PRACTICE

MEDICINE GUIDELINES

Guidelines for Nurses on the Administration of Medicines

NEW ZEALAND NURSES ORGANISATION

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1. Introduction

Historically, nursing as a discipline has had a close association with the storage and administration of medicines and the assessment of the client in relation to them. Today, this association has expanded to include important and complex aspects regarding knowledge of medicines and appropriate dosage, their administration and control, side effects, suitability for the client, adherence, and nurses' ethical and professional responsibilities. The laws regarding the regulation of medicines, their storage, administration and documentation, are also a part of the awareness within which nurses and midwives practise.

Numerous inquiries from nurses/midwives, other health professionals, managers and employers seeking clarity and definition of the parameters surrounding the administration of medicines have prompted New Zealand Nurses Organisation (NZNO) to develop this document. This is the third edition of the *Guidelines for Nurses on the Administration of Medicines*.

The aims are to provide:

> an outline of the medico-legal issues related to medicine administration in the New Zealand (NZ) setting; and

> an aid to finding useful resources.

Individual nurses or midwives must be familiar with local workplace policies and guidelines related to medicines. NZNO staff are also available to discuss individual issues related to medicines, and NZNO colleges and sections are resources for specialty knowledge. Summarised information specific to health care assistants can be found in appendix three.

In June 2011, the NZ and Australian governments agreed to proceed with a joint scheme for regulation of therapeutic products. Therapeutic products include medicines, complementary medicines, dietary supplements and medical devices. In time, the joint arrangements will be administered by a single regulatory agency: the Australian New Zealand Therapeutic Products Agency (ANZTPA). The new agency will combine the Australian Therapeutic Goods Administration and NZ's Medsafe[1]. Establishment of the new agency will affect the way in which medicines and medical devices are regulated in New Zealand. Nurses need to keep up to date with developments in this area. Information on this ongoing project is available from the following website: www.anztpa.org.

> In late 2011, the Government introduced the Medicines Amendment Bill 345-1 (2011). The Medicines Amendment Bill was passed into law on December 4th 2013 and became the Medicines Amendment Act 2013. The new Act:
  - aligns the prescribing framework for nurse practitioners (NPs) with medical practitioners, dentists and midwives ie, NPs are now *authorised* prescribers;
  - establishes a new category of prescriber known as a *delegated* prescriber, who can prescribe under a delegated prescribing order issued by an authorised prescriber (this is different from a *designated* prescriber who is authorised to prescribe under regulations eg.

[1] Medsafe is the New Zealand Medicines and Medical Devices Safety Authority Their website holds consumer and health professional information: www.medsafe.govt.nz

RN prescribing in diabetes health).

The above information has now been incorporated into this booklet.

2. Recommended resources

The following resources have been used in this document and are recommended reading for all nurses and midwives.

- Keenan, R. (Ed). (2010). Healthcare and the law. (4th Ed.). Wellington: Brookers Ltd. This is a NZ text, and includes detailed information on the themes discussed in this guideline. Chapter 10 Prescribing and administration of medicines is particularly relevant.
- Medsafe is the current New Zealand Medicines and Medical Devices Safety Authority. Their website holds both consumer and health professional information: www.medsafe.govt.nz
- The Health Quality and Safety Commission (www.hqsc.govt.nz) have significant resources on medication safety including medicines reconciliation.
- Pharmacology textbooks for nurses and allied health professionals that are written from an Australasian perspective. These can be accessed via websites such as www.medical-books.co.nz.
- Department of Health. (2004). Building a safer NHS for patients: Improving medication safety. This United Kingdom reference is excellent background reading. It can be accessed and downloaded from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084961.pdf
- Ministry of Health. (2011). Medicine care guides for residential aged care. Wellington: Ministry of Health. Available: http://www.health.govt.nz/publication/medicines-care-guides-residential-aged-care
- Ministry of Health. (2013). Medicines Management Guide for Community Residential and Facility-based Respite Services – Disability, Mental Health and Addiction. Wellington: Ministry of Health. Available: http://www.health.govt.nz/publication/medicines-management-guide-community-residential-and-facility-based-services-disability-mental
- Safe Medication Management Programme. (2011). Medicine reconciliation toolkit. Wellington: Health Quality and Safety Commission.
- Ministry of Health (2006/2011 [draft]). Guidelines for the Development and Operation of Standing Orders.
- ACC Treatment injury case studies. Available: http://www.acc.co.nz/for-providers/clinical-best-practice/case-studies/index.htm
- Health and Disability Commissioner Case notes. Available: http://www.hdc.org.nz/decisions--case-notes

3. Glossary

Administer

Administer means to administer to a human being, either:

- Orally, or by injection or by introduction into the body in any other way; or
- by external application, whether by direct contact with the body or not.

Client
The word 'client' is used for convenience, but implies not only a patient in a hospital or nursing home, but also a resident of an aged-care facility, a client in her or his own home or in a community home, a person attending a clinic or a general practitioner's surgery and an employee attending a workplace occupational health service.

Complementary medicines and healthcare products
The New Zealand Medicines Act (1981) uses the general term complementary healthcare products to describe herbal, vitamin, mineral (etc) and dietary supplement products (http://www.anztpa.org/glossary.htm). In Australia, complementary medicines are defined as therapeutic goods such as herbal, vitamin, mineral and homeopathic products that contain certain active ingredients. It is likely that a new definition will be developed once the ANTPA is established.

Dispensing
Dispensing includes:
> the preparation of a medicine for sale to the public (whether in response to the issue of a prescription, or a request by an individual to be supplied with the medicine); and
> the packaging, labeling, recording and delivery of a medicine

Compliance packaging aid/monitored dosage systems
For the purpose of this document, compliance packaging aids (sometimes known as monitored dosage systems) are defined as blister packs, dispensing boxes, dosette boxes, and sachets.

Prescribing
While there is no legal definition of prescribing, a generally accepted definition is '...to designate or order the use of a medicine, remedy or treatment' (www.dictionary.com).

Unregulated health care workers and health care assistants
The term 'unregulated health care worker' is used to describe the variety of health care workers who are not licensed or regulated by any governmental or regulatory body.

Within this definition are both "health care assistants" (HCAs) and "other" unregulated health care workers, such as paramedics, physicians assistants, operating department practitioners and practice assistants.

HCAs and other unregulated health care workers are defined by their level of education and their relationship with registered nurses (RNs), enrolled nurses (ENs) and nurse practitioners (NPs).

An HCA is '*a person employed within a health care, residential or community context who undertakes a component of direct care and is not regulated in law by a regulated authority'* (Nursing Council of New Zealand, 2011b, p.9). HCAs do not usually hold a health qualification above level 4 on the New Zealand Qualifications Authority (NZQA) Framework. HCAs are employed under various titles, including caregivers, health care workers, health assistants, kaimahi hauora, support workers, and HCAs (NZNO, 2010).

For further information please refer to the NZNO position statement on unregulated health care workers (NZNO, 2011) available on the NZNO website: www.nzno.org.nz.

4. Legislation, regulation, guidelines – what's the difference?

Figure one (adapted from Patras, 2009) outlines the difference between legislation, regulation and guidelines. It is important to understand the differences between each and the impact they have on your practise.

For example:

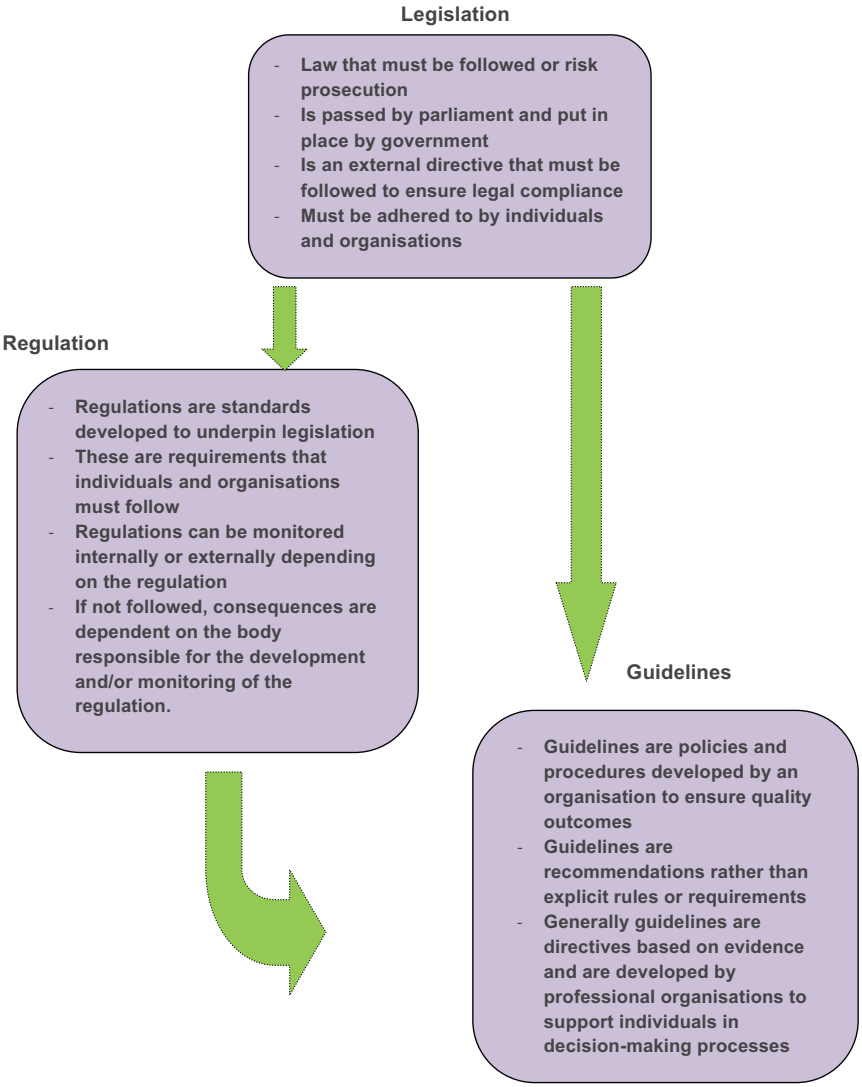
Legislation governs:
> the writing and management of prescriptions;
> the classification of medicines;
> processes for dispensing medicines;
> a consumers' rights;
> privacy and confidentiality;
> the scope of practice of health practitioners.

Regulations govern:
> the classification of some types of prescriber eg. Diabetes nurse prescribers;
> standing orders;
> processes for storing medicines;
> marketing and labeling of medicines

Guidelines govern:
> Best practice models;
> Policies and procedures within organisation

Throughout this document, the differing implications of legislation, regulations and guidelines on the medicines administration process will be described.

Figure 1: Legislation, regulation, guidelines - what's the difference (Patras, 2009)?



5. Regulatory authority requirements

This section presents a brief outline of the regulation of nurses and midwives by the Nursing Council of New Zealand (NCNZ) and the Midwifery Council of New Zealand (MCNZ). This section aims to clarify titles used in NZ, and outlines the significance of this regulation as related to medicine administration.

5.1 The Nursing Council

As the statutory regulatory authority, the Nursing Council governs the practice of nurses. The Council sets and monitors standards in the interests of the public and the profession. The Council's primary concern is public safety.

A regulated nurse means a nurse whose name appears on the register of nurses maintained by the Council in one of the following scopes of practice:

> Enrolled nurse
> Registered nurse
> Nurse practitioner

Each scope has a list of competencies. These competencies are available on the Council's website (www.nursingcouncil.org.nz) in the following documents:

> Competencies for Registered Nurses (NCNZ, 2007).
> Competencies for the Enrolled Nurse scope of practice (NCNZ, 2012).
> Competencies for the Nurse Practitioner scope of practice (NCNZ, 2008).

In addition to defining the scope of practice and competencies for each scope, the Council publishes the *Code of Conduct for Nurses* (NCNZ, 2012). The code provides a guide for the public to assess minimum standards expected of nurses and for nurses to monitor their own performance and that of their colleagues (NCNZ, 2012).
Seven principles with standards form the framework for the *Code of Conduct for Nurses* (2012):

> respect the dignity and individuality of health consumers;
> work in partnership with health consumers to promote and protect their interests;
> provide safe and competent care;
> respect health consumers' privacy and confidentiality;
> work with colleagues in ways that best serve health consumers' interests;
> act with integrity to justify health consumers' trust; and
> maintain public trust and confidence in the nursing profession.

The code is available to download at www.nursingcouncil.org.nz

4.1.1 Nursing implications of medicine administration

A health care team involved in medicine administration may include RNs or midwives, ENs, and HCAs. Each team member needs to understand:

> the competencies for his/her specific scope of practice and/or job description, in conjunction with the principles of the relevant code of conduct. For example, competencies include who can direct and delegate nursing activities such as medicine administration. This is explained in more detail in section nine;
> the scope of practice or job description of their colleagues and its implications; and
> local workplace policies and guidelines that are relevant to administration of medicine.

RNs and ENs need to be aware that, if their practice is investigated, the competencies for their

scope of practice and the principles of the relevant code of conduct will be used as standards against which to assess their practice.

The Nursing Council may register NPs to independently prescribe medicines within their scope of practice (see section 9.2), and RNs as designated prescribers (currently available to nurses who work with people with diabetes and who have made special application to the Nursing Council and meet the educational requirements for registration as a designated prescriber).

5.2 The Midwifery Council

The Health Practitioners Competence Assurance Act 2003 (HPCA Act) established a separate midwifery council. This council is required by Section 11 of the HPCA Act 2003 to prescribe the scope of practice for midwifery. This scope of practice and the competencies for entry to the register of midwives are available on www.midwiferycouncil.org.nz.

As part of their scope of practice, competency 2.13 requires midwives to demonstrate the ability to prescribe, supply and administer medicine, vaccines, and immunoglobulins safely and appropriately within the midwifery scope of practice and the relevant legislation.

The Midwifery Code of Conduct (Midwifery Council of New Zealand, 2010) provides a measure by which midwives' behaviour can be gauged, providing guidance on accountability, professional relationships, inter-professional relationships, and professional behaviour. Registered midwives need to be aware that if their practice is investigated, the competencies for their scope of practice and the principles of the relevant code of conduct may be used as standards against which to assess their practice.

6. The Code of Health and Disability Services Consumers' Rights

6.1 Overview

The Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner, 2004) applies to all health and disability services. This includes:

> public and private services;
> paid and unpaid services;
> all regulated health practitioners;
> HCAs;
> any other person providing health or disability services to a person; and
> people who care for family members.

The code was developed as a result of the Health and Disability Commissioner (HDC) Act 1994. The purpose of the Act is to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights (Health and Disability Commissioner Act, 1994).

This aim is completed through the implementation of the Code of Rights, a complaints process to enable enforcement of the rights, and education for consumers and providers.

The rights are:

Right 1	Right to be treated with respect;
Right 2	Right to freedom from discrimination, coercion, harassment, and exploitation;
Right 3	Right to dignity and independence;
Right 4	Right to services of an appropriate standard;
Right 5	Right to effective communication;
Right 6	Right to be fully informed;
Right 7	Right to make an informed choice and give informed consent;
Right 8	Right to support;
Right 9	Rights in respect of teaching or research; and
Right 10	Right to complain.

Full details about each right is outlined on the Health and Disability Commissioner website: www.hdc.org.nz

5.1.1 Nursing implications of medicine administration

> Every client expects the rights outlined above, and every health and disability provider is subject to the duties in the code. It is vital to be familiar with the details of each right and apply these to the nursing role related to medicine administration, eg a client who refuses prescribed medicines.
> Employers are responsible under section 72(2) of the HDC Act 1994 for ensuring employees comply with the code.
> Under section 72(5) of the same act it is a defence for an employing authority to prove that it "took such steps as were reasonably practical to prevent the employee from breaching the code" (HDC Act, 1994). This emphasises the importance of nurses informing their employer of problems related to enacting the code, and documenting these discussions.

5.1.2 Further information

> Case reviews available from the HDC website outline cases related to medicine administration. These are available for education purposes, and are recommended reading. These can be accessed via www.hdc.org.nz and are found under the heading "commissioners decisions". An example is case 02HDC08949, about an overdose of paracetamol to a three-year-old-child. The case describes how the actions of the nurses involved breached Rights four and 10 of the code and also breached accepted standards of professional nursing practice.
> Further information on the code can be found in the NZNO pamphlet The Code of Health and Disability Services Consumer Rights available for free download on the NZNO website (www.nzno.org.nz).

6.2 Consent

"*It is part of a Health Practitioner's work to touch a client and to carry out procedures on that person, be it washing, or giving medication...According to the law no such action may be taken without the client's consent to it*" (Keenan, 2010, p.86). A client or their guardian has the right to refuse consent to medicine administration. In such situations, the following general principles apply for the health professional involved:

> discuss the situation with the client and significant others, as appropriate, to establish reasons for refusal;
> consider whether the refusal of the medicine compromises the client's condition, or subsequently affects the efficacy of other medicines the client may be taking;
> inform the prescriber or appropriate medical staff/senior nursing staff member on duty or on call;

> accurately document the refusal and discussion.

Consent is potentially a complex issue; this guideline does not attempt to address issues related to clients with a mental health problem, cognitive impairment, intellectual disability, or children. Information can be found on these specific themes in Keenan (2010).

5.2.1 Further information

> www.hdc.org.nz commissioner decision: 01HDC02915. This is a case review related to adolescent consent for medicine administration.
> Keenan, R. (Ed). (2010). Healthcare and the law. 4th Ed.). Wellington: Brookers Ltd.

7. Statutory law regarding control of medicines in New Zealand

There are two main statutes providing for the lawful and unlawful handling, possession, advertising, sale and administration of drugs:

> The Medicines Act 1981 and associated regulations and amendments (the most recent in 2013) which outline the law related "to the manufacture, sale, and supply of medicines medical devices, and related products" (Medicines Act, 1981, p.3). The Medicines Act and Regulations are reviewed at regular intervals. It is important nurses keep up-to-date with changes that may affect their practice.
> The Misuse of Drugs Act 1975 and associated Regulations. This contains provisions regarding the legal and illegal use of controlled drugs.

These acts, statutes and regulations can be found on www.legislation.govt.nz and at some public libraries.

7.1 The Medicines Act 1981 and associated Regulations

There are four classifications/schedules of medicines:

1. *Prescription medicines:* a medicine which can only be sold, supplied or administered pursuant to a prescription by: a person authorised to prescribe medicines eg medical practitioner, dentist, registered midwife, veterinarian, nurse practitioner, optometrist, a designated prescriber;[2] by a delegated prescriber;[3] or in accordance with a standing order.

[2] A designated prescriber is registered health professional authorised under the Medicines Act to prescribe any specified class or description of prescription medicines and who satisfies applicable requirements relating to competency, qualifications or training specified in or imposed under regulations made under the Act – this may include a nurse practitioner or registered nurse.

[3] A delegated prescriber is a health practitioner to whom a delegated prescribing order has been issued. A delegated prescribing order is a written instruction, issued in accordance with regulations by an authorised prescriber (excluding a designated prescriber), authorising a health practitioner to prescribe prescription medicines. The person to whom the delegated prescribing order is issued (the delegated prescriber) may prescribe specified prescription medicines, or a specified class or description of prescription medicines, in accordance with the terms of his or her delegated prescribing order.

2. *Restricted medicines (known as pharmacist-only medicines):* a medicine which can only be sold or supplied by a pharmacist from a pharmacy or hospital, or in accordance with a standing order.
3. *Pharmacy only medicines:* a medicine, which can be sold or supplied from a pharmacy or hospital or an isolated shop which has a license to sell specific medicines, or in accordance with a standing order.
4. *General sale medicines:* are not scheduled or classified and can be supplied from any retail outlet.

7.2 Regulations regarding prescription form

Regulations for the form of prescriptions (how they must be written) and those who can prescribe medicines is established by the Medicines Regulations 1984 and subsequent amendments and regulations.

Section 41 of the Medicines Regulations 1984 (SR 1984/143) (as at August 1, 2011) state under 'Form of Prescription' that every prescription given under the regulations shall:

a) be legibly and indelibly printed;
b) be signed personally by the prescriber with his/her usual signature (not being a facsimile or other stamp), and dated;

c) set out the following information in relation to the prescriber:
   i. the prescriber's full name;
   ii. the full street address of the prescriber's place of work or, in the absence of the prescriber having a place of work, the postal address of the prescriber;
   iii. the prescriber's telephone number;

d) set out:
   i. the surname, each given name, and the address of the person for whose use the prescription is given;
   ii. in the case of a child under the age of 13 years, the date of birth of the child;

e) indicate by name the medicine and, where appropriate, the strength that is required to be dispensed;

f) indicate the total amount of medicine that may be sold or dispensed, or the total period of supply;

g) if the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of dose; and

h) if the medicine is for application externally, indicate the method and frequency of use.

Before administration, the nurse must ensure all prescriptions include all these elements. If these elements are not present, then the nurse must not administer the medicine.

6.2.1 Nursing implications

> Where a nurse encounters poor prescribing practice, it is essential this is addressed. If the nurse feels unprepared to discuss this directly with the prescriber, NZNO recommends the nurse documents the poor practice and reports this to their manager. Completion of an incident report may be required. Where the prescriber is also the manager, the nurse may

wish to seek further advice from their NZNO organiser.
> A new national medication chart for district health boards (DHBs) has been developed and as at October 2011 was being rolled out across all DHBs. See 8.4.5 for further information.

6.2.2 Further information

The Medical Council of New Zealand (2010) produces a useful guideline on good prescribing practice that outlines the responsibilities of the prescriber to ensure appropriate prescribing practice. It is available here: http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf

7.3 The Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977

The schedules of the act classify controlled drugs into various classes depending on the risk to the public. The regulations provide for the prescription and storage of controlled drugs.

6.3.1 Nursing implications

> Nurses need to be aware of legislation regarding the storage, recording and administration of medicines and controlled drugs, and the local workplace policies surrounding such requirements. If clarification is required, ask the liaison pharmacist. See section 11.2 for further information.

8. NZ Health and Disability Services Standards

The Health and Disability Services Standards "*are designed to establish safe and reasonable levels of services for consumers, and to reduce the risk to consumers from these services. The standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001*." (Ministry of Health & Standards NZ, 2008, p.7).

The standards are outlined in the document entitled *Health and Disability Services Standards* (Ministry of Health & Standards NZ, 2008). They include medicine management standards and other related topics, such as quality and risk management systems. Workplaces are audited by independent audit agencies against these standards.

7.1.1 Nursing implications

> The standards outline the employers' responsibilities related to medicines management (see standard 3.12 in the section entitled Continuum of service delivery).
> There are also standards related to staff training and quality improvement.
> The Medicines Care Guides for Residential Aged Care (Ministry of Health, 2011) is a quick medicine management reference tool for all care staff working in residential aged care. The Medicines Care Guides are designed to support best practice in residential aged care and may be used as criteria against which standards are measured during an audit. This publication is available for download from the Ministry of Health (MOH) website (http://www.health.govt.nz/publication/medicines-care-guides-residential-aged-care). We strongly recommend all nurses working in aged l care have a copy and refer to it regularly.
> The Medicines Management Guide for Community, Residential and Facility-based Respite Services – Disability, Mental Health and Addiction (Ministry of Health, 2013) is a further essential guide that outlines expected standards of medicines management in care facilities.

This publication is also available for download from the MOH website: http://www.health.govt.nz/publication/medicines-management-guide-community-residential-and-facility-based-services-disability-mental

> When nursing practice is being investigated by agencies such as the Health and Disability Commissioner, these standards and guidelines can potentially be used to judge what is a reasonable standard of practice.

7.1.2 Further information

> The standards are available to download from the Ministry of Health website: (http://www.moh.govt.nz/moh.nsf/indexmh/certification-standards#view)

> www.hdc.org.nz commissioner decision: 05HDC18726. This is a case review regarding medicine administration within a rest home and includes issues about medicine storage, information and record keeping. In this case two nurses were held in breach of Right Four of the Code of Rights. The breaches were for administering incorrect medications at the incorrect time. The Commissioner advised that nurses should not be expected to undertake domestic tasks when they have a professional responsibility to fulfill. Available: www.hdc.org.nz

9. The medication process

9.1 An overview

The treatment of a client with medicines for therapeutic, diagnostic or preventive purposes involves prescribing, dispensing, administering, receiving and recording medicine/s.

The nursing process also applies to medicine administration, including assessment, planning, implementation and evaluation.

Responsibility for accurate medicine administration lies with many individuals. More importantly, responsibility also lies with the organisational systems in place to support medicine administration (Cohen, 2004). The objective of the following information is to outline the relevant legal and professional aspects of each part of the medication process, and to outline the responsibilities of each multidisciplinary role. Once again, it is vital to be familiar with local workplace policy.

9.2 Prescribing medicines

Which health professionals can prescribe?

> Dentists
> Medical Practitioners
> Registered Midwives
> Nurse Practitioners
> Optometrists
> Designated Prescribers (eg. RN practicing in diabetes health)
> Delegated Prescribers

8.2.1 Authorised prescribers

An authorised prescriber is someone who is authorised to prescribe medicines. This includes:

> Midwives;
> Nurse practitioners;
> Practitioners (medical doctors, dentists);

> Optometrists;
> A designated prescriber (see below).

8.2.1.1 The registered midwife

Amendments to the 1981 Medicines Act and the 1975 Misuse of Drugs Act in 1990 enabled midwives to prescribe prescription medicines without supervision by a medical practitioner. There is no defined list of medicines a midwife may prescribe. However, Regulation 39 of the Medicines Regulations 1984, states that no registered midwife shall "prescribe any prescription of medicine otherwise than for antenatal, intrapartum and postnatal care." Section 8(2)(aa) of the Misuse of Drugs Act 1975 permits midwives to prescribe pethidine, but no other controlled drugs (including benzodiazepines).

8.2.1.2 The registered nurse practitioner

The Medicines Amendment Act 2013 has moved the nurse practitioner from being a designated prescriber to being an authorised prescriber. The nurse practitioner is required to practice within their scope as determined by the Nursing Council of New Zealand and must have completed a specialised course in prescribing at Masters level to be able to prescribe.

8.2.3 Designated prescribers

A designated prescriber is someone, other than a practitioner[4], registered midwife, nurse practitioner, or optometrist who is a registered health professional authorised by regulations under the Medicines Act 1981 to prescribe prescription medicines. A designated prescriber must satisfy the requirements in the regulations, and must meet any applicable requirements in the regulations relating to competency, qualifications, or training. Designated prescribers may be required to prescribe only prescription medicines under the supervision of a practitioner (medical practitioner or dentist) depending on the applicable regulation (section 105B(1)(d) of the Medicines Act 1981).

8.2.3.1 Registered nurses practising in diabetes health

In 2011, the Medicines (Designated Prescriber – Registered Nurses Practising in Diabetes Health) Regulations were passed enabling RNs meeting the requirements outlined in the regulations regarding scope of practice, qualifications, competence and training to prescribe specified diabetes medicines under the supervision of an authorised prescriber (from 1 July 2014 this includes doctors, dentists, registered midwives, nurse practitioners, optometrists and designated prescribers). While the regulations state supervision is required by an authorised prescriber, regulations must be read down to the primary legislation, in this case the Medicines Act. Section 105B(1)(d) of the Act states that where regulations stipulate supervision for designated prescribers that supervision must be provided by a Practitioner (defined in Section 2 of the Act as medical practitioner or dentist). NZNO and the Ministry of Health advise that registered nurses practicing in diabetes health must be supervised by a medical practitioner. If further advice is required, please contact the NZNO Member Support Centre on 0800 283848. The Nursing Council of New Zealand website may also have further advice on this issue.

[4] defined under the Medicines Act 1981 as a medical practitioner or dentist.

8.2.4 Delegated prescribers

A delegated prescriber is a health practitioner to whom a delegated prescribing order has been issued. A delegated prescribing order is a written instruction, issued in accordance with regulations by an authorised prescriber (excluding a designated prescriber), authorising a health practitioner to prescribe prescription medicines. The person to whom the delegated prescribing order is issued (the delegated prescriber) may prescribe specified prescription medicines, or a specified class or description of prescription medicines, in accordance with the terms of his or her delegated prescribing order. Training, qualification and ongoing demonstration of competence will be required of the delegated prescriber.

9.3 Dispensing medicines

8.3.1 Definition

Dispensing is defined as the preparation of a medicine for sale to the public (whether in response to the issue of a prescription or a request by an individual to be supplied with the medicine) and the packaging, labeling, recording, and delivery of that medicine (Medicines Act, 1981).

8.3.2 Which health professionals can dispense?

The Medicines Regulations outline “no person other than an authorised prescriber, veterinary surgeon, pharmacists, pharmacy graduate, a pharmacy technician, a [pharmacist] student, or dispensary technician may dispense a prescription medicine” (Medicines Regulations 1984 42(1)).

Please note: Pharmacy graduates, pharmacy technicians, pharmacist students, pharmacy technician students and dispensary technicians may only dispense prescription medicines under the direct personal supervision of a pharmacist (Medicines Regulations 1984 42(1)(A)).

8.3.3 What activities are classified as dispensing?

> Transferring medication from the original container in which they were dispensed in to another container for administration at a later time or date. For nurses managing patients/clients/consumers going on leave from a service, this can be problematic. For example, if a nurse places medication into an envelope for the patient/client/consumer to take later in the day, this is technically dispensing. Most large organisations have policies to manage this, but smaller organisations must also be aware of these issues and develop appropriate policies as well.
> Filling a client’s compliance packaging aid (monitored dosage system) from other pharmacy labeled containers. (Compliance packaging aids or monitored dosage systems) are defined for this document as blister packs, dispensing boxes, dosette boxes, and sachets). Nurses must NOT tamper with a seal on a box between its closure by the pharmacist and time of administration. See further information under section 10.4.

8.3.4 What activities are **not** defined as dispensing?

NZNO intermittently receives queries from nurses concerned that the preparation of two or more medicines in a syringe/infusion (for example, patient controlled analgesia) is defined as dispensing. This is not dispensing. The preparation of two or more prescribed medicines in a syringe/infusion for imminent administration to a specific client is classified as an administering activity (personal communication, S.Jessamine (Medsafe), July 2007).

8.3.5 Nursing implications

> Dispensing activities must be avoided by nurses.

> If a nurse is exposed to dispensing situations, he/she must alert the manager/employer. The manager/employer has a responsibility to determine protocols and provide resources to deal with dispensing activities that will meet legal requirements.

8.3.6 Further information

The Ministry of Health *Guidelines for Syringe Driver Management in Palliative Care* (2009) provides further information on the use of syringe drivers. Available: http://www.health.govt.nz/publication/guidelines-syringe-driver-management-palliative-care-new-zealand

9.4 Administering medicines

8.4.1 Who can administer medicines?

Any person may administer medicines (including controlled drugs[5]), but whoever administers these is required to do so in accordance with the directions of the prescriber, or in accordance with a standing order.

All people in employment who administer medicines must be familiar with their employer's policies and guidelines regarding medicine administration.

Regulated nurses/midwives need to understand the responsibilities and accountabilities of their scope of practice relevant to medicine administration (see section 9 of this document for further information).

HCAs who administer medicines need to understand their responsibilities and accountabilities (see section 9). This activity is by delegation from a regulated health practitioner and there must be policies and procedures in place to support it.

8.4.2 NZNO position statement on medicine administration

NZNO believes the safe administration of medicines by the regulated nurse/midwife requires professional judgment. This means applying knowledge and experience to the situation. This judgment is directed to fulfilling the standards for the administration of medicines, as outlined in appendix one.

NZNO acknowledges there is a wide spectrum of situations in which medicines are administered. At one extreme, is the client in an intensive care unit receiving complex care that can only be provided by qualified and highly skilled staff. At the other extreme, is the person in their own home administering their own medicines or being assisted in this respect by a relative or another person. The answer to the question of who should administer a medicine largely depends on where within

[5] Section 8(2)(d) of the Misuse of Drugs Act 1975 states "Any person having the care of a patient for whom a controlled drug is supplied by a medical practitioner or dentist, or prescribed by a medical practitioner or dentist and legally supplied, may administer that drug to that patient in accordance with the advice of the medical practitioner or dentist who supplied or prescribed it".

that spectrum the recipient of the medicine lies.

NZNO's position is that where a person is receiving complex care that can only be provided by qualified and highly skilled staff, the nurse must assess the patient's response to the medication. The nurse must also be able to speedily recognize and respond to any adverse reactions/side effects and document them. NZNO recommends that, in these settings, medicines should only be administered by regulated nurses/midwives who are competent in the role and aware of their personal accountability.

NZNO is opposed to involving HCAs in administering medicines in acute care, and/or with ill or medically unstable patients, because the requirements of the standards in appendix one cannot be achieved. Organisations must be aware of the responsibility they hold when allowing non-regulated health professionals (eg. social workers, HCAs) to administer medicines.

8.4.2.1 Further information:

> www.hdc.org.nz commissioner decision, 02HDC08692. This is a case review related to monitoring the effects of medicine post administration. In this case, a nurse was found in breach of Right Four of the Code of Rights for failing to provide an appropriate standard of care to a patient. The nurse failed to undertake appropriate monitoring of the patient following the administration of a drug. The patient subsequently died. Available: www.hdc.org.nz

> www.hdc.org.nz commissioner decision, 03HDC14664. This is a case review related to medicine administration by HCAs. In this case, a nurse was found in breach of Right Four of the Code of Rights for failing to monitor blood glucose levels, failing to provide appropriate training to caregivers and failing to monitor the observations undertaken by caregivers. The nurse appeared before the Health Practitioners Disciplinary Tribunal and was found guilty of professional misconduct. The nurse was ordered to practise only under the supervision of an RN approved by the Nursing Council, and ordered to contribute $10,000 towards the costs of the hearing and prosecution. Available: www.hdc.org.nz

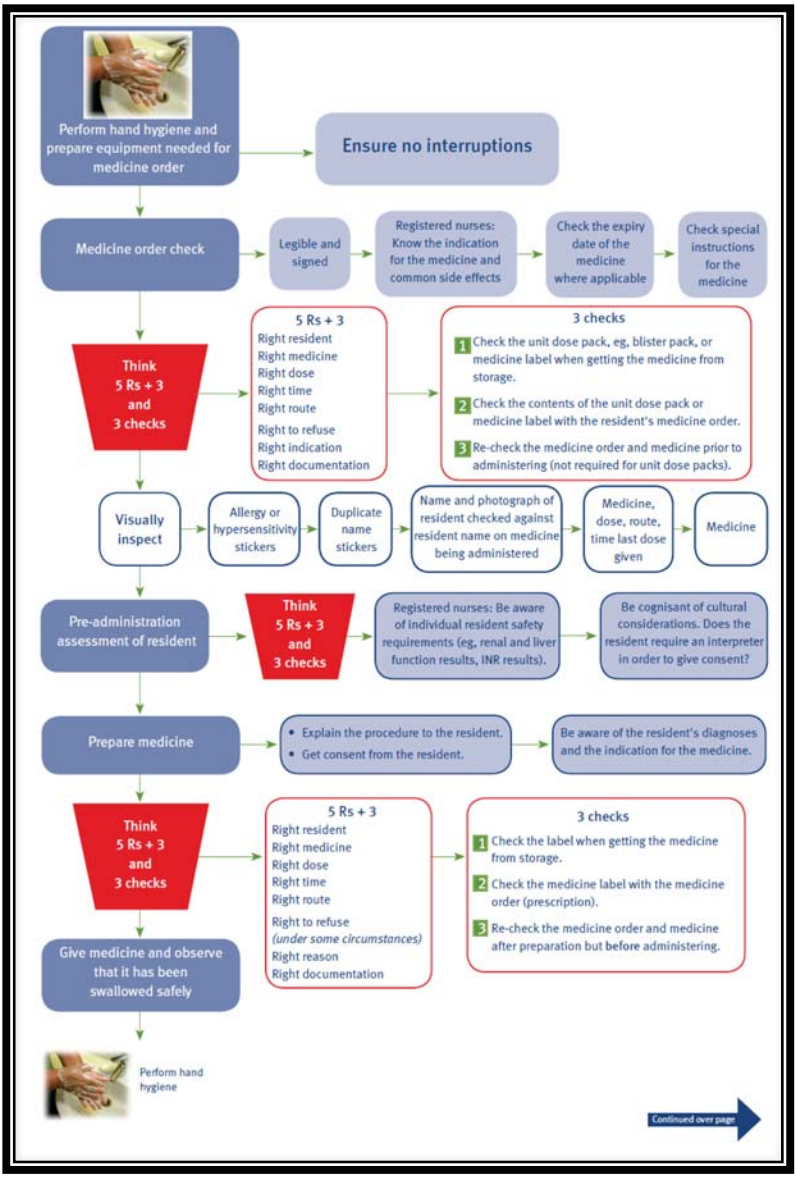
8.4.3 NZNO standards for the administration of medicines

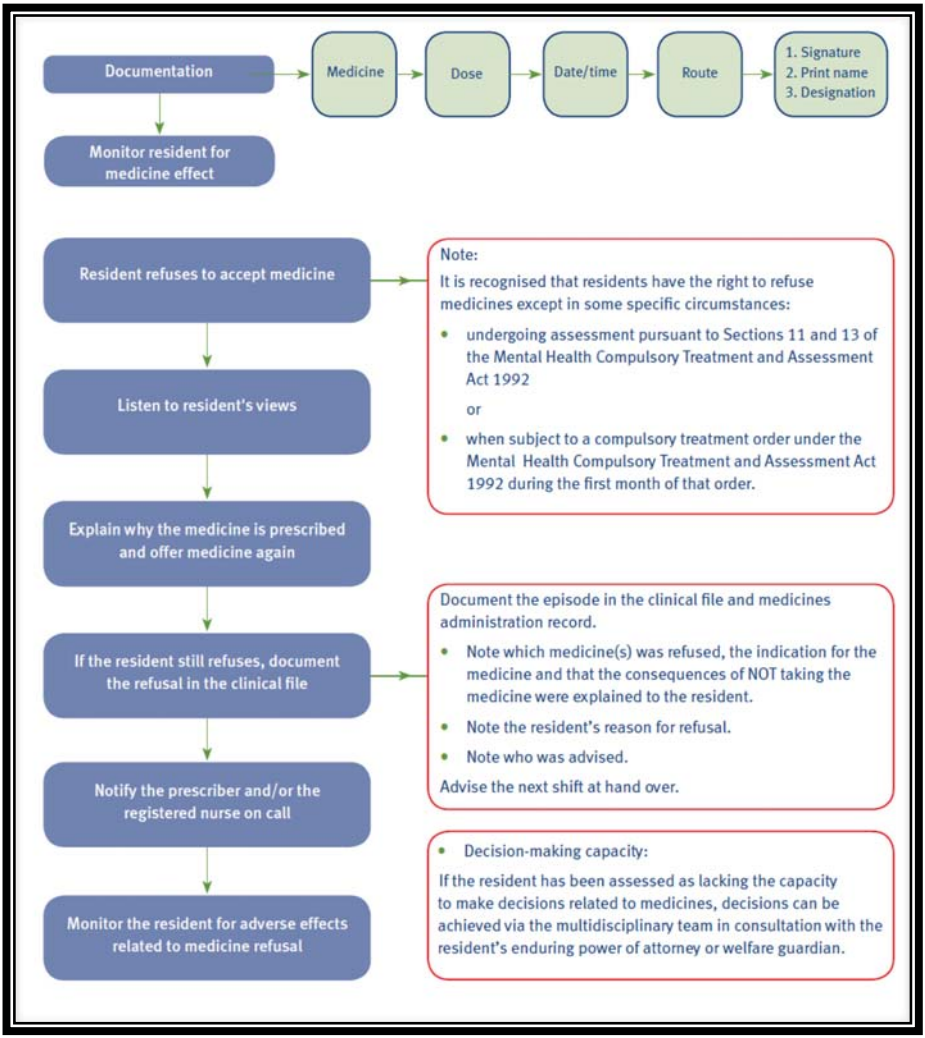
These are outlined in appendix one.

8.4.4 Medicine administration safety

Figure 2 has been copied with permission from MOH and provides a useful outline of the process for medicine administration in older adult residential care.

2: Medicine administration safety in older adult residential care settings (reprinted with permission from the Ministry of Health)




Documentation
Medicine
Dose
Date/time
Route
1. Signature
2. Print name
3. Designation
Monitor resident for medicine effect
Resident refuses to accept medicine
Note:
It is recognised that residents have the right to refuse medicines except in some specific circumstances:
undergoing assessment pursuant to Sections 11 and 13 of the Mental Health Compulsory Treatment and Assessment Act 1992
or
when subject to a compulsory treatment order under the Mental Health Compulsory Treatment and Assessment Act 1992 during the first month of that order.
Listen to resident's views
Explain why the medicine is prescribed and offer medicine again
If the resident still refuses, document the refusal in the clinical file
Document the episode in the clinical file and medicines administration record.
Note which medicine(s) was refused, the indication for the medicine and that the consequences of NOT taking the medicine were explained to the resident.
Note the resident's reason for refusal.
Note who was advised.
Advise the next shift at hand over.
Notify the prescriber and/or the registered nurse on call
Decision-making capacity:
If the resident has been assessed as lacking the capacity to make decisions related to medicines, decisions can be achieved via the multidisciplinary team in consultation with the resident's enduring power of attorney or welfare guardian.
Monitor the resident for adverse effects related to medicine refusal

8.4.5 Preparing and checking medicines for administration

While many medicines can be prepared for administration by an individual regulated nurse, eg tablets that are not controlled drugs (see section 11.2 for further information on controlled drugs), many agencies require some medicines, particularly intravenous (IV) medicines for administration including blood products, and immunisations to be checked by two regulated nurses. It is important to check your individual agency's policies for specific information on who can check medicines.

Where an agency policy requires a medicine to be checked by two people, the second person must ensure they undertake any calculations independently of the first person, where necessary witnesses administration of the medicine, and documents that they have checked and witnessed (where relevant) administration of the medicine in the medication chart.

Employers must ensure a clear, written policy exists on who can prepare and check medicines for administration which takes into account the complexity of the medicine, the patient population and the context of the workplace. If such a policy does not exist, management must be informed.

8.4.6 National medication chart

In 2011, a new, standardised national medication chart was rolled out across district health boards (DHBs) nationally. All nurses working in DHBs should be familiar with the layout and design features of the new chart, including the abbreviations used. A copy of the chart can be found in appendix two.

10. The multidisciplinary team: responsibilities and accountabilities

Responsibility for accurate drug administration lies with many individuals and, more importantly, the organisational systems in place to support medicine administration (Cohen, 2004).

The following outline of roles aims to inform nurses of the various team members' responsibilities and accountabilities, including direction and delegation. It is not definitive but presents an overview relevant to nurses. It is assumed all team members are familiar with relevant national standards and medico-legal issues.

10.1 The employer

> ensures appropriate orientation and education, including competence assessment for all involved in the administration of medicines;
> provides safe systems for the storage, handling and administration of medicines which meet legislative requirements;
> provides job descriptions, policies and guidelines that outline the responsibilities of regulated and unregulated staff members in all steps of the medication process;
> provides adequate resources for current medicine management; and
> informs staff members of risk management processes they can contribute to and/or participate in.

(Ministry of Health & Standards NZ, 2008; Keenan, 2010; Health and Disability Commissioner Act, 1994).

10.2 The prescriber

> ensures whenever possible, the client is aware of the purpose of the treatment, and consent has been obtained;
> ensures the prescription is clearly written, typed or computer-generated, the entry is indelible and dated, any subsidy coding requirements have been included, and the prescription/all entries on the drug chart have been signed individually by the prescriber;
> refuses to dispense any medicine where the form of the prescription is incorrect;
> where the new prescription replaces an earlier prescription, the latter has been cancelled clearly and the cancellation signed and dated by an authorised prescriber;
> ensures the prescription provides clear and unequivocal identification of the client for whom the medicine is intended;
> ensures the substance to be administered is clearly specified and, where appropriate, its form (for example table, capsule, suppository) stated, together with the strength, dosage, timing, frequency of administration, route of administration, quantity and/or duration of treatment; and
> that, in the case of controlled drugs, the dosage is written, together with the number of dosage units or total course, if in an out-patient or community setting, the prescription must be in the prescriber's own hand writing and on the appropriate drug control form. For unusual or dangerous doses of controlled drugs the prescriber must underline the amount and initial in the margin.

10.3 The pharmacist

> checks the prescription is written correctly (to avoid misunderstanding or error) and is signed by an authorised or designated prescriber;
> checks that any newly-prescribed medicines will not have adverse interactions with current medicines;
> provides the medicine in a form relevant for administration to the particular client, in an appropriate container, as well as giving the relevant information and advice on storage and security conditions;
> where the substance is prescribed in a dose, or is to be administered by a route which falls outside the manufacturer's recommendation, the pharmacist will have taken steps to ensure the prescriber is aware and has chosen to exceed that licence;
> if the prescription contains any written amendments made and signed by the pharmacist, the prescriber has been consulted and advised and the amendments have been accepted;
> is available for education to the multidisciplinary team and to the patient/ client/consumer and their family; and
> the pharmacist, in pursuit of her or his role in monitoring the adverse side effects of medicines, should be sent any information the administering health care provider deems relevant.

10.4 The registered nurse (RN) and midwife

> understands the legislative and professional/ethical issues outlined in these guidelines, including the standards outlined in appendix one;
> delegates the administration of medicines to ENs and HCAs according to their employer's policies and guidelines and the Nursing Council guidelines on direction and delegation (NCNZ, 2011a; 2011b);
> where ENs and HCAs are involved with the administration of medicines, the RN or midwife continues to be accountable for directing and delegating the appropriate and safe administration of medicines. "The RN must be available for timely advice regarding any nursing needs" (NCNZ, 2011a, p.4; 2011b, p.4);
> the RN or midwife needs to report concerns about risks in the medication process to

management;
- the RN working in the obstetric setting: Note that one of the competencies for entry to the register for midwifery states that the midwife "directs, supervises, monitors and evaluates the obstetric nursing care provided by registered obstetric nurses, enrolled nurse, registered general nurses or registered comprehensive nurses" (Midwifery Council of New Zealand, 2004, p.6); and
- is aware of and complies with agency policies regarding the preparation and checking of medicines.

10.5 The enrolled nurse (EN)

- understands the legislative and professional/ethical issues outlined in this guideline, including the standards outlined in appendix one;
- understands the responsibilities and accountabilities of the RN/midwife as outlined above;
- is familiar with the employer's policies and guidelines on medicine administration;
- for the EN working in the obstetric setting: Note that one of the competencies for entry to the register for midwifery states that the midwife "directs, supervises, monitors and evaluates the obstetric nursing care provided by registered obstetric nurses, enrolled nurses, registered general nurses or registered comprehensive nurses" (Midwifery Council of New Zealand, 2004, p.6);
- when accepting delegated activities, understands that he/she retains responsibility for their actions and remains accountable to the RN/midwife;
- has a responsibility to inform the RN/midwife if he/she does not believe he/she as an EN has the necessary skills and knowledge to carry out the delegated task; and
- reports concerns about risks in the medication process to the RN/management.

Further information on the role of the EN in the administration of medicine can be found in the NZNO guideline on the place of ENs in the New Zealand health care system (NZNO, 2011a).

10.6 The health care assistant (HCA)

- understands that the regulated nurse/midwife has responsibilities and accountabilities under their scope of practice to the relevant regulatory authority;
- is familiar with their employer's policies and guidelines related to medicine administration, including their individual responsibilities related to achieving the standards in appendix one;
- is aware that when working in the obstetric setting, care provided by the HCA may be directed, supervised, monitored and evaluated by the registered midwife;
- when accepting delegated activities, the HCA understands that he/she retains responsibility for their actions and remains accountable to the RN/midwife;
- understands that the EN may co-ordinate and prioritise the workload for a team of HCAs and act as a resource for them (Nursing Council of New Zealand, 2011a);
- has a responsibility to inform the RN/midwife/EN if they do not believe they, as an HCA, have the necessary skills and knowledge to carry out the delegated task; and
- reports concerns about risks in the medication process to the RN/midwife/EN and management.

10.7 The student nurse

- understands the regulated nurse/midwife has responsibilities and accountabilities under their scope of practice to the relevant regulatory authority;
- is familiar with their educational institutions' policies and guidelines related to medicine

administration, including their individual responsibilities related to achieving the standards in Appendix One;
> understands the clinical agency's policies and guidelines on medicine administration and adheres to these;
> understands they must never administer or supply medicines without direct supervision of a RN/midwife; and
> understands they may decline to undertake a task if they do not feel confident enough to do so.

To achieve the outcomes and standards required for registration, students must be given opportunities to participate in the administration of medicines but this must always be done under direct supervision. Where this is done, both the student and the RN/midwife must sign the patient medication chart. The RN/midwife is responsible for delegating to a student. If the student is not yet ready to undertake administration this should be delayed until the student is ready. Students are not regulated under New Zealand law; therefore it is the nurse or midwife who is accountable for the actions of the student. For this reason, NZNO recommends that, regardless of the level at which the student is studying, ie year one, two or three, medicine administration is always undertaken under the direct supervision of the RN or midwife.

11. Specific professional practices

11.1 Verbal and telephone medicine orders

Acceptance of verbal orders for the administration of medicines is not specifically provided for under legislation. However, the Ministry of Health has provided some guidance for residential care settings. This indicates that, if the RN records the name of the authorised prescriber, recipient, date, and medicine order, (where possible the prescriber faxes a copy of the order to the pharmacy and facility), and the order is signed by the prescriber within two days, then this is acceptable (Ministry of Health, 2011). This documentation process can be applied in general hospital wards. The documentation requirements for verbal orders (eg time frame within which the prescriber is required to subsequently sign the medicine chart) should be described in an organisational policy.

The following table outlines an advisable procedure for taking telephone orders (Keenan, 2010, p.258):

Table 1. How to take a telephone medication order (Keenan, 2010, p.258)

> Write the order as it is being given.
> Read it back to the prescriber.
> Always get a colleague to hear the order from the prescriber and write it down, and repeat it to the prescriber.
> Resolve any discrepancy or difficulty in hearing the order before the telephone conversation is finished.
> The order should be written, preferably on the medication administration form (not on the medication order form), and clearly marked as an administration of a medicine pursuant to a telephone order. (This prevents it being considered a written order by the prescriber, or the erroneous reading of the actual order as a fresh order for repeat administration.)
> Enter administration on the medication administration form as

being given in the usual way, after checking and witnessing, as required.
> Record in the client's notes that special action is required, namely the writing up of the order by the prescriber

In some circumstances, a medical practitioner may also need to prescribe remotely. This may occur in the following situations:

> where a previously unprescribed medicine (eg, in palliative care or remote and rural areas) is required urgently; or
> where medication (not including controlled drugs) has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary.

Use information technology (such as fax, text message or email) to confirm the prescription before the medication is administered. This should be followed up by a new prescription signed by the prescriber who sent the fax/text/email, confirming the changes within normally a maximum of 24 hours.

For remote prescriptions, a verbal order on its own is not acceptable. The fax or email prescription must be attached to the patient's existing medication chart. The RN or midwife is accountable for ensuring all relevant information has been communicated to the prescriber and s/he may refuse to accept a remote prescription, if it compromises care to the patient. In this instance s/he should document accurately the communication that has taken place.

All nurses and midwives must follow local guidelines and policies on verbal and telephone medicine orders.

10.1.1 Text messaging

While not currently common practice in NZ, text messaging may become more common for remote prescriptions. If text messaging is used, the nurse or midwife is responsible for ensuring patient confidentiality and documentation of any text message received (Nursing and Midwifery Council [UK], 2007/2010). This should include documenting the following:

> the complete text message
> the telephone number it was sent from
> the time it was sent
> any response given
> the date and signature of the nurse or midwife who received the text message and
> the date and signature of a second person who has witnessed the text message (preferably another registered health professional).

Following documentation, all texts received should be deleted from the receiving handset.

10.1.2 Further information

> The Ministry of Health and Standards New Zealand (2002) has guidelines for documenting verbal orders. (Available to order from www.standards.co.nz).
> The Ministry of Health has also provided some guidance in the Medicines care guides for residential aged care. (Available from: http://www.health.govt.nz/publication/medicines-care-

guides-residential-aged-care)

> The United Kingdom Nursing and Midwifery Council Standards for Medicine Management (Nursing and Midwifery Council, 2007/2010). Available: http://www.nmc-uk.org/Documents/Standards/nmcStandardsForMedicinesManagementBooklet.pdf

11.2 Standing orders

A standing order is a **written instruction** issued by a medical practitioner or dentist that authorises a specified person or class of people (eg, paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs (Ministry of Health, 2012). Standing orders are useful tools for procuring the administration of treatment or medicines in the absence of a qualified practitioner. However, they need to be approached with caution. Under the Medicines (Standing Order) Regulations 2002 (SR 2002/373) (as at 01 August 2011), standing orders must meet all of the following criteria:

a) be in writing, name the issuer, and be signed and dated by the issuer
b) explain why the standing order is necessary
c) describe the class of persons permitted to supply or administer a medicine under the standing order
d) specify:
    i. the level of competency required of the class of persons permitted to supply or administer a medicine under a standing order, including any training to be undertaken, in the following circumstances:
        - if there is no registration authority for that class of persons or
        - the registration authority for that class of persons has not set any level of competency
    ii. any additional competencies required of the class of persons permitted to supply or administer a medicine under a standing order, including any training to be undertaken, if the registration authority for that class of persons has set levels of competency
e) identify the class of persons to whom a medicine may be supplied and administered under the standing order
f) specify either the period for which the standing order applies or, if no period is specified, state that the standing order is to apply until it is replaced by a new standing order covering the same subject matter or until it is cancelled in writing by the issuer
g) specify the particular circumstances in which the standing order applies
h) specify the treatments to which the standing order applies
i) list the medicines that may be supplied or administered under the standing order, the indications for which the medicine is to be administered and the recommended dose or dose range for those indications, the contraindications for the medicine, the validated reference charts for calculation of dose (if required), the method of administration, and the documentation required
j) specify whether countersigning is required
    (a) if countersigning is required, specify:
    i. the period within which the issuer must countersign the charted treatment, and
    ii. any other requirements for countersigning that the issuer considers appropriate
k) if a policy relating to the standing order exists, attach a copy of that policy, which must have been signed by the issuer, the management of every health provider in which the standing order operates, and every person supplying or administering under the standing order, as applicable
l) describe the scope of the standing order, and
m) define the terms used in the standing order.

Staff administering under a standing order must:

> give the medicines in accordance with the standing order, and
> record the assessment and treatment of the patient (including any adverse reactions) and any monitoring or follow-up needed.

10.2.1 Nursing Implications

> Nurses/midwives wishing to administer medicines under a standing order can only do so if they have signed up to the agency's standing order policy and have met the specified level of competencies (Keenan, 2010, p.265).
> If a standing order specifies the level of competency or additional competencies of a person permitted to supply and administer a medicine under that standing order, then the competency or additional competencies of that person must be reviewed by the issuer at least once a year, commencing from the date on which the standing order was signed by the issuer.
> Standing orders are often embedded in clinical pathways – it is important to understand the obligations surrounding use of standing orders when using a clinical pathway.
> Nurses and midwives must follow local workplace policies and guidelines on the use of standing orders.

10.2.2 Further information

> Further specific information can be found in the Medicines (Standing Order) Regulations 2002 (SR 2002/373) (as at 01 August 2011) available from www.legislation.govt.nz.
> Guidelines for practitioners on developing and using standing orders can be found in the Ministry of Health document: Standing Orders Guidelines (Ministry of Health, 2012). The document is available here: http://www.health.govt.nz/publication/standing-order-guidelines and NZNO strongly recommend workplaces have a copy readily available.

11.3 Unapproved medicines: section 29 Medicines Act, 1981

Occasionally, nurses and midwives will encounter medicines labeled as "section 29". This means that "as well as registered medicines there are unregistered medicines whose distribution and use is unapproved, but that are nevertheless safe and effective and approved overseas" (Keenan, 2010, p.243). (Note: there is no accessible list of these medicines available for nurses. It is the pharmacist's responsibility to notify staff if a medicine is unregistered).

It is important that *the prescriber* is aware of his/her responsibilities in relation to explaining to the client:

> what the implications of section 29 are, and obtaining verbal consent, and
> that the use of a section 29 medicines is reported to Medsafe and recorded on a database. This also requires client consent.

It is recommended that a guideline is developed locally with all relevant stakeholders, if section 29 medicines are used.

10.3.1 Further information

> Is available on www.medsafe.govt.nz: search for "unapproved medicines".
> Your liaison pharmacist.
> See section 11.5 for information on complementary medicines.

11.4 Crushing or disguising medicines

The mechanics of crushing medicines may alter their therapeutic effects rendering them either ineffective or less effective. Medicines should not be routinely crushed unless a pharmacist advises that the medicine is not compromised by crushing and crushing has been determined to be in the patient's best interest. Talk to the pharmacist about the availability of alternative preparations eg. liquid form.

By disguising medicines in food or drink, a patient or client may be led to believe they are not actually receiving medicines. Full consent of the patient or client to have their medicine disguised in food or drink should be obtained before undertaking this practice. In situations where consent is not able to be obtained, the nurse or midwife would need to be certain that what they are doing is in the best interests of the patient and recognise they are accountable for this decision.

11.5 Monitored dosage dispensing

Monitored dosage systems (also known as compliance packaging aids), (ie blister packs, dispensing boxes, dosette boxes, sachets) are systems for supplying and dispensing medicines and are prepared by a community pharmacist. These systems involve dispensing a client's medicine into a special container with sections for days of the week and time within those days.

The supply of the medicines in a special container or blister packs must be accompanied by the appropriate prescription information to the hospital/rest home/residential care/domestic residence. Systems must meet criteria established by Medsafe.

In order to be acceptable for use in hospital/rest home/residential care/domestic residence, the containers for the medicine must:

> be filled by a pharmacist and sealed by them or under their control and delivered complete to the medicine administrator or user;
> be accompanied by clear and comprehensive documentation which forms the authorised prescriber's prescription;
> be able to be stored in a secure place; and
> have a structure that makes it apparent if the containers (be they blister packs, spaces within a container or sachets) have been tampered with between the closure and sealing by the pharmacist and the time of administration.

10.5.1 Nursing implications

> While the introduction of a monitored dosage system transfers to a pharmacist the responsibility for being satisfied the container is filled and sealed correctly to comply with the prescription, it does not alter the fact that the RN administering the medicines must still consider the appropriateness of each medicine at the time of administration..
> It is not acceptable, in lieu of a pharmacist-filled monitored dosage system container, for a health provider to transfer medicines from their original containers into an unsealed container for administration at a later stage. This is a dispensing activity (see section 8.3 for further detail).
> It is also not acceptable to interfere with a sealed section of a monitored dosage system at any time between its closure by the pharmacist and the scheduled time of administration, eg opening a sealed blister pack section, adding a charted antibiotic and taping over the section.
> Where it is not possible for the boxes to be filled and sealed before supplying to the client, the nurse should mark the container only with the day and time the medicines are to be taken, rather than with the name of the medicine. The client should be well instructed (preferably in writing in addition to verbal instructions) on the name of the medicine and should be given any

information regarding taking it, side effects, and relevant contra-indications. (Keenan, 2010, p.255).

> There are potential difficulties associated with individual medicine identification by staff in a monitored dosage system. For example, it may be necessary to withhold a specific tablet such as digoxin. The employer, nurses, doctors, and the liaison pharmacist need to establish a guideline for the management of such a procedure that ensures patient safety.

10.5.2 Further information

An ACC case study on medication administration error outlines some of the risks associated with using monitored dosage dispensing systems and highlights the importance of individual practitioner responsibility in the administration of medicines. The case study is available at: http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/reference_tools/prd_ctrb132496.pdf

11.6 Transcribing

This activity can include:

> writing out a client's current medication on to a Medication Administration Record Chart used as an audit record of medicines administered
> completing a list of a client's current medication in a care plan or medication history in the clients' notes
> producing a medication reminder chart to support clients or their carers in the administration of medicines; and
> writing instructions for health care support workers when delegating the task of administration of medicines.

Transcription is the responsibility of the prescriber.

10.6.1 Nursing implications

> NZNO does not recommend this practice due to:
  - the risk of errors during the transcription, including duplication and/or omission; and
  - the potential for staff to rely on secondary sources rather than the original medication order form, resulting in incorrect medication administration.
> In the case of yellow medication cards (for patient education), it is the responsibility of the prescriber to complete these. The nurse is responsible for:
  - ensuring medications written on the yellow card correspond to the prescriptions given to the patient; and
  - advising the patient to discard any outdated cards.

10.6.2 Further information

Keenan (2010, p.258) outlines the risks associated with the practice of transcribing.

11.7 Medicines reconciliation

Medicines reconciliation is an evidence-based process of obtaining, within 24 hours of admission, the 'most accurate' list of all medications a patient is taking. (Safe Medication Management Programme, 2011). Medicine reconciliation has three core steps:

1. Collecting the 'most accurate' medicines list, using at least two different information sources,

the primary source being the patient.
2. Comparing the 'most accurate' medicines list against the current medication chart and clinical notes for any documented changes to medicines.
3. Communicating any discrepancies (ie undocumented changes, whether intended or not) to the prescriber to reconcile and action.

(Safe Medication Programme, 2011)

While a RN may undertake reconciliation and note any discrepancies in prescribing, the RN will not undertake any resultant transcribing practices.

10.7.1 Nursing implications

> Medicines reconciliation should be carried out by any health practitioner involved in the prescribing, dispensing or administration of medications – this includes medical practitioners, NPs, other designated prescribers, pharmacists and RNs.
> Medicines reconciliation should be carried out for all patients within 24 hours of admission, transfer or discharge from any setting.

10.7.2 Further information

Details on the Safe Medication Management Programme are available from www.safemedication.org.nz.

11.8 Working with children and infants

Children have specific needs and requirements regarding medicines – prescribing can be particularly challenging due to the weight-based dosing calculations, fractional dosing (grams versus milligrams) and the need for decimal points. Nurses and midwives need to be particularly vigilant for prescribing and calculation errors, given the increased risk to an infant or child if an incorrect dose is given.

The following guidelines should help nurses and midwives working with infants and children:

> children and infants should only by weighed in kilograms and kilograms should be the standard weight on prescriptions, medical records and staff communications;
> use oral syringes to administer oral medicines; and
> avoid storing adult and paediatric concentrations in the same automated dispensing machine cabinet drawer or any other storage facility.

NZNO recommend all nurses and midwives working with children undertake regular updates on calculation competence. As per section 8 on administering medicines, where an agency policy requires a medicine to be checked by two people, the second person must ensure they undertake any calculations independently of the first person, where necessary witnesses administration of the medicine, and documents that they have checked and witnessed (where relevant) administration of the medicine in the medication chart.

10.8.1 Further information

> The Joint Commission (2008) has published recommendations for all those involved in the prescribing, dispensing and administering of medicines to children: (http://www.jointcommission.org/assets/1/18/SEA_39.PDF).
> HDC case 02HDC08949 describes a case in which a three-year-old child received an overdose

of paracetamol. Issues associated with the case include the weight of the child, drug calculations and alteration of documentation. www.hdc.org.nz

11.9 Health professionals administering medicines to family & friends

Nurses involved in a personal capacity, such as giving drugs to family members, are professionally accountable for their actions and must fulfill the standards outlined in appendix one. The advice of a community pharmacist should be sought when necessary.

Nurses must also be aware that administering medicines to themselves from anything other than a personal prescription or purchase of an over-- the-counter medicine can be construed as theft, for which the nurse may be held liable under the Misuse of Drugs Act (1975) or the Crimes Act (1961).

11.10 Self administration of medicines by clients

Where self-administration is introduced for all or some clients, arrangements must be in place for the appropriate, safe and secure storage of the medicines. People who will have access to these medicines will be determined by local workplace policy.

For the long-stay client, whether in hospital or in a rest home/residential care, self-administration can help foster a feeling of independence and control. This can be facilitated by the nurse, via a self-administration policy.

For the hospital client approaching discharge who will continue on a prescribed medicines regime following return home, there are obvious benefits to self-administration while still having access to professional support. Health professionals need to be aware of maintaining the standards outlined in appendix one, if they are monitoring self administration by a client.

10.10.1 Further information

Detail on self administration is available in the *Medicines care guides for residential aged care*, available to download from the Ministry of Health website (http://www.moh.govt.nz/moh.nsf/indexmh/medicines-care-guides-for-residential-aged-care).

11.11 Education of staff re medicine administration

While the employer has overall responsibility for the education and professional development of staff (Ministry of Health and Standards New Zealand, 2008), the RN may be involved in teaching other team members about medicine administration and in developing medicine guidelines and policies. The RN needs to meet the Nursing Council's education competencies outlined in the document entitled *Competencies for Registered Nurses* (NCNZ, 2009). The RN must also be aware of their role and responsibilities regarding direction and delegation to ENs and HCAs. Further information on direction and delegation can be found in the Nursing Council documents *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (Nursing Council of New Zealand, 2011b) and *Guideline: delegation of care by a registered nurse to a health care assistant (*Nursing Council of New Zealand, 2011a). These documents are available from the Nursing Council website (www.nursingcouncil.org.nz).

11.12 Automated medication dispensing devices and automated medication management

Some hospitals have commenced using this technology, an example of which is Pyxis. The functions of these devices vary according to the manufacturer and location. Therefore it is vital that guideline development involves all stakeholders.

10.12.1 Implications for nursing

> Nurses or midwives cannot refill an automated dispensing machine. This is considered dispensing and is outside the scope of practice of the nurse or midwife.
> The automatic tracking systems and other features on dispensing machines do not remove the responsibility or accountability of the nurse or midwife to meet the standards for medicine administration outlined in appendix one of this document – in particular the documentation in the patient record of all medicines that have been administered.

10.12.2 Further information

Areas that can be contacted with experience of this technology include Taranaki DHB. If further expertise is required, Medsafe can be contacted for advice.

11.13 Expiry dates

Expiry dates must be strictly adhered to. Exceptions will occasionally occur. For example, in the 2009 H1N1 pandemic, Medsafe approved a two-year extension to the expiry date on existing stocks of Tamiflu. Nurses and midwives must be aware of when such changes occur and their implications for nursing practice.

> An expiry date (month/year) is deemed to expire at the end of the month.
> A use by date (month/year) is deemed to expire the first day of the month.

11.14 New Zealand Universal List of Medicines (NZULM)

The NZULM is a dictionary of trusted, standardised information covering medicines approved for supply in New Zealand, as well as products listed in Pharmac's Pharmaceutical Schedule which fall outside this category. It also includes medicines imported under Section 29 of the Medicines Act. The NZULM introduces a common medicines terminology. Descriptions are standardised, and unique international identifiers assigned for every medicine.

The NZULM is an important new foundation for the health system. It will enhance patient safety, the safe use of medicines, and the efficiency and effectiveness of prescribing and dispensing systems. It will also contribute to better reporting of medicines information, as well as health sector initiatives such as ePharmacy and the New Zealand Medicines Formulary.

10.14.1 Further information

Further information can be found on www.nzulm.org.nz

11.15 Reporting adverse events (errors or incidents)

If an error is made in the administration of a medicine, the RN/midwife must take any action to prevent any potential harm to the patient, and report the error as soon as possible to the

prescriber, the line manager or employer (according to local workplace policy). The RN/midwife must document the incident and the action taken. An incident form must be completed. If an EN, HCA or student nurse makes an error this must be reported to the supervising RN/midwife as soon as possible so the above actions can be taken.

10.15.1 Implications for nursing

> The RN/midwife and EN are accountable for their actions in the administration of medicines to the Nursing or Midwifery Councils.
> Any error or incident should be subject to an investigation – this may be internal or, if serious harm has occurred, this may be external.
> NZNO supports a thorough, open and multi-disciplinary approach to investigating adverse events. This will ensure improvements in practice can be discussed, identified and disseminated.
> It is important an open culture exists to encourage the immediate reporting of errors or incidents in the administration of medicines.

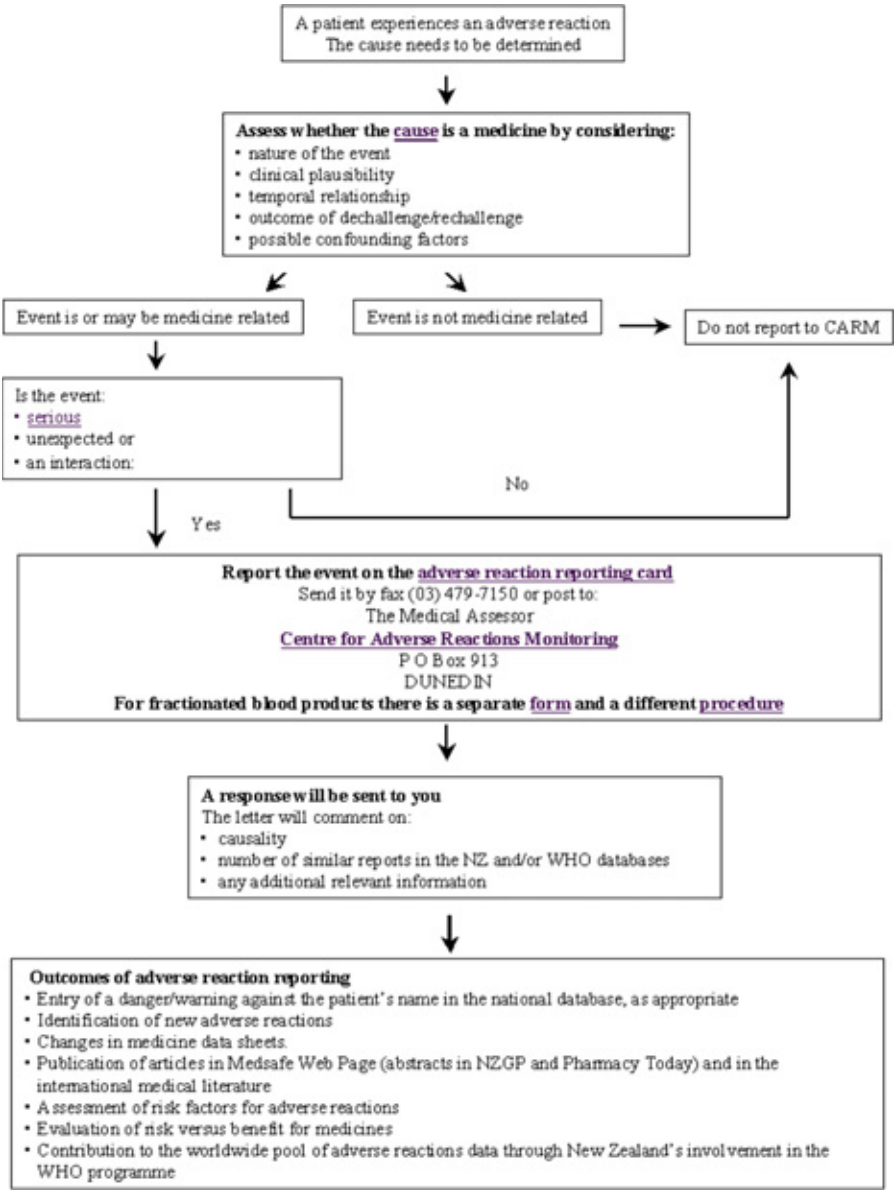
10.15.2 Further information

> NZNO publishes fact sheets on quality, serious and sentinel event investigations and on police investigations. These are available on the NZNO website: www.nzno.org.nz/resources/publications
> HDC case 08HDC20820 describes a case in which three separate medication administration errors were made by three different RNs involving one patient at a rest home. Despite the existence of adequate policies and guidelines for medicine administration and appropriate investigations into each incident, the errors still occurred. This case highlights the importance of constant individual professional vigilance in medicine administration. Available: www.hdc.org.nz.

11.16 Reporting adverse reactions

The Centre for Adverse Reactions Monitoring (CARM) in Dunedin is New Zealand's national monitoring centre for adverse reactions. It collects and evaluates reports of adverse reactions to medicines, vaccines, herbal products and dietary supplements from health professionals in NZ. Currently the CARM database holds more than 80,000 reports and provides New Zealand-specific information on adverse reactions to these products, and serves to support clinical decision-making, when unusual symptoms are thought to be therapy related. Anyone can report adverse reactions to CARM. The following flow chart (figure 2) describes the process for reporting an adverse medicines event to CARM.

Figure 3. Process for reporting adverse reactions to CARM (http://www.medsafe.govt.nz/profs/adverse/reactions .asp)



10.16.1 Further information

> Further information on reporting adverse events can be found at www.medsafe.govt.nz
> For further information on CARM and to report an adverse event go to https://nzphvc-01.otago.ac.nz/carm-adr/index.php
> Further information can be found in the CARM Guide to Adverse Reaction Reporting (CARM, nd).

12. Specific medicine groups

12.1 Immunisations

Regulated nurses/midwives may be involved in vaccination and immunisation programmes. Information regarding this role is available in the *Immunisation Handbook 2011* (Ministry of Health, 2011) which is accessible on www.moh.govt.nz. The official website of the Immunisation Advisory Centre www.immune.org.nz also contains useful resources for nurses involved in immunisation programmes.

Regulation 44A of the Medicines Regulations 1984 (as at 01 August 2011) states that the director-general of health or a medical officer of health may authorise any person to administer a vaccine for the purposes of an approved immunisation programme, if that person, following written application, provides documentary evidence satisfying the director-general or the medical officer of health, that they:

> can carry out basic emergency techniques including resuscitation and the treatment of anaphylaxis;
> have knowledge of the safe and effective handling of immunisation products and equipment;
> can demonstrate clinical interpersonal skills; and
> have knowledge of the relevant diseases and vaccines in order to explain the vaccination to the patient, or to the parent / guardian of the patient who is to consent to the vaccination on behalf of the patient, to ensure the patient or the parent/ guardian can give informed consent to the vaccination.

The Regulations also state that authorisation is valid for a period of two years, is subject to conditions, and may be withdrawn at any time.

11.1.1 Implications for nursing

> The onus is on the nurse to ensure they retain an up to date authorisation to vaccinate and that this is renewed every two years.
> Nurses authorised to vaccinate under Regulation 44A can only do so as part of an approved immunisation programme.
> Nurses must check their local workplace policies and procedures for gaining authorization, and for information on the particular programmes that are authorised.

12.2 Controlled drugs

A list of all controlled drugs is found in the Misuse of Drugs Act 1975 No 116 (as at 05 August, 2014). A register of all controlled drugs must be maintained, and it is the responsibility of the employer to facilitate this.

The following details are required in a controlled medicines register:

> Client's name;

> time and date of administration or destruction of medicine;
> number of medicines;
> names of prescriber; and
> two signatures: one of the person administering the medicine and one witness.

It is recommended that controlled medicine administration be witnessed – this means seeing the medicines being administered and signing as a witness (Keenan, 2010).

Entries in the controlled medicines register recording disposal must be made immediately following the administration of the controlled drug.

There is no specific legal provision regarding the qualifications of the people who are signatories of the controlled medicines register.

Section 28 of the Misuse of Drugs Regulations 1977 (SR 1977/37) (as at 04 July 2013) states that every person in possession of a controlled drug in the course of their profession shall:

a) keep it in a locked cupboard or compartment constructed of metal or concrete or both
b) ensure the cupboard or compartment is securely fixed to, or is part of, the building, ship, aircraft, or vehicle within which the controlled drug is kept for the time being; and
c) ensure the key of the cupboard or compartment is kept in a safe place when not being used. If the building, ship, aircraft, or vehicle is left unattended, that safe place shall not be within that building, ship, aircraft, or vehicle.

In addition, no person in possession of a controlled drug that is kept for the time being within any building, ship, aircraft, or vehicle, shall leave that building, ship, aircraft, or vehicle unattended, unless he has taken all reasonable steps to secure that building, ship, aircraft, or vehicle, and the part of it in which the controlled drug is kept, against unlawful entry.

See appendix four for a full list of controlled drugs that are excluded from the locked cabinet requirement.

All people who administer controlled medications must familiarise themselves with their employer's policies and guidelines on this topic. If this issue is being discussed, it is vital to consider:

> the responsibilities and accountabilities of the regulated and unregulated team members, as outlined in section 10;
> that the standards for medicine administration are met, as outlined in appendix one.

NZNO recommends that clear policies and guidelines are available in all workplaces regarding access to the controlled drugs cabinet and who is able to witness the preparation, administration, and documentation of controlled drugs.

11.2.2 Further information

> Further detail regarding controlled medicine legislation is available in Keenan (2010).
> Your liaison pharmacists will also have expertise on this topic

12.3 Injectable medicines

> The preparation and administration of injectable drugs requires additional skills and knowledge over and above the standards outlined in appendix one.
> Be familiar with local workplace policies and guidelines on which staff can administer injectable drugs, and what training and certification is required.

11.3.1 Further information

> Most DHBs have specialist nurse roles related to intravenous therapy.
> The Health Quality and Safety Commission (www.hqsc.govt.nz) has a growing resource on medication management and safety.
> NZNO colleges and sections are a resource for specialty expertise.
> NZNO has a guideline entitled Guidelines for nurses initiating and administering intravenous therapy in community settings (NZNO, 2012).

12.4 Over the counter medicines

RNs, ENs and midwives who recommend an over-the-counter (OTC) medicine to a person (this may be a client, friend or family member) must know the associated responsibilities and accountabilities of this activity. An OTC medicine is any medicine that can be bought without a prescription and includes the following:

> restricted medicines that can only be sold or supplied by a pharmacist;
> pharmacy-only medicines: a medicine that can only be sold or supplied from a pharmacy; and
> general sale medicines that can be sold at any retail outlet.

(Thompson, 2008)

A RN, EN or midwife is accountable for their nursing advice on and off duty, 24-hours-a-day and must remain within their scope of practice. A RN, EN or midwife recommending OTC medicines must ensure they have sufficient knowledge of the medicine, be able to undertake a comprehensive assessment of the client, understand the limitations of their knowledge on OTC medicines, use appropriate referral, and know how to communicate this effectively to clients, friends and family members when appropriate (Thompson, 2008).

11.4.1 Further information

Where nurses are registered as Quit Card providers, they are able to give people access to fully subsidised nicotine replacement therapy. The Nursing Council and NZNO have issued a joint statement on nurses becoming Quit Card providers that includes useful information on OTC medicines. This document is available for free download from the NZNO website: http://www.nzno.org.nz/resources/nzno_publications

12.5 The administration of complementary medicines

Some RNs and midwives have undertaken complementary medicine education.

NZNO believes the nursing profession has a responsibility to provide evidence for the efficacy and safety of complementary therapies employed as nursing interventions. Nurses who use complementary therapies as part of their nursing practice are responsible for ensuring this is within their scope of practice as defined by the Nursing Council.

The NZNO position statement on Rongoā Māori and complementary therapies (NZNO, 2011b)

provides further information on the potential complexity of complementary and alternative medicines, and the role and responsibilities of nurses who choose to use these as part of their practice or who refer patients to other health practitioners who may provide such medicines.

11.5.1 Nursing implications

If clients are seeking advice from nurses about specific complementary medicines, a discussion involving all stakeholders (eg liaison pharmacist, medical practitioner, prescriber, client) is advisable to help the client to make an informed decision. Issues to consider are:

> whether there is any evidence-based information about the medicine;
> whether the substance is appropriate for the client's condition;
> potential side effects; and
> potential interactions with other prescribed medicines.

NZNO advises nurses not to administer complementary medicines unless they are prescribed by an authorised or designated prescriber and are a registered medicine. Not all complementary medicines are registered and unless the medicine is notified by a pharmacist as a section 29 medicine (see section 10.3). NZNO recommends nurses do not administer unregistered complementary medicines. In some circumstances, it may be appropriate to educate the patient/client/consumer to self-administer complementary medicines.

11.5.2 Further information

NZNO position statement on Rongoā Māori and Complementary Therapies (NZNO, 2011b).

12.6 Use of traditional Māori medicine – rongoā Māori

The administration of Māori herbal medicine involves a strong spiritual element in the preparation of the medicine. The responsibility for traditional Māori medicines rest with the Tohunga/practitioner.

Each tribal areas has different karakia (prayer) and kawa (protocol), although some Tohunga may have been taught from masters of other tribal areas, or may come from a different tribal area to see the person they are administering rongoā to.

If whānau are seeking advice from nurses about traditional Māori medicine, a discussion with all involved, including the tohunga/practitioner, is advisable to help the client to make an informed decision. Issues to consider are:

> whether there is any evidence based information about the medicine;
> whether the substance is appropriate for the client's condition;
> potential side effects; and
> potential interactions with other prescribed medicines.

11.6.1 Further information

Nga Ringa Whakahaere o te Iwi Māori is an independent national network of traditional practitioners or "*Whare Oranga*" which was established to achieve greater recognition for Māori traditional health and healing practices. Information is available on its website: www.nrw.co.nz.

13. Appendix one: standards for the administration of medicines

These are generic standards. Refer to local workplace policy and guidelines for further information specific to your place of work.

12.1 Training and education requirements

The person administering the medicine or delegating responsibility for administration of the medicine will be satisfied that they:

> understand their scope of practice as determined by the appropriate regulatory authority, or understand their role and responsibilities as per their job description in the case of HCAs. If delegating the regulated nurse or midwife should be satisfied the individual to whom they are delegating the administration of medicines has an appropriate level of education and training and has been assessed as competent. Where this is not the case, the regulated nurse or midwife may refuse to delegate, even when requested to do so by another health professional. The regulated nurse or midwife is accountable for their actions including delegation;
> has had adequate training/orientation for the type of medicine being administered;
> is familiar with local area policy and guidelines related to medicine administration; and
> understands the relevant professional and legal issues regarding medicine administration.

12.2 Prior to administration

Prior to administration of medication, the regulated nurse or midwife administering the medicine:

> within the limits of the available information, confirms the correctness of the prescription/medication chart, and the information provided on the relevant containers;
> ensures they are aware of the client's current assessment and planned programme of care; and makes a clinical assessment of the suitability of administration at the scheduled time of administration;
> ensures appropriate protocols regarding the preparation, administration and documentation of controlled drugs are followed (all controlled drugs must be stored in a locked cabinet);
> checks the five rights + three: the right medicine in the right dose must be administered to the right person at the right time by the right route. The nurse is certain the patient is showing the right indications and completes the right documentation before and after administration. The nurse is aware that the person has the right to refuse the medication;
> checks the expiry date of the medicine;
> checks the client is not allergic to the medicine;
> in the case of children and where the dosage of medication is related to weight or surface area (for example cytotoxics), or where clinical condition dictates, ensures the correct weight has been recorded in kilograms only, and that the medicine to be administered has been prescribed in accordance with the correct weight;
> is aware of the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications;
> contacts the prescriber/pharmacists, designated senior health professional as appropriate, if:
  - the prescription/medication chart or container information is illegible, unclear, ambiguous or incomplete;
  - it is believed the dosage or route of administration falls outside the product licence for the particular substance;
  - there are potential adverse interactions with other medicines;
  - where contra-indications to the administration of any prescribed medicine are observed;
> prepares the medicine as specified by manufacturer/area policy and protocols;

- when believed necessary, refuses to administer the prescribed substance. If this situation arises, document clearly the reason and inform the prescriber/medical staff;
- pays due regard to the environment in which care is being given eg appropriate cardiac monitoring is available;
- is certain of the identity of the client to whom the medicine is to be given;
- informs the client of the purpose of the medicine as appropriate, and provides access to relevant client information leaflets; and
- if checking the calculations and preparation of a medicine undertaken by a colleague, is certain the calculations and preparation are accurate. NZNO recommends the nurse checking the calculations and preparation repeats the calculations independently of the colleague.

12.3 During administration

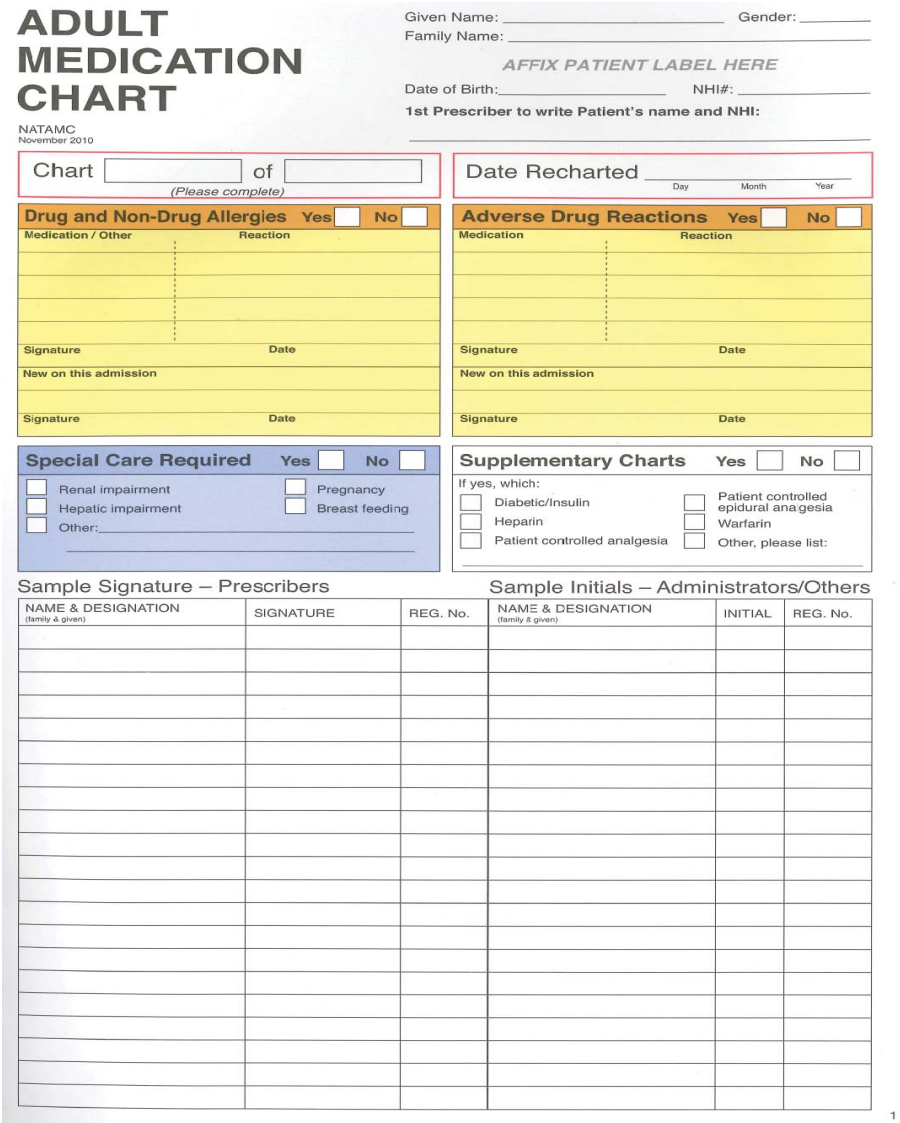
- During the administration of medication, the regulated nurse administering the medicine:
- monitors the patient for adverse effects of the medicine and takes appropriate action as determined by local guidelines, eg anaphylaxis management;
- uses the opportunity, if appropriate, to emphasise to the client and significant others:
- the importance and implications of the prescribed treatment; and
- to enhance their understanding of its effects and side effects.

12.4 After administration

- After administration, the regulated nurse administering the medicine:
- makes clear and accurate recordings of the administration of each individual medicine administered or deliberately withheld, or refused, ensuring any written entries and the signature are clear and legible. Documentation must be timely;
- records the positive and negative effects of the medicine and makes them known to the authorised prescriber; and
- ensures the record is completed, when the task of administering medication has been delegated.

14. Appendix two: national medication chart

To obtain a copy of the national medication chart, please contact your local DHB.



ADULT MEDICATION CHART

NATAMC
November 2010

Given Name: _____ Gender: _____
Family Name: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

1st Prescriber to write Patient's name and NHI:

_____

Chart [ ] of [ ]
(Please complete)

Date Recharted _____
Day Month Year

Drug and Non-Drug Allergies Yes ☐ No ☐

Medication / Other	Reaction

Signature Date

New on this admission

Signature Date

Adverse Drug Reactions Yes ☐ No ☐

Medication	Reaction

Signature Date

New on this admission

Signature Date

Special Care Required Yes ☐ No ☐

- ☐ Renal impairment
- ☐ Hepatic impairment
- ☐ Other: _____
- ☐ Pregnancy
- ☐ Breast feeding

Supplementary Charts Yes ☐ No ☐

If yes, which:

- ☐ Diabetic/Insulin
- ☐ Heparin
- ☐ Patient controlled analgesia
- ☐ Patient controlled epidural analgesia
- ☐ Warfarin
- ☐ Other, please list: _____

Sample Signature – Prescribers

NAME & DESIGNATION (family & given)	SIGNATURE	REG. No.

Sample Initials – Administrators/Others

NAME & DESIGNATION (family & given)	INITIAL	REG. No.

1

15. Appendix three: summarised information for health care assistants

The term 'unregulated health care worker' is used to describe the variety of health care workers who are not licensed or regulated by any governmental or regulatory body. Within this definition are both HCAs and "other" unregulated health care workers such as paramedics, physicians assistants, and operating department practitioners.

HCAs and other unregulated health care workers are defined by their level of education, their relationship with RNs, ENs and NPs, and by the Health Practitioners Competence Assurance Act, 2003.

An HCA is 'a person employed within a health care, residential or community context who undertakes a component of direct care and is not regulated in law by a regulated authority' (Nursing Council of New Zealand, 2011b, p.9). HCAs do not usually hold qualifications above level 4 on the New Zealand Qualifications Authority (NZQA) Framework. HCAs are employed under various titles, including caregivers, health care workers, health assistants, kaimahi hauora, practice assistant and health care assistants (NZNO, 2010).

For further information please refer to the NZNO position statement on unregulated health care workers (NZNO, 2011) available on the NZNO website: www.nzno.org.nz

Although not regulated under the Health Practitioners Competence Assurance (HPCA) Act 2003, HCAs are expected to work within other legislative requirements, such as the Code of Health & Disability Services Consumers' Rights (Health and Disability Commissioner, 2004) and the Health and Disability Services Standards (Ministry of Health & Standards New Zealand, 2008). Although they *cannot* undertake activities regulated by law, such as dispensing and prescribing medicines, HCAs could legally provide most nursing services. However, HCAs will not be investigated by the Nursing or Midwifery Councils if there is an adverse outcome or complaint. HCAs can be investigated by agencies such as the Health and Disability Commissioner and the Human Rights Review Tribunal.

14.1 Direction and delegation

RNs, registered midwives and NPs may direct and delegate the work of HCAs, and ENs may co-ordinate the work of HCAs. The Nursing Council guideline on delegation of care by a RN to a HCA (Nursing Council of New Zealand, 2011a) and guideline on the responsibilities for direction and delegation of care to ENs (Nursing Council of New Zealand, 2011b) outline the responsibilities of RNs, ENs, HCAs and employers in circumstances where direction and delegation is taking place. The guidelines are available on the Nursing Council website: www.nursingcouncil.org.nz.

NZNO opposes HCAs administering medicines in acute care, and to ill patients, as the requirements of the standards in appendix one cannot be achieved.
The HCA has the following responsibilities if they are involved in the administration of medicines:

- understands their role and responsibilities as per their job description;
- understands that the regulated nurse/midwife has responsibilities and accountabilities under their scope of practice to the relevant regulatory authority;
- is familiar with their employer's policies and guidelines related to medicine administration, including their individual responsibilities related to achieving the standards in appendix one;
- is aware that when working in the obstetric setting, care provided by the HCA may be directed, supervised, monitored and evaluated by the registered midwife;

- when accepting delegated activities, the HCA understands that he/she retains responsibility for their actions and remains accountable to the RN/midwife;
- understands that the EN may co-ordinate and prioritise the workload for a team of HCAs and act as a resource for them (Nursing Council of New Zealand, 2011a);
- has a responsibility to inform the RN/midwife/EN if they do not believe they have the necessary skills and knowledge to carry out the delegated task;
- reports concerns about risks in the medication process to the RN/management;
- understands they must undergo and pass competency training before administering medicines.

16. Appendix four: controlled drugs that are excluded from the locked cabinet requirement

(Note, some institutions may still choose to keep these drugs in the locked cabinet for various reasons – make sure you are aware of local policies)

Refer Section 28(4) of the Misuse of Drugs Regulations 1977 (SR 1977/37) (as at 04 July 2013) for further information.

Codeine phosphate syrup:
Codeine phosphate linctus:
Pholcodine linctus:
Pholcodine linctus, strong:
Alprazolam
Amfepramone (2-(diethylamino) propiophenone)
Aminorex
Barbital (5,5-diethylbarbituric acid)
Bromazepam
Brotizolam
Camazepam
Chlordiazepoxide
Clobazam
Clonazepam
Clorazepate
Clotiazepam
Cloxazolam
Delorazepam
Diazepam
Estazolam
Ethchlorvynol (ethyl-2-chlorovinylethynyl-carbinol)
Ethinamate (1-ethynylcyclohexanol carbamate)
Ethyl loflazepate
Fludiazepam
Flunitrazepam
Flurazepam
Halazepam
Haloxazolam
Ketazolam
Loprazolam
Lorazepam
Lormetazepam
Mazindol (5-(4-chlorophenyl)-2, 5-dihydro-3H-imidazo [2, 1-a]-isoindol-5-ol)
Medazepam
Meprobamate (2-methyl-2-propyl-1,3-propanediol dicarbamate)
Methylphenobarbital (5-ethyl-1-methyl-5-phenylbarbituric acid)
Methylprylon (3,3-diethyl-5-methylpiperidine-2,4-dione)
Midazolam
Nimetazepam
Nitrazepam
Nordazepam
Oxazepam
Oxazolam

Pemoline
Phenobarbital (5-ethyl-5-phenylbarbituric acid)
Phentermine (2-amino-2-methyl-1-phenylpropane)
Pinazepam
Pipradrol (1,1-diphenyl-1-(2-piperidyl)methanol)
Prazepam
Pseudoephedrine (other than a preparation referred to in clause 6 of Part 3)
SPA ((−)-1-dimethylamino-1,2-diphenylethane)
Temazepam
Tetrazepam
Triazolam.

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