PRACTICE

TE MAHI NĒHI

MEDICINE GUIDELINES

Guidelines for Nurses on the Administration of Medicines

NEW ZEALAND NURSES ORGANISATION

TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

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1.0 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.

The aims of this document 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 and the safe nurse administration of medicines. These policies and procedures must meet any legislative or regulatory requirements and be updated regularly. NZNO staff are also available to discuss individual issues related to medicines, and NZNO colleges and sections are resources for specialty knowledge.

2.0 Recommended resources

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

> CARM is the Centre for Adverse Reactions Monitoring and has a lot of information about how to report and what to report. Any adverse reactions can be logged online at the following website https://nzphvc.otago.ac.nz/
> Keenan, R. (Ed). (2016). *Healthcare and the law.* (5th 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.
> Health and Disability Commissioner has the full code of patient rights on its home page at www.hdc.org.nz and provides case notes at http://www.hdc.org.nz/decisions--case-notes
> Health Quality and Safety Commission (www.hqsc.govt.nz) have significant resources on medication safety including medicines reconciliation. Also on this website is the Safe Medication Management Programme. (2011). Medicine reconciliation toolkit.
> 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
> Ministry of Health has a plethora of information and guidance on medicine administration, standing orders, Health and disability services standards and the new Therapeutics Products Bill www.moh.govt.nz

> NZ Blood Service has also issued dispensing policy for blood products https://www.nzblood.co.nz/assets/Transfusion-Medicine/PDFs/NZBS-DISPENSING-POLICY-111P001.pdf
> NZNO's publications page has a large number of position statements and guidelines relating to standing orders, documentation, medicine administration, intravenous therapy in the community etc. These have all been referenced within this document and are available at http://www.nzno.org.nz/resources/nzno_publications
> Nursing Council of NZ has all the scopes of practice for regulated nurses and prescribing guidance at http://www.nursingcouncil.org.nz/
> All statutory law regarding the control of medicines in NZ is available at www.legislation.govt.nz

3.0 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.

Cell and tissue therapies

These are derived from living cells and tissues of human or animal origin and include products such as skin grafts, ligaments, demineralised bone matrix, and dental-pulp derived stem cells.

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. 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 as part of the Therapeutic Products Bill being drafted at the time these guidelines were being developed.

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.

Delegated prescriber

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.

Designated prescriber

A designated prescriber is someone, other than a practitioner (medical or dentist), registered midwife, nurse practitioner, or optometrist who is a registered health professional authorised by regulations under the Medicines Act 1981 to prescribe prescription medicines.

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, labelling, recording and delivery of a medicine

General Sales Medicines

Are medicines deemed safer than Pharmacy-only medicines, when taken correctly. These are medicines sold (albeit in small quantities) in general shops with no pharmacy training required for sale. All products must be sold in the manufacturers original packets. (Also called Over-the-counter medicines (OTCs) – see below).

Medicines

This includes blood and blood products and work primarily through pharmacological, immunological or metabolic means. They comprise of substances that interact with human physiological and pathological processes and there may be a narrow margin between the amount required to produce a therapeutic effect and the amount that can cause a toxic effect.

Medical devices

These work primarily through physical and electrical/electronic means and include a vast range of apparatus, instruments and appliances from tongue depressors and bandages to implantable devices such as pace makers, diagnostic tools, software, robotic surgery machines, MRI scanners, and in-vitro diagnostics.

Medicine Reconciliation

Obtaining the most accurate list of patient medicines, allergies and adverse drug reactions and comparing this with the prescribed medicines and documented allergies and adverse drug reactions. Discrepancies are document and reconciled.

Over-the Counter medicines

OTC medicines must be licensed in NZ. There are 4 types;

> Prescription medicines
> Pharmacy only medicines
> Pharmacy medicines, and
> General sale medicines

Pharmacy Medicines

Can only be sold in licensed pharmacies. These are often larger pack sizes of products sold in supermarkets e.g. Ibuprofen.

Pharmacy only medicines

Pharmacist-only medicines (also known as restricted medicines) are a small group of medicines that can be purchased from a pharmacist without a doctor's prescription. They are not available for self-selection from the pharmacy shelves, and the sale must be made by a pharmacist. When selling these medicines, pharmacists must fulfil some special requirements designed to make sure consumers properly informed about the safe and correct use of the medicine.

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). The NCNZ also defines prescribing as *"The steps of information gathering, clinical decision making, communication and evaluation which result in the initiation, continuation or cessation of a medicine"* (Nursing Council of New Zealand, 2017b, pg. 9)

Self-administration of medicines

Where a person administers their own medicines. The person must be assessed by a registered nurse and prescribing practitioner as capable of safely being able to self-administer, and this must be within written policies and procedures.

Standing order

A standing order is a written instruction issued by a medical practitioner, dentist, nurse practitioner or optometrist that authorises a specified person or class of people (e.g. paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs.

Supply

To supply is to furnish or provide a person with the medicine or controlled drug.

Therapeutic product

Is an umbrella term for products that are intended to be used in or on human beings for a therapeutic purpose. Examples of therapeutic purposes include bringing about a physiological response to prevent, diagnose, monitor, alleviate, treat, or cure a disease, ailment, defect, or injury. These include;

> Medicines
> Medical devices, and
> Cell and tissue therapies

There are also hybrids which combine these product types. For example, a metal stent coated with a matrix and endothelial cells is a medical device-cell and tissue hybrid, and a coronary stent with a heparin coating is a medicine-medical device hybrid.

Transcribing

Transcribing is defined as the legitimate copying of prescription information from one source to another without any alterations or additions.

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, 2011c).

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.

'When required' (PRN) medicines

Are those which are ordered by a prescribing practitioner for a specific person and recorded on that person's medicine chart to be taken only as needed.

4.0 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 2016) 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.

Currently the NZ Government is drafting a new regulatory regime to regulate therapeutic products in NZ, this will replace the Medicines Act (1981) and its regulations. The release of this bill for consultation is expected towards the end of 2017.

4.1 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 e.g. medical practitioner, dentist, registered midwife, veterinarian, nurse practitioner, optometrist, a designated prescriber;[1] by a delegated prescriber;[2] or in accordance with a standing 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.

[1] 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.

[2] 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.

4.2 Regulations regarding the 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.

4.2.1 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.

4.2.2 Further information

The Medical Council of New Zealand (2016) 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

4.3 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.

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 Appendix One for further information.

4.4 The Therapeutic Products Bill

Therapeutic product is an umbrella term for products that are intended to be used in or on human beings for a therapeutic purpose. Examples of therapeutic purposes include bringing about a physiological response to prevent, diagnose, monitor, alleviate, treat, or cure a disease, ailment, defect, or injury.

The Government is currently developing a new therapeutic products regulatory regime. As well as replacing and modernising the regulatory arrangements for medicines, the regime will provide regulation of all therapeutic products. This includes medical devices and cell and tissue therapies which are currently not fully regulated in NZ.

The new regime will be flexible enough to ensure effective control over the quickly evolving technology used in therapeutic products, while also being as efficient and cost-effective as possible. It is important to keep informed as this Bill passes through parliament as it will also cover cell and tissue therapies which will be considered a medicine in the future.

The new regime will also look to align with international standards where appropriate, and uphold the quality of regulation currently carried out by the Ministry of Health. This will help to assure the safety of products used in health care delivery in NZ.
Further information is available from the Ministry of Health website at http://www.health.govt.nz/our-work/regulation-health-and-disability-system/therapeutic-products-regulatory-regime

5.0 The medication process

5.1 An overview

The treatment of a patient/ 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. Responsibility also lies with the organisational systems in place to support medicine administration (McBride-Henry & Foureur, 2016). 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. It is vital to be familiar with local workplace policy.

5.2 Prescribing medicines

Which health professionals can prescribe?

> Dentists
> Medical Practitioners
> Registered Midwives
> Nurse Practitioners
> Optometrists
> Designated Prescribers (e.g. RNs practicing in primary health and specialty teams)
> Delegated Prescribers

5.2.1 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).

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 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).

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 NCNZ (2017a) and must have completed a specialised course in prescribing at Masters Level to be able to prescribe.

5.2.2 Designated prescribers

A designated prescriber is someone, other than a practitioner[3], 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).

Registered nurses practising in primary health and specialty teams

In 2016, the Medicines (Designated Prescriber – Registered Nurses) Regulations were passed enabling RNs meeting the requirements outlined in the regulations regarding scope of practice, qualifications, competence and training to prescribe specified medicines **(**NCNZ, 2017a; 2017b). The NCNZ requires RN prescribers to work in a collaborative team with an authorised prescriber. If further advice is required, please contact the NZNO Member Support Centre on 0800 283848. The NCNZ website outlines in detail the requirements for RN prescribing at http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing

5.2.3 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.

5.3 Dispensing medicines

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).

5.3.1 Which health professionals can dispense?

The Medicines Regulations outline “no person other than an authorised prescriber,

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

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)).

5.3.2 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.

5.3.3 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).

5.3.4 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.

5.3.5 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

The NZ Blood Service also have a dispensing policy available at https://www.nzblood.co.nz/assets/Transfusion-Medicine/PDFs/NZBS-DISPENSING-POLICY-111P001.pdf

5.4 Administering medicines

5.4.1 Who can administer medicines?

Any person may administer medicines (including controlled drugs[4]), 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 6 of this document for further information).

HCAs who administer medicines need to understand their responsibilities and accountabilities (see section 6.6). This activity is by delegation from a regulated health practitioner and there must be policies and procedures in place to support it.

5.4.2 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 patient/ 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 that spectrum the recipient of the medicine lies.

NZNO's position is where a person is receiving complex care that can only be provided by qualified and highly skilled staff, the nurse must assess the client's/ 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 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/ clients, 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 (e.g. social workers, HCAs) to administer medicines.

[4] 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".

5.4.3 Medicine administration safety

The MOH provides a useful outline of the process for medicine administration in older adult residential care.

http://www.health.govt.nz/publication/medicines-care-guides-residential-aged-care

5.4.4 Preparing and checking medicines for administration

While many medicines can be prepared for administration by an individual regulated nurse, e.g. tablets that are not controlled drugs (see section 8.2 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 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.

5.4.5 Documentation

All medicines administration must be documented in the medicines record or chart. Such documentation should occur simultaneously with administration and be legible, accurate and meet legislative and organisational requirements, as well as any specific policy requirements of the facility.

The medicines chart should contain at a minimum the complete name and date of birth of the person. People with similar or the same names must have alerts written on their charts.

The medicines chart should have a separate section for PRN medicines; nurse-initiated medicines; once only doses of medicines; medicines which are self-administered by the individual; any complementary, alternative or self-prescribed medicines being taken; and emergency telephone/ facsimile/ email instructions. The medicines chart should also note any allergies or previous adverse drug reactions; and indicate when medicines review is required.

If alternative methods of administering medicines are appropriate, for example, crushing or dispersing tablets, this should also be indicated on the medicines chart. Nurses should be aware of the medicines which can or cannot be reconstituted for administration.

Please also refer to the NZNO Documentation guideline at
Guideline documentation, 2017 (pdf)

National medication chart

In 2011, a standardised national medication chart was rolled out across district health boards (DHBs) nationally. All nurses working in DHBs should by now be familiar with the layout and design features of the chart, including the abbreviations used. Please see Health Quality and Safety Commission for further guidance at https://www.hqsc.govt.nz/assets/Medication-Safety/NMC-PR/NMC-UserGuide-Oct2012.pdf

This document has a section for the prescription of oxygen and other medical gases. Please see section 8.4 for further detail.

6.0 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.

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.

6.1 The employer

> ensures appropriate orientation and education, including competence assessment for all involved in the administration of medicines;
> provides safe systems for medicines storage, handling, administration and documentation 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, 2006; Health and Disability Commissioner Act, 1994).

6.2 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;

- 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
- 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.

6.3 The pharmacist

- checks the prescription is written correctly (to avoid misunderstanding or error) and is signed by an authorised or designated prescriber;
- refuses to dispense any medicine where the form of the prescription is incorrect;
- 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 license;
- 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.

6.4 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;
- for 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.

6.5 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 NZ health care system (NZNO, 2011a) and from NCNZ at http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

6.6 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 (NCNZ, 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. Further guidance is provided by NCNZ at http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

6.7 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 NZ law; therefore it is the nurse or midwife who is accountable for the actions of the student.

> NZNO recommends, regardless of the level at which the student is studying, i.e. year one, two or three, medicine administration is always undertaken under the direct supervision of the RN or midwife.

7.0 Specific professional practices

7.1 Verbal and telephone medicine orders

Acceptance of verbal orders for the administration of medicines is not specifically provided for under legislation. However, the MOH has provided some guidance for residential care settings. This indicates, if the RN records the name of the authorised prescriber, recipient, date, and medicine order (where possible the prescriber faxes/ scan and emails a copy of the order to the pharmacy and facility), and the order is signed by the prescriber within 48 hours, then this is acceptable (Ministry of Health, 2011). This documentation process can be applied in general hospital wards. The documentation requirements for verbal orders (e.g. 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, 2016, *p.312*)

Table 1. How to take a telephone medication order

> 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 completed.
> 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.* (Preventing it being considered a written order by the prescriber or the erroneous reading of the actual written 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 consumer'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 (e.g. 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 a maximum of 24 hours. This needs to be clearly documented and added to the patient's medication chart.

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.

7.1.1 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/ client 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).

All this information should then be added to the individual patient/ client care record, in particular the medication chart.

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

7.1.2 Further information

> 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/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf)
> 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

7.2 Standing orders

A standing order is a **written instruction** issued by a medical practitioner, dentist, nurse practitioner or optometrist that authorises a specified person or class of people (e.g. paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs (Ministry of Health, 2012; Medicine (Standing Order) Amendment Regulations, 2016). 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 or

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 in the consumer's notes.

7.2.1 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, 2016, p.321).

> 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.
> A standing order does not allow a nurse or midwife to generate a prescription and provide it to a patient to take to a pharmacy to be dispensed (with the prescription signed later by the issuer of the standing order).
> A standing order also does not allow a person to provide a patient with a prescription that has been pre-signed by the issuer of the standing order (Ministry of Health, 2012).
> Providing medicines under a standing order requires the nurse or midwife to carry out an assessment, interpret any results, decide on an appropriate medicine and supply this according to the standing order. It is important the nurse or midwife does not **prescribe by proxy**, i.e. assess a patient, decide what medicines are needed, generate a script and then get a prescriber to sign it. NZNO does not support prescribing by proxy due to the risks involved for the patient, nurse and prescriber.
> If a nurse wishes to prescribe, then the nurse needs to undertake the education required by NCNZ (http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing) to include prescribing in their scope of practice.

7.2.2 Further information

> Further specific information can be found in the Medicines (Standing Order) Regulations 2002 (SR 2002/373) (as at 01 August 2011) and the Medicines (Standing Order) Amendment Regulations 2016 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, 2016). The document is available here: http://www.health.govt.nz/system/files/documents/publications/standing-order-guidelines-aug16-v2.pdf and NZNO strongly recommend workplaces have a copy readily available.
> Further guidance is also available in the NZNO guideline: *Standing Orders* available here:
Standing Orders, 2015 (pdf)

7.3 Unapproved medicines: section 29 Medicines Act, 1981

Occasionally, nurses and midwives will encounter medicines labeled as “section 29”. This means “as well as registered medicines there are unregistered medicines whose distribution and use is unapproved, but are nevertheless safe and effective and approved overseas” (Keenan, 2016, p.296).

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
> 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.

11.3.1 Further information

> Is available on http://www.medsafe.govt.nz/profs/RIss/unapp.asp
> Your liaison pharmacist.
> See also section 8.6 for information on complementary medicines.

7.4 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 the medicine is not compromised by crushing and crushing has been determined to be in the patient's/ client's best interest. Talk to the pharmacist about the availability of alternative preparations e.g. liquid form.

By disguising medicines in food or drink, a patient/ client may be led to believe they are not actually receiving medicines. Full consent of the patient/ 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 what they are doing is in the best interests of the patient/ client and recognise they are accountable for this decision. This may involve a discussion with the whanau/ family.

7.5 Monitored dosage dispensing

Monitored dosage systems (also known as compliance packaging aids- i.e. blister packs, dispensing boxes, dosette boxes, and sachets) are systems for supplying and dispensing medicines prepared by a community pharmacist. These systems involve dispensing a patient's/ 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.

7.5.1 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 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 5.3 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, e.g. 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, 2016, p.309).
> 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/ client safety.

7.6 Transcribing

Transcribing is defined as the legitimate copying of prescription information from one source to another without any alterations or additions (NZNO 2016) This may include any of the following activities:

> 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;
> writing instructions for health care support workers when delegating the task of administration of medicines;
> writing medicines in discharge or transfer letters; and/or
> completing patient management plans.

7.6.1 Nursing implications

NZNO does not support the routine practice of transcribing, however NZNO believes transcribing is an appropriate activity within the scope of nursing practice in certain circumstances (as outlined above). Where appropriate guidance, education,

policies and procedures are in place, nurses and midwives may safely transcribe. NZNO recommend any transcribing that has taken place be signed off by the prescriber currently responsible for the patient/ client as soon as practicable. NZNO reminds nurses they are accountable for their practice at all times, including when transcribing.

In some situations a nurse may be asked by a patient/ client or their family to provide a list of currently prescribed medicines. Copying a list of medicines from one form to another is considered a form of transcribing even where dose, frequency and other information may not be copied. If requested to provide such a list, NZNO recommend the nurse follow the procedures outlined in the NZNO guideline *Transcribing medicines* (available at http://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Transcribing%202016.pdf) and ensure their employer have a working policy in place to guide practice. Nurses must remain aware of their responsibilities and accountability at all times.

Note: Photocopying/photographing a Medication Administration Record Chart **is not** transcribing.

7.7 Nurse-initiated medicines

Nurse-initiated medicines are non-prescription (over-the-counter – OTC) medicines that can be administered by a registered nurse when the need arises (Australian Commission on Safety and Quality in Health Care, 2014). OTC medicines can range from general sales to pharmacy only medicines therefore organisations that enable medicines to be initiated by a nurse, usually have a specific list of medicines that can be initiated. This list is usually developed in consultation with an authorised prescriber e.g. nurse practitioner or doctor and/ or pharmacist, and should be reviewed regularly. NZNO recommend only registered nurses initiate medicines.

As nurse-initiated medicines are OTC medicines, a standing order is not required although in some cases a standing order may include OTC medicines.

Further clarification and changes to this may come with the Therapeutics Product Bill. Please see section 4.4.

7.7.1 Nursing implications

It is important to remember in all cases, the nurse must practice within their scope and is accountable for all decisions in relation to the initiation of medicines.

In order to initiate medicines safely it is important:

> The organisation has appropriate policies and procedures in place to enable safe nurse-initiation. These policies and procedures must meet any legislative or regulatory requirements and be updated regularly;
> The nurse has appropriate authorisation from the organisation to initiate medicines;
> The nurse initiating the medicine ensures they are familiar with the medicine's action, recommended dosage and precautions before initiating the medicine;
> Medicines are administrated in consultation with the consumer and/or carer;

> The nurse completes the 'PRN' section of the medicine record including the medicine (including form), dose, recommended frequency and maximum dose per 24 hour period, and the date;
> After the medicine has been administered, the nurse who initiated the medicine records the date, time, quantity administered and also signs and dates the record;
> Any further doses administered within 24 hours of the initial dose must not exceed the recommended frequency or maximum dose for 24 hours. Each administration must be recorded by the nurse initiating the medicine.

7.8 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/ client is taking (Health Quality and Safety Commission NZ (HQSC), 2012). 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 (i.e. undocumented changes, whether intended or not) to the prescriber to reconcile and action.

(HQSC, 2012)

7.8.1 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.

7.8.2 Further information

Details on the Safe Medication Management Programme are available from https://www.hqsc.govt.nz/assets/Medication-Safety/Med-Rec-PR/Med-rec-health-professionals-pamphlet.pdf

7.9 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 will assist nurses and midwives working with infants and children:

> children and infants should only by weighed in kilograms (Kg) 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. 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 they have checked and witnessed (where relevant) administration of the medicine on the medication chart.

7.9.1 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).

7.10 Health professionals administering medicines to family and 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 in administering medicines to themselves from anything other than a personal prescription or purchase of an OTC medicine. Nurses need to avoid the use of medicines being construed as theft, for which the nurse may be held liable under the Misuse of Drugs Act (1975) or the Crimes Act (1961).

7.11 Self-administration of medicines by clients

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

For the long-stay patient/ client, whether in hospital or a rest home/ residential care facility, 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 patient/ 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.

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.health.govt.nz/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf).

7.12 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 NCNZ education competencies outlined in the document entitled *Competencies for Registered Nurses* (NCNZ, 2007). 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 NCNZ documents *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (NCNZ, 2011b) and *Guideline: delegation of care by a registered nurse to a health care assistant (*NCNZ, 2011a). These documents are available from the Nursing Council website (www.nursingcouncil.org.nz).

7.13 Automated medication dispensing devices and automated medication management

Some hospitals are 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 guideline development involves all stakeholders. These systems are not perfect and it is essential the employer provides adequate training on these devices.

7.13.1 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 client/ patient record of all medicines that have been administered.

7.14 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.

7.15 New Zealand Universal List of Medicines (NZULM)

The NZULM is a dictionary of trusted, standardised information covering medicines approved for supply in NZ, 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 important 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. Further information can be found on www.nzulm.org.nz

7.16 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/ client, 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. A reportable event 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.

7.16.1 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.

7.16.2 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
> The Health Quality & Safety Commission of NZ has also recently reviewed and released an updated National Adverse Events policy (2017). This is available at https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/National_Adverse_Events_Policy_2017/National_Adverse_Events_Policy_2017_WEB_FINAL.pdf

7.17 Reporting adverse reactions

The Centre for Adverse Reactions Monitoring (CARM) in Dunedin is NZ'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 NZ-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. This link (http://www.medsafe.govt.nz/profs/adverse/reactions.asp) describes the process for reporting an adverse medicines event to CARM.

7.17.1 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.otago.ac.nz/

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8.1 Acts and Regulations (available www.legislation.govt.nz)

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Health and Disability Commissioner Act 1994 No 88 (as at 03 March 2010), Public Act
http://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html

Health and Disability Services (Safety) Act 2001 No 93 (as at 01 October 2008), Public Act http://www.legislation.govt.nz/act/public/2001/0093/latest/DLM119975.html

Health Practitioners Competence Assurance Act 2003 No 48 (as at 01 August 2011), Public Act http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Human Rights Act 1993 No 82 (as at 01 May 2011), Public Act
http://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html

Medicines Act 1981 No 118 (as at 01 July 2011), Public Act
http://www.legislation.govt.nz/act/public/1981/0118/latest/DLM53790.html

Medicines Regulations 1984 (SR 1984/143) (as at 01 August 2011)
http://www.legislation.govt.nz/regulation/public/1984/0143/latest/DLM95668.html

Medicines (Standing Order) Regulations 2002 (SR 2002/373) (as at 01 August 2011)
http://www.legislation.govt.nz/regulation/public/2002/0373/latest/DLM170107.html

Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005 (SR 2005/266) (as at 25 March 2011)
http://www.legislation.govt.nz/deemedreg/2009/096be8ed8084a248/latest/viewdr.aspx
? update with 2016 reg.

Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011 (SR 2011/54)
http://www.legislation.govt.nz/deemedreg/2011/096be8ed8084a23a/latest/viewdr.aspx

Misuse of Drugs Act 1975 No 116 (as at 01 December 2010), Public Act
http://www.legislation.govt.nz/act/public/1975/0116/latest/DLM436101.html

Misuse of Drugs Regulations 1977 (SR 1977/37) (as at 01 August 2011)
http://www.legislation.govt.nz/regulation/public/1977/0037/latest/DLM54840.html

9.0 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.

9.1 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.

9.2 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 (e.g. 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 license 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.

9.3 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, e.g. 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.

9.4 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.

10.0 Appendix two: 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, physician's 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, 2011c).

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.

10.1 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.

11.0 Appendix Three: Specific medicine groups

11.1 Immunisations

Regulated nurses/ midwives may be involved in vaccination and immunisation programmes. Information regarding this role is available in the *Immunisation Handbook 2017* (Ministry of Health, 2017) which is accessible on www.moh.govt.nz.

Regulation 44A of the Medicines Regulations 1984 (as at 01 August 2011) states 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 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.

11.1.2 Student Nurses participating in immunisations

In 2015 the MOH recommended a standing order would be required authorizing a student nurse to administer vaccines while on placement under the direct supervision of an authorised vaccinator (please see appendix four for the full MOH release). The MOH has also provided a standing order template for this which is also provided in appendix four.

11.2 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 controlled medicine administration be witnessed – this means seeing the medicines being administered and signing as a witness (Keenan, 2016).

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 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 3A 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. 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 6;
> that the standards for medicine administration are met, as outlined in appendix one.

NZNO recommends 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.

11.3 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) at Nurses Initiating and Administering Intravenous Therapy in Community Settings, 2012 (pdf)

11.4 Oxygen and other medical gases

Oxygen and any other medical gas (e.g. Medical air, Nitrous Oxide, Entonox, heliox, carbon dioxide etc) given to a patient/ client is a medicine and as such should be treated like any other medication using the Standards for the administration of medicine (see appendix one). An RN involved with any of these therapies has a responsibility to practice within their scope and is accountable for all decisions in relation to the initiation of these medicines. Individual institutions should also have their own oxygen/ medical gas therapy policies covering all aspects of these therapies whether it be within an institution or home- based therapy (e.g. home based oxygen therapy). It is expected Oxygen therapy/ other medical gas therapy is prescribed on the medication chart and regular monitoring of the individual is required. The Health Quality and Safety Commission provides guidance to this in their National Medication Chart user guide on page 25 at https://www.hqsc.govt.nz/assets/Medication-Safety/NMC-PR/NMC-UserGuide-Oct2012.pdf

11.5 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)

Please also refer to section 7.7 Nurse initiated medicines.

> NZNO believes 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).

Where nurses are registered as Quit Card providers, they are able to give people access to fully subsidised nicotine replacement therapy. The NCNZ 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/Portals/0/publications/Guideline%20-%20Advice%20re%20Nurses%20becoming%20Quit%20Card%20providers,%202016.pdf

11.6 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 NCNZ.

The NZNO position statement on Rongoā Māori and complementary therapies (NZNO, 2011b,
Rongoa Māori and complementary therapies in nursing practice, 2011 (pdf)
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.

11.6.1 Nursing implications

If clients are seeking advice from nurses about specific complementary medicines, a discussion involving all stakeholders (e.g. liaison pharmacist, medical practitioner, prescriber and client) is advisable to assist 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 7.3). 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.

11.7 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 area 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 to whom they are administering rongoā .

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.

11.7.1 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 their Facebook site https://www.facebook.com/pages/Nga-Ringa-Whakahaere-o-te-Iwi-Maori/649337225085822

Appendix Three (A): 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.

12.0 Appendix four: Ministry of Health guidance on Student Nurses administering vaccines

Available to download from http://www.nzno.org.nz/resources/medicines_-_guidelines_and_information

Example standing order

Issued: 00/00/0000	Review date: 00/00/0000
Medicine Standing Order Title	Administration of vaccines from the National Immunisation Schedule by undergraduate student nurses on placement, under the supervision of an Authorised Vaccinator.
Rationale	Any vaccines administered by any person other than an Authorised Vaccinator must be administered under a Standing Order or prescription (Section 44A Medicines Regulations 1984). Student nurses on clinical placement need experiences that will prepare them for the registered nurse role. This includes administration of vaccines in primary health care (administration means all activities related to the immunisation event i.e. assessment, informed consent, communication, providing education and administering the vaccine dose).
Organisation/clinic	Insert Name of DHB / PHU / PHO / Practice / Clinic
Scope (the condition and patient group)	Administration of vaccines from the National Immunisation Schedule for the prevention of vaccine preventable diseases in children aged between birth and under 18 years. Administration of vaccines from the immunisation schedule for the prevention of vaccine preventable diseases in adults aged 18 years and over.
Medicine/s	Vaccines as per the current on-line version of the National Immunisation Schedule
Dosage instructions for each medicine	Dose as per the current on-line version of the National Immunisation Schedule
Route of administration	Route as per the current on-line version of the National Immunisation Schedule
Indication/circumstances for activating the standing order	• An undergraduate student nurse on placement is working under the supervision of an Authorised Vaccinator. • The vaccine is scheduled. • Informed consent is achieved. • The authorised vaccinator accepts responsibility for supervising the student nurse to administer the vaccine.
Precautions and exclusions that apply to this standing order	**Anaphylaxis to a previous dose or any component of the vaccines is an absolute contra indication to further vaccination with that vaccine.** See sections 2 and 4 of the on-line Immunisation Handbook for pre vaccination checklists and precautions.

Persons authorised to administer the standing order	Undergraduate student nurses on placement in the service/practice and working under the supervision of an authorised vaccinator.
Competency/training requirements for the person(s) authorised to administer	• Safe administration of oral and injectable vaccines • Basic emergency techniques including resuscitation and treatment of anaphylaxis • Code of Health and Disability Consumer Rights and informed consent process; relevant legislation (Medicines Act; Standing Orders Regulations).
Countersigning and audit	The standing order does not require counter signing. The Standing Order must be included in the monthly audit of 20% of Standing Order treatments in the practice.
Definition of terms used in standing order	**National Immunisation Schedule** –The schedule issued by the Ministry of Health which stipulates the timing, medicine name, dosage and route for administration of vaccines. **Registered nurse** – a health practitioner deemed to be registered with the Nursing Council of New Zealand as a practitioner in the profession of nursing. **Authorised vaccinator** – a registered nurse authorised to administer vaccines under section 44A of the Medicines Regulations (1984). **Undergraduate Student nurse** – a student enrolled in an approved Bachelor of Nursing programme and on placement for clinical experience as part of that programme.
Additional information	• The Authorised Vaccinator supervising the undergraduate student nurse must satisfy themselves that the student is adequately prepared to undertake the administration of the vaccine. • The Authorised Vaccinator is responsible for the supervision and oversight of the student nurse administering a vaccine under this standing order. • The Authorised Vaccinator is responsible for all documentation related to the vaccination event. • This standing order does not apply to any registered nurse working under the supervision of an Authorised Vaccinator. • Any adverse event that occurs in the course of administration of this Standing Order must be reported within 48 hours and investigated as a critical incident.

Signed by issuer:

Name:		Date:	
Title:	Medical practitioner		

Notes: This standing order is not valid after the review date. The review date is one year after the date that the order was signed by the issuer.

The organisational standing order policy and procedure must be signed by management, the issuer and every person operating under standing orders, and attached to the standing order.