ADMINISTRATION OF MEDICATION

And

CARE PLANNING

COURSE NOTES

BY

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ADMINISTRATION OF MEDICATION

The Nursing and Midwifery Council – Standards of Medicines

“The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council’s register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner (can now also be an independent and supplementary prescriber). It requires thought and the exercise of professional judgement…”

NMC (2010)

WHAT IS MEDICINE?

Medicine is something that treats or prevents or alleviates the symptoms of disease. They can be natural or artificial. There are different types of drugs for different purposes

Administration of medicines is a common and everyday nursing activity. It is a key element of professional practice. There are approximately 7,000 doses per day administered in a typical NHS hospital. (Audit Commission, 2002)
WHAT IS A MEDICATION INCIDENT?

Any preventable medication related event that could have or did lead to patient harm, loss or damage (Doing Less Harm, DoH & NPSA)

TOP FOUR ADMINISTRATION INCIDENTS FOR JAN-MARCH 2008

- Omission of medication during hospital stay
- Frequency more than intended
- Overdose
- Incorrect medication administered
Medication incidents cost the NHS £500 million per year in additional days spent in hospital (Building a Safer NHS for Patients DoH2001)

Medicine given to the wrong patient
- Incorrect use of addressographs
- Kardexes moved
- Identity of patient not confirmed

During Prescribing and administration
- Wrong medicine
- Abbreviations and legibility
- Generic v trade names (wrong or similar names, eg Sulphasalazine/sulphadiazine)
- Wrong dose, wrong strength
PATIENTS RIGHTS

You must gain consent before administering medication. Patients have the right to refuse medicine. If patient refuses then document in RED ink on the MAR and report to nurse in charge.

Covert Medication is when medicines are hidden in food or drink. This practise is not acceptable if the patient is deemed capable of decision making. It can only take place if authorised by the Multidisciplinary Team for the health of the patient concerned.

Ownership of medicine
The prescribed medicine belongs to the patient, not to you or to the facility. You should never share prescribed medicines. Remember you must always check that the label on the medicine matches the person and the Medicine Administration Record.

WHEN A MEDICINE INCIDENT OCCURS

Should an error be made during the administration of medicine, you must report and document the incident immediately. Follow the advise given by the person in charge, and document advise given and action taken.

Always own up to mistakes and do not try to hide them. Errors occurring must be dealt with immediately.
NMC Code of Conduct and Guidelines

Standards – a brief overview

Standard 1 – Methods of supplying and / or administering medicines
- Patient specific direction (PSD)
- Medicines Administration Record (MAR)
- Patient Group Direction (PGD)
- Standard order
- Homely remedy protocol
- Prescription forms

Standard 2 – Checking
Check all directions of administration

Standard 3 – Transcribing
Where medicines are written from one form of direction to administer to another is transcribing. This includes, for example, discharge letters, transfer letters. Any transcription must include the patient’s full name, date of birth, drug, dosage, strength, timing, frequency and route of administration.

Standard 4 – Prescription medicines
Staff may label from stock and supply a medicine to a patient, against a written prescription and advise on its safe and effective use.

Standard 5 – Patients’ own medicines
Patients may use their own medicines once they have been checked, labelled, prescribed and deemed suitable. They should be kept in a locked medicine cabinet/locker. Document if patient refuses to use/dispose of or send home unused medicines.

Standard 6 – Storage
All medicines should be stored as per manufactures instructions
Standard 7 – Transportation
Registered nurses may transport medication and controlled drugs to patients or carers if they are unable to collect them, provided they have been prescribed.

Standard 8 – Administration

The 5 rights – The right patient
The right medicine
The right dose
The right route
The right time

- Check allergies
- You must be aware of the patients care plan
- Assess patient’s condition and administer or withhold medication if appropriate, e.g. Digoxin – not usually given if pulse below 60
- Contact prescriber where contra-indications are discovered or a reaction occurs, or where assessment of the patient indicates that the medicine is no longer needed

Make a clear, accurate and immediate record of the medicine administered, intentionally withheld or refused by the patient and document the reason

Record when delegating the task of medicine administration

Controlled drugs
Administration requires 2 signatures of registered health care professionals (Doctor, dentist, pharmacist) or student nurse with countersignature or midwife.

When not possible, a second suitable person who has been assessed as competent may sign.
The 2nd signatory should witness the whole administration process

Should be stored in a locked cupboard within a locked cupboard
Standard 9 – Assessment
You must carry out initial and continued assessments of patients who self-administer and recognise and act upon changes

Standard 10 – Self-Administration – children and young people
Check with patients, carers or parents prior to discharge or in rehabilitation, that prescribed medication has been taken

Standard 11 – Remote prescription or direction to administer
In exceptional circumstances, fax, text message or email can be used to confirm changes to an original prescription

Standard 12 – Text messaging
Ensure protocols are in place to maintain patient confidentiality and documentation of any text received
NMC Code of Conduct & Guidelines

Standard 13 – Titration
Medication can be administered within a range of dosages, according to patient response and symptom control e.g. Insulin sliding scales or continual nebulised Salbutamol.

Standard 14 – Preparing medication in advance
Never prepare injections in advance
Never administer medication via syringe or container you have not witnessed being drawn up

Standard 15 – Medication acquired over the internet
Never administer medication that has not been prescribed or have a valid prescription

Standard 16 – Aids to support compliance
Patients should be assessed on suitability and understanding of how to use a compliance aid safely
Standard 17 – Delegation
Qualified nurse is responsible for the delegation of any aspects of administration of medicines and they are accountable to ensure the patient / carer or care assistant is competent to carry out the task

Standard 18 – Nursing and midwifery students
Must never administer medicines without direct supervision

Standard 19 – Unregistered practitioners
Qualified nurse must administer medicines as per guidelines then delegate to an unregistered practitioner to assist with ingestion or application of the medicine

Standard 20 – Intravenous medication (I.V.)
2 registrants must check I.V. medication, one of whom should also administer the I.V. medication

Standard 21 – Disposal
Must be disposed in accordance with safety, legal and environmental requirements
Should NOT be flushed down sink/toilet
Should NOT be put into regular waste or clinical waste
You must gain consent of patient before disposing
If the patient has died you must keep the medicine for SEVEN days before disposing.

Standard 22 – Unlicensed medications
A qualified nurse may administer an unlicensed medicine with the patient’s informed consent against a PSD but NOT against a PGD

Standard 23 – Complementary and alternative therapies
Nurses must be trained and competent to practise the administration of complementary and alternative therapies

Standard 24 – Management of adverse effects, errors or incidents
If you make an error take immediate action to prevent any potential harm to the patient and report as soon as possible to the prescriber, your line manager or employer and document your actions
Standard 25 – Reporting adverse reactions
If a patient experiences an adverse drug reaction to a medication, you must take action to remedy harm caused by the reaction. You must record this in the patient's notes, notify the prescriber and notify via the Yellow Card Scheme immediately.

Side effects, precautions & contra indications

Standard 26 – Controlled drugs
Should be given in a timely fashion, in line with the standards for administering medication to patients.

Comply with the legal requirements and approved local standard operating procedures for controlled drugs.
Misuse of Drugs Act 1971
Defines Controlled Drugs as ‘dangerous & otherwise harmful substances’
Identifies 5 different schedules/categories, each with its own level of control.
Refer to The Royal Marsden Hospital Manual of Clinical Nursing Procedures pg 186 for clarification.

Schedule 2 Medicines
Diamorphine, Pethidine, Morphine etc
Kept in secure (usually metal) cupboard - restricted access, only used to house controlled drugs
Found in cupboard within a cupboard; both are kept locked
A register is maintained at ward level to record drugs supplied and used...

Schedule 3 Medicines
Stimulants, Night Sedation, Barbiturates etc
Now found in locked (outer) cupboard
Changes in the storage requirements - relate to the effects of the drugs and the associated risk they pose.

The national minimum standard for care homes offering nursing care is that registered nurses are responsible for administering medicines to people.
A Health Care Worker can give tablets, capsule, or oral mixtures, apply medicated cream/ointment, insert drops to ear, nose or eye, administer inhaled medicine. They should have been appropriately trained in medicine administration.

The care homes procedures must include that care workers can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so.

The healthcare professional must train the care worker and be satisfied they are competent, the care provider should record the details of training as follows:

- What the care worker has been trained to do
- Name of the healthcare professional who provided the training
- Date on which the training was given
- Signature of the care worker who has trained and has agreed to accept the delegation

The MAR is the Medicine Administration Record

A record should be kept of all medicines administered
It informs the user what was given, when it was given, who gave it, to whom, and why.
The MAR will also hold the patient and the prescribers’ details

Completing the MAR

- Never document an action before you take it.
- Never document at arbitrary times
- Never document for someone else
- Be accurate and legible
- Record in black ink
- Sign clearly - be identifiable
Drug Calculations
Unit Conversion – Metric measurements of weight

Name and Abbreviation

Kilogram (kg)
Gram (g)     One thousand grams to a kilogram
Milligram(mg)  One thousand milligrams to a gram
Microgram(mcg)  One million micrograms to a gram or
                 one thousand micrograms to a
                 milligram
Nanogram ng    One thousand nanogram to microgram

Unit Conversion – Metric measurements of weight

Estimation
Always look at the answers you produce to check if they are sensible. A good way is to estimate your answer.

To calculate the dose you give to the patient use the formula:

What you want _ x What it’s in
What you’ve got

Dosage calculations

It is essential when using the formula, that the units of measurement for “What you want” and “What you’ve got” are the same, i.e. both in g or mg or mcg etc.
CARE PLANNING
Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.”

(Nursing & Midwifery Council April 2010)

“The approach to record keeping that the courts of law tends to adopt is that if it is not recorded, it has not been done” NMC 2010

Good record keeping promotes:
- High standards of clinical care and accountability
- Continuity of care
- Better communication & dissemination of information between members of the MDT
- An accurate account of treatment, care planning and delivery of care
- The ability to detect problems at an early stage
- Helps to address complaints or legal processes

Record keeping should demonstrate:
That you have taken all reasonable steps to care for the patient and any action or omission on your part have not compromised their safety, and, A record of arrangements you have made for the continuing care for the patient.
Writing should be-

- Factual, consistent and accurate
- Written as soon as possible after an event has occurred, providing current information on the care & condition of the patient
- Written clearly in such a manner that the text can not be erased
- Written so that any alterations or additions are dated, timed and signed in such a way that the original entry can still be clearly read
- Accurately dated, timed and signed with the signature printed alongside the first entry
- Not include abbreviations, jargon, meaningless phrases, irrelevant speculation or offensive subjective statements
- Written wherever possible with the involvement of the patient or carer and in terms that the patient can understand
- Readable on photocopies

Access to records
Data Protection Act 1984
Regulates the storage and protection of patient information held on computer

Access to Health Records Act 1990
Gives patients the right of access to manual health records about themselves that were made after 1st November 1991

CONFIDENTIALITY

- You need to be fully aware of the legal requirements and guidance regarding confidentiality and ensure your practice is in line with national and local policies
- You should not discuss the people in your care in places where you might be overheard.
- Do not leave records, whether on paper or computer screens, where they might be seen by unauthorised staff or members of the public
- You should not take or keep photographs of any person or their family that are not clinically relevant

INFORMATION SYSTEMS
Never share passwords and do not leave systems open to access when you have finished using them
CARE PLANNING

Care Planning
Planning patient care is one of the most important parts of your role as a nurse.
It provides an account of what you have done, why you did it and an evaluation of the results of your actions.
As a trained nurse you are accountable for the outcome of your own professional actions; morally, professionally and legally accountable.

Care planning should be comprehensive and transparent for the patient, staff and others. It should be underpinned by a framework to guide the process and it should lead to safe and effective care.

NMC 2008
Standard of Proficiency
You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been. As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.
The Nursing Process

THE ASSESSMENT
Is a complex process and should be carried out by a qualified nurse. It allows you to build up a picture of the patient’s health problems, how they are coping with them (or not), and what the possible outcome might be. It helps find out what is normal for the patient in terms of their routines, habits and behaviour. A good assessment should be able to identify actual problems and any potential problems.

Skills needed for assessment
- Interviewing skills
- Observing skills
- Measuring skills
- Communication skills
- Inferring or using evidence
- Analysing information
- Sources of information
- Subjective data - known as qualitative data
- Objective data - known as quantitative data

PLANNING CARE
The nurse identifies goals and plans care that will meet the patient’s needs. The patient is central to this process and should be involved in this stage. Care should be patient-centred and individualised. Care should be evidence based.

SETTING GOALS
Consider the following
- Who is meant to achieve the goal?
- What are they meant to achieve?
- How are they meant to do it?
- When are they to do it by?

PRODUCT -
IMPLEMENTATION
Was patient dignity and respect maintained?
Were the actions consistent with the planned care?
Did you communicate with the patient, carer and colleagues in an effective and considerate way?
Were the actions documented in accordance with trust and professional guidelines and policies?

EVALUATION – the final stage
There are 2 stages in evaluation:
The formative evaluation and summative evaluation.
There must be a baseline in place to make an informed decision during the evaluation stage. When goals are not met, the cyclical process of Assess, Plan, Implement, Evaluate.
If goals met, it is important to ask if the problem has been solved or alleviated.
A MODEL OF NURSING

There is a relationship between nursing models and the problem-solving approach – the process defines the stages we should take, whilst a model describes how we should carry out the stages. Roper, Logan & Tierney 2000 is based on holistic needs of the individual.

Important ideas that can be found within the model are:

- Individuality
- The activities of living
- A dependence–independence continuum
- The progression of a person along a life-span continuum
- Influencing factors

The Roper, Logan & Tierney model is only one framework that can be used to plan care.
We are constantly adding new courses to our syllabus.

Currently on offer we have:

- First Aid at Work
- Emergency First Aid at Work
- 12 hour Paediatric First Aid
- First Aid for Parents
- Moving and Handling of People
- Moving and Handling in Childcare
- Manual Handling of Objects
- Basic Life Support
- Immediate Life Support
- Conflict Resolution and anger management
- Infection Prevention and Control
- Care-Planning for nurses
- Administration of medications
- Understanding Asthma
- Dealing with Epilepsy
- Infection prevention and Control
- Safeguarding Vulnerable Groups
- Taking and Recording Observations

Find out more on our website: www.safe2care.co.uk

We also have launched an on-line learning centre:

www.the-care-college.co.uk.

A great way to keep up-to-date with training in your own time and from the comfort of home.

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