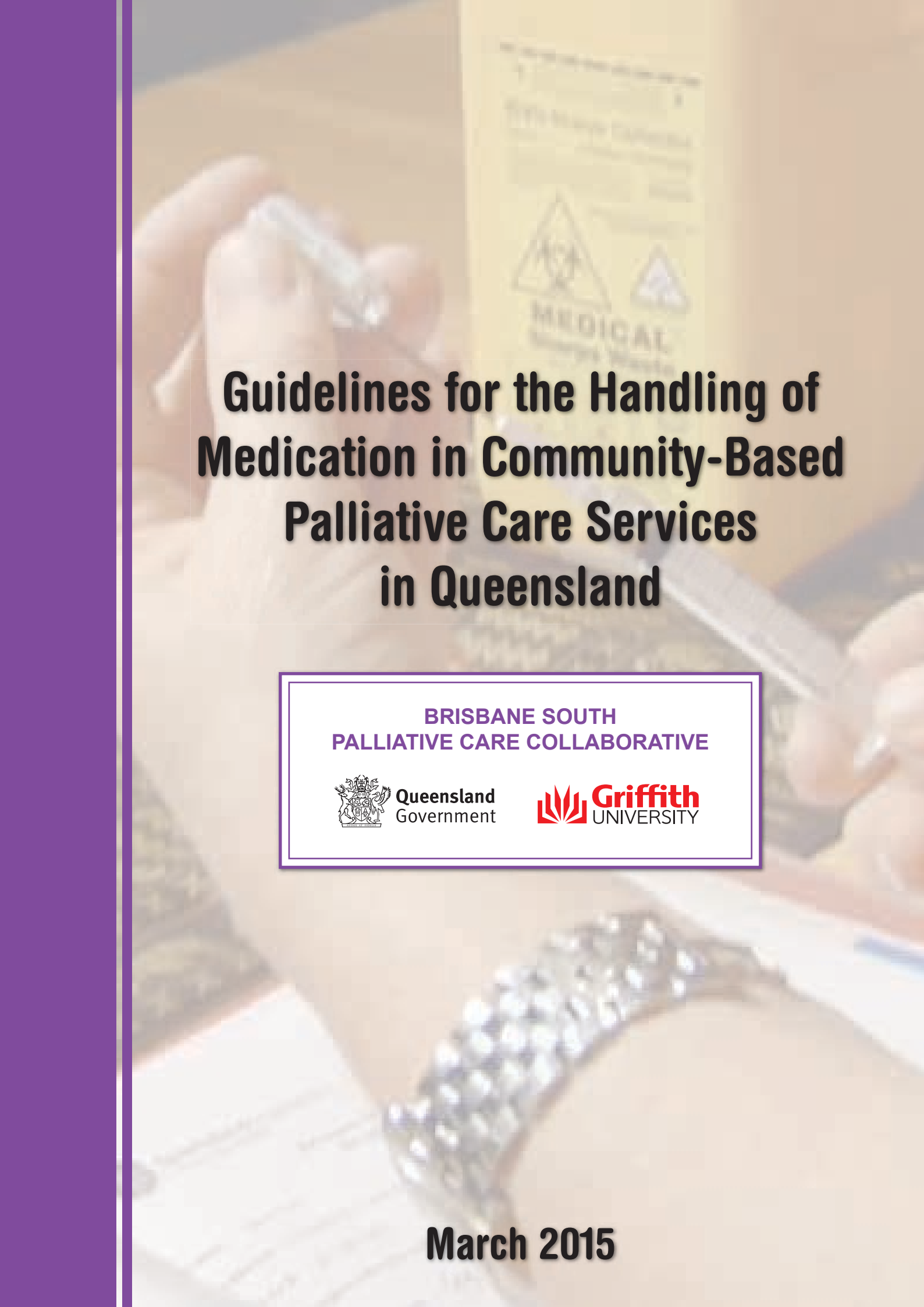


Guidelines for the Handling of Medication in Community-Based Palliative Care Services in Queensland

BRISBANE SOUTH
PALLIATIVE CARE COLLABORATIVE

Queensland Government

Griffith UNIVERSITY

March 2015

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1. INTRODUCTION

Many palliative care patients wish to remain at home for as long a possible. To help achieve this aim, patients need rapid access to medications to provide symptom relief. If symptom relief is not achieved patients may need to present to Emergency Departments and this can result in inappropriate admissions to acute care facilities and poor patient outcomes.

Palliative care service providers recognise the need for patients receiving home based palliative care to:

1. have their independence and quality of life maximised. This includes optimal pharmacological management of the symptoms related to their disease processes

2. remain at home as long as is desired and/or possible; and to

3. be provided with suitable support, including support for their families and carers, to enable their wishes to be fulfilled.

The purpose of this document is to present consensus based best practice for the handling of medication(s) by individuals and staff of community-based palliative care services. The document has been written with consideration of the needs listed above and complies with requirements within the *Health (Drugs and Poisons) Regulation 1996,* including the 1998 amendment to that Regulation.

The document contains guidelines that have been compiled by the Palliative Care Network, Brisbane Forum, Medication Subcommittee and modified by the Brisbane South Palliative Care Collaborative after extensive consultation with key service providers including government and non-government services. The document has been endorsed by the Environmental Health Unit, Queensland Health in October 2008, and Queensland Health Patient Safety and Quality Executive Committee in August 2009.

It is expected that these guidelines will be used by palliative care services to inform the development of detailed protocols and procedures tailored to the requirements of individual services or facilities. Such protocols and procedures support health care providers in the practice of handling and administering medications to palliative care patients living at home.

2. TERMS

In this document the term:

- **'must'** indicates a **mandatory practice** required by law or considered by Queensland Health to be necessary in the interest of patient safety.

- **'should'** indicates a **practice strongly** recommended by Queensland Health.

- **'Palliative Care'** is care provided for people of all ages who have a life limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life.[3]

Disclaimer: The above definition is provided as a guide in the development of an individual organisation's definition of palliative care. Definitions used to access palliative care funding or entry into a hospice may vary.

3. OBTAINING IMPREST SCHEDULED DRUGS AND POISONS

The *Health (Drugs and Poisons) Regulation 1996* is to be amended to enable palliative care services to obtain imprest scheduled medications. The date of amendment is beyond the scope of this document.

4. COMMUNITY-BASED PALLIATIVE CARE SERVICES

These guidelines should be used as the basis for the development of detailed protocols and procedures tailored to individual services or facilities.

4.1 Medication Management

A multi-disciplinary approach to the development of policies, procedures and medication management processes within an organisation is advisable. This approach may be applied to:

- the development and approval of written medication policies and procedures
- the rationalisation of medication use in relation to efficacy, safety and cost
- the analysis of medication incident reports
- any recommendations concerning the ongoing education of staff
- any recommendations concerning quality activities relating to medication administration.

4.2 Drug Storage

PART A: SERVICES THAT ADMINISTER PATIENTS' OWN MEDICATION(S)

4.2.1 Security - All Medications

Health care professionals and care workers must advise consumers that appropriate storage of medicines is important and that medicines must be stored in accordance with any instructions included on the label of the medication.

Generally, medicines should be stored in the original container in a cool, dry place. The stability and effectiveness of some medicines is dependent upon correct temperature storage, for example, those medications requiring refrigeration.

Patients who require assistance with their medication management may also require assistance to store their medicines in a safe manner, for example, away from children and people who may be unable to read or understand labels.

When a patient is required to take their medicine(s) out of the home, the health care professional should provide that person and/or their carer with information on appropriate storage and transport of these medicines. For example, medicines that are normally stored in the fridge can be put in a small esky or insulated lunchbox with a cooler block, if required. The health care professional must inform the patient or responsible lay carer to keep medicines in the original packaging and to observe the directions on the label for safe storage.

4.2.2 Individual Responsibility for Medication Storage and Security

Health care professionals should inform consumers that they (the patient or lay carer) are responsible for safe storage and safety of all medications within their home environment.

4.2.3 Individual Disposal of Medication

Guidelines must be developed for disposal of pre-prepared medications and for disposal of a patient's own stock of medications after obtaining consent from the patient. These can be adopted from "*Guiding Principles for Medication Management in the Community*". [4,5]

PART B: SERVICES WITH A HEALTH SERVICE APPROVAL

4.2.4 Service Responsibility

The Director of Nursing or other designated person is responsible for the storage of all drugs at the service. In these guidelines, this registered nurse will be called the 'designated nurse responsible'. He/she must ensure that correct storage conditions are met in relation to security, temperature and stock rotation.

The designated nurse responsible may delegate this responsibility to another registered nurse. In these guidelines this registered nurse is referred to as the "*authorised person*".

The Safe Medication Management Unit, Queensland Health, is dedicated to reducing patient harm associated with medications by addressing system causes. Individuals within a service are invited to submit anonymous medication incident reports to the Team Leader, Medication Services Queensland (MSQ).

4.2.5 Drug Access

Central Pharmacy supplies medications to Queensland Health facilities and organisations external to Queensland Health generally obtain supplies through authorised private suppliers. Organisations external to Queensland Health obtaining supplies from Central Pharmacy, must do so in accordance with Queensland Health policy "*Supply of Controlled and Restricted Drugs to External Agencies*", and for other authorised providers as per the policies and procedures of the particular organisation. [6]

The utilisation of a patient's own medication as stock medication, even if it is returned or donated to the organisation, is illegal.

4.2.6 Security – Controlled Drugs within the Confine of the Service

Controlled and restricted drugs are to be kept in a secure place, which can be locked when not in use. The key or combination to the secure place shall be kept in the possession of the authorised person. Whilst on a home visit such a secure place may include the boot of a vehicle during visits to patients provided:

- the key to the vehicle is in possession of the authorised person; and

- the scheduled drugs are not visible from the outside of the vehicle (ie. stored in the back of a station-wagon without a luggage cover would not be acceptable).

The receptacle, suitable for storage at a facility, within which controlled and restricted drugs are kept, must be a lockable metal container that is at least 10mm thick with continuous welding of all joints. The tamper proof lock system will be either a combination lock equal to, or equivalent to, the "Sergeant & Greeleaf" type; a lock mechanism equal to, or greater than, a 6-lever pick-proof lock or a 6-lever pick-proof lock. The hinges on the metal receptacle must be constructed of heavy duty steel; with continuous welding to the body of the lid and body; be tamper proof and concealed on the inside of the receptacle if possible, or the receptacle must be deemed to be as secure as this by an Environmental Health Officer of a local Population Health Unit.

The receptacle, suitable for transport, within which controlled and restricted drugs are kept, must be a lockable metal container that is, with continuous welding of all joints or deemed suitable by an Environmental Health Officer. The tamper proof lock system will be either a combination lock or a lock mechanism that is tamper proof resistant. The hinges on the metal receptacle must be sturdy; with continuous welding to the body of the lid and body; be tamper proof and concealed on the inside of the receptacle if possible or the receptacle must be deemed to be as secure as this by an Environmental Health Officer of a local Population Health Unit. [7,8]

Note: Caution will be required concerning the temperature of the vehicle whilst the drugs are inside to ensure compliance with any specified storage requirements. Specific security requirements are further outlined in the *Queensland Health (Drugs and Poisons) Regulation 1996*. [9]

4.2.7 Storage – Temperature Dependent Medication

The temperature at which medications are stored must be consistent with the specification on the label of the manufacturer's container. Most drugs should be stored below 30ºC. Some should be stored below 25ºC; others must be stored in refrigerated conditions. Medications, when in use or when in the possession of the authorised person must, wherever possible, be contained in a thermally appropriate container, such as an insulated brief case.

The storage of individual pre-prepared medications must also be in accordance with the manufacturer's recommendations and supporting data (see Appendix 1).

4.2.8 Stock Rotation

A routine procedure of stock rotation and monitoring of expiry dates must be in place to prevent the accumulation of old stock.

4.2.9 Service Disposal of Medication

Services must develop their own guidelines for appropriate disposal of pre-prepared, excess and unused medication that accord with Queensland Health regulations. This excludes cytotoxic medications as these medications are subject to other disposal restrictions.

4.2.10 Emergency Medication for Home Visits

A service may hold a small range of drugs in a locked 'bag' (or box) that can be taken on home visits for use in an emergency. The service should determine a set list of the drugs and quantities held in the bag(s). The drugs from this list may be obtained by requisition as 'stock' medication, as described in this document in *4.3.1 Stock Medication*.

Controlled drugs (Schedule 8) should not be routinely included in an emergency drug bag supply. However, a service may consider that rare situations exist in some locations where the necessity to make a round trip to obtain a supply of a Controlled drug (Schedule 8) from the service will diminish patient care. In these cases the service may consider the inclusion of a minimal quantity of Controlled drug(s) (Schedule 8) in the emergency bag supply. A record of this stock and its use must be made in a Controlled Drug Register (Schedule 8). A separate register must be used for each emergency bag.

The receptacle, a metal box suitable for transport, within which controlled and restricted drugs are kept, must be a lockable metal container that is, with continuous welding of all joints or deemed suitable by an Environmental Health Officer - refer *4.2.6 Security – Controlled Drugs*. The tamper proof lock system will be either a combination lock or a lock mechanism that is tamper proof resistant. The hinges on the metal receptacle must be sturdy; with continuous welding to the body of the lid and body; be tamper proof and concealed on the inside of the receptacle if possible, or the receptacle must be deemed to be as secure as this by an Environmental Health Officer of a local Population Health Unit. [7,8]

Only personnel who are authorised to possess and administer stock medication to patients may access and carry the emergency drug bag – refer *4.5.1 Who Can Administer?* Administration must be authorised – refer *4.4.1 Medication Authorisation*.

While held at the service, the bag must be stored in a secure locked cupboard. When taken on a home visit, if the bag is to be left in the car, it must be locked in the boot of the car. Following the visit, the bag must be secured by the staff member and returned to the service at the earliest convenience. The staff member must be informed of the possible effect of high temperatures on the drugs if the bag is left for prolonged periods in a hot car. An insulated container must be utilised to hold the bag on these occasions.

4.3 Acquisition of Medication

4.3.1 Stock Medication

The term 'stock medication' refers to medication that has not been individually supplied for a specific patient (eg. by a pharmacist on prescription).

A service may hold a small range of drugs in a locked bag (or box) that can be taken on home visits in an emergency. The service should determine a list of drugs and quantities.

A record must be kept of stock medication that is administered by a nurse or medical practitioner. This record must show drug name, strength and quantity,

patient's name, and staff member's name, signature and date administered. Refer *4.7.1 Drug Register* regarding record keeping for controlled drugs.

It should be noted that endorsed enrolled nurses are authorised to administer medications "under supervision" but are not authorised to supply them. [9]

4.4 Prescribing

4.4.1 Medication Authorisation

'Prescription-only' medication must not be administered to a patient unless a medical practitioner or a nurse practitioner, acting under an approved Health Management Protocol (HMP), has provided an instruction for this. Each instruction for the administration of medication for a patient from any source must be detailed in the patient's medication order record so that a complete and up-to-date reference record is available to staff. Any changes in dosage must also be included in this record.

If a 'prescription-only' medication is to be administered to a patient by service staff from stock, the medical practitioner or the nurse practitioner, acting under an approved HMP, must give an instruction, preferably written on a medication order (or by telephone as described in *4.4.2 Emergency Telephone Orders*). The medication order must bear the name of the community-based palliative care service.

When authorising medication on a medication order record the medical practitioner or the nurse practitioner must legibly enter in ink the following particulars:

- the patient's identifying particulars
- any drug allergies
- the name and strength of the drug and, where necessary, the form of the drug
- full directions for use including the dose, route and frequency of administration
- the nominated review period, if applicable
- the medical practitioner's name (printed), signature and date (each drug order should be signed, it is not sufficient to sign across several orders).

In addition, for patient safety, when ordering PRN (as required) medication, Queensland Health services should comply with the "*Statewide Medication Chart"* Guidelines. [10] The medication order must include the full directions for PRN use including dose, route and frequency of administration and the maximum dose allowable over a 24 hour period.

Services must ensure that a medical practitioner or a nurse practitioner, acting under an approved HMP, regularly reviews medication orders; the period must

not exceed 6 months for Controlled drugs (Schedule 8) or 12 months for Restricted drugs (Schedule 4).

4.4.2 Emergency Telephone Orders

Where a patient is in urgent need of medication, a medical practitioner or a nurse practitioner, acting under an approved HMP, may give emergency verbal authorisation by telephone if he/she is unable to attend.

The person who receives the medication order over the phone must be a registered nurse, a medical practitioner or a pharmacist. The medication order must be read back to the prescriber. As a further check, where possible, the prescriber must confirm the order to a second person. The person receiving the order must write it in the patient's medical notes (including the prescriber's name and number of doses to be given).

When the medication is administered to the patient, the person administering must record the dose given on the medication administration record (or in the notes if no record currently exists) in ink and in some section of the record other than the section for ongoing regular, 'as required', medication. The prescriber must then confirm in writing this administration record within 24 hours and send via post the original copy to the service provider. The service provider must record in the patient's records that written authorisation has been received.

If the medication is to be ongoing, the medical practitioner or a nurse practitioner, acting under an approved HMP, must either:

- write a prescription for dispensing at a community or hospital pharmacy or
- authorise the medication on the medication order record to continue to be administered by writing in the regular or PRN section, as the case may be.

NOTE:

1. The service should have in place a procedure to ensure that emergency verbal orders are vigorously followed up if confirmation is not forthcoming within the designated period.

2. A facsimile copy of a medication order is a legal document; however it is best practice to encourage the medical officer to send the original copy of the medication order in the post.

4.5 Medication Administration

4.5.1 Who Can Administer?

In considering who may administer medication to a patient, the distinction is made between:

- stock medication, as described in *4.3.1 Stock Medication*
- patients' own medication(s), dispensed and labelled by a pharmacist on prescription
- nurse administered medication.

(i) Stock Medication

Only a registered nurse or medical practitioner or nurse practitioner, acting under an approved HMP, may administer 'Prescription-only' stock medication. Administration must be on the prior direction of a medical practitioner or nurse practitioner acting under an approved HMP. Refer *4.4.1 Medication Authorisation*.

For 'non-prescription' stock medication, refer *4.5.5. 'Non-Prescription' Stock Medicine.*

(ii) Patients' Own Medication(s)

On request from a community-based palliative patient, a registered nurse, medical practitioner or nurse practitioner, acting under an approved HMP, can:

- prepare an injection using prescribed medication(s) directly from the patient's own labelled medication(s) container(s)
- administer an injection using prescribed medication(s) directly from the patient's own labelled medication(s) container(s)
- fill a dose administration aid with prescribed medication(s) directly from the patient's own labelled medication(s) container(s); (see Glossary of Terms – Dose Administration Aid) Note: It is recommended that if a dose administration aid is considered appropriate then preferentially a community pharmacist should be approached to provide and fill the aid. Family may also assume responsibility for filling the dose administration aid. A registered nurse can fill a dose administration aid only if there is no other option and if this practice is consistent with the policy of the employing organisations
- enable a patient to take or administer their own prescribed medication(s) and/or

- assist a lay carer to administer a patient's own prescribed medication(s).

In the case of a palliative patient in a community setting, a health care employee who is neither a registered nurse or a medical practitioner or a nurse practitioner, acting under an approved HMP, on request, can provide assistance to enable a patient to take their own prescribed medication(s). Such assistance includes the administration of prescribed medication(s) direct from the patient's own labelled medication(s) container(s) or dose administration aid but excludes the preparation and administration of injections and the filling of a dose administration aid.

(iii) Nurse Initiated Medication

Nurse initiated medications can be selected from S2 and S3 categories of the *Health (Drugs & Poisons) Regulations 1996*. Each service should determine a range of such medications that they will authorise.

(iv) Role of Lay Carer

On request from the patient, a lay carer can assist the palliative patient in their care to take their medication(s) according to the instructions indicated on the patient's own labelled medication(s) container(s). A lay carer must be provided with appropriate training to safely assist with the medication(s) administration.

In the situation where the palliative patient is unconscious or unable to consent to the administration of medication(s), the lay carer can be appointed the Statutory Health Attorney. According to the G*uardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* (section 63) a Statutory Health Attorney has the authority to make health care decisions on behalf of the patient whose ability to make decisions is permanently or temporarily impaired and the Statutory Health Attorney can consent to most health care issues. [11,12,13,14] There is no requirement to complete forms or formally appoint a Statutory Health Attorney. A person automatically acts in this role when the need arises because of their relationship (i.e. spouse or primary lay carer but not a paid worker) with the patient.

4.5.2 Transcribing

Orders in medication order records can only be written and signed by a medical practitioner or nurse practitioner, acting under an approved HMP. The practice known as 'transcribing' whereby others write on a medication order form to direct the subsequent administration of medications to a palliative patient must not occur. Similarly, attachments must not be made to the original medication authorisation in order to extend therapy.

This does not preclude a palliative patient being provided with a list of their medications for their own information.

4.5.3 Procedure for Administering Medication

Refer also to *4.4.1 Medication Authorisation*

A registered nurse administering a stock medication must refer directly to the medical practitioner's or nurse practitioner's, acting under an approved HMP, written instructions except as in *4.4.2 Emergency Telephone Orders* and *4.5.5 Non-Prescription Stock Medication*. The same person must select and prepare the drug. Each time a person administers a stock medication to a patient, he/she must make a record of that administration on the medication order record, or in the patient's notes, as the case may be.

The following points should be noted:

- if the medication order is unclear or ambiguous, the person must contact the prescriber or, if this is not possible, another medical practitioner or nurse practitioner, acting under an approved HMP, or pharmacist for clarification before administering
- to avoid selecting the wrong medication it is emphasised that the person must carefully read the label on the container and check the name and strength against the medication order record
- a new syringe and needle must be used for each administration of an injected medication
- where only a portion of a single use ampoule is required for a patient, the unused balance must be discarded and dose(s) administered documented in the medication order record.

4.5.4 Re-packing

Each medication prescribed to a patient must be packed and fully labelled in accordance with the requirements of the *Health (Drug and Poisons) Regulation 1996* including cautionary labels and the use of child-resistant containers, where required.

Drugs must be left in the supplied container (e.g. medication boxes or dose administration aid) as supplied by the community or hospital pharmacy and administered to a patient directly from that container, except when indicated below:

- A registered nurse may need to prepare up to 24 hours supply of injectable "as required" medication(s), if the carer is unable to do so. These medications will be stored in a fridge in an appropriate container(s), for later administration to the palliative patient by a lay carer. Each syringe must be individually labelled with the medication name and dose, date and time of preparation and signature of the registered nurse who prepared the medication(s). Refer *4.7.2 Witness to Administration and Discarding of patient's own medication*
- Refer to *4.5.1 - (ii) Patients' Own Medication.*

If colour coded labels are used when labelling syringes it is recommended that the colour coding is consistent with the Australian/New Zealand Standards; *"User-applied labels for use on syringes containing drugs used during anaesthesia* ". (Refer Appendix 2)

4.5.5 'Non-Prescription' Stock Medication

The service may approve a list of 'non-prescription' medication(s) that may be administered by a registered nurse without a medical practitioner's or nurse practitioner's, acting under an approved HMP, authorisation (Refer *4.5.1 Nurse Initiated Medication*), provided appropriate detailed written protocols for use are also developed. This may include complementary therapies if appropriate competence can be demonstrated.

'Non-prescription' stock medication that is included on this list must be administered by a registered nurse or endorsed enrolled nurse "under supervision". [8]

It is important to check for other medication(s) (including 'over the counter' or complementary medications) that might interact with prescription drugs. If there are no documented interactions then the medication can be administered. If there are documented interactions the prescriber must be contacted to obtain appropriate instructions.

When a dose of medication from this approved list is administered to a patient, an indelible record must be made in black ink on the medication administration record including, as a minimum, the following details:

- the date and time given
- the name, strength, route and dose of the medication
- the reason for administration of the medication
- the signature of the administering person, printed name and designation.

If medication from this list needs to be administered on a regular basis then a medical practitioner's or nurse practitioner's, acting under an approved HMP, authority must be sought.

4.6 After Hours Emergency Situations

Where an after hours service is provided, the service must develop procedures, in accordance with these guidelines, to deal with after hours emergency situations. Such procedures should include provision for access to appropriately qualified personnel. Refer *4.4.2 Emergency Telephone Orders*.

4.7 Controlled (or Schedule 8) Drugs

Refer to *4.2.6 Security – Controlled Drugs within the Confine of the Service*, regarding storage of Controlled drugs (Schedule 8).

4.7.1 Drug Register

The designated nurse at each service is required to keep a drug register or administration book at the service to record the receipt, administration and any other transaction of all Controlled drugs (Schedule 8) that are stored at the service. The record in the register must be contemporaneous; made as soon as practicable after the 'transaction' occurs, and definitely on the same day.

The drug register or administration record must be in the form of a bound book, the pages of which cannot be removed or replaced without detection and which has consecutively numbered pages.

A separate page in the drug register, or column in the administration book, must be used for each drug and each strength of the drug.

The record must include the following in ink (as are relevant to the transaction):

- the date
- the time of day
- the patient's name, in the case of a drug which is administered to a patient
- the amount received, in the case of receipt of drugs from the pharmacist
- the amount used, in the case of administration of the drug to a patient
- the amount discarded, in the case of only part of an ampoule or tablet being administered to a patient
- the balance of stock remaining after the transaction is made
- the signature of the person making the entry
- the signature of the person who witnessed its receipt, its administration to a patient, or the discarding of the remainder, refer also to *4.7.2 Witness to Administration and Discarding of Patient's own Medication*
- the name of the prescriber.

A person making an entry in a drug register must not make any:

(i) false or misleading entry

(ii) alterations, obliterations or cancellations (including crossing out or drawing a line through an entry). If a mistake is made, it must be left as it is, marked with an asterisk and the entry re-written as appropriate. A note explaining the error must be made in the margin or at the foot of the page, initialled and dated.

4.7.2 Witness to Administration and Discarding of Patient's Own Medication

Where a registered nurse visits a patient at home (or other residential setting) and administers a Controlled drug (Schedule 8) that has been brought from the service, a record must be made in the register of the service showing the amount used for the patient. It is acknowledged that it is usually not possible for a second staff member to be present at the patient's home to witness the administration and therefore, in this case, the countersignature in the register reflects only that the second person witnessed removal of the drug from the designated storage. The actual amount administered and the amount discarded must be recorded on the patient's medication administration record by the administering registered nurse.

Where a patient's own Controlled drug (Schedule 8) is held by the patient at home, no service register record is required of the administration of the medication by service staff. However, for that patient, administration must be recorded in the medication administration record.

4.7.3 Balance Checks

The balance of Controlled drugs (Schedule 8) held by the service must be checked at least once a week. This check must be carried out by a registered nurse and a second person and must be confirmed by a signed entry in the drug register on the relevant page for each drug.

4.7.4 Loss or theft of a Controlled Drug (Schedule 8) or a Restricted Drug (Schedule 4)

In the event of loss or theft of a Controlled drug (Schedule 8) or a Restricted drug (Schedule 4) the Service must:

- inform the local police
- as soon as practicable, report by telephone the loss to the Director of Environmental Health Service of the local Population Health Unit and follow their instructions.

4.7.5 Destruction of Unusable Controlled Drugs (Schedule 8)

Controlled drugs (Schedule 8) that are being stored at the service and have become unusable (e.g. expired, damaged or no longer in use) must only be destroyed in accordance with guidelines from the Director of Environmental Health Service of the local Population Health Unit.

4.7.6 Loss of a Drug Register

When a drug register in a service is lost or destroyed, the service must immediately report the fact and the circumstances of the loss in writing to the Director of Environmental Health Service of the local Population Health Unit.
The service must then make an inventory of all Controlled drugs (Schedule 8) held in stock at the centre and enter the particulars in a new drug register. A drug register in a service must be kept at the service for a minimum of three years from the date of the last entry made in it.

4.8 Dose Administration Aids

In general the term, dose administration aid, describes a device where medications are stored and divided into containers by administration period. A variety of products are available. Individual medications are frequently mixed within these containers and it is therefore difficult to identify each individual medication. Since Queensland Nursing Council professional requirements exclude registered nurses or endorsed enrolled nurses from administering a medication that they cannot adequately identify, these devices generally are not used by these professionals. Lay carers can assist with the administration of medication from a multi-dose dose administration aid. Refer to *4.5.1 – (iv) Role of Lay Carer.*

It is recommended that if a dose administration aid is considered appropriate for a particular palliative patient then a community pharmacist should be approached to provide and fill the dose administration aid. Family may also assume responsibility for filling the dose administration aid.

4.9 Complementary and Alternative Medicines (CAMs)

CAMs are seldom 'prescribed' by doctors and are not available under the Pharmaceutical Benefit Schedule. These medications will not appear in the medication order record. Services should develop local policies on their approach to the administration of these CAM 'medications'.

4.10 Adverse Drug Reactions

An adverse drug reaction is defined as a response to a drug which is noxious and unintended and which occurs at doses normally used in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.

Adverse Drug Reaction (ADR) is the generic term applied to any unexpected and unwanted reaction following the administration of a medication. It may include allergic reactions or dose related side effects. Reactions can be of varied severity from life threatening to minimal inconveniences. All information needs to be shared within the extended health care team to support administration and intention to treat decisions. An ADR record is not, in itself, a contraindication to the utilisation of the involved medication but provides guidance on future drug therapy for a patient. If staff are requested to administer medications to patients who have previously experienced ADRs the staff member must consult with the patients' medical officer or nurse practitioner, acting under an approved HMP, for clarification of the safety of the order.

All health care workers are obliged to record medication allergies and ADR details (the medication and nature of the reaction) for all patients (patients themselves may be more familiar with the term allergy rather than ADR, so this may be a better prompt) in a manner that shares this information within the extended health care team. If the patient is not aware of any previous allergy or ADRs, then "Nil known" should be recorded. If allergy and ADR status is unknown, then "Unknown" should be recorded. If any information is added to this documentation after the initial interview the person adding the information must sign next to the addition. The person documenting the information must: sign, print their name and date the entry.

5. REFERENCES

1. NSW Health Department. *Guidelines for the Handling of Medication in Community-Based Health Services and Residential Facilities in New South Wales*, 1997.

2. Palliative Care Victoria: *Guidelines for the Handling of Medication in Community-Based Palliative Care Services in Victoria*, November, 2002.

3. Palliative Care Australia, *Standards for Providing Quality Palliative Care for all Australians,* 2005.

4. Australian Pharmaceutical Advisory Council "*Guiding principles for medication management in the community*", June 2006.

5. Australian Pharmaceutical Advisory Council "*Guiding principles to achieve continuity in medication management*." July 2005. http://www.dcita.gov.au/home/publications

6. Queensland Health Policy "*Supply of Controlled Drugs (Schedule 8) and Restricted Drugs (Schedule 4) to external agencies*, 2007. http://qheps.health.qld.gov.au/medicines/documents/supply0307.pdf

7. Environmental Health Unit, *Health (Drug and Poisons) Regulation 1996*, 'What Nurses Need to Know', 2000.

8. Environmental Health Unit, *Health (Drug and Poisons) Regulation 1996*, 'What Doctors Need to Know', 2008.

9. Queensland Health, *Health (Drugs and Poisons) Regulation 1996* reprint 1 October 2007. http://www.health.qld.gov.au/health_professionals/medicines/default.asp

10. Queensland Health Procedure "*Statewide Medication Chart" Guidelines, Section 5.1 'As required (PRN) medicines*', 2007.

11. Queensland Health, Environmental Health Unit: *Office of the Chief Health Officer, Administration of Medication by Carers*. Circular 03/98.

12. Department of Justice and Attorney-General. Fact sheet – Statutory Health Attorney. http://www.justice.qld.gov.au/guardian/poa/sha.htm

13. Department of Justice and Attorney-General. Making a health care decision. http://www.justice.qld.gov.au/guardian/ag/hcare.htm

14. White, B., Willmott, L. Rethinking Life-Sustaining Measures: Questions for Queensland. An issues paper reviewing the legislation governing withholding and withdrawing life sustaining measures. 2005. QUT. http://www.eprints.qut.edu.au/archive/00007093/01/7093_1.pdf

15. *Therapeutic Guidelines Palliative Care*, Version 2 2005. Therapeutic Guidelines Limited, Melbourne.

16.

6. GLOSSARY OF TERMS

Term	Definition
Accountability	The state of being answerable for one's actions, and the roles and responsibilities inherent in one's job or position. Accountability cannot be delegated. Accountability is about being answerable for carrying out the tasks/functions inherent in one's role, in a competent manner.
Adverse Drug Reactions	A response to a drug which is noxious and unintended, and which occurs at doses normally used in humans for the prophylaxis, diagnosis or therapy of disease or for the modification of physiological function.
Adverse Event	An incident in which harm resulted to a person receiving health care.
Authority	The person has the authority under the *Health (Drugs and Poisons) Regulation 1996* because of the person's occupation, eg. a doctor, midwife, dentist or because the person holds an office, eg. a general manager of a prison.
Breakthrough Medications	Breakthrough medication is used if symptoms emerge despite the use of background medication(s).
Consent	Consent has its ordinary meaning. To have legal effect, a person's consent must be given freely and voluntarily so, for example, it must not be given because of another person's pressure or coercion. Consent may be implied by a person's conduct. In some circumstances, consent requires particular legal formalities (for example, the completion of a valid Advance Health Directive).
Complementary and Alternative Medicines (CAMs)	CAMs are seldom prescribed by doctors and are not available under the PBS. Only an accredited practitioner in a complementary practice area should recommend or prescribe these products. Administration of these products by RNs and EENs is often inhibited because these products are administered on a regular basis and are not 'prescribed' on a written order by a doctor. Informal lay carers will often administer these products to patients on their behest.
Compliance	A quantitative measure of how closely a consumer follows the intentions and recommendations of a prescribed course of treatment, regardless of their personal beliefs and capabilities. Failure to comply generally has a negative connotation despite the fact that deliberate non-compliance may be a positive expression of the consumer's privacy.
Consultation	Consultation occurs when people seek information or advice and take into consideration the feelings and interests of other members of the medication management team.
Consumer Medicine Information	Brand specific leaflets produced by a pharmaceutical company in accordance with the Therapeutic Goods Regulations to inform consumers about prescription and pharmacist only medicines. Available from a variety of sources for example, enclosed within the medicine package, supplied by a pharmacist as a leaflet or computer printout, provided by a doctor, nurse or hospital, or available from the pharmaceutical manufacturer.
Dispense	To prepare and sell and/or distribute medications on prescription.
Doctor	A registered medical practitioner, such as a general practitioner, medical specialist, consultant medical practitioner or hospital

Term	Definition
	medical officer.
Dose Administration Aids	In general the term describes a device where medications are stored, divided into containers by administration period. Individual medications are frequently mixed within these containers and it is therefore difficult to identify each individual medication. A variety of products are available. The patient must be willing to acknowledge their need to use such a device, assessed for their ability to use the device and trained how to use them to optimise their use.
Drug Therapy Protocol	Under the provisions of Sections 67, 175 and 263 of the *Health (Drugs and Poisons) Regulation 1996,* in accordance with the provisions of the Drug Therapy Protocol (DTP), a nurse practitioner endorsed to practice by the Queensland Nursing Council may prescribe, give a written or oral instruction, supply and administer those drugs listed in the Queensland Health (QH) Standard Drug List for which a Health Management Protocol (HMP) has been developed and approved.
Endorsement	Under the *Health (Drugs and Poisons) Regulation 1996* endorsement means any of the following: (a) an authority; (b) an approval: (c) a certification; (d) a drug licence; (e) a wholesale representative licence; (f) a poison licence; (g) a cyanide permit; (h) a strychnine permit.
Endorsed Enrolled Nurse	An endorsed enrolled nurse is endorsed to administer medications under the *Nursing Act 1992*.
Enrolled Nurse	An enrolled nurse is licensed to practice nursing under the supervision of a registered nurse under the *Nursing Act 1992*.
Health Care Professionals	Doctors, pharmacists, nurses and allied health professionals.
Health Management Protocol (HMP)	HMP outlines the situations and conditions under which the drugs, listed in *the Drug Therapy Protocols* (DTP) may be administered and/or supplied by Registered Nurses with the appropriate endorsement of their Annual Licence Certificate, issued by the Queensland Nursing Council.
Lay Carer	Anyone responsible for, or taking part, in the provision of care for another person, including family members, friends and guardians. A lay carer in this document refers to an unpaid carer and can also be known as informal lay carer.
Medications – Non-Prescription S1 to S3	As described by Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP) and *Health (Drugs and Poisons) Regulations 1996.*
Medications – "Restricted" Prescription S4	As described by Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP) and *Health (Drugs and Poisons) Regulations 1996.*
Medications – "Controlled" Drugs of Dependence S8	As described by Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP) and *Health (Drugs and Poisons) Regulations 1996.*
Medication Error	An error can be defined as failure in the (drug) treatment process that leads to, or has the potential to lead to, harm to the consumer

Term	Definition
	and includes an act of omission or commission. Errors rarely occur as the result of the actions of a single individual. They are usually the result of a series of system failures.
Medication List	A complete and comprehensive list of medicines where there is sufficient information (complete dataset) to fully identify all products. Key elements of the dataset include the name(s), strength and dose form and directions for use.
Medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental welfare of people. Includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route.
Medication Order	Is a written or verbal direction by a person who has the authority, to administer medication including S4 or S8 drugs.
Nurse Practitioner	A registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health-care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health-care delivery that complements other healthcare providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is educated and authorised to practise.
Partnership	Refers to a relationship where there is a sharing of expertise and responsibility among doctors, nurses, pharmacists and consumers for a person's well being. Working in partnership involves consultation between individuals and collaborative decision-making.
Pharmacist	A registered pharmacist practicing in a variety of settings including community, hospital, facilities etc.
Prescribed Medication Name	Medications commonly have two names. The 'trade' name or name allocated by an individual manufacturer to their product and a 'generic' or 'approved' name that has been accepted internationally as describing the specific medication.
Prescriber	A health professional that is authorised by legislation to issue a prescription for the supply of medicines. Usually refers to a medical practitioner (doctor) but may include a nurse practitioner, optometrist or dentist.
Registered Nurse	A registered nurse is registered under the *Nursing Act 1992* such as a registered nurse, community nurse, and specialist nurse such as diabetes educator and psychiatric nurse.
Responsibility	To be entrusted with or assigned a duty or charge. In many instances responsibility is assumed, appropriate with one's duties. Responsibility can be delegated, as long as it is delegated to someone who has the ability to carry out the task or function, and

Term	Definition
	then the person who delegated the responsibility still maintains accountability, along with the person accepting the task or function. Responsibility is about accepting the tasks / functions inherent in one's role.
Service Provider	Provider of health and community care service.
Statutory Health Attorney	A Statutory Health Attorney is needed when decisions about health care have to be made and the adult is too ill or incapable of making decisions. For instance, consent may be needed for medical treatment or an operation while the adult is unconscious. Alternatively the adult could have dementia or an intellectual/psychiatric disability; or an acquired brain injury. As well as having impaired decision-making ability, the adult who needs a Statutory Health Attorney has not: • set out relevant directions for his/her medical treatment in an Advance Health Directive, or • appointed an attorney for personal matters (under an Enduring Power of Attorney or Advance Health Directive), or • had a guardian appointed by the Guardianship and Administration Tribunal (GAAT) for health care matters. The Statutory Health Attorney can consent to most health care issues, including medical and dental treatment and withdrawing or withholding of life sustaining measures. The law lists those who can act as a Statutory Health Attorney. In order of preference (provided they are readily available and culturally appropriate), these people are: • the patient's spouse (if the relationship is close and continuing); • the patient's primary carer, but not a paid carer (although they may receive a carer's pension) • a close adult friend or relative; and • the Adult Guardian as a last resort.
Subcutaneous Injection	An injection of a substance into the subcutaneous tissue of the skin. The subcutaneous route is commonly used in palliative care to deliver bolus or continuous doses of medications for the management of symptoms.
Written instruction	Means any of the following: a) a written direction, other than a prescription or a purchase order, signed by a dentist, doctor, nurse practitioner or surgical podiatrist and on which the date of the direction is shown; b) a standing order signed by a doctor or nurse practitioner and on which the date of the order is shown; c) a written entry on a patient's medical records signed and dated by a doctor or nurse practitioner.

7. APPENDIX 1: Medication Storage Data

Table 1: Medication storage data

Clonazepam	Stable for 24 hours in plastic syringes. Protect from light and store at 15-30 ºC.
Dexamethasone	Protect from light. Store for 24 hour at 15-30 ºC.
Fentanyl	Protect from light.
Haloperidol	Protect from light.
Hydromorphone (Dilaudid)	Should be stored at 15-30 º Celsius.
Hyoscine hydrobromide	No data.
Hyoscine N-butyl bromide	Protect from light.
Ketamine	No data.
Metoclopramide	Protect from light. Store at 15-30 ºC.
Midazolam	Protect from light. Diluted solutions must be stored at 2-8 º C and used within 24 hours.
Morphine	Stable in plastic syringes with plastic caps (not needles) for 67-72 days has been reported. Stability is dependent upon protection from air and light. Solution becomes darker on exposure to light. Should be stored at 15-30 º Celsius.
Prochlorperazine	Protect from light.
Promethazine	Stable for 24 hours in plastic syringes. Protect from light and to be stored a 15-30 ºC.
Octreotide	Must be stored in refrigerator.
Sufentanil	No data.

Sources:

1. Trissel LA. *"Handbook on Injectable Drugs."* 6th edition. American Society of Health-System Pharmacists, 1990.
2. Allinson Y, James A. *"Australian Injectable Drugs Handbook".* 1st edition. Society of Hospital Pharmacy of Australia Publications, 1997.
3. Bing CM, Chamallas SN, Hayes JM, Limburg-Mancini B, Nitzki-George D, Nowobilski-Vasilios A, et al. *Extended Stability for Parenteral Drugs*. 3rd edition. Maryland: American Society of Health-System Pharmacists, 2005.
4. Trissel LA, Leissing NC. *Trissel's Tables of Physical Compatibility.* Illinois, Multimatrix. 1999.

8. APPENDIX 2: AUSTRALIAN/NEW ZEALAND STANDARD 'User-applied labels for use on syringes containing drugs used during anaesthesia'

Standard background colours for user applied labels for use of syringes containing most commonly used "*as required"* medications adapted from the Australian and New Zealand Standard *'User-applied labels for use on syringes containing drugs used during anaesthesia'.*

Table 2: Australian and New Zealand Standard – *'User-applied labels for use on syringes containing drugs used during anaesthesia'*

Drug Classification	Examples	Colour
Antiemetics	Metoclopramide	**Salmon**
Anticholinergic Agents	Atropine; Hyoscine hydrobromide	**Green**
Induction Agents	Ketamine	**Yellow**
Major Tranquillisers	Haloperidol, Chlorpromazine	**Salmon**
Narcotics	Morphine; Fentanyl	**Blue**
Tranquillisers	Midazolam; Diazepam	**Orange**

NOTES



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