

PRACTICE  
TE MAHI NĒHI

MEDICINE  
GUIDELINES

# Guidelines for Nurses on the Administration of Medicines



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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 medicines used. Today, this association has expanded to include important and complex aspects including knowledge of medicines and appropriate dosage, their administration and control, side effects, suitability for the client, adherence, and nurses' clinical judgement and 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.

This document aims to provide:

- an outline of the medico-legal issues related to medicine administration in the Aotearoa New Zealand setting; and
- an aid to accessing useful resources.

Individual nurses or midwives must be familiar with local workplace policies and guidelines related to medicines and the safe nurse administration of them. These policies and procedures must meet legislative or regulatory requirements and be updated regularly. NZNO staff are also available to discuss individual issues related to medicines and their administration, and NZNO colleges and sections are resources for specialty knowledge.

For the purpose of this document we will refer to the 'prescribing health professional' to encompass all those professions with authority to prescribe. Please refer to the glossary for further detail.

This document *does not* cover nurse practitioner prescribing or designated prescribers. The requirements for these prescribers are on the Nursing Council of New Zealand (NCNZ) website at <http://www.nursingcouncil.org.nz/> and will be the subject of future NZNO publications. Midwives are not included in this document either, as they have their own prescribing regulations and should refer to the Midwifery Council of NZ website at <https://www.midwiferycouncil.health.nz/>

Standing orders and transcribing practice are detailed in NZNO position statements and can be found on NZNO's website at

<https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Standing%20Orders%20N2016.pdf?ver=2017-12-21-115844-040> and

<https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Transcribing%20N2016.pdf?ver=2017-12-21-120235-460> respectively.

## 2.0 Recommended resources

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

- The Centre for Adverse Reactions Monitoring (CARM) 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 New Zealand text and includes detailed information on the themes discussed in this

- guideline. Chapter 10, *Prescribing and administration of medicines*, is particularly relevant.
- The Health and Disability Commissioner website has the full code of consumers rights on its home page at [www.hrc.org.nz](http://www.hrc.org.nz) and provides case notes
  - The Health Quality and Safety Commission ( [www.hqsc.govt.nz](http://www.hqsc.govt.nz) ) has significant resources on medication safety, including medicines reconciliation. Also on this website is the Safe Medication Management Programme. (2011). Medicine reconciliation toolkit.
  - The New Zealand Medicines and Medical Devices Safety Authority is usually referred to as Medsafe. Its website holds both consumer and health professional information: [www.medsafe.govt.nz](http://www.medsafe.govt.nz)
  - The Ministry of Health (MOH) has a plethora of information and guidance on medicine administration, standing orders, health and disability services standards, Rongoā Māori and the new Therapeutics Products Bill on its website: [www.moh.govt.nz](http://www.moh.govt.nz)
  - The NZ Blood Service has also issued dispensing policy for blood products which can be found at <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 on 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](http://www.nzno.org.nz/resources/nzno_publications)
  - NZCN has all the scopes of practice for regulated nurses and prescribing guidance at <http://www.nursingcouncil.org.nz/>
  - All legislation regarding the control of medicines in New Zealand is available at [www.legislation.govt.nz](http://www.legislation.govt.nz)

## 3.0 Statutory law regarding control of medicines in Aotearoa 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) 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 regularly. 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](http://www.legislation.govt.nz) and at some public libraries.

### 3.1 The Medicines Act 1981 and associated regulations

There are four classifications/schedules of medicines:

1. *Prescription medicines*: a medicine which can only be sold, supplied or administered pursuant to a prescription by: a person authorised to prescribe Medicines, eg medical practitioner, dentist, registered midwife, veterinarian, nurse practitioner, optometrist, a designated prescriber; by a delegated prescriber, 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 licence 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.

### 3.2 Regulations regarding the prescription form

Regulations on how prescriptions must be written and those who can prescribe medicines is established by the Medicines Regulations 1984 and subsequent amendments and regulations. These may change soon, as the Government is drafting a new regulatory regime for therapeutic products in New Zealand. Please refer to section 3.4 for further detail.

Every prescription form must;

- 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 prescriber's full name, full street address of the prescriber's place of work or the postal address of the prescriber and the prescriber's telephone number;



- d) set out the surname, each given name, and the address of the person for whose use the prescription is given; (NZNO also recommends including date of birth and the national health index (NHI) number). In the case of a child under 13 years, the date of birth of the child must be included.
- e) indicate by name the medicine and, where appropriate, the strength at which it 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) state 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) state if the medicine is for application externally, and indicate the method and frequency of use.

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

### 3.2.1 Nursing Implications

When a nurse encounters poor prescribing practice, it is essential this is addressed directly with the prescriber. NZNO recommends the nurse documents the poor prescribing 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.

## 3.3 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. 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.

## 3.4 The Therapeutic Products Bill

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 New Zealand.

The new regime is expected to 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 New Zealand. Further information is available from the ministry's website at <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/therapeutic-products-regulatory-regime>

## 4.0 The medication process

The treatment of a client with medicines for therapeutic, diagnostic or preventive purposes involves prescribing, dispensing, administering, receiving and recording medicine/s, storage and handling. The nursing process including assessment, planning, implementation and evaluation also applies to medicine administration,

Responsibility for accurate medicine administration lies with many individuals. Responsibility also lies with the organisational systems in place to support safe medicine prescription, supply and administration (McBride-Henry & Foureur, 2006). The following information outlines the relevant legal and professional aspects of the medication-giving process, and outlines the responsibilities of the multidisciplinary team members involved. **It is vital to be familiar with local workplace policies as these may differ between institutions and across the health sector.**

### 4.1 Prescribing medicines

Prescribing health practitioners include:

- Medical practitioners
- Pharmacists
- Registered midwives
- Nurse practitioners
- Optometrists
- Designated prescribers (eg RNs practising in primary health and specialty teams)
- Dietitians
- Dentists

#### 4.1.1 Authorised prescribers

An authorised prescriber is authorised to prescribe medicines and these prescribers include:

- Midwives;
- Nurse practitioners;
- Practitioners (medical doctors, dentists);
- Optometrists;
- A designated prescriber (see below).

#### 4.1.2 E-prescriptions

**The prescribing health professional is the only person** who can generate an e-prescription under their login using their personal electronic signature.

#### **The registered midwife**

Amendments in 1990 to the 1981 Medicines Act and the 1975 Misuse of Drugs Act 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).

## 4.2 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).

### 4.2.1 Which health professionals can dispense?

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

### 4.2.2 What activities are classified as dispensing?

Transferring medication from the original container in which they were dispensed into another container for administration at a later time or date. For nurses managing clients going on leave from a service, this can be problematic. For example, if a nurse places medication into an envelope for the client to take later in the day, technically, this is dispensing. Most large organisations have policies to manage this, but smaller organisations must also be aware of these issues and develop appropriate policies. Nurses using an automated medication-dispensing device (such as pyxis) cannot refill these machines as this is considered dispensing and is outside their scope of practice.

Filling a client's compliance packaging aid (monitored dosage system) from other pharmacy-labeled containers is also considered dispensing. 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 monitored dosage system between its closure by the pharmacist and time of administration.

### 4.2.3 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).

### 4.2.4 Nursing implications

- Dispensing activities must be avoided by nurses.
- If a nurse is exposed to dispensing situations, s/he must alert the manager/employer. The manager/employer has a responsibility to determine protocols and provide resources to deal with dispensing activities and these must meet legal requirements.

<sup>1</sup>defined under the Medicines Act 1981 as a medical practitioner or dentist

## 4.3 Administering medicines

### 4.3.1 Who can administer medicines?

Any person may administer medicines (including controlled drugs<sup>2</sup>), but whoever administers these is required to do so in accordance with the directions of the prescribing health professional, or in accordance with a standing order.

All employed staff 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 concerning medicine administration (see section 5.4).

Health Care Assistants (HCAs) who administer medicines need to understand their responsibilities and accountabilities (see section 5.6). This activity is by delegation from a regulated health practitioner, there must be policies and procedures in place to support it.

### 4.3.2 NZNO position statement on medicine administration

NZNO believes the safe administration of medicines by the regulated nurse 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 range of situations in which medicines are administered. At one extreme, it's the client in an intensive care unit receiving complex care whose medication can only be provided by qualified and highly-skilled staff. At the other extreme, it's 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 *Who should administer a medicine?* largely depends on where within that range the recipient of the medicine lies.

NZNO's position states that when a person is receiving complex care that can only be provided by qualified and highly skilled staff, the nurse must assess the client's response to the medication. The nurse must also be able to speedily recognise 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 opposes HCAs' involvement in administering medicines in acute care, and/or to ill or medically unstable 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 (eg social workers, HCAs) to administer medicines.

<sup>2</sup> 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".

### 4.3.3 Preparing and checking medicines for administration

While many medicines can be prepared for administration by an individual regulated nurse, eg tablets that are not controlled drugs (see section 7.1 on controlled drugs), many agencies require some medicines, particularly intravenous (IV) medicines for administration including blood products, and vaccines, to be checked by two regulated nurses (please see sections 7.2 & 7.5). 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 witness administration of the medicine, and document in the medication chart that they have checked and witnessed (where relevant) administration of the medicine.

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

The Ministry of Health provides a useful outline of the process for medicine administration in the aged residential care (ARC) sector. RNs, ENs and HCAs working in this sector should familiarise themselves with this document at <http://www.health.govt.nz/publication/medicines-care-guides-residential-aged-care>

### 4.3.4 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. Use of the NHI is also recommended.

The medicines chart should have a separate section for pro re nata (PRN) or 'as required' medicines; nurse-initiated medicines (see section 6.7); once only doses of medicines; medicines which are self-administered; 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 a review of the client's medicines is required.

If alternative methods of administering medicines are appropriate, eg 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. (Refer to [www.medsafe.govt.nz](http://www.medsafe.govt.nz))

Please also refer to the NZNO Documentation guideline at <https://www.nzno.org.nz/LinkClick.aspx?fileticket=GH84aNBNd64%3d&portalid=0>

### **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. Some ARC facilities are also using it. Please see the HQSC's website for further guidance at

<https://www.hqsc.govt.nz/assets/Medication-Safety/NMC-PR/NMC-UserGuide-Oct2012.pdf>

This chart now includes a section for the prescription of oxygen and other medical gases (refer to section 7.3).

## **5.0 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.

### **5.1 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).

### **5.2 Prescribing health professionals (including NPs)**

- ensure, wherever possible, the client is aware of the purpose of the treatment and that 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;
- ensures, that where a 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 (eg tablet, capsule, suppository) is 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 handwriting 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.

### 5.3 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, and gives the relevant information and advice on storage and security conditions;
- where the substance is prescribed in a dose, or is to be administered by a route which falls outside the manufacturer's recommendation, the pharmacist will have taken steps to ensure the prescriber is aware and has chosen to exceed that licence;
- if the prescription contains any written amendments made and signed by the pharmacist, the prescriber has been consulted and advised and the amendments have been accepted;
- is available for education to the multidisciplinary team and to the client and their family; and
- the pharmacist, in pursuit of her/his role in monitoring the adverse side effects of medicines, should be sent any information the administering health-care provider deems relevant.

### 5.4 The registered nurse

- 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 NCNZ guidelines on direction and delegation (NCNZ, 2011a; 2011b);
- where ENs and HCAs are involved with the administration of medicines, the RN **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);
- must report concerns about risks in the medication process to management and the prescriber;
- 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.

### 5.5 The enrolled nurse

- 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 Competency 4.6 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, 2007);

- when accepting delegated activities, understands that s/he **retains responsibility for their actions and remains accountable to the RN/ midwife**;
- has a responsibility to inform the RN/midwife if s/he does not believe s/he, 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) at

<https://www.nzno.org.nz/Portals/0/publications/NZNO%20guidelines%20on%20the%20place%20of%20enrolled%20nurses%20in%20the%20NZ%20health%20care%20system%20July%202011%20final.pdf?ver=2011-08-05-094829-587>

And from NCNZ at

<http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses>

## 5.6 The health care assistant

- understands that the regulated nurse 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 **s/he 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  
arrow here for consistency of stylereports 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>

## 5.7 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 institution’s policies and guidelines related to medicine administration, including their individual responsibilities related to achieving the standards in appendix one;
- understands the 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; an
- 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 medication chart. The RN/midwife is responsible for delegating to a student. If the student is not yet ready to undertake administration, this should be delayed until the student is ready. Students are not regulated under New Zealand law; therefore **it is the nurse or midwife who is accountable for the actions of the student.**

NZNO recommends, regardless whether the student is year one, two or three, medicine administration is **always undertaken** under the direct supervision of the RN or midwife.

## 6.0 Specific professional practices

### 6.1 Verbal and telephone medicine orders

Acceptance of verbal orders for the administration of medicines is not specifically provided for under legislation. Many individual health-care institutions have their own policies to cover this. However, the MOH has provided some guidance for ARC settings. If the RN records the name of the authorised prescriber, recipient, date, and medicine order (where possible the prescribing health professional faxes/scans 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 (MOH, 2011). This documentation process can also be applied in general hospital wards and primary health care settings. The documentation requirements for verbal orders (eg time frame within which the prescribing health professional 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*. (This prevents 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. I don't understand this sentence.
- Record in the client's notes that special action is required, namely the writing up of the order by the prescriber.

In some circumstances, the prescribing health professional may also need to prescribe remotely. This may occur in the following situations:

- where a previously unprescribed medicine (eg in palliative care or remote/ rural areas) is required urgently; or

- where medication (not including controlled drugs) has been prescribed before 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 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/email, confirming the changes within 24 hours. This needs to be clearly documented and added to the client's medication chart.

For remote prescriptions, a verbal order on its own is **not acceptable**. The fax, email or photograph of the prescription must be attached to the client's existing medication chart. The RN 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 client. In this instance, s/he should document accurately the communication that has taken place.

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

### 6.1.1 Text messaging

While not currently common practice in New Zealand, text messaging of prescriptions may slip into practice in remote communities. NZNO **does not** recommend the use of text messages as a form of prescribing. There are very few programmes available that allow text messages to be downloaded and added to electronic client records.

The Nursing Council (for consistency) does not recommend the use of text messaging for comprehensive health matters about a client either. It recommends a phone call or face-to-face meeting would be more appropriate (NCNZ, 2013). A Skype, Facetime or Zoom call maybe of use in situations where a nurse is physically isolated from the prescriber.

If there is no alternative and text messaging is used (PXT, MMS or written text), the nurse is responsible for ensuring client confidentiality and documentation of any text message received. NZNO recommends 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 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 client care record, in particular the medication chart.

## 6.2 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 (eg paramedics, RNs) who do not have prescribing rights, to administer and/or supply specified medicines and some controlled drugs (MOH, 2012; Medicine (Standing Order) Amendment Regulations, 2016). Standing orders are useful for procuring the administration of treatment or medicines in the absence of a qualified practitioner. However, they need to be approached with caution. NZNO has developed a guideline on standing orders. Please refer to at <https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Standing%20Orders%20N2016.pdf>

## 6.3 Unapproved medicines: Section 29 Medicines Act, 1981

Occasionally, nurses 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 *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 data base which also requires client consent.

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

### 6.3.1 Further information

- Is available on <http://www.medsafe.govt.nz/profs/Rlss/unapp.asp>
- From your liaison pharmacist.
- See also section 8.6 for information on complementary medicines.

## 6.4 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 this form has been determined to be in the client’s best interest. Talk to the pharmacist about the availability of alternative preparations, eg liquid form or suppository.

By disguising medicines in food or drink, a client may be led to believe they are not actually receiving medicines. Full consent of the 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 would need to be certain that what they are doing is in the best interests of the client and recognise that the nurse is accountable for this decision. This situation may involve a discussion with the *whānau* or family.

## 6.5 Monitored dosage dispensing

Monitored dosage systems (also known as compliance packaging aids, ie 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 client's medicine into a special container, with sections for days of the week and times 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/ ARC/ domestic residence. Systems must meet criteria established by Medsafe.

To be acceptable for use in hospital/ ARC/ 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 (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.

### 6.5.1 Nursing implications

- 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. This 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, eg opening a sealed blister pack section, adding a charted antibiotic and taping over the section.
- Where it is not possible for the boxes to be filled and sealed before supplying to the client, the nurse should mark the container with the day and time the medicines are to be taken only, 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 client safety.

## 6.6 Transcribing

Transcribing is defined as the legitimate copying of prescription information from one source to another without any alterations or additions (NZNO 2016).

**NZNO does not support transcribing as a routine practice**, however, NZNO believes transcribing is an appropriate activity within the scope of nursing practice in certain circumstances (outlined in NZNO's Transcribing guideline). Please refer to NZNO guideline *Transcribing medicines* available at:

<https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Transcribing%20N2016.pdf?ver=2017-12-21-120235-460>

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

## 6.7 Medicines reconciliation

Medicines reconciliation is an evidence-based process of obtaining, within 24 hours of admission, the 'most accurate' list of all medications a client is taking (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 client.
2. Comparing the 'most accurate' medicines list against the current medication chart and clinical notes for any documented changes to medicines.
3. Communicating any discrepancies (ie undocumented changes, whether intended or not) to the prescriber to reconciled and action (HQSC, 2012).

### 6.7.1 Nursing implications

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

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>

## 6.8 Nurse-initiated medication

Nurse-initiated medicines (NIM) are non-prescription (over-the-counter – OTC) medicines that can be administered by an RN when the need arises (Australian Commission on Safety and Quality in Health Care, 2014). NIM are not to be used when a standing order is required (see section 6.2). 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 specified list of these medicines. This list is usually developed in consultation with an authorised prescriber, eg NP or doctor and/or pharmacist, and should be reviewed regularly. NZNO recommend only RNs initiate medicines.

**NIM must be approved by a health-care facility**, with input from the prescribing health

professionals before being administered by an RN or EN. NIMs are not specifically provided for under legislation. They are intended for a single dose, or for a very short course, until the care recipient's prescribing health professional can evaluate the ailment further.

Medication that may be nurse-initiated in a health-care facility **must be approved** by that facility's medicines committee or clinical governance group. Nurses may then initiate a medicine that has been listed by the health facility and endorsed by the facility's medicines committee or equivalent group.

Written policies must be in place for each medication and must clearly outline the procedure to be adopted by the nurse, including sufficient detailed information so the nurse can make informed decisions as to when/when not to administer the medication. The NIM template provided for microlax enemas in appendix four is an example of an appropriate guide. Such templates should be developed for all medications on the organisations NIM's list.

NIM are appropriate for one-off or occasional medications. Any person with an ongoing need for medication should be referred to a prescribing health practitioner for assessment.

Before administering a NIM, the nurse must determine the following:

- the client's current health status/diagnosis and current medications;
- that the client has not already been prescribed the medication;
- that the medicine is not contraindicated with other medication that they are taking;
- that medications are not contraindicated with client's current diagnosis, eg contraindications for enemas may include recent or current bowel perforation, undiagnosed abdominal pain, diverticulitis, ulcerative colitis, Crohn's disease, severe or internal haemorrhoids, and tumours of the rectum or colon;
- the expected effects of the medicine;
- any known allergies or previous reactions to medicines experienced by the care recipient; and
- as with all medication administration, the nurse must record the outcome in the client's progress notes once the medicine has been given.

An example of a NIM would be a nurse working in the community or in an ARC facility initiating bowel management medication for a client who may otherwise be in significant discomfort awaiting a doctor to see them and prescribe appropriate bowel interventions.

The following must be documented for NIM:

- date and time NIM administered;
- generic name of medicine;
- route of administration (approved abbreviations may be used);
- dose to be administered;
- initiator to sign and print name; and
- the words 'nurse -initiated medicine'.

RNs and ENs who recommend an OTC medicine to a person (this may be a client, friend or family member) must know the associated responsibilities and accountabilities of doing so. An OTC medicine is any medicine that can be bought without a prescription, eg, a nurse working in primary care might recommend an OTC for head lice. (see section 7.4)

*'Registered nurses are legally able to administer over the counter medications eg paracetamol without a prescription or a Standing Order. However ... there is no subsidy available for over the counter medications which are administered without a prescription or Standing Order.'* (personal communication, J. O'Malley, Chief Nurse, Ministry of Health, September 2012)

## 6.9 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 need to be particularly vigilant in looking for prescribing and calculation errors, given the increased risk to an infant

or child if an incorrect dose is given.

The following guidelines will help nurses working with infants and children:

- children and infants should only be 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 other storage facility.

NZNO recommends all nurses 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, witness administration of the medicine, and document that they have checked and witnessed (where relevant) administration of the medicine on the medication chart.

#### 6.9.1 Further information

- The Joint Commission (2008) has published recommendations for all those involved in the prescribing, dispensing and administering medicines to children: ([http://www.jointcommission.org/assets/1/18/SEA\\_39.PDF](http://www.jointcommission.org/assets/1/18/SEA_39.PDF)).

### 6.10 Health professionals administering medicines to family and friends

Nurses involved in a personal capacity, such as giving medication 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 careful in self-administering medicines from anything other than a personal prescription or purchase of an OTC medicine. Nurses must not use medicines available from work places, the risk being it is construed as theft, for which the nurse may be held liable under the Misuse of Drugs Act (1975) or the Crimes Act (1961).

### 6.11 Self-administration of medicines by clients

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

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

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

### 6.11.1 Further information

Details on self-administration are available in the *Medicines care guides for residential aged care*, available to download from the MOH website (<http://www.health.govt.nz/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf> ).

## 6.12 Education of staff re medicine administration

While the employer has overall responsibility for the education and professional development of staff (MOH and Standards New Zealand, 2008), the RN may be involved in teaching other team members about medicine administration and in developing medicine guidelines and policies. The RN needs to meet the Nursing Council's education competencies outlined in *Competencies for Registered Nurses* (NCNZ, 2007). The RN must also be aware of their role and responsibilities regarding direction and *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 NCNZ website ([www.nursingcouncil.org.nz](http://www.nursingcouncil.org.nz)).

## 6.13 Automated medication dispensing devices and automated medication management

Automated dispensing systems are drug-storage devices or cabinets that electronically dispense medications in a controlled fashion and track medication use. Their principal advantage lies in permitting nurses to obtain medications for clients at the point of use. Most systems require user identifiers and passwords. Internal electronic devices track nurses accessing the system, track the clients for whom medications are administered, and provide usage data to the hospital's pharmacy.

Most hospitals are using this technology, an example of which is Pyxis. The use of this technology is now being taken up by the community health sector and ARC. . The use of automated dispensing devices continues to evolve. Some health-care organisations deploy one or several devices in selected areas that are floor-stock intensive, such as hospital emergency departments. Some devices are used for selected categories of medications, eg controlled substances that have tracking and documentation requirements. Some organisations have devices throughout client care areas to cover nearly all medications used. Therefore, it is vital policy development involves all stakeholders using the devices and the policy must assign responsibility for and addresses issues of security. These systems are not fail-safe, and it is essential the employer provides adequate training on their use.

### 6.13.1 Implications for nursing

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

These systems require identifiers and passwords; therefore, it is essential to keep these up to date. Do not assist colleagues by accessing the system on their behalf; they must have their own identifier and password.



## 6.14 Expiry dates

Expiry dates must be strictly adhered to. Exceptions will occasionally occur, eg in the 2009 H1N1 pandemic, Medsafe approved a two-year extension to the expiry date on existing stocks of Tamiflu. Nurses 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.

## 6.15 Reporting adverse events (errors or incidents)

If an error is made in the administration of a medicine, the RN must take every action to prevent any potential harm to the client, and report the error as soon as possible to the prescribing health professional, the line manager or employer (according to local workplace policy). The RN 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 as soon as possible so the above actions can be taken.

### 6.15.1 Implications for nursing

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

### 6.15.2 Further information

- NZNO publishes fact sheets on quality, serious and sentinel event investigations and on police investigations. These are available on the NZNO website: [www.nzno.org.nz/resources/publications](http://www.nzno.org.nz/resources/publications)
- The HQSC has also recently reviewed and released an updated National Adverse Events policy (2017). This is available at [https://www.hqsc.govt.nz/assets/ReportableEvents/Publications/National\\_Adverse\\_Events\\_Policy\\_2017/National\\_Adverse\\_Events\\_Policy\\_2017\\_WEB\\_FINAL.pdf](https://www.hqsc.govt.nz/assets/ReportableEvents/Publications/National_Adverse_Events_Policy_2017/National_Adverse_Events_Policy_2017_WEB_FINAL.pdf)

## 6.16 Reporting adverse reactions

CARM in Dunedin is New Zealand's national monitoring centre for adverse reactions. It collects and evaluates reports of adverse reactions to medicines, vaccines, herbal products and dietary supplements from health professionals in New Zealand. Currently, the CARM database holds more than 80,000 reports and provides New Zealand-specific information on adverse reactions to these products, and serves to support clinical decision-making when unusual symptoms are thought to be therapy related. Anyone can report adverse reactions to CARM. This link

(<http://www.medsafe.govt.nz/profs/adverse/reactions.asp>) describes the process for reporting such an event.

#### 6.16.1 Further information

- Further information on reporting adverse events can be found at [www.medsafe.govt.nz](http://www.medsafe.govt.nz)
- For further information on CARM and to report an adverse event go to <https://nzphvc.otago.ac.nz/>

### 6.17 New Zealand Formulary

The New Zealand Formulary (NZF) is an independent resource providing health-care professionals with clinically validated medicines information and guidance on best practice, enabling health-care professionals to select safe and effective medicines for individual clients.

The NZF is a free resource for all health-care professionals prescribing, dispensing and administering medicines in community and hospital care. It aids decision-making and contributes to best practice through standardised and evidence-based information on medicines. Over time, the NZF will be fully integrated into the e-health environment, including prescribing and dispensing systems across primary and secondary care. It can be accessed at <http://www.nzformulary.org/>

## 7.0 Specific medicine groups

The groups of drugs listed below are often seen across the health sector, from community-based institutions to hospitals, so it is important nurses are aware of, and familiar with these groups.

### 7.1 Controlled drugs

Controlled drugs are used in all parts of the health sector. 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 on 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 secure when not being used. If the building, ship, aircraft, or vehicle is left unattended, the key needs to be secured outside of 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 s/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 3 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 5.0;
- 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.

## 7.2 Injectable medicines

Injectable medicines are also now administered throughout our health services. The preparation and administration of injectable drugs requires additional skills and knowledge over and above the standards outlined in appendix one. It is important nurses are familiar with local workplace policies and guidelines on which staff can administer injectable drugs, and what training and certification is required.

### 7.2.1 Further information

- Most DHBs have specialist nurse roles related to intravenous therapy;
- The HQSC ([www.hqsc.govt.nz](http://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 *Guidelines for nurses initiating and administering intravenous therapy in community settings* (NZNO, 2012), it is currently under review and will be updated in 2018. It can be accessed at

[Nurses Initiating and Administering Intravenous Therapy in Community Settings. 2012\(pdf\)](#)

## 7.3 Oxygen and other medical gases

Oxygen and any other medical gas (eg medical air, nitrous oxide, entonox, heliox, carbon

dioxide etc) given to a 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). A RN/EN involved with any of these therapies has a responsibility to practise within their scope and is accountable for all decisions in relation to initiating 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 a home, (eg home-based oxygen therapy). Oxygen therapy/other medical gas therapy should be prescribed on the medication chart and regular monitoring of the individual is required. It may also be covered by a standing order for specific clients in specific settings. These standing orders should remain with the client's clinical record and medication chart.

The HQSC 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>

## 7.4 Over-the-counter medicines

RNs and ENs who recommend an OTC medicine to a person (this may be a client, friend or family member) must know the associated responsibilities and accountabilities of doing so. An OTC medicine is any medicine that can be bought without a prescription, eg, a nurse working in primary care might recommend an OTC for head lice. This does *not* include supplying medicines from a prescribers practitioner supply order (PSO).

OTC medicines include the following:

- restricted medicines that can only be sold or supplied by a pharmacist;
- pharmacy-only medicines, ie 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).

*'Registered nurses are legally able to administer over the counter medications eg. Paracetamol without a prescription or a Standing Order.'* (personal communication, J. O'Malley, Chief Nurse, Ministry of Health, September 2012)

NZNO believes a RN or EN is accountable for their nursing advice on and off duty, 24-hours-a-day and must remain within their scope of practice. A RN or EN 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 (Thompson, 2008).

Where nurses are registered as Quit Card providers, they are able to give people access to fully subsidised nicotine replacement therapy. The Nursing Council and NZNO have issued a joint statement on nurses becoming Quit Card providers. This document is available for free download from the NZNO website:

<https://www.nzno.org.nz/LinkClick.aspx?fileticket=PPIB3IXJWPM%3d&portalid=0>

## 7.5 Immunisations

Regulated nurses across the health sector may be involved in vaccination and immunisation programmes. Information regarding this role is available in the *Immunisation Handbook 2017* (MOH, 2017) which is accessible on [www.moh.govt.nz](http://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 client, or to the parent/guardian of the client who is to consent to the vaccination on behalf of the client, to ensure the client or the parent/guardian can give informed consent to the vaccination.

The regulations also state authorisation is valid for two years, is subject to conditions, and may be withdrawn at any time.

### 7.5.1 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 for gaining authorisation, and for information on the particular programmes that are authorised.

### 7.5.2 Student nurses participating in immunisations

In 2015, the MOH advised a standing order would be required authorising a student nurse to administer vaccines while on placement under the direct supervision of an authorised vaccinator. The MOH has also provided a standing order template for this which is also provided in appendix five.

## 7.6 The administration of complementary medicines

Some RNs have undertaken complementary medicine education.

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

The NZNO position statement on Rongoā Māori and complementary therapies (NZNO, 2011b) provides further information on the potential complexity of complementary and alternative medicines, and the role and responsibilities of nurses who choose to use these as part of their practice or who refer clients to other health practitioners who may provide such medicines.

## Nursing implications

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

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

NZNO advises nurses not to administer complementary medicines unless they are prescribed by an authorised prescribing health professional 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 6.3). NZNO recommends **nurses do not administer unregistered complementary medicines**. In some circumstances, it may be appropriate to educate the client to self-administer complementary medicines.

## 7.7 Use of traditional– Rongoā Māori medicine

A strong spiritual element is involved in the preparation of Māori herbal medicine.. The responsibility for traditional Māori medicines rests 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 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.

### 7.7.1 Further information

Ngā 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.

The findings of the Waitangi Tribunal include the expectation that Maori traditional health and healing practices are acknowledged and supported.

<https://www.waitangitribunal.govt.nz/news/ko-aotearoa-tenei-report-on-the-wai-262-claim-released/>

## 8.0 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.

### **Aged Residential Care**

A general term referring to all levels of care including rest home level care, hospital level care, specialised dementia care and psycho-geriatric hospital level care.

### **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 ARC, but also a client or care recipient 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 health-care 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.

### **Designated prescriber**

A designated prescriber is someone who is a registered health professional authorised by regulations under the Medicines Act 1981 to prescribe prescription medicines, for example diabetes nurse specialists who prescribe within diabetes care and under the supervision of a medical practitioner.

The title differentiates them from practitioners (medical or dentist), registered midwife, nurse practitioner, or optometrist with full prescribing rights.

### **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**

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 a client's 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.

### **Nurse-initiated medicines**

These are non-prescription (over-the-counter – OTC) medicines that can be administered by an RN when the need arises. Organisations that enable medicines to be initiated by a nurse, must have a specified list of these medicines. This list is usually developed in consultation with an authorised prescriber, eg NP or doctor and/ or pharmacist, and should be reviewed regularly.

### **Over-the counter medicines**

OTC medicines must be licensed in New Zealand. There are four 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, eg 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.

### **Practitioner Supply Order (PSO)**

'A practitioner supply order is a written order made by a practitioner on a form supplied by the



Ministry of Health, or approved by the Ministry of Health, for the supply of community pharmaceuticals to the practitioner. The pharmaceuticals are for emergency use, for teaching and demonstration purposes, and for provision to certain patient groups where individual prescription is not practicable.’ (MOH, 2015)

The strictly limited list of subsidised pharmaceuticals and the quantities that can be used can be found in Section E part 1 of the Schedule. There is a larger schedule for remote rural practices.

### **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 Nursing Council 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*” (NCNZ, 2017b, p.9)

### **Prescribing health professional (prescriber)**

For the purpose of this document, this person is someone who has authority to prescribe medication. This may be a doctor, midwife, NP, or a RN designated prescriber.

### **Self-administration of medicines**

Where a person administers their own medicines. The person must be assessed by an RN 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, NP or optometrist that authorises a specified person or class of people (eg paramedics, RNs) 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**

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**

The legitimate copying of prescription information from one source to another without any alterations or additions.

### **Unregulated health care workers and health care assistants**

Health care workers who are not licensed or regulated by any governmental or regulatory body.

This includes HCAs and “other” unregulated health care workers, such as paramedics, physicians assistants, operating department practitioners and practice assistants. HCAs are employed under various titles, including caregivers, health care workers, health assistants, kaimahi hauora, support workers, and HCAs (NZNO, 2011c).

HCAs and other unregulated health care workers are defined by their level of education and their relationship with RNs, ENs and 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.

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](http://www.nzno.org.nz).

#### **‘When required’ (PRN) medicines**

These are medicines ordered by a prescribing practitioner for a specific person and recorded on that person’s medicine chart and are to be taken only as needed.

## 9.0 References

- Australian Commission on Safety and Quality in Health Care. (2014). *National residential medication chart (NRM3): User guide for nursing and care staff*. Sydney, Australia: ACSQHC. Retrieved from [http://www.safetyandquality.gov.au/wp-content/uploads/2012/02/SAQ123\\_NursesUserGuide\\_V6.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2012/02/SAQ123_NursesUserGuide_V6.pdf)
- Health and Disability Commissioner. (2004). *Code of Health & Disability Services Consumers’ Rights*. Wellington: Health and Disability Commissioner.
- Keenan, R. (Ed). (2016). *Healthcare and the law*. (5th Ed.) Wellington: Brookers Ltd.
- McBride-Henry, K. and Foureur, M. (2006) Medication administration errors: Understanding the issues. *Australian Journal of Advanced Nursing* 23:3 p. 33-41
- Midwifery Council (2004). *Competencies for Entry to the Register*. Wellington: Midwifery Council of New Zealand. Available: <https://www.midwiferycouncil.health.nz/sites/default/files/professional-standards/Competencies%20for%20Entry%20to%20the%20register%20of%20Midwives%202007%20new%20form.pdf>
- Ministry of Health. (2017). *Immunisation Handbook 2017*. Wellington: Ministry of Health.
- Ministry of Health (2016). *Standing order guidelines*. (2<sup>nd</sup> Ed.) Wellington: Ministry of Health.
- Ministry of Health (2015) *Using Practitioner Supply Orders and Standing Orders in the Rheumatic Fever Prevention Programme*. Wellington: Ministry of Health.
- Ministry of Health. (2011). *Medicines care guides for residential aged care*. Wellington:

- Ministry of Health. Available: <http://www.health.govt.nz/publication/medicines-care-guides-residential-aged-care>
- Ministry of Health. (2009). *Guidelines for Syringe Driver Management in Palliative Care in New Zealand*. Wellington: Ministry of Health. Available: <http://www.health.govt.nz/publication/guidelines-syringe-driver-management-palliative-care-new-zealand>
- Ministry of Health and Standards New Zealand. (2008a). *Health and Disability Services Standards (NZS 8134). Te Awarua o te Hauora*. Wellington: Ministry of Health and Standards New Zealand.
- Ministry of Health and Standards New Zealand. (2008b). *Health and disability services (core) standards (NZS 8134.1:2008)*. Ministry of Health and Standards New Zealand.
- New Zealand Nurses Organisation. (2016). *NZNO guideline transcribing medicines*. Wellington: New Zealand Nurses Organisation.
- New Zealand Nurses Organisation. (2011). *NZNO position statement on unregulated health care workers*. Wellington: New Zealand Nurses Organisation.
- New Zealand Nurses Organisation. (2011a). *Guideline on the place of enrolled nurses in the New Zealand health care system*. Wellington: New Zealand Nurses Organisation.
- New Zealand Nurses Organisation. (2011b). *NZNO position statement on Rongoā Māori and complementary therapies in nursing practice*. Accessed on 15.06.17 at [New Rongoa Māori and complementary therapies in nursing practice, 2011 \(pdf\)](#)
- New Zealand Nurses Organisation. (2011c). *Unregulated Healthcare Workers Education Framework*. Wellington: New Zealand Nurses Organisation.
- New Zealand Nurses Organisation. (2012). *Guidelines for nurses initiating and administering intravenous therapy in community settings*. Wellington: New Zealand Nurses Organisation.
- Nursing Council of New Zealand (2017a) *Competencies for the nurse practitioner scope of practice*. Accessed on 11.10.17 at <http://www.nursingcouncil.org.nz/Education/Nurse-practitioner>
- Nursing Council of New Zealand. (2017b). *Guideline for registered nurse prescribing in community health (Trial and evaluation 2017)*. Accessed on 18.05.17 at <http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing/Registered-nurse-prescribing-in-community-health>
- Nursing Council of New Zealand. (2016) *Guidelines for registered nurses prescribing in primary health and specialty teams*. Accessed on 05.06.17 at <http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing/Registered-nurse-prescribing-in-primary-health-and-specialty-teams>
- Nursing Council of New Zealand. (2013). *Guidelines: Social media and electronic communication*. Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. (2012). *Code of Conduct for Nurses*. Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. (2011a). *Guideline: delegation of care by a registered nurse to a health care assistant*. Accessed on 15.06.17 <http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses>

Nursing Council of New Zealand. (2011b). *Guideline: responsibilities for direction and delegation of care to enrolled nurses*. Accessed on 15.06.17 at <http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses>

Nursing Council of New Zealand (2007). *Competencies for Registered Nurses*. Wellington: Author. (Amended September 2016).

Safe Medication Management Programme. (2011). *Medicine reconciliation toolkit*. Wellington: Health Quality and Safety Commission.

The Joint Commission. (2008). *Sentinel event alert: preventing pediatric medication errors*, 39. Illinois, USA: The Joint Commission. Available: [http://www.jointcommission.org/assets/1/18/SEA\\_39.PDF](http://www.jointcommission.org/assets/1/18/SEA_39.PDF)

Thompson, C. (2008). Recommending over-the counter medicines – what is involved? *Kai Tiaki Nursing New Zealand* 14(6), 26.

Wilkinson, J. (2014) The Medicines Amendment Act 2013: Changes for NP and RN prescribing. *Te Puawai* April 2014, 6-8

## 9.1 Acts and Regulations (available [www.legislation.govt.nz](http://www.legislation.govt.nz))

Crimes Act 1961 No 43 (as at 19 March 2012), Public Act <http://www.legislation.govt.nz/act/public/1961/0043/latest/DLM327382.html>

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—Registered Nurses Practising in Diabetes Health)

Regulations 2011 (SR 2011/54)

[http://www.legislation.govt.nz/regulation/public/2016/0140/latest/whole.html?search=sw\\_096be8ed8135b3f1\\_SR+2011%2f54\\_25\\_se&p=1](http://www.legislation.govt.nz/regulation/public/2016/0140/latest/whole.html?search=sw_096be8ed8135b3f1_SR+2011%2f54_25_se&p=1)

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>

# 10. Appendix 1: 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.

## 10.1 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 an other 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.

## 10.2 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 client 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.

### 10.3 During administration

During the administration of medication, the regulated nurse administering the medicine:

- monitors the client 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.

### 10.4 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.

## 11.0 Appendix 2: 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](http://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.

### 11.1 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](http://www.nursingcouncil.org.nz).

NZNO opposes HCAs administering medicines in acute care, and to ill clients, 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; and
- understands they must undergo and pass competency training before administering medicines

## 12.0 Appendix 3: 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.

# 13.0 Appendix 4: Example of Nurse-Initiated Medication Policy for Microlax Enema

Source: Lake Taupō Hospice 2018, shared with permission.

**Insert Organisation logo**

## Nurse-Initiated Medication

### Microlax Enema

Issued: <b>Insert date</b>	Review date: <b>Insert date</b>
<b>Bowel Care</b>	For treatment of constipation for palliative patients in the care of <b>Insert Organisation</b>
<b>Rationale</b>	This Nurse-Initiated Medication aims to provide patients with treatment for the immediate relief of constipation without delay
<b>Organisation/Clinic</b>	For the use by Registered Nurses employed at <b>Insert Organisation details</b>
<b>Scope (the condition and patient group)</b>	For the immediate treatment of constipation in adults over the age of 16yrs who have been admitted to <b>Insert Organisation</b>
<b>Medicine/s</b>	Microlax enema
<b>Dosage Instructions for each medicine</b>	1 pm
<b>Route of administration</b>	Per rectum
<b>Indication/circumstances for activating the Nurse-Initiated medication</b>	To provide relief from constipation where there is evidence of a rectum loaded with hard faecal matter without impaction
<b>Precautions and exclusions that apply to this Nurse-Initiated medication</b>	Precaution: A rectal examination is recommended on all patients with constipation to decide on appropriate treatment required Precaution: Contraindications to enemas include recent or current bowel perforation, undiagnosed abdominal pain, diverticulitis, ulcerative colitis, Crohn's disease, severe or internal haemorrhoids, and tumours of the rectum or colon. Other conditions of concern include recent lower gastrointestinal surgery and a history of heart disease or renal failure, due to the potential for electrolyte imbalance
<b>Persons authorised to administer the Nurse-Initiated medication</b>	Registered Nurses employed by <b>Insert Organisation</b>
<b>Competency/training requirements for the person(s) authorised to administer</b>	Prior to administering a microlax enema under this NIM, the registered nurse is required to undergo the in-house training on the policy, procedure and documentation requirements for nurse-initiated medicines and to have followed the The Palliative Care Handbook: guidelines for clinical management and symptom control (8 <sup>th</sup> ed.) Auckland, New Zealand: Crucial Colour
<b>Countersigning</b>	Countersigning is not required Routine documentation in <b>insert organisations requirements</b> is required
<b>Definition of terms used in Nurse-Initiated medication</b>	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). NIM are not to be used when a Standing Order is required (see section 6.2). 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.
<b>Additional Information</b>	Associated Document Examples <b>Insert Organisation</b> Nurse-Initiated Medication Policy/procedure/guideline/templates MacLeod, R., Vella-Brinca, J., & Macleod, S. (2016). The Palliative Care Handbook: guidelines for clinical management and symptom control (8 <sup>th</sup> ed.). Auckland, New Zealand: Crucial Colour. Lakes District Health Board Lippincott Procedures and Nursing Reference Centre <a href="http://midlandlearning.elearning.ac.nz">http://midlandlearning.elearning.ac.nz</a> <a href="#">Insert Organisation Home Page</a>
<b>Prescribing Health Professional:</b>	
Name:	Date:
Title:	

## 14.0 Appendix 5: Ministry of Health guidance on Student Nurses administering vaccines

Available to download from [http://www.nzno.org.nz/resources/medicines\\_-\\_guidelines\\_and\\_information](http://www.nzno.org.nz/resources/medicines_-_guidelines_and_information)

### Example standing order

Issued: 00/00/0000		Review date: 00/00/0000	
<b>Medicine Standing Order Title</b>	Administration of vaccines from the National Immunisation Schedule by undergraduate student nurses on placement, under the supervision of an Authorised Vaccinator.		
<b>Rationale</b>	<p>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).</p> <p>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).</p>		
<b>Organisation/clinic</b>	Insert Name of DHB / PHU / PHO / Practice / Clinic		
<b>Scope (the condition and patient group)</b>	<p>Administration of vaccines from the National Immunisation Schedule for the prevention of vaccine preventable diseases in children aged between birth and under 18 years.</p> <p>Administration of vaccines from the immunisation schedule for the prevention of vaccine preventable diseases in adults aged 18 years and over.</p>		
<b>Medicine/s</b>	Vaccines as per the current on-line version of the National Immunisation Schedule		
<b>Dosage instructions for each medicine</b>	Dose as per the current on-line version of the National Immunisation Schedule		
<b>Route of administration</b>	Route as per the current on-line version of the National Immunisation Schedule		
<b>Indication/circumstances for activating the standing order</b>	<ul style="list-style-type: none"> <li>• An undergraduate student nurse on placement is working under the supervision of an Authorised Vaccinator.</li> <li>• The vaccine is scheduled.</li> <li>• Informed consent is achieved.</li> <li>• The authorised vaccinator accepts responsibility for supervising the student nurse to administer the vaccine.</li> </ul>		
<b>Precautions and exclusions that apply to this standing order</b>	<p><b>Anaphylaxis to a previous dose or any component of the vaccines is an absolute contra indication to further vaccination with that vaccine.</b></p> <p>See sections 2 and 4 of the on-line Immunisation Handbook for pre vaccination checklists and precautions.</p>		

<b>Persons authorised to administer the standing order</b>	Undergraduate student nurses on placement in the service/practice and working under the supervision of an authorised vaccinator.
<b>Competency/training requirements for the person(s) authorised to administer</b>	<ul style="list-style-type: none"> <li>• Safe administration of oral and injectable vaccines</li> <li>• Basic emergency techniques including resuscitation and treatment of anaphylaxis</li> <li>• Code of Health and Disability Consumer Rights and informed consent process; relevant legislation (Medicines Act; Standing Orders Regulations).</li> </ul>
<b>Countersigning and audit</b>	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.
<b>Definition of terms used in standing order</b>	<p><b>National Immunisation Schedule</b> – The schedule issued by the Ministry of Health which stipulates the timing, medicine name, dosage and route for administration of vaccines.</p> <p><b>Registered nurse</b> – a health practitioner deemed to be registered with the Nursing Council of New Zealand as a practitioner in the profession of nursing.</p> <p><b>Authorised vaccinator</b> – a registered nurse authorised to administer vaccines under section 44A of the Medicines Regulations (1984).</p> <p><b>Undergraduate Student nurse</b> – a student enrolled in an approved Bachelor of Nursing programme and on placement for clinical experience as part of that programme.</p>
<b>Additional information</b>	<ul style="list-style-type: none"> <li>• The Authorised Vaccinator supervising the undergraduate student nurse must satisfy themselves that the student is adequately prepared to undertake the administration of the vaccine.</li> <li>• The Authorised Vaccinator is responsible for the supervision and oversight of the student nurse administering a vaccine under this standing order.</li> <li>• The Authorised Vaccinator is responsible for all documentation related to the vaccination event.</li> <li>• This standing order does not apply to any registered nurse working under the supervision of an Authorised Vaccinator.</li> <li>• 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.</li> </ul>

**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.