

MEDICATION SAFETY

ADMINISTRATION AND CHECKING PROCEDURE BY NURSING/MIDWIFERY/MEDICAL STAFF AND STUDENTS

AIMS

- To ensure patient safety when administering medications
- To provide a clear and consistent organisational framework for nurses, midwives, medical staff and students concerning the administration of medications

SCOPE OF PRACTICE

- All staff and students must work within their scope of practice/ competency at all times, using the “[decision making framework](#)” as a guide.²
- See also Department of Health WA Operational Directives: [OD 0215/09: Storage and recording of restricted Schedule 4 medicines](#) & [OD 0141/08: Code of practice for the handling of Schedule 8 medicines \(drugs of addiction\) in hospitals and nursing posts](#) or their relevant updates.
- Have achieved the medication calculation competency at university/TAFE or on commencement of employment at KEMH prior to administering any medications. Employers are to ensure employees have and maintain required qualifications.²
- Should know the medication’s actions, side effects, usual dosage, and be familiar with the “first dose” policy for [epidurals](#).
- Check that patients have a valid medical order, except those medications listed as [non-prescription nurse/ midwife initiated medications](#).
- [Verbal orders](#) are emergency prescriptions from an authorised prescriber (NP or medical practitioner) over the telephone which should be countersigned on the medication chart by a NP or medical practitioner within 24 hours.¹ They may be taken in an emergency when the Medical Practitioner cannot personally visit the woman and for insulin where the dose may vary according to plasma glucose levels. The verbal order should be recorded on the woman’s medication chart and a second nurse/ midwife will repeat the prescription to the Medical Practitioner over the telephone.

CHECK THE SIX PATIENT RIGHTS & ALLERGIES

- Right Drug; Patient; Dose; Time; Route; & Documentation¹; any allergies.
- Refer to Clinical Guideline [Medication Safety: Intravenous Medications – Checking and the Administration of by Medical and Nursing / Midwifery Staff](#)

MEDICATION REFUSAL BY THE WOMAN

- A woman may refuse a medication, which should be documented in the medical record and on the relevant medication chart.
- In addition, if a Schedule 4 or Schedule 8 medication is refused by the woman then:
 - The nurse/ midwife is to contact the appropriate medical practitioner as soon as possible for review,
 - The medical practitioner is to review the woman,
 - The outcome of the review is to be documented in the medical record.

MEDICATION ROUTE

See [Schedule 4](#), [Schedule 8](#), [WNHS Policy 057 \(ID badge\)](#) and relevant KEMH medication route Clinical Guidelines for specific administration procedures. Including: [Administration of medications](#), [Post operative nausea and vomiting protocol](#), [Neuraxial blockade](#), [Gynaecological pain management](#), [10.4:Medication administration to the neonate](#), [Parenteral therapy](#), [Intramuscular injections](#).

Epidural:

- See KEMH Clinical Guideline Section [E 4 Labour Analgesia](#) or competency requirements.

IV medications:

- Medical/ midwifery/ nursing staff will check all IV medications with a RN/ RM/ pharmacist or Medical Practitioner prior to administration, with the exception of anaesthesia and life threatening emergencies.
- The nurse/ midwife/ medical practitioner who prepared the medication must administer it & sign the medication sheet with time/ date administered.
- The first IV dose may be administered by a RN/ RM for all IV medications listed in the KEMH Clinical Guidelines or other individual protocol authorised by each specific unit and may commence IV infusions including those prepared in pharmacy and opioid infusions.
- EN's that are not IV competent:
 - may not give bolus medications directly into the cannula, or flush a cannula, or add drugs/ electrolytes to bottles or bags.

- EN's that are IV competent may:
 - Set up for the insertion of a peripheral IV infusion & prepare the administration set,
 - Check and change a bag of IV fluid at the bedside in accordance with clinical guidelines; calculate & regulate the flow rate, & record amount,
 - If the infusion stops, inspect the site and position of the limb and report any observation to a RN, and
 - On completion of the infusion or further use, remove the cannula from the vein and apply a dressing.
 - may not care for unstable patients or those receiving infusions that have a low therapeutic range or require frequent observations to determine dose adjustment.¹ See also [OD 0376/12 Medication Administration: Role of the Enrolled Nurse](#).

See also [KEMH Clinical Guideline Section A: 4.14 Labelling of injectable medicines and fluids](#).

High Risk Medications

- All staff are to be familiar with [high risk medications](#) used in the Health Service and use care and consideration when administering these medications

NEONATAL MEDICATIONS

- See Clinical Guidelines Section B [10.4 Medication Administration to the Neonate](#) including neonatal [IV](#), [IM](#), [Vit K](#) & [Hep B vaccine](#) / [Hep B immunoglobulin](#).
- Two Registered Nurse/ Midwives (or one Midwife or Registered Nurse and one neonatal medication competent student) are required to check/sign neonatal medications. See also: [Neonatal medication chart example](#).
- Only Registered Nurses/ Midwives and students who have completed the KEMH practical assessment: "Neonatal Intravenous Medication Administration: Workplace Competency Assessment Form" can perform neonatal IV medication administration. This is to be completed on the ward with the Clinical Development Midwife or a Clinical Midwife.
- All Registered Nurses/ Midwives are accountable for their own practice and therefore competency. Any Registered Nurse/ Midwife who has not undertaken neonatal IV medication administration in the last 12 months shall update their knowledge and skills by attending an 'update' session before continuing to practice this skill.

USE AND STORAGE OF MEDICATIONS

- A medication infusion via any route may be administered indefinitely until either completed or no longer required (e.g. Patient controlled analgesia).
- Store in locked medication cupboard, trolley, fridge or room in the manufacturer's original pack or pharmacy labelled containers. Decanting from one container to another is not permitted.
- Store and administer in accordance with the manufacturer & pharmacist's recommendations regarding temperature, exposure to light and expiry dates.
- Medications cannot be mixed for IM, SC, IV or epidural delivery unless compatibility has been confirmed by a pharmacist or product literature.
- Only if multi-use medication vials are in use is a nurse/midwife permitted to administer a medication previously prepared by another person. The medication must be:
 - Labelled clearly with the information pertaining to its initial admixture including names of the nurse/midwife involved, and
 - Checked in the usual manner.

TABLE OF MEDICATION CHECKING / ADMINISTRATION FOR QUALIFIED STAFF AT KEMH

Registered with AHPRA & working as:	<u>IV</u> *	Oral	IM *	Subcutaneous */ per rectum(PR)/ per vagina (PV)	Sublingual trans-dermal, eye, ear, nasal, topical, & nebulised	<u>Epidural</u> *	Restricted Schedule <u>4 / 8</u>	Verbal/ phone orders *
Mothercraft nurse or EN (with notation on their registration that they do not hold a qualification in medication administration^)	x	x	x	x	x	x	x	x
<u>EN medication competent</u>	If completed IV competency: Fluids without additives only, no IV bolus.**	✓	✓	✓ RN, NP, or Medical Practitioner must delegate the task ¹	✓	x**	S4 ✓. May check but not administer or check destruction of S8 ¹	✓
RN &/or RM	✓ ^{^^}	✓	✓	✓	✓	After epidural competency achieved	✓	✓
RN / RM not employed by KEMH (e.g. Agency)	Must be checked by a KEMH RN or RM	✓	✓	✓	✓		✓	✓
Nurse practitioners	✓	✓	✓	✓	✓		✓	✓
Eligible midwives	✓	✓	✓	✓	✓		✓	✓
Medical Practitioners	✓	✓	✓	✓	✓		✓	N/A

Key: * = Must be checked by second Registered Nurse/ Midwife/ Medical Practitioner prior to administration; ** =IV competent EN's may perform & document vital signs for a patient receiving opioid infusions, cytotoxic, epidural, regional medications when the RN has commenced the medication & directed the EN under direct supervision of the RN & the EN is qualified in the relevant medication & authorised to do so by local policy¹; ^ = Notation: 'Does not hold Board-approved qualification in administration of medicines'. ^^ = After the approval of the CMC/ Manager /Coordinator.

TABLE OF MEDICATION CHECKING / ADMINISTRATION FOR STUDENTS AT KEMH

Registered with AHPRA / working as:	IV *	Oral	IM *	Subcutaneous *, per rectum(PR), per vagina (PV)	Sublingual trans-dermal, eye, ear, nasal, topical, & nebulised	Epidural *	Restricted Schedule 4 / 8	Verbal/ phone orders *
<u>RN students</u>	Only under direct supervision of a RN / RM. Skill level depends on appropriate theoretical assessments, course stage attained & student scope of practice.					✗	✗ No S8's ⁴ .	✗
RN Midwifery student	✓	✓	✓	✓	✓	✓ After epidural competency achieved, under direct supervision of RM	✓ S 2/ 3/ 4 need a RM to check**** medication against women's medication chart. ✓ S8 with RM	✓
Non-RN Midwifery student (BMid or BN/BM)***	Only under direct supervision of a RN / RM. Skill level depends on appropriate theoretical assessments, course stage attained & student scope of practice. Oral, IM, IV, Subcut after completion of relevant clinical skill assessments as determined by university.					After epidural competency achieved, under direct supervision of RM LA only ✗No S8's ⁴ .	✓ S2/S4 only under supervision of a RN/RM ✗No S8 ⁴ , but may participate as a 3 rd checker when within scope of student practice.	✗
Medical students	Only under direct supervision of a RN/ RM/ Medical Practitioner.					✗	✗ ⁴	✗

Key: * = Must be checked by second Registered Nurse/ Midwife prior to administration; *** = Check with student for competency level and scope of practice; **** = checking to bedside not required.

Abbreviations: AHPRA= Australian Health Practitioner Regulation Agency; BMid= Bachelor of Midwifery; BN/BM= dual nursing & midwifery degree; EN = Enrolled Nurse; LA= local anaesthetic; KEMH= King Edward Memorial Hospital; NP= Nurse Practitioner; RN= Registered Nurse; RM = Registered Midwife; S= Schedule.

REFERENCES (STANDARDS)

1. Department of Health Western Australia. [Operational Directive OD 0376/12: Medication administration: Role of the Enrolled Nurse](#). WA: Government of Western Australia; 2012.
2. Nursing and Midwifery Board of Australia. Fact sheet: Enrolled nurses and medicine administration. Melbourne: **NMBA**. 2013. Available from: www.nursingmidwiferyboard.gov.au
3. Poisons Act 1964: Poisons Amendment Regulations 2012, (2012).
4. Department of Health Western Australia. [Operational Directive OD 0141/08: Code of practice for the handling of Schedule 8 medicines \(drugs of addiction\) in hospitals and nursing posts](#). WA: Government of Western Australia; 2008. Nursing and Midwifery Office. Fact sheet: Schedule 8 (S8) medications - Undergraduate nurses and midwives.

National Standards – 4 Medication Safety

Legislation – Poisons Act 1964: Poisons Amendment regulations 2012,(2012).

Related Guidelines / Policies – [Section P Pharmacy and Medications](#)

Other related documents – Nil

RESPONSIBILITY

Policy Sponsor	Pharmacy
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