** = refused

17. **W** = withheld

18. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Turbohaler Procedure:
1. Wash and dry their hands before starting dispensing medications
2. Staff must refer to Medication chart and follow the 7 Rights, cross check with the Turbohaler
   2.1 Right Resident:
      • By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
      • Noting and checking to see the resident’s allergies
   2.2 Right medicine
      • Including checking expiry date
   2.3 Right dose
   2.4 Right time
   2.5 Right route
   2.6 Right documentation
   2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt
4. Sit Resident in comfortable position, ask the resident for consent, ensuring privacy.
5. Unscrew the cap from the turbohaler and lift it off.
6. Holding the turbohaler upright with the colored grip downwards (blue/brown), turn the grip one-way as far as it will go, then twist the grip back again until it clicks
7. Ask resident to breath out gently, away from the turbohaler
8. Place the mouthpiece between the resident’s lip and ask the resident to breathe in forcefully and deeply through their mouth
9. Repeat if more that one dose is required
10. Replace the cap and screw it shut
11. Provide oral fluids and encouragement
12. Must check and ensure residents has successful inhaled their medications
13. Wash and dry hands or use waterless hand wash
14. Sign after administration on the medication chart at the correct date and time
Medication Chart Codes to be used at this facility:
15. A = Absent
16. D = Drs Instructions
17. F = Fasting
18. H = Hospital
19. L = Social Leave
20. M = refer to progress notes
21. N = nil stock
22. O = outing (medication with residents)
23. R = refused
24. W = withheld
25. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Accuhaler Device Procedure:

1. Wash and dry their hands before starting dispensing medications
2. Staff must refer to Medication chart and follow the 7 Rights, cross check with the Accuhaler device

2.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

2.2 Right medicine
   - Including checking expiry date

2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**

4. Sit Resident in comfortable position, ask for consent, ensuring privacy.

5. Hold the outer case in one hand and hold the thumb of your outer hand on the thumb grip, push the thumb away from you as far as it will go

6. Hold the accuhaler with the mouthpiece towards you, slide the level away from you, slide the level away from you as far as it will go until it clicks. It is now ready to use. Everytime the lever is pushed back a dose is made available for inhaling

7. Ask resident to breathe out as far as possible, NEVER breath INTO the accuhaler

8. Place the accuhaler to the resident’s lips and ask them to breathe in steadily and deeply through the accuhaler not through their nose

9. Remove the accuhaler, Resident to hold their breathe for about 10 seconds or as long as possible

10. Resident to breathe out slowly

11. Repeat if another dose is required, sliding lever down to reload dose

12. Close the accuhaler by pushing the thumb grip back into place.

13. Provide oral fluids and encouragement

14. Must check and ensure residents has successful inhaled their medications

15. Wash and dry hands or use waterless hand wash

16. Sign after administration on the medication chart at the correct date and time

**Medication Chart Codes to be used at this facility:**

17. **A** = Absent
18. **D** = Drs Instructions
19. **F** = Fasting
20. **H** = Hospital
21. **L** = Social Leave
22. **M** = refer to progress notes
23. **N** = nil stock
24. **O** = outing (medication with residents)
25. **R** = refused
26. **W** = withheld

27. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
**Administration of Spiriva via Handihaler Procedure:**

1. Wash and dry their hands before starting dispensing medications
2. Staff must refer to Medication chart and follow the **7 Rights, cross check with the Spirvia box & Resident's own handihaler**

### 2.1 Right Resident:
- By checking the Medication ID Chart for the resident's photograph and asking his/her name (if applicable)
- Noting and checking to see the resident’s allergies

### 2.2 Right medicine
- Including checking expiry date

### 2.3 Right dose

### 2.4 Right time

### 2.5 Right route

### 2.6 Right documentation

### 2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**

4. Insert the capsule in the centre chamber of the handihaler and close the mouthpiece firmly until you hear a click

5. Sit Resident in comfortable position, ask for consent, ensuring privacy

6. Hold the handihaler upwards and press the green piercing button all the way in until it release back. **Never press the green button more than once**

7. Hold the handihaler device upright and position the mouthpiece, closing the Resident's lips tightly around the mouthpiece

8. Ensure hands are not covering the air vents at the bottom of the device.

9. Ask resident to keep their head upright and breathe in slowly and deeply but at a rate to hear or feel the capsule vibrate.

10. Ask the resident to hold their breath as long as is comfortable while removing the handihaler from their mouth

11. Provide oral fluids and encouragement

12. Must check and ensure residents has successful inhaled their medications

13. Discard the capsule from the centre chamber. When necessary clean &rinse the handihaler with warm water. It takes 24hrs to air dry

14. Wash and dry hands or use waterless hand wash

15. Sign after administration on the medication chart at the correct date and time

**Medication Chart Codes to be used at this facility:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Absent</td>
</tr>
<tr>
<td>D</td>
<td>Drs Instructions</td>
</tr>
<tr>
<td>F</td>
<td>Fasting</td>
</tr>
<tr>
<td>H</td>
<td>Hospital</td>
</tr>
<tr>
<td>L</td>
<td>Social Leave</td>
</tr>
<tr>
<td>M</td>
<td>refer to progress notes</td>
</tr>
<tr>
<td>N</td>
<td>nil stock</td>
</tr>
<tr>
<td>O</td>
<td>outing (medication with residents)</td>
</tr>
<tr>
<td>R</td>
<td>refused</td>
</tr>
<tr>
<td>W</td>
<td>withheld</td>
</tr>
</tbody>
</table>

26. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Nebuliser Procedure:
1. Wash and dry their hands before starting dispensing medications
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the nebul
2.1 Right Resident:
   • By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   • Noting and checking to see the resident’s allergies
2.2 Right medicine
   • Including checking expiry date
2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt
4. Inform resident of their medications
5. Sit resident in comfortable position with nebulizer near power point, obtain consent and explain what you are going to do, ensuring privacy
6. Open nebulizer the bowl, and place solution of nebul (s) into bowl, screw back top of bowl & mask/mouth piece.
7. Switch nebulizer machine after 5-10 minutes, your presence or you may continually need to supervise residents that present to be difficult
8. Remove mask or mouthpiece from resident
9. Take the mask and bowl, rinse with warm water and allow to drip dry.
10. If steroid is nebulized, cover resident’s eyes with damp cloth, while machine is nebulizing, and rinse face after use.
11. Provide Resident with oral fluids and encouragement
12. Must check and ensure residents has successfully completed their medications
13. Wash & dry hands or use the waterless hand wash
14. Sign after administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:
15. A = Absent
16. D = Drs Instructions
17. F = Fasting
18. H = Hospital
19. L = Social Leave
20. M = refer to progress notes
21. N = nil stock
22. O = outing (medication with residents)
23. R = refused
24. W = withheld
25. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Patches Procedure:

1. Wash and dry their hands before starting dispensing medications.
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the Patch packaging.

2.1 Right Resident:
- By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
- Noting and checking to see the resident’s allergies

2.2 Right medicine
- Including checking expiry date

2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt.
4. Inform resident of their medications and obtain consent.
5. Sit the resident in a comfortable position explain to the resident what you are going to do, ensuring privacy.
6. Check the resident’s skin is clean, dry & non-oily
7. **Do Not** apply patch onto same site as previous application
8. Take the backing off half the patch
9. As you apply the patch on the skin, peel the rest of the backing
10. Do not touch the sticky side of the patch, applying immediately after opening
11. Press firmly in place for about 10 seconds, making sure it sticks well
12. Must check and ensure residents patch is successfully applied
13. Wash & dry hands or use the waterless hand wash
14. Sign after administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:

15. A = Absent
16. D = Drs Instructions
17. F = Fasting
18. H = Hospital
19. L = Social Leave
20. M = refer to progress notes
21. N = nil stock
22. O = outing (medication with residents)
23. R = refused
24. W = withheld
25. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Administration of Topical cream/ointment Procedure:

1. Wash and dry their hands before starting dispensing medications.
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the packaging.

2.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

2.8 Right medicine
   - Including checking expiry date

2.9 Right dose
2.10 Right time
2.11 Right route
2.12 Right documentation
2.13 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt.

4. Inform resident of their medications and obtain consent.

5. Sit the resident in a comfortable position explain to the resident what you are going to do, ensuring privacy.
   6. Check the resident’s skin is clean, dry & non-oily
   7. Apply to affected area as per recommendation on the pack/tube.
   8. Take the top off.
   9. Apply amount as recommended and rub in if recommended.

10. Wash & dry hands or use the waterless hand wash
11. Sign after administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:

12. A = Absent
13. D = Drs Instructions
14. F = Fasting
15. H = Hospital
16. L = Social Leave
17. M = refer to progress notes
18. N = nil stock
19. O = outing (medication with residents)
20. R = refused
21. W = withheld
22. Monitor redness or rash on applied skin for any reaction.
Administration of Suppository Procedure:

1. Wash and dry their hands before starting dispensing medications
2. Staff must refer to Medication chart and follow the **7 Rights, cross check with the suppository packaging**
   2.1 Right Resident:
      - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
      - Noting and checking to see the resident’s allergies
   2.2 Right medicine
      - Including checking expiry date
   2.3 Right dose
   2.4 Right time
   2.5 Right route
   2.6 Right documentation
   2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**
4. Obtain consent & lie the resident in comfortable position on the side with a blue sheet underneath, explain what you are going to do and ensure privacy
5. Ensure they are covered with sheet uncovering only the buttocks
6. Put on a non-sterile glove, remove wrapper from suppository
7. Lubricate finger & suppository
8. Gently insert the suppository by directing it with the finger, through the anus approximately 3\(\frac{1}{2}\) cm into the rectum.
9. During the insertion, ask resident to take deep breaths through their mouth.
10. Encourage resident to retain suppository for the correct length of time. A suppository inserted to cause a bowel action should be retained for 20 minutes.
11. Make sure resident has easy access to toilet facilities or staff are aware of the suppository and toileting needs
12. Remove gloves and wrappings
13. Ensure resident is comfortable and nurse call bell is within easy reach
14. Wash and dry hands.
15. Sign after administration on the medication chart at the correct date and time

**Medication Chart Codes** to be used at this facility:

16. A = Absent
17. D = Drs Instructions
18. F = Fasting
19. H = Hospital
20. L = Social Leave
21. M = refer to progress notes
22. N = nil stock
23. O = outing (medication with residents)
24. R = refused
25. W = withheld
26. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before
Emergency Medications

Policy
The Director of Nursing approves our emergency medication stock after being determined by our Medication Advisory Committee. Any insufficient stock or expiry of stock must be reported to the Director of Nursing for immediate replacement.

Emergency Mandatory Requirements:

1. **Emergency Ward stock (injection)** | **Location of Stock**
   - Adrenaline 1mg/ml (1 Box) | Emergency Box
   - Maxolon Injection 10mg/2mls. (1 Box) | Emergency Box
   - Stemetil Injection 12.5mg/ml (1 Box) | Emergency Box
   - Valium Injection 10mg/2mls (1 Box) | Emergency Box
   - Furosemide 20mg/10ml (5 amps) | Emergency Box
   - Morphine 10mg/ml (5 amps) | S8 Cupboard

2. **Antibiotic Ward Stock**

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin 500mg</td>
<td>Alphamox, Amoxil</td>
</tr>
<tr>
<td>Amoxicillin 250mg</td>
<td>Alphamox, Amoxil</td>
</tr>
<tr>
<td>Cephalexin 500mg caps</td>
<td>Ibilex, Keflex</td>
</tr>
<tr>
<td>Cephalexin 250mg caps</td>
<td>Ibilex, Keflex</td>
</tr>
<tr>
<td>Amoxicillin-Potassium Clavulanate 875mg</td>
<td>Augmentin Duo Forte, Clamoxyl Duo Forte</td>
</tr>
<tr>
<td>Roxithromycin 300mg</td>
<td>Rulide, Biaxsig</td>
</tr>
<tr>
<td>Roxithromycin 150mg</td>
<td>Rulide, Biaxsig</td>
</tr>
<tr>
<td>Trimethoprim 300mg</td>
<td>Alprim.Triprim</td>
</tr>
<tr>
<td>Augmentin Duo Suspension</td>
<td>Augmentin, Clamoxil, Clavulin</td>
</tr>
<tr>
<td>Cephalexin 250mg/5ml Syrup</td>
<td>Ibilex, Keflex</td>
</tr>
<tr>
<td>Amoxicillin 250mg/5ml Suspension</td>
<td>Alphamox, Amoxil, Cilamox, Moxaxin</td>
</tr>
<tr>
<td>Clarithromycin 250mg</td>
<td>Klacid</td>
</tr>
<tr>
<td>Metronidizole 400mg</td>
<td>Flagyl</td>
</tr>
</tbody>
</table>

3. Emergency drugs/Antibiotics must be supplied by a pharmacist only in the manufacturer's original pack

4. Emergency stock and Antibiotic stock is **checked monthly** for sufficient stock with the exception of Morphine (S8 24hr check)

5. Emergency and Antibiotic stock is available, stored in the correct location and has not expired

6. **RN only** to remove/administer from the Emergency stock/Antibiotic stock one dose at a time as required. Recorded in Emergency/Antibiotic Register (Morphine emergency stock must be recorded in the Schedule 8 Register as per S8 policy & procedure)
Emergency stock or Antibiotic Procedure:

1. Emergency drugs/Antibiotics must be supplied by a pharmacist only in the manufacturer's original pack.
2. Emergency stock and Antibiotic stock is checked monthly for sufficient stock.
3. Check for expiry and report one month prior to expire to the Director of Nursing or Care Manager for replacement of stock.
4. Once medication stock is prescribed by the LMO outside of pharmacy operating hours, or delayed deliver or when the resident condition is critical then commence from the Emergency medication stock or Antibiotic stock immediately.
5. RN only to remove/administer from the Emergency stock/Antibiotic stock.
   Medication nurses/PCW can assist and to notify the RN.
6. Wash and dry their hands before starting.
7. Staff must refer to medication chart and follow the 7 Rights, cross check with the blister pack/drug packaging.
   7.1 Right Resident:
      - By checking the Medication ID Chart for the resident's photograph and asking his/her name (if applicable)
      - Noting and checking to see the resident's allergies
   7.2 Right medicine
      - Including checking expiry date
   7.3 Right dose
   7.4 Right time
   7.5 Right route
   7.6 Right documentation
   7.7 Right reason
8. Record in the Emergency/Antibiotic Register (Morphine emergency stock must be recorded in the Schedule 8 Register & S8 policy & procedure must be followed).
   The following details are required
   8.1 The date & time of day
   8.2 The Resident's name (When administering to the resident), or Check or Correct (When Checking Balance records) or Received from Pharmacy
   8.3 The amount given when administered to the resident or the amount received from the amount discarded (if applicable)
   8.4 The balance of stock remaining after the transaction is made
   8.5 Signature of person making the entry/administering person
   8.6 Signature of the person witness for (Morphine stock only)
   8.7 Name of the prescriber & Expiry date (for Emergency/Antibiotic Register)
9. RN to Administer the medication to the resident
10. Wash & dry hands or use waterless hand wash
11. Sign off on medication chart once swallowed by the resident
12. To continue the above procedures until resident's own stock has arrived from pharmacy in their own name.
Schedule Substances of Drugs of Addiction

Policy
Medication of controlled substances must be carefully monitored and accurately recorded with the NSW legislation regulations.

Schedule Substances of Drugs of Addiction Mandatory Requirements:

1.2 Storage of Scheduled Substances
- Drugs of addiction (S8/S4) must be to be securely stored in a safe/cupboard that is securely fixed to the premises and kept locked when not in immediate use.
- The S8 key & S4 key can be kept together but must be separate from all other keys
- The key must be at all times be kept with the Registered Nurse on duty on the premises at all times and handover to the next RN on duty/In-charge

1.3 Balance Checks
- S8 stock balance check to be conducted every week on Fridays and recorded in the Drug Register by two RNs or with one RN & one EEN / delegated medication nurse on duty
- Check expiry of drug and report to DON for immediate replacement or destruction
- DON to check the S8 twice a year during March and September

1.4 Destruction of Schedule 8
- S8 to be destroyed by the an Accredited Pharmacist and the Director of Nursing or her substitute Care Manager (Deputy Director of Nursing)
- If after being checked out from Drug records and resident refuses, including crushed DD Drugs, S4 medication and any other medication including the pain patch to be discarded in the yellow bin supplied by the pharmacist. Yellow bin should be taken away by the pharmacist and replaced with a clean one monthly, on the beginning of each month.

1.5 Lost or Missing
- Lost or missing S8 or S4 must be reported to the DON immediately
- Complete a Medication Incident Form
- DON to investigate into the discrepancy and report to the Pharmaceutical Services Branch, NSW Department of Health Phone: (02) 9879 3214, Fax: (02) 9859 5165

1.6 Drug Register
- The Drug register to have a separate page for each resident's type of drug and each strength
- If a mistake is made, it must be left as it is, marked with an asterisk*, the entry rewritten as appropriate and note explaining the error must be made in the margin or at the foot of the page, initialled and dated
- Resident drug Index page is updated with correct pages
- The Drug register must include the following detail:
  - The date & time of day
➢ The Resident’s name (When administering to the resident), or Check or Correct (When Checking Balance records) or Received from Hospital/home/Pharmacy (When the S8 is received onto the premises)
➢ The amount given when administered to the resident or the amount received from the amount discarded (if applicable)
➢ The balance of stock remaining after the transaction is made
➢ Signature of person making the entry/administering person
➢ Signature of the person witness
➢ Name of the prescriber

Administering of S8 Procedure:

1. Wash and dry their hands before starting
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the blister pack/drug packaging

2.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

2.2 Right medicine
   - Including checking expiry date

2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason

3 Consult the Doctor immediately if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt

4 The drug register must include the following details
   ➢ The date & time of day
   ➢ The Resident’s name (When administering to the resident), or Check or Correct (When Checking Balance records) or Received from Hospital/home/Pharmacy (When the S8 is received onto the premises)
   ➢ The amount given when administered to the resident or the amount received from the amount discarded (if applicable)
   ➢ The balance of stock remaining after the transaction is made
   ➢ Signature of person making the entry/administering person
   ➢ Signature of the person witness
   ➢ Name of the prescriber

5. S8 must be administered and dispensed by a Registered Nurse and countersigned by a second staff witness who has witnessed the entire procedure of recording, dispensing/receiving and administering/discarding

6. Administer the S8 to the Resident following the 7 rights
7. RN & second witness to ensure resident has successfully swallowed/applied/injected S8
8. If the resident refused to take the S8 drug, then, 2 staffs should witness that it is discarded into the sharp bin. A second entry into the drug register book as refused by resident and discarded and signed by 2 staffs. The medication chart should reflect that resident refused medication with entry of ® and document in progress notes of the same problem.

9. In the case when only a portion of the medication is required, the reminding medication discarded into the sharp bin witnessed by 2 staffs and a second entry in the drug book to state the amount discarded, signed by 2 staffs.

10. Wash & Dry hands or use waterless hand wash

11. RN to sign Medication Chart after administering to resident on the medication chart at the correct date and time

12. To notify the DON or Care Manager of any ceased or deceased residents that needs to be destroyed as soon as possible

13. S8 must be dispensed from the Resident’s own individual stock that has dispensed by a Pharmacist or using the facility’s emergency ward stock (Morphine ampoules only)
NURSE INITIATED MEDICATIONS

Policy
Staff are permitted to give initiate medications as specified on the Nurse Initiated Medication Chart, that has been approved by our Medication Advisory committee (MAC).

Nurse Initiated Medication Mandatory Requirement:

1. Each individual Resident must have a Nurse Initiated Medication form signed by their LMO and kept with the Resident’s Medication Chart folder.
2. Nurse Initiated Chart must have the following details:
   - Resident Full Name
   - Date of Birth
   - Allergies
   - Treating Doctor’s Name
   - Doctor’s Signature
   - Valid date (reviewed within the last 12 months by the Doctor)
3. Staff must only give Drugs listed on the Nurse Initiated form approved by MAC. However in the absence of valid or doctor’s signature, if the resident has no allergies or other contraindications to the drugs listed, Nurse Initiated Medications maybe given if they are needed urgently.
4. Nurse initiated medications given must be recorded on the Resident’s medication chart under the “Nurse Initiated column” by completing the following details.
   - Drug given
   - Dose
   - Route
   - Date & Time
   - Signature and Reason for giving the medication.
5. Document in the Resident’s progress notes your interventions, reason for the nurse initiating the medication and the outcome of your interventions. Alternatively, document on the “yellow” PRN Progress Note stickers and paste into the Resident’s progress notes by completing the details on the sticker.
6. Residents requiring regular administration of nurse initiated medications, must be referred to the LMO for further review and investigation. Refer to the Dose Protocol on the Nurse Initiated Medication Chart for guidelines of when to contact the LMO.
Administering Nurse Initiated Medication

Procedure:

1. Each individual Resident must have a Nurse Initiated Medication form signed by their LMO and kept with the Resident’s Medication Chart folder. However in the absence of valid nurse initiated form or doctor’s signature, if the resident has no allergies or other contraindications to the drugs listed, Nurse Initiated Medications maybe given if they are needed urgently.

2. Nurse Initiated Medication is valid for 1 year from the date signed by LMO. It is the responsibility of the Registered Nurse or delegated medication person to ensure that the resident Nurse Initiated form is valid and current.

3. The RN or delegated medication person is to refer to Individual Resident’s Nurse Initiated form/chart and follow the 7 Rights and cross check with the ward stock medication/drug.

3.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies

3.2 Right medicine
   - Including checking expiry date

3.3 Right dose
3.4 Right time
3.5 Right route
3.6 Right documentation
3.7 Right reason

4. Once the Nurse initiated medication has been administered to the Resident, wash & dry hands or use waterless hand wash.

5. Record on the Resident’s Medication Chart, in the Nurse Initiated column by completing the following details. Medication given, Dose, Route, Date, Time, Signature and Reason for giving the medication.

6. Document in the Residents progress notes your interventions, reason for the nurse initiating the medication and the outcome of your interventions. Alternatively, document on the “yellow” PRN Progress Note stickers and paste into the Residents progress notes by completing the details on the sticker.

7. Residents requiring regular administration of nurse initiated medications, must be referred to the LMO for further review and investigation. Refer to the Dose Protocol on the Nurse Initiated Medication Chart for guidelines of when to contact the LMO.
INJECTABLE MEDICATIONS

Policy
Vials and ampoules of injected medications are used in accordance with the manufacturer's recommendations and/or the pharmacy providers' directions for storage, administration and disposal. Insulin Nova Pen or refill vials to be dated when opened and discarded 30 days (following month same date).

Insulin Penfill/Nova Pen Procedure:
1. Wash and dry your hands before starting. Waterless hand wash is acceptable.
2. Staff must check the Resident’s Blood Sugar Level (BSL) prior to administering insulin and ensure it is within the Resident’s individual Diabetic Protocol prior to administering insulin.
3. Staff must refer to medication chart and follow the 7 Rights, cross check with the insulin penfill/Novapen
   3.1 Right Resident:
      • By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
      • Noting and checking to see the resident’s allergies
   3.2 Right medicine
      • Including checking expiry date
   3.3 Right dose
   3.4 Right time
   3.5 Right route
   3.6 Right documentation
   3.7 Right reason
4. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt.
5. Obtain consent from the Resident and explain to them the procedure.
6. Resident is sitting or lying a comfortable position, ensuring dignity and privacy.
7. Remove the lid covering the penfill/Novapen, gentle shake the insulin mixture if required.
8. Remove the paper tab off the Novo fine needle and screw onto the penfill/novopen.
9. Remove the Novo fine Needle lid and prime the pen by holding it upright and turn the dial (with the window visible to you) to 1-2 units and press the button fully down/in until it returns to zero (0), drops of insulin will appear. Repeat dialling process if the if not primed.
10. Dial the pen to the correct dosage unit ordered as per medication chart.
11. Insert the needle into the skin, pressing the button down until it returns to zero (0). Continue to keep the needle in the skin for at least 6 seconds to ensure that the full dose has been injected.
12. Appropriate injection sites are, thighs, abdomen or upper arm.
13. Carefully remove the needle by placing the pen with the needle in the groove in the sharps bin to unscrew. Twist pen anti clockwise until needle drops off safely into the sharps bin.
15. Wash and dry hand or waterless hand wash.
16. Sign after administration on the medication chart at the correct date and time.
Intramuscular or Subcutaneous Procedure:
1. Wash and dry their hands before starting the procedure.
2. Staff must refer to medication chart and follow the **7 Rights, cross check with the ampoule or vial order**
   2.1 Right Resident:
      • By checking the Medication ID Chart for the resident's photograph and asking his/her name (if applicable)
      • Noting and checking to see the resident's allergies
   2.2 Right medicine
      • Including checking expiry date
   2.3 Right dose
   2.4 Right time
   2.5 Right route
   2.6 Right documentation
   2.7 Right reason
3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. **Never administer if in doubt**
4. Open the medication ampoule, by protecting your fingers by using a tissue or the sealed alcohol wipe
5. Using a 19g needle draw up the contents of the ampoule, then remove the 19g needle and discard it directly into the sharps bin
6. While holding the syringe, open a 23g needle (intramuscular injection) or a 25G needle (subcut injection) and attach to the syringe. Do not remove the cover of the needle.
7. Expel the air from the syringe until a drop of fluid appears at the tip of the needle under the cover or until the required dose/volume of medication remains in the syringe
8. Place the syringe, needle and alcohol swab in the kidney dish to take to the beside
9. Identify the resident and check the medication and dose in the medication chart again.
10. Obtain consent and explain the procedure to the resident and ensure the dignity and privacy prior to the procedure/repositioning resident if required
11. Open the alcohol swab and clean the skin over the injection site using a circular motion and rotating outwards
12. Injection technique:
   12.1 Subcut- Pinch the skin and insert the needle at an angle of 45 degrees
   12.2 Intramuscular- Stretch the skin and insert the needle at an angle of 90 degrees. Withdraw the plunger slightly. If blood enters the syringe, withdraw the needle a little as it maybe in a blood vessel
13. Intramuscular sites
   • Arm: Deltoid muscle of the upper arm- used for small amounts of medication
   • Thigh: upper antero-lateral aspect
   • Buttock: divide the buttock into four sections. Inject into the upper outer quadrant of the buttocks. Avoid hitting nerve or major blood vessels
14. Inject the drug slowly and remove the needle quickly while placing swab over the site. Place the syringe/needle in the sharps bin. **Never recap a used needle to prevent needle stick injury**

15. Gentle massage the injection site with the swab. Apply pressure for 1-2 minutes to prevent bruising. Leave resident comfortable

16. Wash & dry hands or use waterless hand wash

17. Sign after administration on the medication chart at the correct date and time and other relevant documentation if required
CRUSHING (ALTERING) OF MEDICATION

Policy
If at all possible medication should not be crushed. Any resident who has difficulty swallowing, or is reluctant to swallow tablets, must be reported to LMO for consideration of prescription of medication in a liquid form or alternative preparation of the required medication.

Some tablets and capsules should not be crushed or altered.

Procedure to identifying if medications are Crushable:
1. When resident is experiencing swallowing difficulty or reluctant to swallow tablets, refer to LMO for assessment of swallowing ability and review of medication formulation, change to another medication or stopping medication that are no longer necessary.
2. If the medication does not have liquid form, possible alternative medications that may be supplied in enteric coated capsules or sustained released pellets which may be sprinkled on food provided that the pellets are not crushed or chewed.
3. Consult the pharmacist if alternative is being sought.
4. As a general rule, the following types of tablets should not be crushed:
   - Enteric coated tablets - if a drug is destroyed by gastric acid or is irritating to the gastric mucosa, it is usually enteric coated so that it passes through the stomach intact.
   - Sustained release tablets are also designed not to be crushed. If the tablet is scored then it may be broken in half but not crushed or chewed.

It should be remembered that crushing might shorten the onset of action. Once the tablet is crushed, it should be given promptly in jam or food. The pestle and mortar must be cleaned in between crushing of tablets unless using patty paper cup provided for crushing tablets.

When administering crushed medication, resident should be as upright as possible when having medication. Give sufficient water to swallow the medication and avoid oesophageal irritation

Document the need for crushing tablets for individual Residents Nursing Care Plan and Resident Medication Identification Chart in medication folder.
Medication Policy and Procedure

Medication Administration- Crushing Procedure:
1. Wash and dry their hands before starting and throughout the course of dispensing medications.
2. Staff must refer to medication chart and follow the 7 Rights, cross check with the blister pack/drug packaging.

2.1 Right Resident:
   - By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   - Noting and checking to see the resident’s allergies.

2.2 Right medicine
   - Including checking expiry date

2.3 Right dose
2.4 Right time
2.5 Right route
2.6 Right documentation
2.7 Right reason

3. Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt.
4. Press the contents of the blister(s) directly into the medication cup or disposable muffin cup paper liner.
5. Place the muffin cup paper liner with the medications to be crushed in the mortar and pesto.
6. Place another muffin cup liner on top of the medications and crush.
7. Remove the muffin cup liner and mix with puree fruit, jam and resident’s preference.
8. Inform resident of their medications, provide fluids and encouragement.
9. Must check and ensure residents swallowed their medications successfully.
10. Wash & dry hands or use waterless hand wash.
11. Sign after administration on the medication chart at the correct date and time.

Medication Chart Codes to be used at this facility:
12. A = Absent
13. D = Drs Instructions
14. F = Fasting
15. H = Hospital
16. L = Social Leave
17. M = refer to progress notes
18. N = nil stock
19. O = outing (medication with residents)
20. R = refused
21. W = withheld
22. Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before.
Medication Policy and Procedure

**DIABETIC MANAGEMENT**

**Policy**
All diabetic residents blood sugar levels are controlled within normal ranges as per individual diabetic protocol as specified by LMO.

**Diabetic Management Mandatory Requirement:**
1. All Diabetic Residents must have a Diabetic Management Protocol
2. Diabetic Management Protocol- clearly has the Resident’s Name/details (ID Label sticker is appropriate)
3. Diabetic Management Protocol- In the important section: Doctor’s Name is visible
4. Diabetic Management Protocol- Is signed by the Doctor
5. Diabetic Management Protocol- Date of authorisation
6. Diabetic Management Protocol is reviewed by LMO when necessary
7. Guide for Hyperglycaemia BSL is specified by LMO
8. All Resident insulin dependent have a glucagon kit and is not expired
9. Ward Stock of glucagon x 2 is available and is not expired
10. Opened insulin is dated opened and discarded 30 days from the date of opening
11. Red dot diabetic are located in the following areas/forms
   - Resident Wardrobe ID picture
   - Medication Chart Identification Chart
   - Emergency Kit- Resident Progress Notes
12. Updated Diabetic Register with National diabetes numbers & cards
13. Pharmacy has been informed of updated Diabetic Register
14. Diabetic information is noted on Diet Sheet located in the kitchen
15. Diabetic information is noted on Nutrition & Hydration assessment and NCP
16. Resident on insulin is noted in the NCP under Complex Health or Medication
17. Diabetic resident’s BSL is record as per LMO order ie Daily, TDS, BD, etc.
18. Residents with fluctuated BSL requires additional BSL recorded at before bed (2100hr) and during the night (at around 0200hr).
19. Hypoglycaemia incidents is correctly managed as per individual protocol:
   - BSL is rechecked 15mins until above 4.0mmol/L
   - Complex carbohydrate /next meal given
   - BSL rechecked within 2hours in case of secondary fall
   - Insulin delayed
20. Glucagon sub-cut given is recorded on the Nurse Initiated Medication Chart
21. Clearly documented in Resident’s progress notes & BSL Record chart
22. LMO informed if BSL is <4.0mmol/L for more than 3 consecutive times in 24hrs
23. Regularly frequent hypoglycaemia incidents (ie 3-4 incidents within one month) is reviewed by the LMO
24. Hyperglycaemia incidents is correctly managed as per protocol:
   - Reviewed the meal (ie type of food the resident has had)
   - Repeat BSL prior to resident’s next meal or tea/supper
   - PRN Insulin given if ordered
   - Consecutive high readings, staff or LMO has investigated into infection
Medication Policy and Procedure

Procedure Hypoglycaemia Management for CONSCIOUS:

➢ If BSL is less than 4.0mmol/L and resident is conscious:
1. Give 3 glucose tablets or lemonade 75ml to 150ml or fruit juice 60ml to 120ml
2. BSL rechecked in 15mins
3. If BSL remains below 4.0mmol/L repeat step 1 & 2
4. Complex carbohydrate given if BSL is above 4.0mmol/L ie sandwich, weetbix or next meal if available
5. Delay Insulin until after the complex carbohydrate or when BSL is above 4.0mmol/L
6. LMO authorisation of omitted insulin
7. BSL rechecked within 2 hours in case of secondary fall
8. LMO informed if BSL is below 4.0mmol/L for more than 3 consecutive times in 24hours
9. BSL is correctly recorded on BSL Records chart reflecting the abnormal reading and management
10. Resident progress notes reflects the abnormal reading and the staff’s management

Procedure Hypoglycaemia Management for UNCONSCIOUS:

➢ If BSL is less than 4.0mmol/L and resident is unconscious:
1. Press for emergency assistance
2. Commence resident on 4L/min of oxygen and administer Glucagon 1mg subcut
3. BSL is correctly recorded on BSL Records chart reflecting the abnormal reading and management
4. Repeat BSL every 15mins until resident regains consciousness
5. Repeat Glucagon 1mg subcut in 20mins if BSL remains low
6. Call Emergency paramedics (000) if the resident does not respond to above treatment
7. Resident progress notes, BSL recording chart reflects the abnormal reading and the staff’s management
8. Record the Glucagon subcut given on the nurse initiated medication chart

Procedure Hyperglycaemia Management:
1. Review the resident’s meal (amount and type of food) that was eaten that day
2. Has the resident been out or she/he had any visitors?
3. Repeat the BSL prior to resident’s next meal or tea/supper break
4. Give PRN insulin of ordered as per medication chart if charted.
5. If BSL continues to remain high or abnormal compared to Resident’s last few recording, check resident for signs of infections such as UTIs, and refer to LMO for review.
Medication Policy and Procedure

Sample of Diabetic Protocol Form:

Guide for HYPOGLYCAEMIA Management

B.S.Ls less than ___4___mmol/l

- Review the meals (amount and type of food) that the resident has had that day.
- Has the resident been out or has she/he had any visitors?
- Do Not Omit insulin without LMO authorisation.

Resident conscious & able to eat/drink BSL < 4.0mmol/L

Give 3 Glucose tablets or 75 – 150ml L lemonade or 60-120ml of fruit juice

Recheck BSL in 15mins.

Is BSL ≥ 4.0mmol/L?

- Yes
  - Give complex carbohydrate ie. Sandwich, weetbix or if
  - Recheck BSL within 2 hours in case of secondary

- No
  - Recheck BSL prior to resident’s next meal or tea/supper break

Resident Unconscious & BSL < 4.0mmol/L

Ring Nurse Assist for emergency staff assistance.

Commence 4L/min Oxygen and administer Glucagon 1mg subcut

Repeat BSL every 15mins until the resident regains consciousness

Repeat Glucagon 1mg S/cut in 20mins if BSL remains low

Call Emergency Paramedics (000) if the resident does not respond to treatment.

If the Resident is hypoglycaemic before a meal or when the next insulin injection is due, then delay the insulin administration until after meal and/or correction of the hypoglycaemia.

IMPORTANT: Inform Dr______________ when BSL record is above/below the protocol for more than 3 consecutive times in 24hrs

Doctors Signature: ________________________       Date: _____________

Guide for HYPERGLYCEMIA Management- BSLs more than ______ mmol/l

- Review the meals (amount and type of food) that the resident has had that day.
- Has the resident been out or has she/he had any visitors?
- Repeat BSL prior to resident’s next meal or tea/supper break
- Give PRN insulin if ordered as per medication chart
- Check for signs of infection and refer to LMO if evidence suggests infection.

IMPORTANT: Inform Dr______________ when BSL record is above/below the protocol for more than 3 consecutive times in 24hrs

Doctors Signature: ________________________       Date: _____________
Medication Policy and Procedure

Procedure for Blood Sugar Taking:

**Note: No Test strip code check required using glucometer FreeStyle**

1. Organizes appropriate equipment
2. Wash and dry their hands before starting
3. Checks expiry date of strips and date container opened (if applicable)
4. Ensures machine is clean and functional
5. Addresses resident by preferred name
6. Explain to resident what you plan on doing, obtain consent and ensure privacy through the procedure
7. Comfortably sit or positions resident correctly
8. Place on non-sterile disposable gloves
9. Chooses appropriate site ie finger tip
10. Prepares site appropriately milking or massaging the fingertip and ensure fingertip is clean to prevent abnormal reading. If necessary, clean the resident's finger with a wet paper towel
11. Puncture the finger-tip correctly with a lancet
12. Places drop of blood on strip
13. Wipe blood off punctured site with cotton wool or gauze
14. Wait for the BSL glucometer reading and inform resident of the result
15. Leave resident in a comfortable condition and nil bleeding from finger tip
16. Cleans/ disposes of equipment appropriately
17. Washes and dries hands
18. Record & document on the BSL Record chart
19. Ensure Resident's individual Diabetes Management Protocol of Hypoglycaemia and Hyperglycaemia is managed per LMO order
20. Explain to resident what you plan on doing, obtain consent and ensure privacy through the procedure
21. Comfortably sit or positions resident correctly
22. Place on non-sterile disposable gloves
23. Chooses appropriate site ie finger tip
24. Prepares site appropriately milking or massaging the fingertip and ensure fingertip is clean to prevent abnormal reading. If needed clean resident's if with a wet paper towel
25. Puncture the finger tip correctly with a lancet
26. Places drop of blood on strip
27. Wipe blood off punctured site with cotton wool or gauze
28. Wait for the BSL glucometer reading and inform resident of the result
29. Leave resident in a comfortable condition and nil bleeding from finger tip
30. Cleans/ disposes of equipment appropriately
31. Washes and dries hands
32. Record & document on the BSL Record chart
33. Ensure Resident's individual Diabetes Management Protocol of Hypoglycaemia and Hyperglycaemia is managed per LMO order
Medication Policy and Procedure

Sample of Blood Sugar Level Record:

Blood Sugar Level Records
NAME: Mrs Abc______ DOB: ___30/7/29______________ MRN: ___123_______
Doctor: ___Dr Xyz ___________________
Allergies: ___Penicillin_________ Room Number: _30______________ BSL
Frequency: ___BD_________________

Those with fluctuating BGL to record BGL at 9 am and 2am

<table>
<thead>
<tr>
<th>Date</th>
<th>B.S.L</th>
<th>Before Breakfast</th>
<th>After Breakfast</th>
<th>Before Lunch</th>
<th>After Lunch</th>
<th>Before Dinner</th>
<th>After Dinner</th>
<th>Before Bed 9am</th>
<th>Over Night 2am</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/7/13</td>
<td>B.S.L</td>
<td>6.0</td>
<td>9.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Orange juice given. Rechecked BSL 4.5 &amp; dinner given. BSL repeated 2 hrs later 6.8</td>
</tr>
<tr>
<td>8/7/13</td>
<td>B.S.L</td>
<td>8.0</td>
<td>3.3</td>
<td>6.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/7/13</td>
<td>B.S.L</td>
<td>6.4</td>
<td>8.5</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/7/13</td>
<td>B.S.L</td>
<td>7.0</td>
<td>7.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/7/13</td>
<td>B.S.L</td>
<td>5.9</td>
<td>8.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medication Policy and Procedure
Medication Policy and Procedure

MANAGEMENT OF ANAPHYLAXIS

Procedure:
1. If the resident is unconscious, lay the resident on the left side to keep the airway clear.
2. Give Adrenaline (only by a RN) by deep intra muscular injection unless there is a strong central pulse and the resident’s condition is good. See below for dosage. If there is no improvement in the resident’s condition by 5 minutes, repeat doses should be given then repeat to a maximum of 3 doses.
3. Administer oxygen.
4. Never leave resident alone.
5. If appropriate, begin cardiopulmonary resuscitation.
6. Transfer to hospital if indicated.

ADRENALINE DOSAGE

The recommended dose of 1:1000 Adrenaline is 0.01 mg/kg body weight given by deep intra muscular injection. Adrenaline 1:1000 contains 1 mg of Adrenaline per ml. The following table lists the doses to be used if the weight of the individual is not known.

Doses of 1:1000 (one in one thousand) Adrenaline for infants and children:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>0.05 – 0.1ml</td>
</tr>
<tr>
<td>1 – 2 years (approx. 10kg)</td>
<td>0.1 ml</td>
</tr>
<tr>
<td>2 – 3 years (approx. 15kg)</td>
<td>0.15ml</td>
</tr>
<tr>
<td>4 – 6 years (approx. 20kg)</td>
<td>0.2ml</td>
</tr>
<tr>
<td>7 – 10 years (approx. 30kg)</td>
<td>0.3ml</td>
</tr>
<tr>
<td>11 – 12 years (approx. 40kg)</td>
<td>0.4ml</td>
</tr>
<tr>
<td>12 years and over</td>
<td>0.4 – 1.0ml</td>
</tr>
</tbody>
</table>

1.0 ml is the maximum dose
Medication Policy and Procedure

PARACETAMOL

Policy

Paracetamol is to be administered as indicated and maximum dosage written by VMO

Use of Paracetamol Procedure:

Paracetamol may be used to treat

1. fever where the temperature is over 38 degrees Celsius, and / or
2. pain

Paracetamol is NOT to be used to treat

1. mild fever (38 degrees Celsius or under)
2. gastroenteritis, or
3. as a sedative

The adult oral dosage recommendations

- 500mg to 1000mg every 4 to 6 hours as required.
- No more than 4 gm (8 tablets) should be given in 24 hour period or 60milligrams/kg/day for residents with normal or average build.

Paracetamol Order

- All medication orders for Paracetamol, including PRN orders, must specify a maximum number of doses per day
- The body weight should be considered for residents whose weight are not normal and recommended doses should be adjusted accordingly by VMO when prescribing Paracetamol.
- The doses must be written in milligrams (mg) or grams (g), and not in millilitres (ml).
- Elderly residents should be prescribed reduced dose due to decreased clearance. Ideal dosage should be based on lean body weight (LBW). Formula for LBW is gender and body mass index (BMI) dependent as shown below:
  - LBW Male – 1.1 x Wt – 0.0128 x BMI X Wt
  - LBW Female – 1.071 x Wt – 0.0148 x BWI x Wt

BMI = Weight in kilogram divided by height in centimetres for ages 18 years or over.
Medication Policy and Procedure

HANDLING OF CYTOTOXIC DRUGS

Policy
Cytotoxic drugs are to be handled with adequate precautions to minimise risk associated with occupational low level exposure to cytotoxic drugs. E.g Methoblastin

Administering cytotoxic drugs procedure:
1. Cytotoxic drugs are to be stored at below 30°C
2. Wash and dry their hands before starting and throughout the course of dispensing medications
3. Staff must refer to medication chart and follow the 7 Rights, cross check with the blister pack/drug packaging

3.1 Right Resident:
   • By checking the Medication ID Chart for the resident’s photograph and asking his/her name (if applicable)
   • Noting and checking to see the resident’s allergies

3.2 Right medicine
   • Including checking expiry date

3.3 Right dose

3.4 Right time

3.5 Right route

3.6 Right documentation

3.7 Right reason

Consult the Doctor or Pharmacist if unsure of the timing or frequency of any medications or illegible/unclear medication orders. Never administer if in doubt

4. Use non-touch technique or wear non sterile gloves

5. Press the contents of the blister directly into the medication cup, with a spoon, administering cytotoxic medication to resident.

6. Do not crush tablet when cytotoxic drug is prescribed in tablet form

7. Refer to LMO for alternative form if resident has swallowing difficulty

8. Inform resident of their medications, provide fluids and encouragement

9. Must check and ensure residents swallowed their medications successfully

10. Remove gloves if used, wash hands & dry hands or use waterless hand wash

11. Sign after administration on the medication chart at the correct date and time

Medication Chart Codes to be used at this facility:

12. A = Absent
13. D = Drs Instructions
14. F = Fasting
15. H = Hospital
16. L = Social Leave
17. M = refer to progress notes
18. N = nil stock
19. O = outing (medication with residents)
20. R = refused

GVN.0001.0001.0817
Medication Policy and Procedure

21 W = withheld
22 Complete Medication Incident Form of any medication errors identified, discrepancies or missing signatures from the day before

**Accident or Incident when handling cytotoxic drugs procedure:**

1. When there is accidental direct skin contact with cytotoxic drug, wash skin immediately with soap and lots of water.
2. In case of contact with eyes, flush affected eye with copious amount of water for at least 15 minutes, assure adequate flushing by separating eyelids with fingers.
3. Then call or see a doctor when practical
4. Complete a Medication incident form & Staff Accident/Incident for further follow up and investigation
Medication Policy and Procedure

ORAL METHOTREXATE

Policy

Oral Methotrexate is taken as a single dose once a week or divided dose at 12 hourly intervals over 2 days, once a week.

Safe use of Oral Methotrexate Procedure:

1. When a weekly dose is prescribed, the doctor must specify and write on the medication chart clearly that Methotrexate is to be given once a week, written in full and underline, not abbreviated, and specify the day to be given.
2. Do not choose Monday, as Mon or Monday can be mistaken for Mane.
3. The days on the chart when Methotrexate is not to be given must be scored out.
4. Resident on Methotrexate must be observed and monitored for toxicity or intolerance. Signs of toxicity may present as breathlessness, dry persistent cough, nausea, vomiting, diarrhoea, sore throat, mouth ulcers and bruising.
5. Monitor resident’s renal status during Methotrexate therapy as renal impairment can result in accumulation of Methotrexate.
6. Methotrexate is a folate antagonist. Folic acid is usually prescribed to reduce risk of Methotrexate toxicity. As both tablets are yellow, caution must be exercised so as not to confuse the two tablets, particularly where the dosage instruction differ.
7. Methotrexate must not be kept as an imprested stock in the facility.
8. During administration of medication, where a registered nurse (R.N.) finds the medication order to be unclear or has reason to query the dosage prescribed, he/she must contact the doctor or a pharmacist for clarification before administration.
9. Registered nurse should be equipped to provide counselling on Methotrexate to residents.
10. Counselling to residents on Methotrexate should include:
    a. emphasis on the once a week dosage by naming the day of the week. It should be stressed that additional doses of the medication must not be taken “as needed” for symptom control.
    b. Information on the importance of regular monitoring tests, on symptoms of toxicity.
11. When handling oral methotrexate, R.N. must follow the safety procedure for handling cytotoxic drug and related waste.
Medication Policy and Procedure

MEDICATION FOR RESIDENT ON OUTING WITH RELATIVE

Policy
All medication shall be given to the relative who is accompanying the resident while on outing, as prescribed by the LMO and in accordance with recognised nursing principles and practices.

Procedure:
1. Give the medications required by the resident to relative, in original Webster pack/s or bottle/s when being taken for leave or outing.
2. Explain to relative the time of medication according to Webster pack needed to be given to resident.
3. Educate relative regarding storage of medication during outing.
4. Record on the Medication chart.

Medication Chart Codes to be used at this facility:
5. A = Absent
6. D = Drs Instructions
7. F = Fasting
8. H = Hospital
9. L = Social Leave
10. M = refer to progress notes
11. N = nil stock
12. O = outing (medication with residents)
13. R = refused
14. W = withheld

15. Document in the resident’s progress notes whom the medications were given to any additional information or explanations given to them.
Medication Policy and Procedure

TELEPHONE/FAX/EMAIL ORDERS

Telephone order Procedure:
1. This procedure should be compliant with State laws and regulations. An order that is faxed to Garden View constitutes a telephone order.
2. An order that is verbally communicated to the Registered Nurse and should also be heard by a second respondent to validate the order.
3. The order is then written in ink directly onto the resident’s medication chart, signed and dated by the Registered Nurse & the signature of the second respondent that validated the order.
4. A written entry into the resident’s medication chart should then be made or signed within 24 hours by the LMO.
5. Document in the Resident’s progress notes the telephone order, reason for the order and the outcome of the resident’s condition
6. Write in the Dr’s Communication book to sign the telephone order
7. Alternatively, the LMO can now fax or email the medication order to the facility. This order constitutes a legal order and does not have to be written onto the medication chart within 24 hours. It is up to the discretion of the LMO as to the appropriate time for review of the resident or medication.
8. The pharmacist should also be directly notified of medication changes by the LMO either verbally or in writing.

NOTE: Verbal order is only accepted if absolutely necessary, i.e. if LMO does not have a fax machine and cannot come and write it up.

If this procedure is not followed, the appropriate action specified in the State regulations should be taken. (In NSW, if a written entry is not made into the residents’ medical record within 7 days of the verbal order, the LMO must be reported to the Director General of Health).
Medication Policy and Procedure

MEDICATION ORDERING

Policy
The pharmacy is responsible for the supplying of routine weekly 7-day single dose blister packs. Non-blistered medications or any changes with medication orders are the responsibility of Registered Nurse or the delegated medication person to notify the Pharmacy.

Procedure:
- RN to fax or email orders, changes to pharmacy before 2pm Monday to Friday.
- The Pharmacist is responsible for the re-ordering of regular medication on the pharmacy-files.
- Registered Nurse in-charge on evening shift is responsible to reorder eye drops monthly (at end of month) and when new eye drops received, the night Registered Nurse is to discard the old eye drop and date the new ones on the last day of the month.
- Registered Nurses are responsible to re-order lotions and creams, Dangerous Drugs and the PRN medications. Pain patches should be reordered when the last one is used.
- The Pharmacist keeps the scripts and will send reminder notes to the prescribing doctors when scripts are needed.
- RNs to photo copy chart if there is any changes to Medication or new orders and fax or email to pharmacy.
- Medication stock will be delivered at approximately 4pm. The Registered Nurse receiving the medication must sign after checking that all medication is correctly delivered.
- Weekly webster packs will be delivered on Friday. Saturday and Sunday RN to check packed medication against the med charts for any mistakes and notify pharmacy to rectify. Each night, 36 residents to be checked.
- All S8 (DD’s) received must be initialled by the receiving RN. Two people (2 RNs or RN and another staff) must sign when entered into the drug book.
- When sending the owing scripts to the pharmacy, to attach a note stating “return of owing scripts”.
- RN’s must identify which medication is wanted when sending a script with multiple orders.
- Form for New Residents must be completed for all new admissions and fax or email to pharmacy.
- When a resident is discharged, RN is responsible to notify the pharmacist by a fax.
- No medication will be dispensed from pharmacy without a script.
- Insulin to be dated when opened. When opened, the insulin can be kept for one month, provided that the batch has not passed its use-by date (refer to the box of the vial).
Medication Policy and Procedure

1. CHANGE IN MEDICATIONS

Altered dosage procedure:
1. When there is medication change, e.g. by the visiting doctor, the medication chart with the dose change is to be faxed to the pharmacy immediately, thus the pharmacy records could be updated, and the appropriate repackaging could occur and the correct Webster card delivered.
2. The appropriate medicine concerned would also be delivered in a Webster card from pharmacy the same evening to be used for remaining days of the week.

Discontinued medication procedure:
1. Should a doctor cease a resident’s medication, place a “Ceased” label on top of the tablet of the Webster card.
2. If the medicine is in its original container, to remove it from the trolley or cupboard and place it in the pharmacy box for return to pharmacy.
3. Then fax to pharmacy the ceased medication alerting them to cease the medication when they pack the next Webster.

Urgent medication procedure:
1. Fax copy of medication chart and pharmacy form & write “URGENT”
2. Call Pharmacy and inform them it’s urgent
3. Refer to Emergency Ward stock supply and administer from stock if available

Non-urgent medication procedure:
1. Refer to Ordering from Pharmacy for procedure

Dropped or lost medication procedure:
1. Tablets lost or dropped during administration, to use the last day in the pack
2. Inform pharmacist immediately for replacement
3. Complete an incident form
Medication Policy and Procedure

DISPOSAL OF UNWANTED MEDICATION

Policy
All unwanted medication is returned to pharmacy for appropriate disposal. S8 medicines are disposed of according to legislative requirements.

Procedure:
1. All medication is returned to pharmacy for disposal when:
   - It is expired
   - The medication package is opened and is discontinued
   - The medication package is opened and resident is deceased

2. Any unopened medication is returned to pharmacy for credit to resident's account upon resident's discharge or change of medication, provided the package is not damaged or defaced.

3. Pharmacy disposal or return box is located in the RN station

4. S8 to be destroyed by an Accredited Pharmacist and the Director of Nursing or her substitute Care Manager (Deputy Director of Nursing) of any ceased or expired or discharged resident(s)

ADVERSE DRUG REACTION REPORTING

Procedure:
1. Any adverse or suspected adverse reaction to any suspected medications or new medication orders, stop administering the medication or remove the medication ie patch.

2. Documented in the progress notes, the reaction/side effect, resident’s status, vital signs and reported immediately to the LMO

3. Continue to monitor the Resident’s condition and if condition rapidly declines, send to hospital

4. Alert DDON or DON.

5. LMO to assess the Resident’s condition and cease the medication as soon as possible if causing the adverse reaction
Medication Policy and Procedure

MEDICATION INCIDENTS / ERRORS

Examples of a medication incident or problems are:
- The wrong medication being supplied to Resident
- The medication being stored in the wrong place
- The wrong medication being administered, including wrong dose/strength
- The medication being given to the wrong resident
- Medication duplication
- The wrong medication being signed for administration
- Packing of ceased medication, wrong medication or wrong dose.
- Pre-dispensing, post-dispensing.
- The controlled substances register being incomplete or incorrect
- Medication orders not being documented on-site by the LMO

Medication Incident Procedure:
1. Any medication error is to be documented on a medication incident form
2. Report should include a description of the incident
3. The medical officer or Pharmacy is notified if necessary
4. Observation & vital signs monitoring if medication was given to the wrong resident or ceased medications

Medication Incident

Incident Report Completed

D.D.O.N., L.M.O and Pharmacist (if necessary) to be notified

Action Taken

Review by Medication Officer and D.O.N.

Action

Medication Advisory Committee

Action/Recommendation by Medication Advisory Committee
Medication Policy and Procedure

LMO MEDICATION REVIEWS

Procedure:
1. LMO to review each of the resident’s medications by having to re-document, date and sign them on a new medication chart every three months.
2. In addition, when a LMO visits a resident, the RN/RN-Assist on duty will document in the progress notes that the medications have been reviewed at the time of the visit. LMO must also document it in the resident’s medical notes that they have reviewed the resident’s medications.

RESIDENT MEDICATION MANAGEMENT REVIEW
(RMMR)

Policy
Collaborative RMMR is available to all permanent residents in the facility. Meditrax Australia is undertaking the Medication reviews for residents of Garden View Aged Care.

Procedure:
1. A collaborative RMMR is available to a new resident on admission into Garden View Aged Care. An existing resident can have a RMMR on an "as required" basis. Each resident is entitled to one RMMR in any twelve month period, except where there has been a significant change in medical condition or medication regimen.
2. RMMR may be initiated by the resident’s doctor, the reviewing pharmacist, supply pharmacist, staff or other member of resident’s health care team, the resident or resident’s representative.
3. An RMMR may be required where there has been a significant change in the resident’s medical condition or medication regimen, example as follows:
   - Recent discharge from an acute hospital
   - Significant changes to medication regimen in the past three months
   - Change in medical conditions or abilities
   - Prescription of medication with a narrow therapeutic index or requiring therapeutic monitoring
   - Presentation of symptoms suggestive of an adverse drug reaction
   - Sub-therapeutic response to treatment
   - Suspected non-compliance with mediation
Edication Policy and Procedure

EDUCATION and TRAINING

Policy

It is the policy of the Garden View that management and staffs has appropriate knowledge and skills to perform their roles effectively.

Procedure:

1. Garden View Aged Care will provide on-going education and training for care staff on a regular basis to ensure that care staff has the skills and appropriate knowledge to perform their tasks effectively.
2. Non Registered Nurses appointed medication duties must demonstrate proven competency in medication administration before allowed to perform the task.
3. Registered Nurses competency will be assessed as required or when changes in practices
4. Topics for education may be identified by the Medication Advisory Committee, educator or request from registered nurse.

AUDITING MEDICATION MANAGEMENT

Tools for Auditing:

- Storage
- Medication Administration
- Emergency Medication
- Schedule Substances of Drugs of Addiction
- Nurse Initiated Medications
- Diabetic Management

➢ Refer to Audit Results for attachment
## COMPETENCY ASSESSMENTS

Staff Name: ___________________________ Commenced Date: ___________________________

<table>
<thead>
<tr>
<th>Summary of Training Dates</th>
<th>Date</th>
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<tbody>
<tr>
<td>1. Medication Administration- Oral Procedure</td>
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<td>2. Medication Administration- PRN (as required) Procedure</td>
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<td>3. Administration of Eye drop Procedure</td>
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<td>4. Administration of Eye Ointment Procedure</td>
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<td>5. Administration of Ear Drop Procedure</td>
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<td>6. Administration of Nasal Spray Procedure</td>
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<td>7. Administration of Liquid Medication Procedure</td>
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<td>8. Administration of Inhaler/Puffer Procedure</td>
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<td>9. Administration of Turbohaler Procedure</td>
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<td>11. Administration of Spiriva via Handihaler Procedure</td>
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<td>12. Administration of Nebuliser Procedure</td>
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<td>14. Administration of Suppository Procedure</td>
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<td>15. Administration of Schedule 8 medications</td>
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<td>16. Emergency stock or Antibiotic Procedure</td>
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<td>17. Administering Nurse Initiated Medication Procedure</td>
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<td>18. Insulin Penfill/Nova Pen Procedure</td>
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<td>19. Intramuscular or Subcutaneous Procedure</td>
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<td>20. Medication Administration- Crushing Procedure</td>
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<td>21. Diabetic Management &amp; procedures</td>
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<td>22. Blood Sugar Taking &amp; recording BSL on Chart</td>
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<td>23. Administering cytotoxic drugs procedure</td>
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<td>24. Accident or Incident when handling cytotoxic drugs procedure</td>
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<td>25. Safe use of Oral Methotrexate Procedure</td>
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<td>26. Medication for resident on outing with relative</td>
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<td>27. Telephone/Fax orders</td>
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<td>28. Medication ordering</td>
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<td>29. Change in Medications</td>
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<td>30. Disposal of unwanted Medications</td>
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<td>31. Adverse drug Reaction Reporting</td>
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<td>32. Medication Incidents/Errors</td>
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## Staff Practical Competency Assessment

- **Key code against the procedure:** ✔ = Met  ✗ = Not Met

**Comments/Improvement Feedback to Staff:**

<table>
<thead>
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<th>Date of Practical Assessment:</th>
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<tbody>
<tr>
<td>Name of Competency Assessment Conducted:</td>
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<td>Staff Name:</td>
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<td>Assessed By:</td>
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<td>Assessor’s Signature &amp; Position:</td>
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<td>Recommendation: (Passed &amp; Competent, further practical assessment or Failed):</td>
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**Date Competent:** ________________  **Assessor’s Signature:** ____________________

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 GVN.0001.0001.0829
## Audit Results

- **Key code against the procedure:** ✔ = Met  ✗ = Not Met  NA = Not Applicable

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<td>Audited By:</td>
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<td>Signature &amp; Position:</td>
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### Audit Result:

Total of Correct answers ÷ Numbers Questions = %

### Comments of Results:

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### Action Plan & Outcome:

- 
- 
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**Signature:**

**Position:**

**Date:**

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