QUALITY PROCEDURE

RESIDENTIAL AGED CARE SERVICES MEDICATION MANAGEMENT

INDEX

1. PURPOSE

Residents of Alzheimer's Association Queensland (AAQ) Residential Aged Care Services (RACS) will have all medications administered correctly, as prescribed and approved by the Medication Advisory Committee and in accordance with:

- Health (Drugs and Poisons) Act 1996
- Aged Care Act 1997
- Health Practitioner Regulation National Law Act 2009
- Quality of Care Principles (under the Aged Care Act 1997)
- Guiding Principles for Medication Management in Residential Aged Care Facilities 2012
- Australian Aged Care Quality Agency Standards, particularly 2.7

2. GUIDING PRINCIPLES FOR MEDICATION MANAGEMENT IN RESIDENTIAL AGED CARE (RAC) FACILITIES.

These Principles apply whether a paper based or electronic medication system in used.

This Procedure is based on the Seventeen Principles. Staff involved in Medicines are to be familiar with and should refer to the Principles:

Principle One	Medication Advisory Committee
Principle Two	Information Resources
Principle Three	Selection of Medicines
Principle Four	Complementary, Alternative and Self- Selected Non- Prescription Medicines
Principle Five	Nurse Initiated Non-Prescription Medicines
Principle Six	Standing Orders
Principle Seven	Medication Charts
Principle Eight	Medication Review and Medication Reconciliation
Principle Nine	Continuity of Medicines Supply
Principle Ten	Emergency Stock of Medicines
Principle Eleven	Storage of Medicines
Principle Twelve	Disposal on Medicines
Principle Thirteen	Self-Administration of Medicines
Principle Fourteen	Administration of Medicines by RAC staff
Principle Fifteen	Dose Administration Aids
Principle Sixteen	Alteration (crushing) of Oral Dose Forms
Principle Seventeen	Evaluation of Medicine Management

3. PROCEDURE

3.1 Medication Charts (Principle 7)

All residents must have a current, accurate and reliable record of all medicines selected, prescribed and used, to support safe prescribing and administration of medicines and effective communication of medicines information between residents and their health care professionals, and between care settings.

Medication orders are never to be transcribed by nursing staff onto medication charts. Medication orders must be legible, signed and dated in the medical practitioner's handwriting in black ink. Medical Practitioners must rewrite an order if they are not clear, or be phoned to clarify the order if to be administered immediately. The Registered Nurse (RN) is then to confirm all discussions by documenting in the Progress Notes.

Fax orders for medications may be accepted from the Medical Practitioner. The RN will fax a copy of the medication chart to the Medical Practitioner, on receipt of medication chart the RN will fax to the pharmacy. On supply; new administration page to be printed and medications can be administered as ordered.

Registered Nurses arrange the review of the drug chart by the Medical Practitioner *at least every 3 months.*

Identification photographs must be added to medication charts with the name of the resident and the date the photograph was taken. Photos are checked regularly for residents' appearance and at least annually.

Residents with similar or same names have brightly coloured alert stickers or tabs present/ attached to their charts.

All residents have a medication care plan/ identification page that stipulates any medication related practice to assist with administration. This is to be reviewed at every care plan review or when a resident's condition changes.

Medication orders are only to be recorded on medication charts. The following details are written or are part of all medication charts:

- Complete name of resident
- Date of birth of resident
- Allergies marked yes or no and details
- A Medical Practitioner's signature for every medication ordered
- Every order dated by the medical practitioner
- All routes of administration
- Legible medications names
- Identifiable Medical Practitioner signatures
- Correct frequency identified from the Medical Practitioner's orders
- Correct dosages for the medication ordered

- Registered nurses signature following administration
- Relevant months and years
- The date of the next administration of infrequent medicines (e.g., medicines given 2-3 monthly), even if the administration does not occur within the time span covered by that chart
- If alternative methods of administering medications are necessary, e.g. "crush medications able to be crushed"
- PRN. medication orders
- Medication phone orders
- Date/s of reviewed by the accredited pharmacist and medical practitioner
- Details of resident self-administered

3.2 Administration of Medicines by RAC staff (Principle 14)

3.2.1 General

- The prescribing of drugs is the sole responsibility of the medical officer providing a legal and legible order, with the exception of nurse initiated drugs.
- The administration of medications is the responsibility of the Registered Nurses/ Enrolled Nurse (licensed for medication endorsement).
- Resident's details on medication chart must clearly state resident's name, D.O.B. and allergies
  For the prescription to be valid the following must be present:

  - *Name and strength of the drug*
  - *Route of administration*
  - *Dose to be given*
  - *Frequency of administration*
  - *Signature of prescribing Medical Officer*
  - *Recorded in ink*
  - *Recorded in the Medical Practitioner's own handwriting*
  - *Date of commencement of therapy*

- Medications are administered only to residents for whom they are prescribed.
- A Registered Nurse/ Enrolled Nurse, referring directly to the medication chart administers medications to residents.
- When and prior to administering:

  - The resident must be identified prior to administration
  - The drug must be checked three (3) times prior to administration
  - The drug name, strength, dose, route, time, allergies and date to be given must be checked prior to administration
  - All staff who administer medications are to administer these medications from their original container e.g. packet's and/or the pharmacy multi dose package
  - If the RN/EN is administering medication from a multi-dose sachet, then he/she should sign for each medication given on the residents' medication chart

- Drug allergies are identified and recorded (in red) on the medication chart. RN is to ensure Medical Practitioner and pharmacist are made aware of allergies.

- If there are any changes in the resident's condition or behaviour, which may be attributed as an adverse reaction to a new drug, it must be reported to the Medical Practitioner and Pharmacist, the Pharmacist can then assist in determining if it is drug related.
- Residents are to be encouraged, not forced to take medication.
- **Do not** try to conceal medications in important foods and do not mix in **a full bowl of food.**
- Medications are **not** to be left on resident's lockers or on dining tables for the resident to take later, administering staff must remain with the resident until the medication is seen to be swallowed.
- Medication chart only to be signed when medication has been observed to be ingested.
- If the resident is unable to swallow tablets, a liquid or other alternative must be obtained by contacting the Medical Practitioner and the pharmacist to determine the most appropriate type.
- If a suitable liquid alternative is unavailable the Medical Practitioner and pharmacists are to determine the suitability of the medication for crushing. Medical practitioners are to ensure details of altered dose forms are clearly documented or medication charts.
- The practice of cutting in half tablets is discouraged. Wherever possible, Medical Practitioners are to change dose/ prescription of medication rather than order half a tablet. If half a tablet is used the remaining half should be disposed of and not kept for administering at a later date.
- If a medication is not given, this must be documented on the medication chart with the relevant reason noted. A list of abbreviations for this is on the bottom of the signing sheet.
- T the Medical Practitioner is to be contacted for further orders if medications continue not to be given.
- Eye drops and eye ointments should be discarded one month after opening; the date the bottle was opened must be recorded on the bottle. The expiry dates on bottles should be checked each time before administration.
- Anginine expires ninety (90) days after opening; the date of opening must be noted on the bottle.
- Insulin- the date the vial or cartridge is opened must be noted on the container. Expiry times may differ. Staff are to check carefully. Then clearly write DISPOSAL DATE on container.
- Insulin is to be administered at room temperature.
- Other medications may denature after opening, guidelines by the pharmacist are to be followed as provided.

3.2.2 Telephone orders/ Emergency medicines

Only in emergency situations will a telephone order be taken. All telephone orders must be heard and signed for by two people one of whom must be an RN. RN to follow up with Medical Practitioner to sign order within 3 days.

3.2.3 PRN (as required)

- PRN medications are those which are ordered by a medical practitioner for a specific resident to assist in the control of a specific condition
- PRN orders are recorded by the Medical Practitioner in a separate section in the medication chart
- These are initiated by the R.N. using clinical judgement to decide their necessity

- The administration of PRN medications must be ordered on the resident's medication chart and documented in the progress notes, *detailing what was administered; why and when it was given; and the outcome*
- If PRN's are administered on a regular basis RN should contact the Medical Practitioner for review

3.2.4 Enrolled Nurses

- Must have license endorsement by AHPRA to administer medications. The license is to be sighted by Director of Care (DOC) and Human Resources who will keep record of same and provide such information to Registered Nurses
- Can practice in accordance with section *162 and 252 of Health (Drug and Poisons) Regulations 1996*
- Are able to calculate drug doses, recording, checking and administration of drugs and poisons S2, S3, & S4 under the direct or indirect supervision of a Registered Nurse
- At no time can an Enrolled Nurse administer a **Schedule 8 (S8) drug**. The Enrolled Nurse will be able to calculate drug dosage and check (in compliance with legal requirements) when required to check **Schedule (S8) drugs** administered by a RN
- Cannot administer intravenous and intrathecal medications. This also applies to administration of medication that are additives to intravenous infusions
- Can only administer **PRN (when necessary)** medication following **assessment b**y an **RN** or Medical Practitioner prior to administration and delegated to by same
- Is responsible for ensuring the safe administration and handling of drugs, for monitoring and evaluation of the response to drugs and for reporting to the RN any signs and symptoms of possible adverse effects
- Is permitted to be in possession of keys to the dangerous drug cupboard when necessary

DIRECT SUPERVISION: Means that the RN is actually present and observing or working with the person.

INDIRECT SUPERVISION: Requires the RN to be available for reasonable access, but not necessarily present when the activity is being carried out.

3.2.5 Injectables

Injectable medicines must be checked by two people, one of whom must be a Registered Nurse before administration, including Insulin.

3.2.6 Ordering/ Supply

- Pharmacy send packed medications weekly as prescribed
- Registered Nurses order additional stock as required
- When administering medications, note how much medication is left in the container, re-order as necessary. This will cover any time lag due to weekends and Public Holidays
- Some medications are available without prescriptions (i.e. creams). RN to consult with Pharmacist.
- All scripts are kept at the pharmacy. Any scripts received from Medical Practitioner are to be forwarded to pharmacy as soon as possible

- Pharmacy directly liaise with Medical Practitioner regarding any outstanding scripts
- Ensure the resident's name, date and the medication/s required are written clearly on the order
- Written records to be completed for all orders, incorporating faxes, electronic records
- Paper based records to be kept for one month

WHEN MEDICATIONS ARE DELIVERED:

- The RN on duty will check that the medications delivered are the drugs ordered for the individual Residents
- Note if any medications ordered have not been delivered or if there are any medications delivered that have not been ordered
- Medications are then to be placed in the appropriate storage places, i.e. drug trolley, fridge

3.2.7 Controlled Drugs (Schedule Eight)

RECEIPT PROCEDURE:

- Controlled drugs (S8) will be delivered as required by the pharmacist representative, receipted by a RN and signed into the controlled drugs register by both parties before placing drugs into the **locked Controlled Drug safe**
- The drug will not become the responsibility of the Facility until signed into the register by the RN and the pharmacist's representative
- The controlled drugs are to remain in the blister packs / containers in which they are dispensed
- Entries of drugs into Controlled Drugs Book will be in red ink while issues from the stock will be recorded in black ink
- New issues of Controlled Drugs are to be added to the current page of the unit Controlled Drugs Book for that drug, so that a cumulative record is kept

STORAGE PROCEDURE**:**

- Controlled Drugs must be stored in the Controlled Drugs safe
- The key to the Controlled Drugs safe is to be kept at all times with the Registered Nurse on duty or Enrolled Nurse, only if necessary
- The keys are not permitted to leave the clinical area
- The Controlled Drugs safe is to be kept locked at all times except when drugs are being placed in, or removed from it
- The Controlled Drugs safer is to be used for the sole purpose of storing Controlled Drugs
- In the event that the drug keys are taken from the Facility, every effort must be made to contact the person concerned to return the keys as soon as possible. Third parties (police, spouse) should not be enlisted to return the keys

RECORDING OF TRANSACTIONS:

- Under the *Health (Drugs and Poisons) Act 1996* each Aged Care Facility is required to maintain a Controlled Drug Register in which every transaction involving a Controlled Drugs must be entered
- Every transaction involving Controlled Drugs must be recorded
- A separate page is to be used for each type and strength of drug
- A current index must be maintained and page numbers are not to be obliterated once entered

- Each page must be completed before a new one is commenced
- No page is to be removed or stuck down
- This record is audited from time to time by a representative of the State Health Department
- A separate page is to be used for each resident with name and strength of the drug
- All entries must be recorded clearly - and full signature of person administering and checking is required - INITIALS ARE NOT ACCEPTED (except in the case of administration audit)
- Entries recording newly received drugs will be entered in red
- No entries made in the controlled drug book is to be erased, obliterated or cancelled. If transcription errors occur, cancel the documentation in the controlled drug register by drawing a single line through the error which is then initialled. Corrections are to be documented in the comments column and are to include:

    - Date
    - relevant data
    - initials of person making entry

- No blank lines are left between entries
- When a Controlled Drugs Book is completed it is stored for two years from the last transaction
- The first entry of the new book will read: date, transferred from page "x" of old book, balance "y"
- On commencement of a new Controlled Drugs Book two Registered Nurses will transfer documentation from the old book to the new book with the second Registered Nurse countersigning the transfer documentation
- Two Registered Nurses are to record the transfer of Controlled Drugs from one unit to another if the need arises
- Administration entries in the Controlled Drug Book must include:

    - Date and time of drug administration
    - Resident's given and surname
    - Amount, in dosage, of the drug administered
    - Quantity of drug remaining in the cupboard
    - Signatures of both the person administering the drugs and the person checking the drug

Note*: LIQUID PAPER OR ERASURES ARE NOT TO NE USED.*
POST-IT NOTES ARE NOT TO BE USED.

ADMINISTRATION:

- Controlled drugs are to be checked and administered by two Registered Nurses (where possible) or by a Registered Nurse and an Enrolled Nurse
- Assistant Nurses/Personal Care Workers are not to be requested to check drugs unless there are no other trained staff members available
- If AIN/PCW are requested to check medications, they must be deemed competent at orientation and annually
- Controlled drugs are to be administered only on the written and signed prescription of a medical officer

- **Verbal orders will only be accepted under very limited circumstances – see telephone orders and emergency medicines 3.2.2.**
- Registered Nurses **must:**

    - Read the medical officer's signed order, which must include name of resident, date, drug, dose, route, frequency of administration and time over which drug is to be given if appropriate
    - Take medication to the resident
    - Explain the procedure to the resident and reassure
    - Check for allergies:
    - Be aware of contraindications of use of drugs
    - Be aware of cumulative effect of drug half life
    - Be aware of signs of hypersensitivity

- Confirm the "five rights" of administration:

    - Right resident
    - Right medication
    - Right dosage
    - Right route
    - Right time

- Check expiry date on medication container
- Check the medication is being administered at the prescribed time and has not already been given
- Count the number of drugs (ampoules, tablets, amount of mixture) in stock against number in drug register, if correct remove amount required and ascertain that the drug is correct against the medication order, replace remaining drugs in locked cupboard
- If the count is not correct lock the cupboard and immediately complete an incident form and report to the Director of Care
- If the full volume of an ampoule is not used, the unused portion must be discarded into the Sharps container, and must be witnessed by two people
- Ascertain that the drug is being administered to the correct resident by verbally identifying resident, and checking photo on medication chart
- Both staff should be with the resident until resident administration is complete
- Ensure that the administration of the drug is recorded in the dangerous drug book by the Registered Nurse giving the drug and countersigned by the checking nurse
- If administering PRN Controlled Drug, document in Progress Notes as per this procedure
- The checking nurse must always be present when the drug is given

DAMAGED STOCK / REMNANTS OF INFUSIONS:

- When an ampoule or tablet is broken, the entry in the controlled drug (S8) register remains the same as for any other entry; i.e. the ampoule is recorded as destroyed and the entry signed by the person responsible, and countersigned by a member of the nursing staff who has verified the damage and checked the accuracy of the entry
- Damaged ampoules are to be disposed of in the sharps container
- This damage must be committed to an incident report and forwarded to Director of Care, and must contain full details of the circumstances surrounding the incident

- Remnants of Controlled Drug infusions; Two Registered Nurse (where possible) or an RN and EN and an Enrolled Nurse are to supervise the disconnecting of the infusions and disposal of the fluid down the sink
- Assistant Nurses/Personal Care Workers are not to be requested to witness disposal unless there are no other trained staff members available

DISPOSAL:

- The Registered Nurse is to telephone the Pharmacist at the supplying pharmacy and request the Pharmacist or representative to visit the facility for collection of drugs
- The Registered Nurse checks the amount of drugs to be returned with the Pharmacists Representative and enters 'Return to pharmacy' in the Controlled Drug Record on the appropriate page, recording the date, time and the remaining balance
- Both the Registered Nurse and the pharmacist or representative must sign the Controlled Drug Record

AUDITS:

- Stock checks of controlled (S8) drugs must be carried out by two RN's at a changeover of shift
- Confirmatory signatures are required in the Controlled Drugs stock book check in which the handover of drugs is signed for
- All controlled drugs (ampoules, tablets, mixtures, suppositories etc.) must be accounted for; any discrepancy must be reported immediately to the Director of Care
- Additionally, the discrepancy must be recorded on an incident form and a copy of the incident form given to the Director of Care or delegate
  The Director of Care and/or Clinical Nurse and a RN will carry out an audit of Controlled drugs on a monthly basis in accordance with *Clause 110(1) (b) & (4)* of the *Health (Drugs & Poisons) Regulations 1996*
- This audit is to be recorded as check completed on each page and signed

DISCREPANCIES/STOCK SHORTAGES:

In accordance with *Clause 110(2) (b) of the Health (Drugs & Poisons) Regulations 1996, t*he following are to be immediately reported to the Queensland Health Population Unit:

a) *Any inconsistency between the controlled drug in stock and the drugs that the records indicate should be in stock, OR*
b) *Any apparent excessive use of a controlled drug; OR*
c) *Any contravention of the Health (Drugs & Poisons) Regulations 1996*

For the purposes of this clause, reports made to the nearest office of the Environmental Health Branch of Queensland Health will be considered as reports made to the Chief Executive Officer of the Queensland Department of Health.

3.2.8 High Risk Medications

Are those medications with a narrow therapeutic index or require therapeutic monitoring, i.e. insulin, anti-coagulants. Insulin and anti-coagulants are to be checked by 2 staff RN and EN or RN and Assistant Nurse/ Personal Carer) prior to administration. If AIN/PCW are requested to check medications, they must be deemed competent at orientation and annually.

3.2.9 Adverse reactions

- Residents and healthcare professionals are encouraged to report any suspected adverse reaction to a prescription, non-prescription or complementary medicine to the Therapeutic Goods Administration (TGA). THE Medical Practitioner and/ or Pharmacist to make a report on:

    - **The Blue Card Adverse Reaction Reporting Form**
    - This is available for completion and downloading for submission by post, fax or email from **www.tga.gov.au/safety/problem-medicines-forms-bluecard.htm, or Australian Adverse Drug Reaction Reporting System,** an online reporting system available at **www.ebs.tga.gov.au/ebs/ADRS/ADRSRepo.nsf?OpenDatabase**

- All known allergies are to be written in red on the medication chart and on Admission Form
- If nil allergies known this is to be written on medication chart and on Admission Form as "NIL KNOWN ALLERGIES"
- The introduction of new medications is a time of importance for staff awareness and observation
- Asthmatic residents / known allergic residents should be carefully observed when a new medication is introduced
- Adverse drug reactions come in numerous forms from mild to severe depending on the individual reaction
- Refer to MIMS or pharmacist to access specific adverse reactions / interactions to new medications
- If adverse reactions are noticed or suspected by staff, report immediately to Registered Nurse.
- Ascertain severity of reaction
- If symptoms mild, attend to basic observations T, P, R, BP and Pearl, question and observe resident - then notify medical practitioner of your concerns
- If symptoms are severe contact the medical practitioner immediately and maintain continuous observation of resident
- Document all new allergies onto medication chart and document record of incident in progress notes details of treatment and results
- Notify family and DOC of incident and outcome

3.2.10 Calculations, measurements and timings

Drug Dosage Calculation:

$$\frac{\text{Strength Required}}{\text{Strength in Stock}} \times \frac{\text{Volume}}{1}$$

Drip Rate Calculation:

$$\frac{\text{Volume ordered} \times \text{Drop Factor}}{\text{Time in minutes}}$$

Measurements:

MASS
1. 1,000 micrograms (micro) = 1 milligram (mg)
2. 1,000 milligrams = 1 gram (gm)
3. 1,000,000 micrograms = 1 gram
4. 1,000 grams = 1 kilogram (kg)
5. 1,000,000 milligrams = 1 kilogram
VOLUME
1. 1,000 millilitres (ml) = 1 litre (1)
LENGTH
1. 1,000 microns (u) = 1 millilitre (mm)
2. 100 centimetres (cm) = 1 metre (m)
3. 1,000 millimetres = 1 metre

Timings:

To minimise the risk of adverse drug events the following two hour time bands are acceptable:

Medication time 0800 Time band will be 0700 to 0900 hours
Medication time 1200 Time band will be 1100 to 1300 hours
Medication time 1700 Time band will be 1600 to 1800 hours
Medication time 2000 Time band will be 1900 to 2100 hours

3.2.11 Cytotoxic Drugs

- Pharmacist to notify facility if any resident is taking any cytotoxic drug
- Medication Identification page (medication care plan) to specify required practices, at a minimum glove should be worn when handling
- Cytotoxic drugs should not be crushed
- RN to put in place necessary additional precautions as identified by Pharmacy:
    - PURPLE gloves, linen/ rubbish bags and bins may be required.

3.2.12 Staff competencies

Registered and Enrolled Nurses will complete medication management competency on commencement of employment at orientation and annually. 100% pass rate is required.

Registered and Enrolled Nurses will complete the online medication management module in Online Learning Solutions annually.

If the Registered and Enrolled Nurses is responsible for a medication error DOC to ensure further education, competencies and reporting as appropriate.

If AIN/PCW are requested to check medications, they must be deemed competent at orientation and annually.

3.3 Alteration (crushing) of Oral Dose Forms (Principle 16)

Where ever possible oral dose forms of medicines should not be altered and staff administering medicines are to know (and have access to information) which medicines can be safely altered.

Staff should:

- Know whether the resident is ordered medication that should not be altered
- Know/ research whether there are alternatives available
- Adhere to the "do not alter/ crush" reference list
- Make themselves aware of the potential risk/s associated with altering particular medications
- Know whether the medium used for administration for altered medications is appropriate and safe
- Know the best way to administer the altered medications mixed with the medium for each resident
- Minimise the risks of medication contamination
- Use strict infection control practices

3.4 Nurse Initiated Non-Prescription Medicines (Principle 5)

Nurse initiated medicines are non-prescription medicines and are only appropriate for one off or occasional use. The procedure and Nurse Initiated list is reviewed regularly by the MAC and comply with relevant national, state legislations and regulation.

Registered Nurses may initiate or delegate to an Enrolled Nurse, drug therapy or administer non-prescription medications when the need arises in accordance with the pre-approved Nurse Initiated List.

Every year the Nurse Initiated list will be reviewed and approved by the appropriate Medical Practitioner and reviewed at the Medical Advisory Committee.

If the medicine becomes routine a review by the medical practitioner is arranged as soon as possible. All Nurse initiated medicine should be documented in the medication chart and progress notes, detailing what was administered, why, when it was given and the outcome.

3.5 Standing Orders (Principle 6)

AAQ does not have Standing Order arrangements in their RAC's.

3.6 Self Administration of Medicines (Principle 13)

RAC staff support residents who wish to administer their own medicines as part of maintaining their independence. The *Quality of Care Principles 1997* recognises that residents are encouraged to retain their personal, civic, legal and consumer rights, and promote knowledge about his or her medicines.

Residents are to be formally assessed as being able to self-administer their medicines, including prescription, non-prescription and complementary and alternative medicines (CAMs).

The person's capacity and willingness to self-administer their medicines should be re-assessed regularly, and especially when there is a change in health or cognitive status.

- Residents self-medicating must complete **(RNC-F-159)** "Authorisation for Resident to Administer/Store Own Medications"
- A record of all medications self-administered by the resident must be approved and recorded by the Medical Practitioner on the resident's medication form
- All medications of residents who are self-medicating must be locked up within their room
- No record is required at the facility of when a resident administers their own medications, but it is preferable that a record of the supply of such medications be maintained by either the pharmacy or the facility to ensure resident compliance with medications
- If it is noted that there appears to be resident non-compliance with medication administration, then facility staff should notify the resident's Medical Practitioner and the RN repeat the Medication Assessment-Self Administration located in iCare. This assessment is to be repeated 12 monthly or when the resident's condition changes
- Residents are encouraged to take their medication records and Medical Practitioner's Notes to their Medical Practitioner for updating, if attending a Medical Practitioner outside the facility

3.7 Complementary, Alternative and Self- Selected Non- Prescription Medicines (Principle 4)

RACS staff encourage residents and their carers to take a Quality Use of Medicines (QUM) approach when selecting or using these medicines and ensure safe storage, administration, monitoring and be aware of adverse reactions and medicine interactions.

Staff liaise with all parties to ensure this is enacted in a safe responsive manner according to individual residents' needs and preferences.

3.8 Continuity of Medicines Supply (Principle 9)

Residents' medicines supply is maintained to reduce disruption of their access to needed medicines. For example:

- A resident needs a new medicine or an urgent change to dose or dose form of their existing medicine after normal business hours
- Where a resident is transferred from hospital or another care setting with limited or no supply of medicines
- Or where a resident is on a short break such as respite care, leave or an outing
    - If a resident is going on leave all medications (including unpacked) required by the resident are to be given in container labelled with their name, address, date and the time medications are

Where a dose administration aid (DAA) such as a blister pack, bubble pack or sachet is used, continuity of medicines supply will be maintained by the Pharmacy who will send newly prescribed medications in clip lock bags until the medication is packed into the weekly sachet rolls.

3.9 Storage of Medicines (Principle 11)

All medicines, including self-administered medicines, are stored safely and securely and in a manner, that maintains the quality of the medicine and protects the safety of all residents, staff and visitors. Storage practices maintain the quality of each medicine, taking into account any recommended storage conditions (e.g. refrigeration) as outlined in the medicine product Information.

- Medications are stored individually in a locked storage facility, i.e. trolley, cupboard
- All medications must be clearly labelled with a resident's name. Any items, which are not named, must be disposed of
- No medication is to be shared between residents
- RN's or EN's are the only staff permitted to carry keys to locked rooms, trolleys, cabinets
- Schedule 8 medicines require storage as per *Health (Drugs and Poisons) Act 1996*
- Medication trolleys must NEVER be left unattended when unlocked and kept within sight during drug round
- Medication fridges are to be used solely for that purpose
- Temperatures of medication fridges are to be checked and recorded daily on **(RNC-F-115)**
- If the medication fridge temperature is outside the required range (2- 8 °) corrective actions must be put in place immediately and details recorded on **(RNC-F-115)**
- The medication fridge must be locked or located on a locked room at all times and should only be opened to attends to a matter related to the medications and only medications are to be stored within it
- Fridges should be checked and cleaned weekly, defrosted as required

3.10 Emergency Stock of Medicines (Principle 10)

AAQ RAC's maintain a limited supply of emergency medications for emergency after hours use. Any stock removed from this supply must be recorded against the resident receiving it.

The whole box or bottle of medication must be removed from emergency stock. Is it them replaced with the pharmacy supply with the appropriate labels. Single doses are not to be dispensed from emergency stock apart from emergency medications, such as ampoules of Lasix.

The pharmacy checks and reconciles the stock monthly. The pharmacy maintains integrity of the stock, replenishes and rotates stock and checks expiry dates at least monthly.

3.11 Selection of Medicines (Principle 3)

RACS staff should support informed and considered selection of all medicines (prescribed, non-prescribed, complementary or alternative) and persons authorised to prescribe and order medications according to their scope of practice and prescribing authority and medications will be administered according to prescriptions, pre-approved list/s for standing orders or nurse initiated medications.

3.12 Medication Review and Medication Reconciliation (Principle 8)

Each residents' medication management is reviewed regularly and as required. The focus of the review is the resident's health, independence, care and comfort. Medication review involves the resident/ legal representative, Medical Practitioner, pharmacist and nursing staff. A Resident Medication Management Review (RMMR) should be undertaken by a Pharmacist soon after admission and second yearly. Additional reviews can be attended in changed circumstances.

The Medical Practitioner must review the resident's medications (and sign that it has been completed on the medication summary page) every three (3) months.

Medication reconciliation should be undertaken regularly to ensure current medications match with prescribed medications.

Examples of circumstances that should trigger a RMMR or medication reconciliation are:

- admission to the RACF from the community, hospital or other care setting
- transfer from the RACF to the community, hospital or other care setting
- When a resident's condition changes (i.e. fall/s, cognition, physical function)
- Presentation of symptoms that may suggest an adverse drug reaction
- When medicine orders change or a new medicine is ordered (particularly those with a narrow therapeutic index or require therapeutic monitoring, i.e. insulin, anti-coagulants)
- when medication charts are rewritten
- Following a medication review

3.13 Dose Administration Aids (Principle 15)

Dose Administration Aids (DAAs) are blister packs, bubble (Webster) packs or sachets. They can be unit dose or Multi dose. Some medicines are not suitable for DAAs (i.e. PRN's, cytotoxic, Schedule 8).

DAA's should be prepared, labelled, distributed, stored and used according to relevant legislation and regulation, professional guidelines and standards. Staff are to ensure medicine changes are communicated, documented and administered checking that DAA's are correct and if not, ensuring prescribed medicines are ordered, supplied and administered.

3.14 Disposal on Medicines (Principle 12)

Medicines that are unwanted, have been ceased or have expired are to be disposed of. RAC staff are to contact supplying pharmacy to collect unused/ discontinued medicines. All medicines are to be stored as per this policy in the interim.

3.15 Evaluation of Medicine Management (Principle 17)

Continuous quality improvement in medication management should be an ongoing process with evidence of follow up action and outcomes.

1. Audits

Audits are undertaken as per Moving on Audits Annual Residential Schedule and as required by RAC or corporate staff. Other internal checks to be undertaken as stipulated by Director of Care.

2. Medication Errors

If an **administration** medication incident occurs, RN to **notify**:

- Medical Practitioner
- Director of Care if concerned about resident's condition/ safety
- Resident / relative of resident
- The RN is to maintain and document status of resident e.g. B.P, Pulse, PEARL, colour, level of consciousness and responsiveness to pain, nausea and any other adverse signs or symptoms
- Complete an incident form
- Document incident in the nursing notes
- The Registered Nurse must know the medication administered - i.e. mode of action, contraindications, side effects, compatibility with other drugs and emergency treatment of adverse reactions
- Refer to Australian Medicine Handbook, MIMS online, Therapeutic Guidelines, Pharmacist and Medical Practitioner if there are questions concerning adverse reactions
- The medication error incident log identifies the Staff Member who made the error, the resident and the date and time the error occurred

If a **Packaging** and/ or **Dispensing** medication incident occurs:

- Contact supply Pharmacy as soon as possible to alert them to error
- Request immediate rectification of chart and or packaged medication
- Write incident form and forward to pharmacy for further investigation and resolution

If a **Prescribing** error:

- Contact Medical Practitioner immediately and have order rectified

If **Missing signatures**:

- The Registered Nurse is responsible for checking the previous shifts medication signatures, e.g. the RN on the afternoon shift, prior the administration of medications, check that morning's signatures on the signing sheet
- Attempt is made to contact the previous RN/ EN immediately and ascertain whether the medication has been given. If the medication has not been given than a reason for non-administration is to be sought
- If it has been ascertained that an omission is can be reasonably assumed, then the usual steps are followed i.e. complete incident form, notify Medical Practitioner and notify Next of Kin

- The Director of Care or his/ her delegate will check all medication signing sheets regularly (monthly) for missing signatures or codes
- If a person has continued non-adherence to safe medication practice then the staff member involved will be required to attend additional medication competency training
- Continued poor practice will result in formal performance management review that may result in disciplinary action

Medication Incidents are reviewed by the DOC as soon as practicable and at least monthly, reviewing trends and implementing corrective actions and education as required.

If the error is related to Controlled Drug administration and /or documentation the DOC investigates as soon as possible and immediate remedial actions (competency; theory and/ or practical, performance management) will be commenced with the person/s concerned.

Medication Incident Reports containing medication errors are tabled at the Medication Advisory Committee Meeting and facility Registered Nurse / Enrolled Nurse meetings for discussion and evaluation.

3.16 Information Resources (Principle 2)

Residents, carers, RACS staff and visiting health care professionals have access to current and accurate information on medicines and their safe and effective use in the treatment and care of older people, including those with complex health conditions.

Residents and their carers have information to support decision-making about their medicines, informed consent, and the resident's own medication management.

Staff and visiting health care professionals have information resources to support and guide their medication roles and responsibilities within their scope of practice.

Current resources are available for Residents, their carers, staff and visiting health care professionals at each RACS, for example:

- Aged Care Learning Solutions- Medication Management module
- Australian Medicine Handbook
- MIMS online
- Quality Use of Medicines (QUM) online learning
- Applicable Therapeutic Guidelines, i.e. Palliative Care

3.17 Medication Advisory Committee (Principle 1)

A Medication Advisory Committee (MAC) is a group of multidisciplinary advisors (RACS management, nurse/s, medical practitioner/s, pharmacist/s and residents (if able)).
The MAC assist in the development, promotion, monitoring, review and evaluation of medication management policies, procedures and forms that will have a positive impact on the health and quality of life for residents supporting safe, effective, evidence based practice and Quality Use of Medicines (QUM).

The MAC meetings will be held *six monthly* or more often if deemed necessary by the Committee or Management and be referenced and minuted.

4. REFERENCED DOCUMENTS

RNC-F-115	Medication Refrigerator Temperature Monitoring
RNC-F-159	Authorisation for Resident to Administer/ Store Own Medication
RNC-F-238	Medication Administration Competency and Calculations
RNC-F-248	Medication Consent Form

APPROVED BY: _____

CHIEF EXECUTIVE OFFICER

DATE: 24.11.2017