**Canberra Health Services**

**ClinicalPolicy**

**Medication Handling**

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| Purpose |

This policy consolidates best practice principles on medication procurement, possession, storage, prescribing, dispensing, supplying, administering, and recording at Canberra Health Services (CHS) in accordance with the requirements of the *Medicines, Poisons and Therapeutic Goods Act* (ACT) 2008 and the *Medicines, Poisons and Therapeutic Goods Regulation* (ACT) 2008.

It is the responsibility of all staff to be familiar with and to comply with the requirements of the *Medicines, Poisons and Therapeutic Goods Act* (ACT) 2008 and the *Medicines, Poisons and Therapeutic Goods Regulation* (ACT) 2008. Failure to do so may constitute an offence under the legislation.

Best practice principles are adopted from recognised standards, such as those published by the Australian Commission on Safety and Quality in Health Care and the Commonwealth Department of Health.

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| Scope |

The policy applies to all CHS staff. The policy does not apply to medication handling and administration by ACT Ambulance Service.

For the purposes of this policy a child is aged 16 years and under.

An adult is aged 17 years and older.

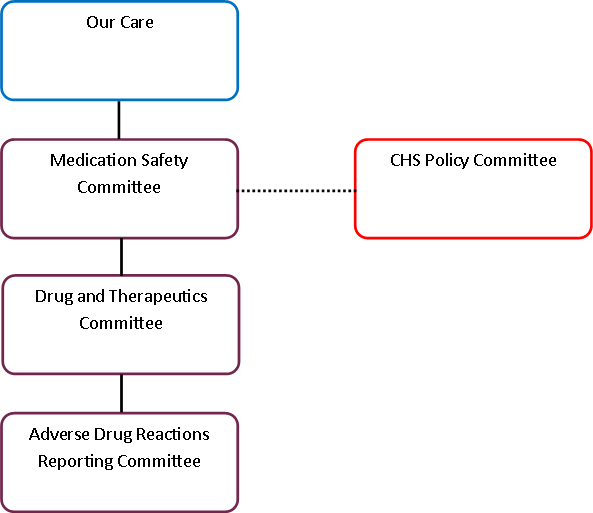
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| Section 1 – Governance |

The *Medicines, Poisons and Therapeutic Goods Act* (ACT) 2008 and the Medicines, Poisons and Therapeutic Goods Regulation (ACT) 2008 describes the required procurement, possession, storage, prescribing, dispensing, supplying, administering, and recording of both scheduled and non-scheduled medications in the ACT.

It is the responsibility of the health practitioner as governed by their registration and scope of practice to comply with legislative requirements, CHS Policy and associated procedures and guidelines. As with all aspects of care, health practitioners should only undertake medication management activities that they are legally entitled to perform, educationally prepared for, competent to undertake and for which they are willing to be accountable.

## Governance Structure



## Medication Safety Committee (MSC)

The MSC will provide oversight of compliance with medication safety standards and will be responsible for the governance of quality and safe procurement, storage, prescription, supply and administration of medication at CHS.

The MSC will monitor the performance of the Medication Management System and lead and direct medication related initiatives.

The functions of the MSC include:

* The development and approval of medication policy and procedures that support the quality, safe and cost-effective use of medicines, including all aspects of medication management.
* The collation and analysis of medication incident reports. Where appropriate, this function may be delegated to a sub-committee.

The membership of the MSC will be multi-disciplinary. The MSC will be chaired by a senior officer of CHS. The MSC will also have consumer representation.

The Medication Safety section of the National Safety and Quality Health Care Standards, details the mechanisms for health service organisations to provide the development and implementation of governance arrangements and organisational policies, procedures and/ or protocols for medication safety.

The MSC reports directly to the Our Care Committee and can escalate issues to this committee as required.

## The Drug and Therapeutics Committee

The Drug and Therapeutics Committee (DTC) must be multidisciplinary and include clinicians with relevant expertise in the safe, rational, high quality and cost-effective use of medications. The DTC should include representation from CHS executive and the pharmacy, medical and nursing disciplines.

The DTC works to support equity in access to evidence-based, cost effective and safe medicine use. The CHS Pharmacy Department is responsible for ensuring that medicines of the highest possible quality and safety are procured at the lowest possible cost.

The functions of the DTC include:

* Formulary management, that is the evaluation of medications for use in CHS, including the ‘off-label use’ (‘unapproved use’) of medications where that use is outside of normal clinical practice.
* Making recommendations to the relevant delegate regarding the addition of a medicine to the formulary, or use of a medicine for a specific patient through the Individual Patient Use (IPU) pathway. The relevant delegate is the head of Department and/or Executive Director for the Division where the medicine requested is to be used, or the Chief Executive Officer or Chief Operating Officer if the cost of treatment and financial delegations require this.
* The approval and review of medication standing orders for medication administration.
* The approval and review of nurse-initiated medications.
* Effectively communicating and monitoring the DTC’s decisions, throughout CHS.

The DTC may have sub-committees to help with some of its duties.

The DTC reports to the MSC. Both the DTC and the MSC will adhere to the guiding principles endorsed by the [Council of Australian Therapeutic Advisory Group (CATAG)](http://www.catag.org.au/).

### CHS Formulary

The CHS Formulary is a list of medications that have been endorsed by the DTC and the relevant delegate for:

* the treatment of CHS inpatients including short courses on discharge from the hospital, and/or
* outpatients (non-admitted) who are being reviewed at CHS clinics.

These medications are held in stock within Canberra Hospital or can be obtained in a timely manner. They are available for prescribing by authorised prescribers according to formulary restrictions. The CHS [Formulary](https://actgovernment.sharepoint.com/:w:/r/sites/Intranet-CHS/Shared%20Documents/Standard%20Hospital%20Formulary%20Submission%20Application.docx?d=w7f26c93cd36145a8a1eb852391dda18a&csf=1&web=1&e=3oHzAV) is accessible via the “who we are” section of the CHS HealthHub home page.

As a general rule, combination products will not be listed on the formulary unless the active ingredients cannot be administered separately from individual medications (e.g. combination asthma inhalers, combination glaucoma eye drops, Parkinson’s medications, antiretrovirals and some antihypertensive plus diuretic medications). Not all strengths of every medication will be stocked.

For inpatients of CHS hospitals, the CHS formulary and its restrictions take precedence over any prescribing restrictions outlined in the [Pharmaceutical Benefits Scheme](http://www.pbs.gov.au/pbs/home) (PBS).

Prior to initiating any medicine for an inpatient, consideration should be given as to how ongoing supply of the medication will be obtained (if required) after discharge. If the medication:

* Is not listed on the Formulary for outpatient supply from CHS pharmacy; and
* Is not listed on the Pharmaceutical Benefits Scheme (PBS) or is restricted to other indications,

An application to the DTC must be made to secure ongoing supply before treatment has been initiated.

Formulary restrictions apply regardless of the source of medication and the same mechanism for access applies to compassionate stock or medicines received through access programs of any type.

### Access to Non-Formulary Medicines

To access a medication that is not listed on the formulary, or to use a medication outside of the CHS formulary restriction for a particular patient, approval must be obtained from the delegate on the following recommendation from the DTC. This must be done prior to CHS Pharmacy dispensing the medication.

The treating specialist must submit an [Formulary application](https://actgovernment.sharepoint.com/:w:/r/sites/Intranet-CHS/Shared%20Documents/Standard%20Hospital%20Formulary%20Submission%20Application.docx?d=w7f26c93cd36145a8a1eb852391dda18a&csf=1&web=1&e=3oHzAV) to the DTC prior to commencing therapy with a non-formulary medication regardless of listing on the PBS schedule. IPU applications can be considered by the DTC members out of session, with a response provided within two business days in urgent scenarios.

When a patient is admitted to a CHS Hospital and requires ongoing treatment with a medication which is not listed on the CHS formulary, CHS has a duty of care to provide an alternative medication which is listed on the formulary or to continue to supply the medication to the patient. An alternative is to use the patient’s own supply.

Applications are required to be submitted to DTC to list a new medication or dose form on the formulary, or to modify the restriction outlined for a medication.

### Special Access Scheme (SAS)

The Therapeutic Goods Administration ([TGA](https://www.tga.gov.au/form/special-access-scheme)) manages the Special Access Scheme (SAS). This scheme enables case by case, individual patient access to a therapeutic good that is not listed on the Australian Register of Therapeutic Goods (ARTG) and could not be lawfully supplied otherwise. Patients are grouped into three categories under the scheme:

* Category A: is a notification pathway that can be used if the situation is life threatening and immediate access is required.
* Category B: is an application pathway that can be used by a clinician for a medicine that is not used through category A or listed for use under category C.
* Category C: is a notification pathway that allows certain groups of clinicians to access medicines with an established history of use.

Some SAS medications are listed on the formulary and therefore do not require a submission to DTC prior to inpatient use.

Any SAS item not listed on the formulary will require clinical justification and approval for supply on an individual patient basis from relevant delegate via the DTC. Following approval, [Category A](https://www.tga.gov.au/sites/default/files/special-access-scheme-category-a.pdf), [Category B](https://www.tga.gov.au/sites/default/files/special-access-scheme-category-b.pdf) or [Category C](https://www.tga.gov.au/sites/default/files/special-access-scheme-category-c-form-01.pdf) forms (as appropriate) must be submitted to the CHS Pharmacy to obtain SAS medication supply in accordance with TGA requirements. The prescriber must also ensure that a patient consent form is completed and filed in the patient’s clinical record. Where medication is not being supplied by CHS Pharmacy, the SAS forms (as appropriate) should be forwarded to the patient’s preferred community (retail) pharmacy to obtain SAS medication supply.

### Medicines Used in Clinical Trials

A clinical trial involving medication(s) administered to or used on humans must be approved by the ACT Health Human Research Ethics Committee. Depending on the clinical trial, the TGA may also need to approve or be notified of the trial. For further details please refer to the National Health and Medical Research Council [National Statement on Ethical Conduct in Research Involving Humans](https://www.nhmrc.gov.au/guidelines-publications/e72).

### Medication Access Programs (MAP)

Medication Access Programs (MAP) is a term that refers to any program offered by pharmaceutical companies which enable patient access to medications through a deferred cost, cost free or subsidised access arrangement. This includes product familiarisation programs, compassionate use programs, expanded access programs and cost-share programs.

All MAP must be reviewed by the DTC before a patient can commence on the program.

DTC approval of a MAP does not commit CHS to subsequently placing the medication on the formulary. The purpose of MAP review by the DTC is to allow CHS prescribers the opportunity to use, where clinically appropriate, evaluate and become familiar with a medication, without putting patients or CHS at risk of inappropriate discontinuation of therapy or unanticipated costs at the cessation of a program. For further details please refer to the Council of Australian Therapeutics Advisory Groups’ [Guiding Principles for Medication Access Programs in Australian Public Hospitals](http://www.catag.org.au/guiding-principles-for-medication-access-programs-in-australian-public-hospitals/).

### Outpatient Prescriptions

Outpatient prescriptions are generally dispensed at a community (retail) pharmacy under the PBS. CHS Pharmacy will only dispense the following for outpatients:

* Section 100 Highly Specialised Drugs
* Human Immunodeficiency Virus (HIV) Post Exposure Prophylaxis (PEP) kits for CHS staff
* Medication for Medicare non-eligible asylum seekers
* DTC approved IPU medications with current DTC approval
* Medications listed on the CHS Formulary for outpatient use
* Items on private prescription, following appropriate clinical review and at the discretion of the Director of CHS Pharmacy, and at the cost to the patient or their agent. This may include dispensing or compounding fees as appropriate.

## Medication Recalls/Shortages

A medication recall involves the removal of the medication from supply on the Australian market for reasons relating to the product’s quality, safety, or efficacy.

The medication recall process is administered by the Commonwealth TGA in co-operation with the particular product’s sponsor (the Australian manufacturer or the distributor), as detailed in the [Commonwealth’s Uniform Recall Procedure for Therapeutic Goods](https://www.tga.gov.au/recall-procedure).

Medication recalls vary in the risk they pose to patient safety. A medication recall can occur because of a simple problem such as a minor labelling or packaging error, or a more fundamental problem such as an increase in unexpected side effects or adverse events.

The TGA classifications for recalls are:

Class I. When products are potentially life-threatening or could cause a serious risk to health.

Class II. When product defects could cause illness or mistreatment, but are not Class I.

Class III. When product defects may not pose a significant hazard to health, but withdrawal may be initiated for other reasons.

Within CHS, medication recall notification process occurs in accordance with the Management of Recalls Alerts and Product Corrections procedure available on the Policy and Guidance Documents Register.

**Note**: The database includes recalls relating to therapeutic devices as well as medications

### Retention of Recall Records

The CHS Director of Pharmacy is responsible for the management of recall records in accordance with the *Management of Notifications Relating to Medicine or Medical Device Recalls and Medicine Shortages Procedure*. Recall notices will be held by the Pharmacy Purchasing Officer.

## Medication Problem or Defect Reporting

All staff must be alert to the possibility of defects in the medications they handle and must report any anomaly which may indicate a deficiency in the quality, safety, or efficacy of the product.

Such problems could include incorrect or illegible product labelling, discolouration, cloudiness, or incorrect tablets / capsules in a pack.

Any suspected or known problem or defect with a medication must be reported promptly to the TGA. The staff member who identifies the problem or defect is responsible for reporting. The TGA [Medicine or vaccine defect report](https://www.tga.gov.au/medicine-or-vaccine-defect-report) must be used for problem or defect reporting. Problems requiring urgent investigation must be reported immediately to the TGA by telephone on 1800020653. This information should also be forwarded to CHS Pharmacy Services. Products which are suspected or known to be faulty must not be exchanged by a supplier or manufacturer without first establishing that the problem has been correctly reported to the TGA.

## Medication Incidents

All staff must report incidents, including near-miss incidents associated with medication using the clinical incident register in RiskMan in accordance with the Incident Management - Clinical Policy and Incident Management - Clinical Procedure available on the Policy and Guidance Documents Register.

## Adverse Drug Reactions

The World Health Organisation defines an adverse drug reaction (ADR) as an action which is noxious and unintended, and which occurs at doses normally used for the prevention, diagnosis, or treatment of disease or for modification of a physiological function. An adverse reaction does not include the toxic effects of an overdose.

An ADR includes adverse reactions due to a:

* Drug - drug interaction
* Drug - food interaction
* Drug – disease state interaction

Reporting and thorough documentation of adverse drug reactions is essential for:

* Preventing the re-administration of a drug or related drug that has previously caused an adverse reaction in a particular patient
* Preventing beneficial drug treatment from being withheld
* Promoting safe prescribing
* Disseminating appropriate alerts and education on the use of drugs to relevant health practitioners
* Informing the TGA for medication post-marketing surveillance purposes

All adverse drug reactions must be:

* Recorded in the patient’s clinical record
* Added as an alert on Clinical Portal Alerts Management System
* Reported to the Adverse Drug Reaction Reporting Committee (ADRRC)
* For all Adverse Event Following Immunisation (AEFI) report to ACT Health, Health protection Service within 48 hours (refer to Section 7 – Immunisations CHS Management of Anaphylaxis in Adults, Children and Infants Guideline)
* Clearly documented in the relevant section of the patient’s discharge summary.

Adverse drug reactions may be reported by any health practitioner by completing the [online reporting form](https://fsms.act.gov.au/ADR/ADR_URNEntryPage.aspx) available via the CHS HealthHub > Clinical Apps > Adverse drug reactions. Completed forms will automatically be forwarded to the ADRRC secretariat email account.

**Note**: Some ADR will also be classified as incidents. For all ADRs, a clinical incident notification via RiskMan will need to be completed in addition to reporting to the ADRRC, and the circumstances regarding the ADR should be investigated to determine whether any additional action should have been taken to prevent its occurrence.

### ACT Health Adverse Drug Reaction Reporting Committee (ADRRC)

The ADRRC will:

* Analyse ADR reports from CHS and Calvary Public Hospital Bruce to determine causality prior to scanning the report into the patient’s clinical records.
* Undertake measures to prevent inappropriate administration of a drug that has previously caused an adverse reaction including entering, when appropriate, adding an ADR alert for the patient in the Alerts Management System, and ensuring communication of review to the primary care team and patient.
* Provide copies of ADR reports to the TGA Office of Medicines Safety Monitoring for entry into the national database.
* Educate hospital staff and consumers to promote best practice in managing and reporting of ADRs, to ensure high-quality and consistent reporting across Canberra Health Services and Calvary Public Hospital.
* Provide clinical advice on the management of ADRs.
* Make recommendations on quality improvement activities resulting from auditing ADR management processes to the DTC and Medication Safety Committee.
* Implement and evaluate evidence-based ADR management and prevention initiatives and programs that can be monitored against the accreditation standards.
* Lead the development and review of policies and procedures related to ADR management.

## Registration of Health Practitioner

Authorised Staff are required to renew their registration annually as per *Annual Renewal of Health Practitioner Registration Policy*.

## Australian Health Practitioner Regulation Agency (AHPRA) Notification of National Board Conditions and Voluntary Undertakings

The National Boards can impose conditions on the registration of a health practitioner that restrict the health practitioner’s practice in some way to protect the public. The National Boards can also seek and accept an undertaking from a health practitioner to limit the health practitioner’s practice in some way if this is necessary to protect the public. An undertaking is voluntary, whereas a condition is imposed on a health practitioner’s registration.

### S8 Medication Condition or Voluntary Undertaking

Amongst other things, AHPRA has power to apply restrictions on health practitioner’s prescribing, possession, supply, administration, handling and/or dispensing of S8 medicines.

### CHS Management Action Following Notification of a National Board Restriction for Medical Officers and Dentists

The Medical Officer Support, Credentialing, Employment and Training Unit (MOSCETU) within the Medical Services Group, are responsible for managing all conditions and undertakings on the registration of doctors and dentists. It does so in accordance with relevant legislation, including the *Health Practitioner Regulation National Law* (National Law) and the *Health Act 1993* (ACT).

When a National Board restricts the registration of a doctor or dentist working in the ACT, the restriction is immediately notified to MOSCETU by way of the AHPRA Practitioner Information Exchange (PIE) electronic notification service and shortly thereafter by letter to the Chief Executive Officer (CEO) of CHS. The restrictions are also publicly available on the [Register of Practitioners](http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx). Some conditions may not be publicly available but will be made available to MOSCETU and the CEO of Canberra Health Services.

#### **Giving Effect to a National Board Restriction for Doctors and Dentists**

So that proper effect can be given to a National Board condition and / or undertaking, when MOSCETU receives notification of a National Board condition and / or undertaking, it advises all relevant persons of the National Board condition and / or undertaking, including but not limited to the following:

* CEO of Canberra Health Services
* For doctors, the Executive Director of Medical Services
* For dentists, the Director of the Dental Health Program
* Executive Director of the relevant clinical area
* Clinical Director of the relevant clinical area (who is then required to inform the immediate supervisor of the health practitioner)
* For S8 medication conditions or undertakings, the ACT Chief Pharmacist and CHS Director of Pharmacy.

#### **MOSCETU Process for Coordinating National Board Restrictions for Doctors and Dentists**

Within MOSCETU, the Manager – Credentialing and Scope of Clinical Practice team coordinates all work around restrictions placed on the registration of senior medical officers, whereas the Director of MOSCETU coordinates all work around restrictions placed on the registration of junior medical officers.

In accordance with the *Health Act 1993*, the Executive Director of Medical Services (who is also the Medical Administrator of the ACT Health Medical and Dental Appointment Advisory Committee, MDAAC), notifies MDAAC members of National Board conditions and / or undertakings applied to all senior medical officers and dentists (as these conditions and / or undertakings amend the scope of clinical practice of these health practitioners, for which MDAAC has legislated authority to oversight).

### Giving Effect to a National Board Restriction for Allied Health Practitioners

For notifications relating to Allied Health practitioners, AHPRA provides notification to the Director General ACT Health, who in turn notifies the Profession Lead of the discipline through the Chief Allied Health Officer.

### Giving Effect to a National Board Restriction for Nursing and Midwifery

For notifications relating to nurses and midwives, AHPRA provides notification to the Director General ACT Health, who in turn notifies the Chief Nurse who provides notification to relevant staff within the nursing hierarchy.

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| Section 2 – Prescribing |

A prescription (or medication order) is mandatory for all medications and therapeutic agents administered to a patient regardless of form, administration route or schedule.

**Note**: All staff are required to work within their designated scope of practice.



## Authorised Prescribers

The following staff are authorised to both issue a prescription for dispensing by a registered pharmacist, and order medication for administration on a medication chart or other approved form, in accordance with any endorsements, notations and conditions included with the person’s registration on the AHPRA website as well as any condition on the person’s employment at CHS:

* **Medical Practitioner**
* **Provisionally Registered Medical Practitioner (medical intern)** only for the prescribing to an inpatient, day only patient, or on discharge and under the supervision of a medical practitioner.

**Note**: Provisionally Registered Medical Practitioners cannot issue PBS prescriptions for use outside of an institutional setting. Only practitioners with a prescriber number can issue PBS prescriptions.

* **Nurse Practitioner** within the scope of practice under the Health Regulation 2004, s11.
* **Midwife** in accordance with the National Health Act 1953 Commonwealth, s93 those medications listed on the PBS for prescribing by an authorised midwife. If the prescriber is an eligible midwife – the words ‘for midwifery use only’ are to be used.
* **Dentist** for dental treatment only. If the prescriber is a dentist – the words ‘for dental treatment only’ are to be used
* **Optometrist** with endorsement on the person’s registration by the Optometry Board of Australia to prescribe (and supply) specified Schedule 2, Schedule 3 and Schedule 4 medications for optometrical treatment only. If the prescriber is an optometrist – the words ‘for optometry use only’ is to be used.

**Note**: Medical and Dental students are not authorised to issue prescriptions or order medications

## Consistent Prescribing Terminology

The use of error prone and potentially dangerous abbreviations and dose expressions in the prescribing of medications is a critical patient safety issue and a major cause of medication errors.

Prescribers must use prescribing terminology and abbreviations, consistent with the Australian Commission on Safety and Quality in Health Care ‘[Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines](https://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-medicines/recommendations-terminology-abbreviations-and-symbols-used-medicines-documentation)’ in all records, other related documents and electronic systems.

Additionally:

* Medication names must not be abbreviated and should be as the active ingredient generic name of the medication, except in specific circumstances when the ordering by the proprietary name (‘trade name’ or ‘brand name’) is necessary to avoid confusion. Examples are listed in Attachment 1.
* The route for administration must be specified.
* In the case of liquid medications, the strength and the dose in grams, milligrams or micrograms (not millilitres) must always be specified e.g. morphine oral mixture (10mg/mL) Give 10mg every 8 hours.
* Where a medication order deliberately contains an unusual or dangerous dose, the prescriber must underline the dose and initial beside it. Where using an electronic prescription, some acknowledgement that the dose is deliberately unusual must be made by the prescriber.

## Paediatric Prescribing

The Australian Commission on Safety and Quality in Health Care recommends that authorised prescribers clearly specify the following on all prescriptions for infants and children:

* Age and/or date of birth
* Current body weight
* Basis for the dose calculation, for example mg/kg, if appropriate.
* Dose in units of mass e.g. 150mg per dose, given four times a day. It may not be applicable to specify the dose in units of mass in certain circumstances, such as when prescribing eye drops, ear drops, topical products, inhalers or insulin.

Dose calculations in obese or overweight infants and children using ‘total body weight’ may result in overdosing for some medicines, please refer to Therapeutic Guidelines or Australian Medicines Handbook Children Dosing Companionfor advice on individual medicines. For older paediatric patients, or those over 40 to 50 kg, ensure that the upper dose limits for adults are not exceeded.

## Issuing Prescriptions for CHS Pharmacist Dispensing

### Prescriptions for Scheduled Medications

A prescription (as opposed to a medication chart order) supplied/dispensed at CHS for a scheduled medication must: -

1. Be signed by the prescriber; and
2. If the prescriber amends the prescription – be initialled and dated beside the amendment by the prescriber; and
3. Be written in terms and symbols used in ordinary professional practice; and
4. If the prescription is for an unusual or dangerous dose – include the prescriber’s initial beside an underlined reference to the dose.

A prescription must include the following:

* The date the prescription is issued;
* The name, contact details and signature of the prescriber;
* The medicine, and the form, strength and quantity and frequency of the medicine, to be dispensed or administered under the prescription;
* The name and address of the person for whom the medicine is prescribed;
* Directions about the use of the medicine, including the dose and regimen of the medicine, that are adequate to allow the medicine to be taken or administered safely;
* The number of times the medicine may be dispensed or administered under the prescription
* If the prescription is for a controlled medicine:
* The relevant approval particulars; and
* If the prescription is a repeat prescription – the period that must elapse between each dispensing or administration of the medicine;
* If the prescriber is a dentist – the words ‘for dental treatment only’;
* If the prescriber is an eligible midwife – the words ‘for midwifery use only’;
* If the prescriber is an optometrist – the words ‘for optometry use only’;
* If the prescription is an original of a prescription that was faxed by a prescriber to a pharmacist – the prescription is endorsed with words to the effect that the prescription was faxed on a stated date;
* If the prescription is a written confirmation of an oral prescription (verbal order) – the prescription is endorsed with words to the effect that the prescription is a confirmation copy of an oral prescription issued to a named pharmacist on a stated date.

### Restrictions on Prescribing Certain Schedule 4 Medications

Due to potential hazards with their use, the prescribing of certain Schedule 4 medications is restricted under the provisions of the *Medicines, Poisons and Therapeutic Goods Regulation (ACT) 2008*, Part 3.2 to medical practitioners in accordance with the corresponding qualifications and / or conditions:

|  |  |
| --- | --- |
| **Restriction** | **Medication** |
| A specialist practising in Dermatology | Isotretinoin\* (for oral use), acitretin\*, etretinate\*, thalidomide |
| Specialist physician | Tretinoin (for oral use), thalidomide, lenalidomide, ambrisentan\*, acitretin\*, bexarotene\*, bosentan, sitaxentan\*, teriparatide\* |
| Specialist practising in the specialist area of Mental Health  Doctor employed by territory and working under supervision of Chief Psychiatrist under Mental Health (Treatment and Care) ACT 2015  Must be registered as a prescriber with Clozaril Patient Monitoring System (CPMS) | Clozapine |
| Specialist practising in specialist area Neurology or Rehabilitation | Nabiximols\* |
| Specialist practising in specialist area of Gynaecology or Obstetrics | Clomiphene\*, cyclofenil\*, corifollitropin\*, dinoprostone, follitropin alpha\*, follitropin beta\*, luteinising hormone\*, urofollitropin\* |
| Specialist practising in specialist area of Gynaecology or Obstetrics  Must be registered with MS 2 Step. | Mifepristone |
| Women’s Health General Practitioner Staff Specialists registered with the MS 2 Step program | Mifepristone |
| Specialist practising in specialist area of Endocrinology | Clomiphene\*, cyclofenil\* |
| Specialist practising in specialist area of  Neurology, Paediatrics or Sleep Medicine | Sodium oxybate |

***Note: Specialist*** includes a doctor training in a specialist area.

\* These agents are non-formulary at CHS and also require DTC approval for use.

However, a patient admitted for unrelated treatment already being prescribed the medication by the relevant specialist and still undergoing treatment at the time of admission may be prescribed the medication on a medication chart by an authorised prescriber at the hospital for the term of the patient’s inpatient stay. Patients should have sufficient supply at home and should not be provided additional supply on discharge.

### Prescribing Schedule 4D (S4D) Medications

The ACT legislation does not define S4D medications. CHS considers the following medications as S4D.

|  |  |
| --- | --- |
| Armodafinil (non-formulary) | Oxazepam |
| Bromazepam (non-formulary) | Paracetamol 500 mg/Codeine 30 mg |
| Clobazam | Paraldehyde |
| Clonazepam | Phenobarbital (phenobarbitone) |
| Chloral Hydrate | Phentermine (non-formulary) |
| Dextropropoxyphene (non-formulary) | Propofol (specific exemptions exist for GEHU and Operating Theatres)\* |
| Diazepam | Pseudoephedrine |
| Ephedrine | Temazepam |
| Lorazepam | Tramadol |
| Methoxyflurane | Triazolam (non-formulary) |
| Midazolam | Zolpidem (non-formulary) |
| Modafanil (non-formulary) | Zopiclone (non-formulary) |
| Nitrazepam |  |

These medications require secure storage in all areas outside of CHS Pharmacy. They must be requisitioned and accounted for in the same manner as Schedule 8 medications.

\*Gastroenterology, Hepatology Unit (GEHU) and Operating Theatres must store and record propofol as per specific arrangements, including keeping of a central register and documentation of all transfers between central storage areas and procedural areas. Whenever not in direct use, propofol must be returned to secure storage.

### Requirements for Authority to Prescribe Certain Schedule 8 Medications

When prescribing a Schedule 8 medication, it is the responsibility of the prescriber to ensure they have obtained the appropriate approval as per [Medicines, Poisons and Therapeutic Goods Regulation](https://www.legislation.act.gov.au/sl/2008-42/), ACT (2008) Part 13.1.

An authority is automatically granted to an authorised prescriber to prescribe Schedule 8 medications under the following circumstances:

* CHS inpatient setting (with the exception of methadone and buprenorphine for opiate withdrawal), and
* CHS outpatient setting (with the exception of methadone and buprenorphine for opiate withdrawal) - for patient’s use for a duration of two months or less,
* An authorised prescriber is able to prescribe methadone or buprenorphine to a drug-dependent person who is a CHS patient (but not a Canberra Hospital inpatient, see 2.3.6) if:

Prescribing is in accordance with opioid dependency treatment guidelines; and

The authorised prescriber makes an application under section 560 to prescribe the medicine not later than 72 hours after the doctor first prescribes buprenorphine or methadone for the patient.

The prescription must be annotated with details of the standing approval as appropriate i.e. the words ‘standing opioid dependency treatment approval’.

For all other circumstances the prescriber is required to apply to the Chief Health Officer (CHO) for authority.

### Discharge Medication Prescriptions and Discharge Summary

At the time of discharge, the patient's medication regimen must be reviewed by an authorised prescriber as part of the patient's general review prior to discharge.

The discharge summary should identify all current medication and also identify changes made to the medication regimen during the patient’s stay and outline the reason(s) for the changes wherever possible.

The discharge summary is the responsibility of the medical officer. Any ‘patient held’ medication list prepared for the patient is the responsibility of the pharmacist. These documents must be amended if changes are made to the discharge medications.

Discharge medications must be prescribed on an approved Discharge Medication form or [Clinical Portal](http://concertoportal/concerto/Login.htm) Discharge Summary Document. All sections of the discharge form must be completed.

A legible copy of the discharge summary must be sent to the patient’s nominated General Practitioner (or other primary care provider) as soon as possible, as per the Discharge Summary Completion Inpatients Procedure, available from the Policy and Guidance Documents Register.

**Note**:

When suplying discharge medication prescriptions to patients, consideration must be given to any potential risks associated with the provision of such medications. For example, steps must be taken to prevent access to potentially hazardous or lethal quantities of discharge medication for patients who may be at elevated risk of intentionally or accidentally overdosing on their medication. Such steps may include providing a limited supply of discharge medication or ensuring management of prescriptions by a responsible third party (e.g. carer, mental health service provider etc).

### Opioid Maintenance Therapy - inpatients

A Medical Practitioner or Provisionally Registered Medical Practitioner (medical intern) is able to prescribe, for an inpatient, ongoing methadone or buprenorphine (including buprenorphine/naloxone) therapy for the management of opioid dependence, without written approval from the Chief Health Officer (CHO) as per section 555 of the *Medicines, Poisons and Therapeutic Goods Regulation* (ACT) 2008.

Before prescribing methadone or buprenorphine (for the management of opioid dependence), a fax of the current prescription and dosing history (minimum of 3 days dosing history) must be obtained from the regular dispensing pharmacy or dosing centre.

On discharge, the CHS Pharmacy must contact the regular dispensing pharmacy or dosing centre to provide evidence of their dosing record during the admission (i.e. fax copy of the inpatient chart).

Any ‘take-away’ doses provided to the patient before admission must be located before the issue of any supply of methadone or buprenorphine from CHS Pharmacy Services.

If a patient has missed their usual dose of methadone or buprenorphine for more than 3 days, and they have not been a hospital inpatient with alternate opiate treatment, the re-initiation of methadone or buprenorphine must be under the supervision of the Alcohol and Drug Service Medical Specialist.

Any initiation or dose titration of methadone or buprenorphine must be done by the Alcohol and Drug Service Medical Specialist, and the relevant CHO approval must be sought.

### Dexamfetamine and methylphenidate

Where possible, the patient’s own supply of dexamfetamine, lisdexamfetamine or methylphenidate should be obtained for inpatient use. This is to avoid the situation of oversupply on discharge and subsequent misuse. If patient’s own supply is obtained, it must be assessed by a clinical pharmacist for suitability for use. Any patient’s own supply must be recorded in the Patient’s Own Schedule 8 register, as per Section 4.3.6.4 and stored with other Schedule 8 medications.

A Medical Practitioner or Provisionally Registered Medical Practitioner (medical intern) is able to prescribe, for an inpatient, ongoing dexamfetamine or methylphenidate therapy, without written approval from the CHO as per section 555 of the *Medicines, Poisons and Therapeutic Goods Regulation* (ACT) 2008.

Before prescribing dexamfetamine and methylphenidate for an inpatient, the patient’s dispensing history, and where possible a copy of the relevant prescription, must be obtained from the regular dispensing pharmacy.

## Security of Prescription Pads and Forms

Prescription forms include:

* those for internal use for prescribing within the hospital
* those for external use for prescribing in the community
* hospital pads
* medical officers’ private prescription pads
* blank forms for computer generation of prescriptions,

but exclude medication charts used for prescribing and administering medicines for inpatients.

Forms: PBS prescription pads (with the Canberra Hospital PBS prescribing number), non-personalised authority PBS prescriptions and white coloured CHS outpatient prescriptions will be ordered by CHS Pharmacy and stored securely in CHS Pharmacy. CHS Pharmacy Service must maintain a tracking and accountability system for all prescription forms distributed to patient care areas.

Only registered health practitioners are able to collect prescription pads/forms from the CHS Pharmacy. Empty prescription pads should be returned to CHS pharmacy when replacement is required. Once distributed the registered practitioner is responsible for the security of the prescription pad/form.

Due to the risk of prescription forgeries on stolen prescription pads/forms, authorised prescribers must ensure that prescription pads and forms are securely stored when not in immediate use and return unwanted prescription pads to the CHS Pharmacy.

Suspected theft of prescription forms / pads must be:

* Reported on clinical incident management system RiskMan
* Reported to Health Protection Service.

The report of a detected prescription forgery must additionally be reported to ACT Policing.

## Medication Chart Prescriptions in Inpatient Care Areas

### Medication Charts

CHS has adopted the use of Australian Commission on Safety and Quality in Health Care National Inpatient Medication Charts (NIMC).

Please refer to the [NIMC User guide](http://www.safetyandquality.gov.au/wp-content/uploads/2014/07/NIMC-User-Guide.pdf) for further information regarding the endorsed use of these charts.

CHS will continue to adopt nationally approved charts as they are endorsed and mandated. Other medication charts (including specialty medication charts) and approved forms may be used throughout CHS, once endorsed by the MSC and the CHS Clinical Forms Review Panel.

### Medication Prescription for Administration

A medication prescription on an approved medication chart must clearly specify:

* The generic name of the medication, except in specific circumstances as listed in Attachment 1 when the ordering by the proprietary name (‘trade name’ or ‘brand name’) is necessary to avoid confusion;
* Form and route of administration, and
* The indication for treatment, and
* For a ‘regular’ medication;
* The dose to be administered, and
* The frequency and times for administration to the patient, and
* The maximum number of doses or the maximum duration of treatment with the medication, (except where the prescriber’s intention is for the duration of the medication chart), or
* For a ‘when required’ (‘prn’) medication;
* The maximum individual dose, and
* The maximum daily dose, and
* The hourly frequency for administration to the patient, and
* The maximum number of doses or the maximum duration of treatment with the medication (except where the prescriber’s intention is for the duration of the medication chart), and
* The date of the medication order, or
* Where applicable, the date and time of an amendment to the medication order, or
* Where applicable, the date and time of ceasing a medication order prior to what
* was originally ordered, and
* The prescriber’s name (printed) signature and contact telephone / pager number.
* Medication orders should only contain abbreviations in universal and common use as per the Australian Commission on Safety and Quality in Health Care ‘[Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/recommendations-terminology-abbreviations-and-symbols-used-medicines-documentation)’.

### Ceasing a Medication prescription on a Medication Chart

When ceasing a medication prescription, the prescriber must draw a clear line through the order in both the prescription and the administration record sections, taking care that the line does not impinge on other prescriptions. The original prescription must not be obliterated.

The prescriber must write the reason for changing the order (e.g. cease, written in error, increased dose etc), the date and their initials in the administration record section.

When a medication prescription needs to be changed, the prescriber must not write over the prescription. The original prescription must be ceased and a new prescription written.

In addition, the reason for an amendment to, or cessation of a medication order should be documented in the patient’s clinical record, signed and dated by the prescriber with their name and contact telephone / pager number.

### Regular Review of Medication Prescriptions

The authorised prescriber is responsible for the regular review of medication prescriptions. The frequency of review should be in accordance with clinical risk.

Inpatient medication prescriptions are valid for a maximum of seven (7) days. After this time prescription require review and re‐prescribing to continue. Intravenous and antibiotic agents should be reviewed more frequently (at least every 3 days). [Long‐stay](http://www.safetyandquality.gov.au/wp-content/uploads/2009/01/82309-NIMC-long-stay-PDF-kb90.pdf) NIMC and electronic prescribing systems require review at 7 days, but not re‐prescribing.

For Community-based patients, a new prescription must be obtained every 6 months for ongoing medication administration by community nurses.

The outcome of the follow up and any resulting medication changes must also be documented in the patient’s clinical record.

### Emergency Verbal or Telephone Prescription Orders

**Note**: Verbal or telephone orders are not permitted for any chemotherapy agents (regardless of the route of administration or whether they are being for oncologic or non-oncologic indications).

In an emergency, an authorised prescriber may either verbally (face to face or by telephone), direct a registered pharmacist to dispense a prescription for any Schedule 4 or Schedule 8 medication.

The authorised prescriber must:

1. Immediately issue a prescription, and
2. Endorse the prescription with words that indicate the prescription has been issued in confirmation of a verbal, telephone direction to the registered pharmacist (named), and
3. Send the prescription without delay and within 24 hours to the registered pharmacist to whom the direction was given.

### Verbal and Telephone Medication Prescription Orders

**Note**: Verbal or telephone orders are not permitted for any chemotherapy agents (regardless of the route of administration or whether they are being for oncologic or non-oncologic indications).

When an authorised prescriber is unable to be physically present to write a medication chart prescription, the order may be given verbally (face to face or by telephone).

The person receiving such an order must be a [person approved to administer](#_Who_May_Administer) or prescribe medication at the particular patient care area.

The authorised prescriber must provide all of the following:

* The patient’s name and relevant identifiers (as per the Patient Identification and Procedure Matching Procedure),
* The medication’s active ingredient / s, proprietary name (where applicable) dose form (where multiple forms are available),
* The dose to be administered,
* The route for administration,
* The frequency and times for administration,
* The maximum number of doses or the maximum duration of treatment with the medication.

Due to the risk of misinterpretation, all prescriptions orders received by telephone must be read back to the prescriber with the numbers as separate words, for example, as ‘fifty milligrams, five zero milligrams’ for a 50mg dose.

For a telephone prescription order which relates to all Schedule 8 medications, substantial risk medications and intravenous medications for CHS inpatients, the telephone prescription order must also be repeated to a second person as detailed in Section 5.3. An exception to this is in the community setting where a second person is not available.

For verbal (face to face) prescription orders, a mechanism must be used to confirm that the order has been clearly communicated. This may include the use of a second person as described above, and in Section 5.3, or may include a process whereby the health practitioner receiving the prescription order repeats the prescription order to confirm with the prescriber.

The authorised prescriber who prescribes a medication for patient administration verbally (face to face) or by telephone must confirm within 24 hours all doses administered by:

* Counter-signing the record of administration on the patient’s medication chart for inpatients, and
* Reviewing the patient as soon as appropriate in the circumstances of the case.
* For Community based patients, a new written prescription must be faxed or emailed to the health centre.

This process must also be followed when the authorised prescriber is changing or ceasing a particular prescription on a medication chart. Additionally, the prescriber must document the reason for changing / ceasing the order in the patient’s clinical record when next at the facility.

### Transcribing of external medical orders into the electronic medical record

Transcribing of medical orders should only be undertaken when a medication order originates outside the electronic medical record and cannot be entered into the electronic Medical Administration Record (MAR) by a medical officer.

This circumstance applies to the Community Care Program, for medication orders received from medical officers who do not have access to the patient’s electronic medical record. This includes General Practitioners and Private Specialists who are not employees of Canberra Health Service or Calvary Public Hospital Services.

In this case medication orders are faxed or emailed to Central Health Intake to be transcribed into the patient’s electronic medical record.

The medication order will be entered into the MAR and signed by a Level 2 Registered Nurse. The order will then be sent via an embedded workflow to a second Registered Nurse to check and confirm that the transcribed order is correct. The original medication order is then scanned into the patient’s electronic medical record and placed in the Media tab (see Attachment 6).

An annotation is added to the MAR indicating that the order has been transcribed and that the clinician must view the original medication order from the Media tab of the patient’s electronic medical record prior to administering the medication in accordance with Section 5.4.

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| Section 3 – The CHS Pharmacy Service |



## Responsibility

The Director of Pharmacy is responsible for the storage of all medications at The Canberra Hospital other than those that have been supplied to a patient care area.

The Director of Pharmacy is also responsible for overseeing and advising on the appropriate storage of medications in other areas of CHS including patient care areas and intravenous fluid stores. Storage of medications must meet legislative requirements and comply with the [ACSQHC Principles for the safe selection and storage of medicines](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/principles-safe-selection-and-storage-medicines-guidance-principles-and-survey-tool).

The range and quantities of medications held by the CHS Pharmacy Service must include consideration of circumstances when a patient will be admitted to CHS requiring a previously prescribed essential medication for which their supply has been unexpectedly exhausted.

## Medication Procurement

### Medication Purchasing

CHS Pharmacy Service may purchase medications in accordance with the supply contracts arranged by the NSW State Contracts Control Board. However, where a required medication is not available as a contract item, a better price can be negotiated directly with the manufacture or the supplier, it may be purchased from a non-contract supplier. ACT procurement policies and processes must be adhered to.

The package and label of any new medicine e.g. new formulary listing, SAS or Section 19A stock to address a shortage must be examined to identify any potential for confusion and compliance with best practice labelling. The purchase of medicines with similar packaging should be avoided where possible.

Purchase Orders (different to medication orders) for medications may be placed with the supplier in writing, or by telephone, fax or electronic mail.

### Deliveries to the CHS Pharmacy Service

Medication deliveries that are received by a non CHS Pharmacy Service staff member, such as by stores or administration staff, must be transferred to the CHS Pharmacy Service immediately on arrival.

### Receipting for Deliveries of Schedule 8 Medications

When a parcel containing a Schedule 8 medication is delivered to CHS, the recipient must sign the courier’s ‘proof of delivery’ document (either electronically or in hard copy) for the unopened sealed parcel.

When the Schedule 8 medication parcel is received at the CHS Pharmacy Service, further to checking the contents against the original purchase order, a delegated registered pharmacist, or the authorised officer, must sign and date a receipt confirming the supply of the individual Schedule 8 medication(s), and forward this receipt confirmation by post or fax to the supplier within 24 hours of the delivery. A copy of the signed and dated receipt confirmation must also be retained at the CHS Pharmacy Service.

The Schedule 8 medication(s) received at the CHS Pharmacy Service must be immediately recorded in the CHS Pharmacy Service drug register and locked in a Schedule 8 vault.

## Medication Storage in the CHS Pharmacy Service

### Medication Security and Access – General Provisions

The CHS Pharmacy Service is a high security area.

All stocks of medications in the CHS Pharmacy Service must be regularly checked to ensure proper storage conditions are met, i.e. temperature control and security, including:

* A cyclical stock count every week
* A daily stock count is completed prior to daily ordering, to enable adjustment of ordering if required
* General stock is counted once per year
* Schedule 4D medications (as listed in Section 2) are counted once per month
* Refrigerated stock is counted once per quarter
* Schedule 8 medications are counted once per week

Stock rotation procedures must be in place to ensure storage and stock issue is by expiry date, with the closest expiry date issued first.

The following must also be considered:

* Accessibility via window or door breaches.
* Security of the drugs safe and storage.
* Ability to detect intrusion – intruder alarms. The ability to activate or deactivate intruder alarms must be restricted to authorised personnel. Where this involves a Personal Identification Number (PIN) code the PIN code must be changed on a regular basis.
* Accessibility of the pharmacy from the roof and availability of access to the roof.
* Security of staff including duress alarms and duress response.
* Ability to control and identify persons accessing pharmacy, e.g. by visual identification or card access.
* Using a two-door entry approach (i.e. one door for the public and hospital staff to enter to access front glass transaction windows and a separate door for the entry of pharmacy staff to the pharmacy)
* External lighting, duress alarms and security arrangements, and access/egress arrangements.
* Provision for closing off open areas at the front of the pharmacy out of business hours, (e.g. by a locked door from the corridor or locked windows that do not pose additional manual handling risks)
* Doors are kept closed and locked to restrict entry. Fit doors with self-closing devices, and have the door connected to an intruder alarm.
* An intruder alarm system that meets Australian Standard AS 2201 and incorporates a duress alarm/s to enable staff to activate the alarm in the event of an emergency Restricting access to the pharmacy to authorised staff only and controlling this by:
* Having a restricted swipe card access only
* Keeping doors closed and locked to restrict entry
* Ensure, where the risk assessment warrants it, that mobile staff have personal duress alarms.

### After-Hours Access to the CHS Pharmacy Service

Entering the CHS Pharmacy Service after hours must only occur

* In the presence of the on-call pharmacist or
* By security in the event of an emergency

Any keys, including electronic keys, or codes used for emergency access to the CHS Pharmacy Service should be held under maximum security within the CHS Security Service.

Regular (annual) audits of the entry system should be undertaken. Any noted security breaches must be reported to the relevant Executive Director(s).

### Storage of Temperature Sensitive Medications

Storage temperatures must be consistent with the range specified on the manufacturers’ labels (typically not above +25°C for ‘general’ storage, between +2 to +8°C for refrigerated storage, and below -20°C for freezer storage).

The temperature of medication fridges and freezers in pharmacy are monitored in real time via Wi-Fi connection with data stored on a server. This is in addition to Building Maintenance System (BMS) monitoring. Refer to Medication Fridge Temperature Monitoring policy for further details.

Regular maintenance of medication fridges and freezers must be undertaken to ensure appropriate storage conditions can be maintained.

In the event of temperature storage conditions falling outside those specified by the manufacturer, the Director of Pharmacy must review the event and take appropriate action.

### Storage of Schedule 8 Medications

All Schedule 8 medications in the CHS Pharmacy must be stored in a separate safe or vault, apart from all other medications or goods (except cash or documents). Schedule 8 medications which have been individually dispensed to a patient for discharge may be stored on a shelf within the dispensary while awaiting collection.

When in use the safe must comply, at a minimum, with the requirements of Medicines, Poisons and Therapeutic Goods Regulation (ACT) 2008, Schedule 5 Part 5.8, ‘[Requirements for vaults](http://www.legislation.act.gov.au/sl/2008-42/current/pdf/2008-42.pdf)’. In particular, the

* safe / vault must be kept locked when not in immediate use.
* combination to unlock the safe / vault must only be known to authorised registered pharmacists.

## Medication Supplies

### Preparation and Distribution Standards

Standards for the preparation of medications must be in accordance with the *Society of*

*Hospital Pharmacists of Australia (SHPA) Guidelines for Medicines Prepared in Australia*

*Hospital Pharmacy Departments* and *the Pharmaceutical*

*Inspection Co-Operation Scheme* [Guide to Good Practices for the Preparation of Medicinal Products in Healthcare Establishments](https://picscheme.org/docview/3443).

The CHS Pharmacy Service must maintain the appropriate standards for manufacturing and quality assurance as detailed in these standards. Staff performing these duties must have appropriate training, skills and demonstrated competency to complete manufacturing tasks.

The SHPA [Standards of Practice in Dispensing and Distribution for Pharmacy Services](https://onlinelibrary.wiley.com/doi/10.1002/jppr.1785) provides guidance on Pharmacy Service practices that:

* Deliver medications to patients in a timely manner, and
* Support the lowest possible medication error rate, and
* Minimise the cost of medications stored throughout the facility, and
* Minimise wastage, and
* Minimise opportunities for misappropriation of medications, and
* Provide data on medication usage, and
* Identify unusual medication usage patterns.

The SHPA also publishes practice standards relevant to the hospital setting on topics including:

* Clinical pharmacy services.
* Investigational drugs services.
* Medication safety practices.
* Medication reconciliation.
* Palliative care pharmacy practice.
* Emergency medicine pharmacy practice.
* Mental health pharmacy practice.
* Critical care pharmacy practice.
* Clinical oncology pharmacy practice and the handling of chemotherapy drugs.
* Patient self-administration of medications.

[Guidelines for Pharmacy Practice](http://www.pharmacyboard.gov.au/Codes-Guidelines.aspx) approved by the Pharmacy Board of Australia cover the dispensing of medications, specific practice issues and specialised supply arrangements.

Professional Practice Standards published by the Pharmaceutical Society of Australia are also directly relevant to the provision of high quality, reliable health care services and products from the CHS Pharmacy Service, including those for:

* Dispensing practices.
* Dose Administration Aids services.
* Extemporaneous dispensing.
* Compounding aseptic preparations.

The [National Safety and Quality Health Service Standards](https://www.safetyandquality.gov.au/standards/nsqhs-standards/medication-safety-standard) published by the Australian

Commission on Safety and Quality in Health Care include recommendations to promote the safe storing, manufacturing, compounding, dispensing, and distribution of medications at Standard 4 – Medication Safety.

### Authorised Recipients of CHS Pharmacy Service Medications

The CHS Pharmacy Service is only authorised to supply medication to:

* CHS areas, either as imprest stock or as patient labelled medication, and
* To inpatients of the hospital on discharge as patient-labelled medication, and
* To non-admitted patients / outpatients attending a public health clinic as patient labelled medication, and
* Others as per contractual agreement.

#### Supplies to ACT Ambulance Service

CHS Pharmacy Department is able to supply medication to the ACT Ambulance Service based on agreement between the Head of the Ambulance Service (or delegate) and the Director of Pharmacy (or delegate). This supply agreement is regularly reviewed using a risk assessment approach to ensure safe patient outcomes.

#### Supplies to the Police Watch House

CHS Pharmacy Department is able to supply medication to the ACT Police Watch House to facilitate continuation of therapy for persons held in custody based on an agreement between the nurse / midwife in charge of medications at the Police Watch House and the Director of Pharmacy (or delegate) and regularly reviewed using a risk assessment approach.

#### Supplies to South Care Retrieval Service

CHS Pharmacy Department is able to supply medication to the South Care Retrieval Service based on an agreement between the Head of the South Care Retrieval Service (or delegate) and the Director of Pharmacy (or delegate) and regularly reviewed using a risk assessment approach.

#### Supply to other Public Hospitals

CHS Pharmacy Department is able to supply medication to other public hospitals to facilitate timely access to medications when required. Requests must come directly from the pharmacy on the approved documentation for processing by the CHS Pharmacy Purchasing Officer (or delegate). The receiving hospital will be charged for the stock on a cost recovery only basis.

#### Supply to Private Hospitals

CHS Pharmacy Department is able to supply medication to private hospitals to facilitate timely access to medications when required. Requests must come directly from the pharmacy on the approved documentation for processing by the CHS Pharmacy Purchasing Officer (or delegate). The receiving hospital will be charged for the stock accordingly.

#### Supply to other Pharmacies

CHS Pharmacy Department is able to supply medication to community pharmacies to facilitate timely access to medications when required. Requests must come directly from the pharmacy on the approved documentation for processing by the CHS Pharmacy Purchasing Officer (or delegate). The receiving pharmacy will be charged for the stock accordingly.

### Payment for Supply of Medications

All CHS inpatients will be supplied prescribed medications without charge. This is in accordance with the National Health Care Agreement and means that neither public nor private inpatients will be charged for prescribed medications.

Outpatients are required to pay a patient co-payment as per the ACT Health Fees Determination.

No patient co-payments are required under the following circumstances:

* HIV post exposure prophylaxis for ACT Health staff members due to occupational exposure
* Medicare non-eligible asylum seekers
* Medicare non-eligible patients with HIV
* Medication for tuberculosis patients
* Requests made under the *Children and Young People Act 2008*
* Medications supplied under an approved clinical trial

In the treatment of cancer, medication co-payments are paid by the ACT Government on behalf of patients for a defined list of cancer medicines. Refer to the following webpage for more information <https://www.canberrahealthservices.act.gov.au/before,-during-and-after-your-care/coming-for-cancer-treatment/before-you-arrive/will-i-have-to-pay-for-my-cancer-care>.

### Highly Specialised Drugs (HSD) Program

The Australian Government provides funding for certain specialised medications as

PBS items under the Highly Specialised Drugs (HSD) Programs provided for under Section 100 of the National Health Act 1953.

HSD are medications for the treatment of chronic conditions which, because of their clinical use or other specific features, are restricted to supply through public and private hospitals having access to appropriate specialist facilities. To prescribe these drugs as pharmaceutical benefit items, medical practitioners are required to be affiliated with these specialist hospital units. A General Practitioner or non-specialist hospital doctor may only prescribe HSD to provide maintenance therapy under the guidance of the treating specialist.

Under this program the Commonwealth PBS funds an agreed list of HSD for specified medical indications for use by outpatients and those patients attending day services in a public hospital.

Details of the medications and the associated medical indications can be found on the [Commonwealth Department of Health and Ageing Section 100 – Highly Specialised Drugs Program website](http://www.pbs.gov.au/info/browse/section-100/s100-highly-specialised-drugs).

## Movement of Controlled Medications from CHS Pharmacy to Patient Care Areas

Controlled (Schedule 8 & 4D) medications must be ordered and signed (signature and printed name) by a registered pharmacist or a registered nurse / registered midwife according to an agreed imprest list, on a Drugs of Addiction Requisition Book. Certain medications may require a medication chart (NIMC) to be supplied to pharmacy prior to supply, to verify the exact medication required (e.g. oral methadone, dexamfetamine, hydromorphone). Requisition books must be provided to CHS Pharmacy Services by 11 am, to ensure timely delivery of orders.

Patient care areas should order controlled medications on their assigned days, according to the agreed imprest list with re-order points and quantities to order. Exceptions due to new medication orders or patient admissions may necessitate an order at other times and days of the week.

Controlled medications will be packed into a green tamper proof bag prior to delivery. Controlled medications are delivered to patient care areas on a schedule by a courier as arranged.

#### The Courier or Pharmacist Delivering the Schedule 8 Medicines

The courier or pharmacist delivering the Schedule 8 medicines must obtain a ‘proof of delivery’ receipt (either electronically or in hard copy) for the unopened sealed parcel from the registered nurse / registered midwife to whom the parcel is delivered. The courier or pharmacist must then arrange for this ‘proof of delivery’ receipt to be forwarded to CHS Pharmacy Service.

#### The Registered Nurse / Registered Midwife receiving the Schedule 8 Medicines

The registered nurse / registered midwife must sign and date the ‘proof of delivery’ receipt (either electronically or in hard copy) for the unopened sealed parcel received from the courier or pharmacist.

The registered nurse / registered midwife receiving the Schedule 8 medication must immediately record the acquisition in the patient care area Schedule 8 drug register in accordance with Section 4.13.1, and immediately store the medications in the patient care area’s Schedule 8 drug storage unit. A witness must be present to confirm both actions by the registered nurse / registered midwife and sign the relevant entry(s) in the patient care area drug register, in accordance with Section 4.13.3.

The registered nurse / registered midwife who receives the medication at the patient care area must also sign and date the ‘Requisition for Supply of Drugs of Addiction’ receipt confirming the quantity of the medication(s) received. This white receipt must be forwarded by the registered nurse / registered midwife to CHS Pharmacy Service within 24 hours, for retention at CHS Pharmacy Service. A copy of this receipt must also be retained at the patient care area in the form of a carbon copy in the requisition book.

### Schedule 8 Medication Collection from CHS Pharmacy by a Registered Nurse / Registered Midwife (RN / RM)

A registered nurse / registered midwife from a patient care area may collect Schedule 8 medication ordered from CHS Pharmacy. The registered nurse / registered midwife collecting the medication must produce their hospital photo identification, sign and date a receipt confirming the quantity of the medication supplied, and the receipt must be retained at the CHS Pharmacy Service. A copy of this receipt must also be retained at the patient care area.

The registered nurse / registered midwife collecting the Schedule 8 medication must immediately record the acquisition in the patient care area Schedule 8 drug register in accordance with Section 4.13.1, and immediately store the medications in the patient care area’s Schedule 8 drug storage unit. A witness must be present to confirm both actions by the registered nurse / registered midwife and sign the relevant entry(s) in the patient care area drug register, in accordance with Section 4.13.3.

## Dispensing Patient-Labelled Medications

### Prescription Orders for Dispensing Inpatient or Clinic Administered Labelled Medications

For inpatient or clinic use, patient-labelled medications may be dispensed:

1. From the authorised prescriber’s clear and legible prescription order on the patient’s medication chart or approved form forwarded to the CHS Pharmacy Service by fax, email (as a scanned copy) or another approved electronic form, or from a photocopy made in CHS Pharmacy

1. On a prescription issued by an authorised prescriber, with the relevant details listed in Section 2.
2. The registered pharmacist dispensing a medication for an individual patient should review the medication order/ prescription in the context of the patient’s full medication regimen (where available) prior to the drug being dispensed. If the patient’s weight is not recorded on the medication chart, and required for dose calculation, the registered pharmacist will contact the nursing team leader and the medical team to review and update the medication chart accordingly.
3. When the patient is an infant or child the registered pharmacist should review the appropriateness of the prescribed dose, verify all dose calculations and the specified dose, prior to the drug being dispensed. The weight of the infant/child should be present on all medication charts. If the weight is not present the registered pharmacist will contact the nursing team leader and medical team to weigh patient and update the medication chart accordingly.

### Discharge Medications

Discharge medications may be dispensed from:

* A prescription issued by an authorised prescriber, with the relevant details listed in Section 2.3.1 for Scheduled medications (see also Section 2. for the provision of the verbal (face to face), telephone, fax or email order of an authorised prescriber), or
* A discharge medication order/prescription on an approved electronic or paper form.

The registered pharmacist dispensing medication for an individual patient should review the medication order/ prescription in the context of the patient’s full medication regimen (where available), prior to the medication(s) being handed to the patient (or patient’s carer).

When the patient is an infant/child the registered pharmacist should review the appropriateness of the prescribed dose, verify all dose calculations and the specified dose prior to the medication(s) being handed to the patient’s parent or carer. The pharmacist should discuss and clarify with parents/carers the reason for the medications use, the correct dose and instructions for administration, and demonstrate how to measure and administer the dose, if required.

Ward stock should not be supplied to patients for the purpose of discharge. All medicines supplied by CHS Pharmacy Services on discharge must include adequate labelling details and instructions for use. Details must include those described in Section 3.10.

### Outpatient Dispensing

Only S100 medicines and DTC approved (formulary listed or IPU approved) medicines will be dispensed for outpatients by CHS Pharmacy Services.

Prescriptions to dispense Schedule 4 medications and Schedule 8 medications for the use by outpatients must be in the form detailed in Section 2 for Schedule 4 and Schedule 8 medications.

Once all possible dispensing’s have been issued on a prescription, it should be marked as dispensed and cancelled.

## Prescription Forgeries

Forgery is deemed a serious incident and will be investigated accordingly. Upon detection, all forged prescriptions should immediately be cancelled by crossing the prescription and clearly annotating the word “cancelled”.

Detected prescription forgeries for any medication must be reported to the:

* ACT Policing, and
* ACT Chief Pharmacist at the Health Protection Service, and
* Head of the relevant department.

A Clinical incident report in RiskMan must be completed and submitted through the clinical incident register. All reports must be made within 24 hours of detecting the forgery and should include a copy of the cancelled prescription.

The same action should be taken for any prescription felt to have been altered by someone other than the authorised prescriber, or if the dispensing pharmacist suspects or believes that the prescription was provided by a prescriber on the basis of false information.

## Dispensing Re-Packaged Patient-Labelled Medications

When dispensing re-packaged medications for individual patient use, patient labelling must be in accordance with Part 2 of the [Poisons Standard](https://www.legislation.gov.au/Details/F2016L01071).

## Child Resistant Packaging

### Legislative Framework

[Therapeutic Goods Order No. 80 Child-Resistant Packaging Requirements for Medicines](http://www.comlaw.gov.au/Details/F2014C00067)

[(TGO 80)](http://www.comlaw.gov.au/Details/F2014C00067) specifies those medications that must be supplied in child resistant packaging and the situations and conditions under which they are exempt from these requirements.

[Therapeutic Goods Order No. 80A Amendments to Therapeutic Goods Order No. 80](http://www.comlaw.gov.au/Details/F2012L01920)

[Child-Resistant Packaging Requirements for Medicines (TGO 80A)](http://www.comlaw.gov.au/Details/F2012L01920) amends TGO 80 with an additional list of medications that also require child resistant packaging.

TGO 80 specifies the standards that child resistant packaging must meet and provides exemptions to the use of child resistant packaging, including (but are not limited to) the following medications:

* To be used by, or administered to, a patient for treatment in a public hospital, private hospital, nursing home, dental hospital or dental surgery, or
* Intended to be administered by injection, or
* A solid or semi-solid (excluding solid dosage forms) preparation intended for application to the skin or mucous membrane, including transdermal patches, or
* A liquid or semi-solid preparation intended for application to the eye, ear or mucous membrane, and supplied in a container that:
* has a nominal capacity of not more than 20mL, or
* is fitted with a restricted flow insert, or
* an individually wrapped powder, or
* a liquid preparation in spray presentation if;
* the delivery device is engaged into the container in such a way that prevents it from being readily removed, and
* direct suction through the delivery device results in delivery of no more than one dosage unit, and
* actuation of the spray device is ergonomically difficult for young children to accomplish, or
* A paste, powder or gel for the cleaning of teeth.

### Settings Where Child Resistant Packaging Must Be Used

All medications identified by TGO 80 and TGO 80A as requiring child resistant packaging, and that are not exempted, must be supplied in child resistant packaging. This includes the supply by both a registered pharmacist and an authorised prescriber.

Medications for use within the hospital and outside of the hospital that require child resistant packaging include, but are not limited to:

* Outpatient dispensed medications, and
* Discharge medications, and
* Medications dispensed for day or weekend leave, and
* Emergency Department, and Walk-In Centres pre-packs of medication, and
* Other situations where the medication may later be supplied to a patient for ‘take-home’ use.

## Labelling of Dispensed Medications

Dispensed medications must be labelled in accordance with *Medicines, Poisons and Therapeutic Goods Regulation* (ACT) 2008, Section 123 and the *Poisons Standard*.

The dispensed medicine must have a label that includes the following:

1. The name of the person for whom the medicine is dispensed, and
2. The medicine’s approved name and brand name, and
3. The form, strength and the quantity dispensed, and
4. If the package of the dispensed medicine is not a manufacturer’s pack – the relevant expiry date for the medicine
5. The date of dispensing, and
6. The name, address and telephone number of the pharmacy from which the medicine is dispensed, and
7. The initials or other identification of the dispensing pharmacist
8. The Pharmacy Service’s dispensing reference number, and
9. Directions about the use of the medicine that are adequate to allow the medicine to be taken or administered safely, including any warning statement in the [Medicines and Poisons Standard, Appendix K](http://www.comlaw.gov.au/Details/F2015C00043) (Drugs required to be labelled with a sedation warning) applying to the medicine, and
10. The words ‘KEEP OUT OF REACH OF CHILDREN’, and
11. If the substance is intended for external use only, the words ‘FOR EXTERNAL USE ONLY’ or the word ‘POISON’ in red on a white background, and
12. If the substance is supplied in the circumstances referred to in Section 2.on a verbal, telephone, email or fax order, the words ‘EMERGENCY SUPPLY’, and
13. Any ancillary label / s required for the particular active ingredient / s with the associated warning statement, and
14. If the prescriber is a dentist – the words ‘for dental treatment only’, and
15. If the prescriber is an eligible midwife – the words ‘for midwifery use only’, and
16. If the prescriber is an optometrist – the words ‘for optometry use only’, and
17. In the case of a preparation for which a proprietary product or a standard Australian Formulary does not exist, registered pharmacists must ensure that the dispensed medication clearly indicates the strength of the preparation with the dose prescribed and any additional detail relevant to the formula used.

### Ancillary Labels

Some ancillary labels are mandatory — these are listed in the [Standard for the Uniform Scheduling of Medicines and Poisons](https://www.tga.gov.au/publication/poisons-standard-susmp) (SUSMP). The routine use of other ancillary labels in the Australian Pharmaceutical Formulary and Handbook is recommended having regard to each patient’s circumstances.

## Unregistered Medications Used in Clinical Trials

A clinical trial drug which is not registered or listed on the ARTG must be labelled, stored, prescribed and administered as per any other Schedule 4 medication.

No co-payments are charged for medications supplied to patients enrolled in a registered clinical trial.

## Records of Dispensing

A registered pharmacist must record the dispensing of patient-labelled medication by:

* Entering the details in an approved computer dispensing system (such as ‘Merlin’), or
* Writing the details in a prescription book, or
* Retaining the prescription, or a copy of the prescription or medication chart order (as applicable) in chronological order of the date on which the medications were dispensed.

The record of the dispensing of a patient-labelled medication must include:

1. The pharmacist’s name;
2. The date on which the prescription or order was issued;
3. The prescriber’s name;
4. The date on which the prescription was dispensed;
5. For a repeat prescription – the number of the repeat dispensed;
6. The CHS Pharmacy Service’s dispensing reference number;
7. The name, and address of the person for whom the medicine is dispensed;
8. The medicine’s approved name and brand name;
9. The form, strength, and the quantity dispensed;
10. Where repeats are ordered for Schedule 8 or Schedule 4D medications, the interval at which the medication may be repeat supplied;

Irrespective of the recording system used, the (original) dispensed prescriptions for Schedule 8 medications, must be retained by CHS Pharmacy Services for 2 years and must be available for inspection on request by an authorised inspector of ACT Health or police officer.

## Ward Stock (Imprest) Supplies to Patient Care Areas

### Requisitions for Imprest Medications

Imprest ward stock or “non-patient labelled” stock medications will be overseen by CHS Pharmacy Service in accordance with the approved imprest list for the patient care area.

The range of medications and respective stock levels on an imprest list must be set by agreement between the nurse / midwife in charge of the patient care area and the Director of Pharmacy (or delegate) and regularly (at least annually) reviewed using a risk assessment approach.

The CHS Pharmacy Service must maintain a record of all supplies of imprest medications to patient care areas.

### Re-Packaging and Labelling of Imprest Supplies

Imprest medications supplied from the CHS Pharmacy Service to patient care areas should preferably be in the manufacturers’ original packs. These original packs do not have to be further labelled but supplementary labelling may be applied as deemed appropriate by the supplying registered pharmacist.

Any re-packaging of medications for imprest stock must be carried out under the supervision of and checked by a registered pharmacist before delivery to the patient care area.

The packaging of re-packed items must be in accordance with the provisions of Part 2, sections 20 to 26 of the SUSMP. Child Resistant Packaging must be included as per section 3.9.

Labelling of re-packed items for imprest stock must include, as a minimum, the following details:

* The medicine’s approved name or brand name;
* The form, strength and the quantity supplied;
* The batch number and expiry date of the original pack, or the CHS Pharmacy Service’s batch number in the case of a CHS Pharmacy Service manufactured preparation;
* The name or other identifier of the pharmacy or CHS area from which the medicine is supplied;
* The CHS Pharmacy Service’s dispensing reference number;
* If applicable, that the preparation is a Schedule 8 or Schedule 4D medication;
* The words ‘KEEP OUT OF REACH OF CHILDREN’;
* If the substance is intended for external use only, in red on a white background the words ‘FOR EXTERNAL USE ONLY’ or the word ‘POISON’;
* Any applicable additional information included on the manufacturer’s original pack.

## CHS Pharmacy Service Schedule 8 Medication Accountability

### Entries in the Schedule 8 Drug Register

The CHS Pharmacy Service must record all transactions of Schedule 8 medications in a drug register.

The drug register must contain consecutively numbered pages. A separate page must be used for each form and strength, of the Schedule 8 medication.

A ‘signature register’ should be maintained by the Director of Pharmacy with the name, and signature of all staff authorised to access Schedule 8 medications in the pharmacy.

The record in the drug register must be made on the day the transaction occurred and must include:

* The date of the transaction, and
* The name and address of the supplier from whom the medication was received or the name and address of the person to whom the medication was supplied, except;
* In the case of dispensing to an inpatient only, the patient’s identification number (Unit Record Number) may be entered instead of the address, or
* In the case of a supply to a patient care area, the name of the ward, unit, clinic or service, and
* The quantity of the medication received, supplied, or destroyed, and
* The balance of the medication after the transaction. With regard to repacked liquid medications, overage (excess) to the physical balance in the Schedule 8 medication storage unit is accounted for by adjusting the balance upwards on the next available line of the page. Deficits must be recorded and reported in accordance with Section 3.12, and
* The prescription reference number in the case of a medication supplied on a prescription, or the supplier’s invoice or reference number in the case of a medication obtained from a pharmaceutical wholesaler, and
* The requisition number from the request form for imprest supplies, or the name of the authorised prescriber for patient-labelled medications, and
* The full and legible name and signature of the registered pharmacist or authorised pharmacy staff member,
* Where the Schedule 8 medication is destroyed, in accordance with the additional requirements detailed in Section 3.15.3.

A registered pharmacist, or authorised CHS Pharmacy staff member who makes an entry in the Schedule 8 drug register:

* Must not make a false or misleading entry, and
* Must not make any alterations, obliterations or cancellations. That is, no lines may be drawn through entries, no entries scribbled out or crossed out in any way, nor numerals altered. If a mistake is made, the entry must be left as it is, marked with an asterisk, rewritten as corrected on the next line with a note explaining the error (signed and dated) also marked with an asterisk.

### Schedule 8 Medication Balance Checks

A check of the balance of all Schedule 8 medications held in the CHS Pharmacy Service must be completed weekly, at a minimum, and at other times as deemed necessary by the Director of Pharmacy.

The balance must be recorded under the last entry for each individual medication and signed and dated.

Any detected loss (deficit) must be reported as per Section 3.16.

## Disposal / Destruction of Medications

### Disposal of Medications – General Requirements

Non-Schedule 8 medications (including S4D medications), will be disposed of in a pharmaceutical waste bin for incineration. Cytotoxics will be disposed of in a purple cytotoxic bin for incineration.

Expired, unusable or unwanted medication must not be collected for the purpose of donation for humanitarian relief, in accordance with the *‘*[*Australian guidelines for* *medication donations to developing countries*](https://www1.health.gov.au/internet/main/publishing.nsf/Content/EEA5B39AA0A63F18CA257BF0001DAE08/$File/Aus-Guidelines-for-drug-donations-to-developing-countries-1996.pdf)’.

### Destruction of Expired, Unusable or Unwanted Schedule 8 Medications

The following people are prescribed as witnesses in relation to the discarding of Schedule 8 medications according to the [Medicines, Poisons and Therapeutic Goods Regulation](http://www.legislation.act.gov.au/sl/2008-42/current/pdf/2008-42.pdf) (ACT) 2008;

* an ambulance officer employed by the Commonwealth, the Territory or a State;
* A dentist (not including an intern or trainee);
* A doctor (not including an intern or trainee);
* A medicines and poisons inspector
* A registered midwife
* A registered nurse
* A registered nurse practitioner
* A registered pharmacist

A prescribed discarding witness may discard a controlled medicine in the presence of another prescribed discarding witness (see list above). The witnesses specified above must not be a prescribed witness to the discarding of a controlled medicine if the person is;

* Related to, a close friend of or employed by the person discarding the medicines; or
* The supervisor of the person discarding the medicine; or
* Supervised by the person discarding the medicine.

The corresponding Schedule 8 drug register entry recording the destruction must include the following:

* The quantity of the particular Schedule 8 medication destroyed, and
* The date of the destruction, and
* The name and signature of the person destroying the medication, and
* The name and signature of the person who witnessed the destruction.

Schedule 8 medications must be destroyed in such a way that the medications are made unidentifiable (that is, not disposed of intact in the original labelled packaging), unrecoverable and unusable, and are not likely to cause undue damage to the environment or pose a risk to any person.

### Recommended Methods for the Destruction of Schedule 8 Medications

The destruction of Schedule 8 medications at the CHS Pharmacy Service must be recorded in the drug register, as described in Section 3.15.2. Where appropriate, the person destroying the medication should wear disposable gloves and / or a disposable mask.

After the destruction:

* The containers and implements used in the destruction must be thoroughly washed, and
* Hands must be thoroughly washed with warm soapy water, and
* A final check of the area where the medications were destroyed must be conducted to make sure that no drug material has been inadvertently left on the floor, bench, sink or surrounding areas.

The packaging must also be destroyed. When separated from the medication being destroyed, cardboard packs and emptied foils should be disposed of in a suitable secured receptacle.

The preferred mechanism for destruction of Schedule 8 medications is to use commercially available drug waste bins which are kept on imprest in many care areas or available through pharmacy. Instructions for use of these kits are available on the product website [www.drugwaste.com.au](http://www.drugwaste.com.au). This website also provides links to Material Safety Data Sheets for the product.

Two separate types of drug waste bins are available. One is for the destruction of liquids (including oral and injectable liquids), the other is for tablets and capsules. It should be noted that tablets and capsules may take up to 24 hours to be rendered completely destroyed. Drug waste bins with tablets and capsules should be stored in a controlled medicines cabinet on the ward, or in pharmacy, for 24 hours before being disposed of in pharmaceutical waste. Liquid medicines are immediately denatured and liquid drug waste bins do not require storage in a locked cabinet.

Once drug waste bins are ready for disposal, they may be placed into a pharmaceutical waste bin either in the clinical care unit (if one is present) or sent to pharmacy for destruction.

Alternative procedures for the destruction of Schedule 8 medications are:

***A. Tablets, Capsules and Suppositories***

1. Crush the medication in the mortar / container with a pestle or similar implement, mix with an adequate quantity of hot soapy water. Take care that no drug material is forced out of the container during this process.
2. Pour the resulting slurry onto absorbent material such as cat litter granules and dispose of in a yellow clinical waste bin or sharps container.

***B. Oral Liquids***

1. Pour the liquid onto absorbent material such as cat litter granules.
2. Dispose of in a yellow clinical waste bin or sharps container.

***C. Powders and Granules***

1. Mix the powder in a suitable container with an adequate quantity of hot soapy water.
2. Pour the resulting slurry onto absorbent material such as cat litter granules.

***D. Injectable Medications***

Glass ampoules / small vials:

1. Open ampoule carefully, withdraw contents and expel onto absorbent material such as cat litter granules.
2. Dispose of in a sharp’s container.

Plastic ampoules, plastic IV infusion bags and large vials;

1. Pour the contents onto absorbent material such as cat litter granules.
2. Dispose of in a yellow clinical waste bin.

***E. Transdermal Patches and Sublingual Film***

Transdermal patches must be removed from the packaging and folded in half so that the medication is trapped within the adhesive surface, then disposed of in a ‘sharps’ container.

**Caution:** Fentanyl patches, even once used by a patient or when expired, contain sufficient

fentanyl to cause life-threatening respiratory depression in an opioid-naïve person if absorbed. If during the destruction of fentanyl patches the active layer comes into contact with the skin or other body surface, immediately wash off thoroughly with soap and water

## Reporting Lost or Stolen Accountable Medications (supplied by CHS Pharmacy)

Accountable medications for reporting purposes are defined as Schedule 8 medications, Schedule 4D medications and ‘patient own’ medications.

The registered pharmacist who detects the loss, theft or deficit of an accountable medication must immediately:

* Report this fact to the Director of Pharmacy, and
* Complete and submit a RiskMan report through the clinical incident register.

This includes all medication that cannot be supplied or used, such as the loss of liquid by spillage, and the loss in broken or damaged bottles and ampoules, but does not include medication that is intact but expired, unusable unwanted, and is instead destroyed in accordance with Section 3.15.2 for Schedule 8 medications and Section 3.15.1 for other accountable medications.

The registered pharmacist who detects the loss, theft or deficit of any Schedule 8 medication must also immediately record the physical balance on hand in the Schedule 8 drug register with an explanatory note highlighting the count balance deficit.

The Director of Pharmacy must:

* Notify the Health Protection Service
* Ensure that a full investigation of the loss, theft or deficit of the medication is conducted.
* With a confirmed or suspected theft, report the event to the local police.
* With confirmed misappropriation by a staff member, report the matter to the particular health practitioner’s national registration board as well as to the Health Protection Service.

Where there is no apparent loss of medication, but a concern exists of possible, or admitted, misappropriation of medication by a staff member, this must similarly be reported to the Director of Pharmacy for further appropriate action, as detailed above. Failure to report these incidents may result in harm to a patient or to the member of staff, particularly where a possibility exists that this staff member is drug dependent and / or health impaired.

## Reporting a Lost, Destroyed or Tampered Schedule 8 Drug Register

A registered pharmacist / authorised officer of the CHS Pharmacy Service who detects that a drug register appears lost, destroyed, has had pages removed, or has tampered entries or pages must immediately report the matter to the Director of Pharmacy.

The Director of Pharmacy must immediately:

* Notify the Chief Health Officer or their delegate (e.g. the Chief Pharmacist of the ACT) in writing of the known detail of the circumstances of the loss, destruction or tampering, and
* Arrange for a registered pharmacist to carry out a balance check of Schedule 8 medications involved, and enter the particulars in a new drug register, and
* Complete and submit a RiskMan report through the clinical incident register.

## Retention Periods for Records, Prescriptions and Drug Registers

In accordance with the CHS Records Disposal Schedule for Clinical Records, the following retention periods apply to records relating to dispensing and supply of medications by the CHS Pharmacy Service:

* Two years for prescriptions (except ‘Section 100’ Highly Specialised Drugs Program prescriptions which are for seven years), drug registers, records of medication chart orders, requisitions, receipts / records of deliveries, inventory control records, manufacturing records and purchase orders for all medications and pharmaceuticals.
* Seven years for records relating to the supply of medications under the ‘Section 100’ Highly Specialised Drugs Program, Special Access Scheme approvals and records relating to the organisation’s compliance with mandatory or optional standards or with statutory requirements.
* Fifteen years for clinical trial drugs or until the patient attains the age of 25 years of age, whichever is longer.

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## 

## Responsibility for Medication Procurement and Storage

The registered nurse / registered midwife in charge of a patient care area (Clinical Nurse Consultant – CNC or equivalent) is responsible for the procurement and storage of all medication in that area. This person must ensure that the medications are stored in accordance with all legal requirements and that the correct provisions are met in relation to medication security, temperature control (ambient and fridge), stock rotation, and disposal of expired and unwanted medications.

Where the person in charge of a patient care area is not a registered nurse or registered midwife the responsibility for the procurement and storage of medications is delegated to an appropriately authorised person (for example certain nuclear medicine departments, radiography departments, dental clinics, and other Territory operated health centre, correctional facility, opioid dependency treatment centre or Children and Young Persons detention place) as applicable.

Patient care area medication management systems must include:

* The range and quantities of medications stocked (imprest) in each patient care area being appropriate for the needs of the area, and
* Storage of medications in the packaging supplied by CHS Pharmacy Service in an organised manner that minimises medication error due to a mix-up between preparations, and
* Storage of medications according to legislative requirements, and
* A routine procedure of stock rotation and monitoring of expiry dates, and
* Unwanted, unusable, or expired medications disposed of in accordance with Section 4.15 and also Section 4.15.2 for Schedule 8 medications, and
* Temperature storage consistent with the specifications on the manufacturers’ packs.
* Medications requiring refrigeration should be monitored daily in accordance with Section 4.2.5.

## Medication storage

Medications supplied to patient care areas from CHS Pharmacy Service must be stored in the packaging they are supplied in by CHS Pharmacy.

Medicines that are individually dispensed for a patient by the Pharmacy Department (‘Patient Labelled Medicines’) are used exclusively for that patient and returned to Pharmacy when the patient is discharged, or if treatment is discontinued according to Section 4.15. These medicines must not be stored in the patient care area for safe keeping and future use.

### Storage of Unscheduled, Schedule 2, Schedule 3 and non-Appendix D Schedule 4 Medications

Medications in Schedule 2 (‘Pharmacy Medicine’), Schedule 3 (‘Pharmacist Only

Medicine’), non-Appendix D Schedule 4 medications and unscheduled medications must be stored out of patient and public access. Storage of these medications must also comply with the [ACSQHC Principles for the safe selection and storage of medicines](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/principles-safe-selection-and-storage-medicines-guidance-principles-and-survey-tool). In addition, Schedule 2, Schedule 3 and non-Appendix D Schedule 4 medications must be stored in a locked room or a locked cabinet securely attached to the wall or floor of the premises, with access limited to authorised personnel. Authorised personnel are registered nurses, registered midwives, enrolled nurses, CHS Pharmacy staff members or authorised prescribers.

Exceptions to the above storage requirements:

1. On a medication trolley used for medication rounds, which must be locked and/or be kept in a locked room when not in use, or
2. On an anaesthetic trolley or operating theatre trolley which must be locked and/or kept in a locked room when not in use, or
3. Minimal quantities of medications on an emergency trolley, or
4. In a secure bedside cabinet.

The key, code or combination used to unlock the room, cabinet, or trolley must only be provided to a registered nurse, a registered midwife, an enrolled nurse, a CHS Pharmacy staff member or an authorised prescriber.

#### **Storage of medicines for individual patients in Patient Care Areas**

All patients cared for across CHS will have a storage receptacle that contains all of the medicines that they are taking (with the exception of controlled medicines, some injectable medicines and medicines with special storage requirements).

This receptacle will:

* be labelled, at all times, with the patient’s identification details, and
* contain packets of medicines from imprest supply (not loose strips), and
* contain items that have been dispensed for that patient by the Pharmacy Service, and
* be stored securely on the medication trolley, and
* be taken to the bedside, or other area in which patients are administered medicines as outlined in Section 5.6 Principles for Safe Medication Administration

#### **Intravenous Potassium in Patient Care Areas**

The administration of intravenous (IV) potassium is a potentially dangerous procedure:

* Errors in calculation or admixture of concentrated potassium containing solutions can result in serious adverse reactions and even death;
* IV bolus administration of concentrated potassium can be lethal;
* When high concentrations are used, even minor divergence from the recommended rate of administration can be cardiotoxic.

The storage, prescribing, preparation, administration and monitoring of intravenous potassium must only be in accordance with the hospital policy’s listed below:

* Termination of Pregnancy (TOP), Miscarriage or Fetal Death
* Paediatric and Adolescent Diabetes – Management
* Electrolyte Replacement Guidelines (Adults)
* NICU Drug Manual Page – Potassium
* High Risk Medicine Standard: Potassium and other Electrolyte

#### **Availability of Concentrated Potassium Ampoules**

To minimise the possibility of patient harm, Pharmacy Service supply of concentrated potassium ampoules is restricted to the following patient care areas:

* Emergency Department Resuscitation Bay
* Intensive Care Unit
* Neonatal Intensive Care Unit
* Operating Theatres
* Paediatric High Care

Loaning or sharing of concentrated potassium ampoules to any other patient care area is not permitted under any circumstances. The need for concentrated potassium in these areas will be periodically reviewed.

#### **Storage of Concentrated Potassium Ampoules in Patient Care Areas**

The patient care areas listed above who store concentrated potassium ampoules, must adhere to specific conditions for the storage, labelling and the security of the concentrated potassium ampoules.

These conditions are:

* concentrated potassium ampoules must be stored separately from all other medicines;
* concentrated potassium ampoules must be stored in the packaging they are supplied in by the Pharmacy Department, including any fluorescent labelling
* concentrated potassium must never be “loaned or shared” between patient care areas; even out of business hours. Staff requesting ampoules of concentrated potassium should be re-directed to commercially prepared pre-mixed bags of potassium chloride or potassium dihydrogen phosphate available from the After-Hours cupboard. If requests are made in business hours, staff should be directed to the Pharmacy Department.

### Storage of Schedule 4D Medications in Patient Care Areas

Schedule 4D medications must be stored apart from all other medications and goods (such as keys, cash and documents), except:

* When stored in the Schedule 8 safe, or
* When stored on an emergency trolley, anaesthetic trolley, or operating theatre trolley. In these cases, Schedule 4D medications must be kept at minimal levels and the trolleys kept in a locked room when the patient care area is closed, with access only by authorised persons.

Where Schedule 4D medications are stored apart from Schedule 8 medications, this must be in a separate safe or cupboard securely attached to the premises, and which is kept securely locked when not in immediate use. This can include but is not limited to the ‘Schedule 8 drug cabinet within a Schedule 4D drug cupboard’ model.

Where the same key is used to access both Schedule 4D and Schedule 8 medications, this key must be kept separate from all other keys (other than any other key used to access a separate Schedule 8 safe).

Where Schedule 4D and Schedule 8 medications are stored in the same storage unit, the procedures for the custody of the Schedule 8 medication storage unit key must be followed as detailed in Section 4.2.3. This will restrict access to the key to a registered nurse / registered midwife or an authorised prescriber.

### Storage of Schedule 8 Medications in Patient Care Areas

All Schedule 8 medications must be stored in a locked vault, ward safe or automated dispensing cabinet which is affixed to a solid wall or floor, as per requirements in the Medicines, Poisons and Therapeutic Goods Regulation (ACT) 2008 (this includes patient’s own Schedule 8 medication(s) and Schedule 8 medication(s) labelled for supply to a patient on discharge). In addition to Schedule 8 legislative requirements the [ACSQHC Principles for the safe selection and storage of](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/principles-safe-selection-and-storage-medicines-guidance-principles-and-survey-tool) medicines should be followed.

Where a key is used to access the Schedule 8 safe, transfer of the custody of the key must be strictly controlled, including being kept separate to all other keys.

The registered nurse / registered midwife in charge of the patient care area should hold the Schedule 8 safe key during his / her work shift, and hand the relevant key to each registered nurse / registered midwife or authorised prescriber requesting access to the Schedule 8 safe as required.

However, in the case of a Schedule 8 safe within an operating theatre, a delegated registered nurse / registered midwife in charge or an authorised prescriber (such as an anaesthetist) should hold the key on behalf of the registered nurse / registered midwife in charge.

When a patient care area is closed for any purpose, any keys to that area’s Schedule 8 safe should be returned to the CHS Pharmacy Service. In the event that the CHS Pharmacy Service is closed, keys to an area’s Schedule 8 safe are to be securely locked in a designated location. Patient care areas that are routinely closed over short periods of time (for example on weekends) must be securely locked to prevent unauthorised access.

Any spare keys to a patient care area Schedule 8 safe should be retained in the safe/vault in the CHS Pharmacy Service.

A code or combination required to unlock the Schedule 8 safe must only be provided to a registered nurse / registered midwife or an authorised prescriber. Regular changing of this code or combination is required.

Schedule 8 medications must not be transferred to medication trolleys for administration during a medication round.

#### Lost or Misplaced Schedule 8 keys

If the keys to the Schedule 8 safe go missing during a shift, this must be reported immediately to the CNC / Team Leader, who must ensure that the following steps are taken as a matter of urgency:

* Ask all staff on duty to check if they have the keys on their person.
* Contact staff who may have left the premises.  If one of them has the key, they must return it immediately.
* Conduct a thorough search of the environment.
* If the keys remain missing (either assumed lost or with a member of staff unable to return it) then the duplicate key may be requested from the CHS Pharmacy Service.
* Carry out a full stock check, as soon as access is available.
* If the lock has to be replaced, ensure that the cupboard is not left unsupervised until that has been completed.
* Complete a RiskMan report through the clinical incident register, recording all relevant details and actions taken.
* Depending on the circumstances, it may also be appropriate to inform ACT Policing.

### Storage of Medications in Automated Dispensing Cabinets

Separate to the requirements detailed in Sections 4.2.1 to 4.2.3, the use of automated dispensing cabinets in patient care areas also requires the following:

* The automated dispensing cabinet(s) must be securely attached to the wall or floor of the patient care area
* Consideration for the security of the automated dispensing cabinet(s) to include closed circuit television (CCTV) monitoring.
* The automated dispensing cabinet system should be evaluated against the Core Processes detailed in the Institute for Safe Medication Practices ‘ISMP Medication [Guidance on Automated Dispensing Cabinets](https://www.ismp.org/sites/default/files/attachments/2018-03/ISMP02B-ADC%20Guidelines-0706%20_6_.pdf)’ to confirm the safe and quality use of the system.
* Medications must be stored in the automated dispensing cabinet in the packs received from the CHS Pharmacy Service.
* Electronic access to the particular medications in the automated dispensing cabinets must be restricted to staff members authorised to administer those medications and approved by the registered nurse / registered midwife in charge of the patient care area. Service staff members may be permitted access to the cabinets for the purpose of stocking medications, other than Schedule 8 medications.
* Schedule 8 medication stocking must be completed by a registered nurse / registered midwife with a witness (second person) authorised by the registered nurse / registered midwife in charge of the patient care area.
* Each staff member must be assigned unique electronic access to the respective medication receptacles, within the automated dispensing cabinet that the person is authorised to access.
* The use of an authorised ‘second person’ to witness medication administration must include that person logging into the automated dispensing cabinet system to access the particular medication required.
* All access events by staff members must be recorded and retained in the automated dispensing cabinet system for the purpose of audits.
* The automated dispensing cabinet system must include back-up provisions to access medications in the case of a power failure or electronics malfunction.
* Regular audits to detect unauthorised use, review the safety of the system and review the efficiency of the system must be undertaken.

### Storage of temperature sensitive medication in Patient Care Areas

Medications that require storage under refrigerated conditions (between +2 and +8 degrees Celsius) must be stored in a purpose built medication grade fridge. This fridge must only store medicines and all other goods (food, blood products, nutritional supplements etc.) must be stored separately.

Maintaining the temperature of the medication fridge within +2 and +8 degrees Celsius ensures that safe and effective treatment is provided to patients of CHS.

The temperature of medication fridges across CHS are monitored:

* in real time via Wi-Fi connection with data stored on a server, or
* in areas where Wi-Fi is not available, the medication fridge temperature is monitored via a manual process by staff in the area.

For full details on how to request maintenance for your medication fridge, how to purchase a new medication fridge, monitor your medication fridge, respond to a temperature excursion involving your medication fridge, refer to Medication Fridge Temperature Monitoring policy.

### Principles for the Safe Storage of Accountable Medications in Patient Care Areas

Schedule 8 medications and Schedule 4D medications are defined collectively as ‘accountable medications’.

In accordance with the [ACSQHC Principles for the safe selection and storage of medicines](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/principles-safe-selection-and-storage-medicines-guidance-principles-and-survey-tool) actions must be taken to minimise risks associated with storing and handling accountable medications in patient care areas. These actions may also include the following:

Regular review of the range and quantity of accountable medications, with;

* An annual review of usage and frequency of ordering using CHS Pharmacy information system reports.
* Minimisation of the range of strengths and quantity of each medication routinely stocked.
* Establishing an agreed list of routinely stocked medication and quantities, and adding this list to CHS Pharmacy inventory computer systems.
* Checking the RiskMan reports to identify incidents or near misses including those that may have resulted from selection error, and identify elevated risk medications stocked that may require further consideration including:
* High potency medications such as hydromorphone.
* Unusual strengths or routes of administration.
* Multiple strengths of the same medication.
* Look alike or sound alike preparations.
* Similar manufacturer packaging.
* Bulky items, such as one litre bottles.
* Oral liquids, as it may be difficult to perform balance checks.
* Reviewing controls based on risk assessment, for example:
* Identifying items which should not be routinely stocked, but should instead be dispensed for individual patients and returned to the CHS Pharmacy Service when no longer in use.
* Separate shelf locations for items prone to mix-up, such as oxycodone, hydromorphone and morphine preparations. Due to the number of incidents relating to errors involving hydromorphone being administered instead of morphine, and vice versa, consideration should be given to storage in different Schedule 8 medication storage units, particularly in high use areas. Hydromorphone that is issued to patient care areas other than Medical Oncology, will be supplied and should remain stored in a clip lock orange bag to reduce selection error.
* Redesigning accountable medication storage units, such as increasing capacity, separated storage of Schedule 8 and Schedule 4D medications, or separate storage for large volume preparations.
* Labelling medication storage units with the included contents.
* Maintaining separate, clearly labelled drug registers for items prone to mix-up.
* Matching the order of medications in drug registers to the shelf order in the storage units.
* Reviewing workflow by:
* Ensuring authorised persons are not accessing a Schedule 8 medication storage unit alone.
* Ensuring two person checks can be performed with both people sighting the original prescription/medication order at the time of the selection and preparation for the correct route (ie. oral) of the prescribed dose, and both being present for the administration of the dose and the discarding of any unused portion.
* Ensuring oral / enteral dispensers are always in use for oral liquids.
* Checking for clutter, and reviewing signage.
* Adding a workbench underneath drug storage units to reduce spillage and breakage.
* Eliminating the location of waste bins from under drug storage units to reduce potential losses.
* Labelling of shelves and medications with:
* The inclusion of suggested order quantities.
* The inclusion of warning labels for considerable risk preparations, applied to shelf labels and / or to individual products.
* The use of ‘Tall Man’ lettering.

Note: new line Medication storage areas are to be considered in the development or redevelopment of clinical areas for medication safety, as well as for routine storage / access requirements.

Considerations in the redesign should include:

* Reviewing number of patients, patient case mix, and therefore medication requirements which may inform different storage requirements.
* Increasing the size of medication storage units that are routinely supplied, depending on the anticipated volume of medication to be stored.
* Considering the appropriateness of the use of automated drug cabinets.
* Ensuring adequate bench space surrounding the medication storage units, and positioning in a low traffic area.
* Ensuring medication storage units are accessible without undue bending or reaching.
* Reviewing the proximity of the sink / waste disposal unit to the medication storage units.
* Ensuring larger metal safes have floor reinforcement or supports.

## Medication Procurement by Patient Care Areas

### General Provisions

Patient care areas may obtain medications from:

* The CHS Pharmacy Service, either supplied. as imprest stock, or labelled for individual patient use, in accordance with a medication chart order/ prescription issued by an authorised prescriber or
* Mitchell Supply Services as approved by the Clinical Commodities Committee

Community based patients may have medications dispensed:

* from CHS Pharmacy Service on discharge from Canberra Hospital, or as prescribed in a CHS Outpatient clinic; or
* from their community pharmacy.

### Delivery of Medicines to Patient Care Areas

#### Maintenance of Cold Chain

The Centre for Disease Prevention and Control define cold chain as the temperature controlled environment used to maintain and distribute vaccines in optimal conditions.

The links in the cold chain begin with the manufacturer and follow the transport of vaccines by the distributor to the pharmacy then finally to the patient. This concept is as important for vaccines as for any refrigerated medicine as it helps to maintain the potency and stability of the medicine.

Refrigerated medicines that are supplied from the CHS Pharmacy Service are supplied in a way to maintain the cold chain:

* Outer packaging of medicines are labelled with blue ‘REFRIGERATE – DO NOT FREEZE stickers;
* When the dispensed medicine is released by the pharmacist in the dispensary, it is placed in a silver foil bag to create a visual alert that the medicine is a fridge line. Note that these bags are not insulating and the medicine must be stored inside a fridge. Once dispensed to a patient, medicines are stored in a monitored medication fridge in the pharmacy until the courier delivers them to the patient care area;
* Utilising an esky with an ice brick, the courier delivers refrigerated medicines to the medication fridge in the patient care area within 90 minutes of collection from pharmacy

For more information regarding cold chain management of medicines, refer to the Canberra Health Services Medication Fridge Temperature Monitoring Policy

For more information regarding cold chain management of vaccines, refer to Vaccine Cold Chain Management Procedure.

#### Delivery of Schedule 8 Medicines to Patient Care Areas

For information regarding the process of delivering Schedule 8 medicines to patient care areas, please refer to Section 3.5

#### Delivery of Medicines After-Hours

Central Equipment and Courier Services couriers will deliver medicines from CHS Pharmacy to patient care areas within Canberra Hospital campus, including Adult Mental Health Unit (AMHU) within CHS Pharmacy opening hours. The last courier round occurs at 1900 hours on weekdays and 1700 hours on weekends.

Once the CHS Pharmacy has closed, the After-Hours CNC will supply medicines from the After-Hours Cupboard and deliver to the patient care areas, or arrange for the RN from the ward to collect the medicine from the After-Hours CNC. Refer to Section 4.8 for further detail.

Where transport to AMHU is required after 1900 hours on weekdays or 1700 hours on weekends, the After-Hours CNC or on-call Pharmacist will arrange for transport via security.

### Receipting Schedule 8 Medication Deliveries in Patent Care Areas

To document receipt of a Schedule 8 medication delivery, the registered nurse / registered midwife who receives the Schedule 8 medication delivery must immediately enter the supply in the patient care area drug register in accordance with Section 4.13.1 and lock the medication in the Schedule 8 drug storage unit with a witness as described in Section 4.13.3.

Regular auditing of Schedule 8 medications is mandatory for each patient care area.

### Transferring Schedule 8 Medications between Patient Care Areas

Within Canberra Hospital, Schedule 8 medications may only be transferred between patient care areas after hours when the CHS Pharmacy Service is not available.

The After-Hours CNC must approve and co-ordinate any transfer of S8 medications between patient care areas.

If the medication being borrowed is one for which the patient care area has a register, the register must be taken with the registered nurse to the lending patient care area. If the medication being borrowed is not one for which the patient care area has a register, the ‘Miscellaneous’ register must be used.

The lending patient care area must sign the medication out of their register as ‘Transferred to patient care area X’ along with all other relevant details (date, time etc.) The entry must be signed by the registered nurse removing the medication from the safe for transfer, and the registered nurse receiving the medication.

The receiving patient care area must sign the medication into their register as ‘Received from patient care area X’ along with all other relevant details (date, time etc.) The entry must be signed by the registered nurse removing the medication from the safe for transfer and the registered nurse receiving the medication.

Arrangements should be made as soon as is practical to obtain subsequent supplies of the medication from the CHS Pharmacy Service.

### CHS Pharmacy Service Packs or Re-Packs

All medications must be stored in patient care areas in the same container as received from the CHS Pharmacy Service. This applies to either the manufacturer’s original pack, or a re-packed medication labelled by a registered pharmacist.

An exception is provided for medications required urgently in medical emergencies on emergency, resuscitation or anaesthesia trolleys, where rapid access is essential and the quantity held is minimal, and in accordance with a standard stock list appropriate for the purpose.

Re-packing must not occur outside of the CHS Pharmacy Service, including the ‘pooling’ of medication from multiple containers into one container, re-labelling or over-labelling of containers, or re-packing from bulk stock into smaller containers.

### Patient’s Own Medication

#### Patient Care Areas (Inpatients)

A patient’s own medication may only be used for the patient in the event that the patient care area does not have immediate access to CHS stock of the medication.

CHS stock of the medication must be obtained by the patient care area as soon as possible, and when received, the patient's own supply must be withdrawn from use.

Exceptions may be made in the case of specialised formulations for individual patients

(such as paediatric patients), personal use items for self-administration (for example, eye drops and inhalers), clinical trial drugs, Special Access Scheme medications, non formulary medications and complementary medicines. A registered pharmacist should verify the suitability for use of the medication in the particular circumstances, that is, without replacing the medication with CHS Pharmacy Service stock.

Patient’s own medication that are not a Schedule 8 medicine, are to be stored inside green clip lock ‘patient’s own medication bags’ with a patient addressograph attached. The medications are to be entered into the Patient’s Own Medicine white paper register upon receipt from the patient and stored in the allocated locked cupboard within the medication room. These medications do not need to be checked at change of shift.

Patient’s own medications that are Schedule 8 medicines must be accounted for at every change of shift. Refer to Section 4.3.6.4.

Wherever possible, patient’s own medication should be used to conduct the best possible medication history and medication reconciliation. Once a medication history has been completed, the medicines can be returned to the patient to be taken home by a relative. Ideally, the medicines should be seen and reviewed by a pharmacist before they are returned to the patient to be taken home.

If the medications are not sent home with a relative, upon ward transfer of the patient between patient care areas, the patient’s own medications are to be written out of the Patient’s Own Medicine white paper register and transferred with the patient to their new ward.

If the medications have not been sent home with a relative, at the time of discharge from hospital, the patient’s own medications are to be written out the Patient’s Own Medicine white paper register and returned to the patient.

#### Patient Care Areas (Outpatients)

Patient’s Own Medication may be used by patients attending (non Inpatient) day centres (see Section 5.12) where the staff member is assisting the patient in self-administration.

The use of a patient’s own medication in a patient care area must be specifically notated by an authorised prescriber as appropriate for use alongside the medication order on the medication chart.

#### Infection Control Considerations with Patient’s Own Medications

Where the patient is known to be colonised with a multi-resistant organism, or where there are other concerns about the cleanliness of the medication, the outer packaging of the medication should be wiped with an appropriate cleaning wipe when received and prior to placement in a patient’s own medicine bag.

#### Patient’s Own Schedule 8 Medications

The registered nurse / registered midwife who receives a patient with their own Schedule 8 medication(s) must immediately enter the supply in the patient care area drug register (patient’s own Schedule 8 medication register) in accordance with Section 4.13.1.

A balance check of the patient’s own medication must be performed at the time of entry and at the time the medication is handed back to the patient. The medication must be placed in a green clip lock ‘patient’s own medication bag’, and sealed before being secured in the Schedule 8 drug storage unit. The package is to be sealed using a patient addressograph with the signature of the two registered nurses / registered midwives who received the Schedule 8 from the patient across the addressograph in such a way that any tampering would be evident.

At each shift change, the seal of a patient’s own medication bag is to be checked that it remains untampered with and this is to be documented in patient’s own Schedule 8 medication register.

#### Disposal of Patient’s Own Medication

When not returned to the patient for whatever reason, patient’s own medications must be disposed of in accordance with Section 4.15.1 and Section 4.15.2 (for Schedule 8 medications), and must not be retained as stock for administration to other patients. Patient’s own medicines are the property of the patient and where possible, consent to destroy them must be obtained.

Community patients should be advised to return unused, unwanted or out-of-date medication to their community pharmacy for safe disposal. During home visits, nurses must not remove unused, unwanted or out-of-date medications from the patient’s home and should instead advise the patient to return these medications to their community pharmacy for disposal. An exception would be the situation whereby, based on a risk assessment, leaving a medication in the patient’s home could result in harm to the patient or to a person with access to the home. In such situations, the medication should be disposed of at the closest community pharmacy.

### Complementary Medicines

CHS does not routinely recommend the use of non-evaluated complementary medicines, as their safety, efficiency, appropriateness and interaction with other drugs cannot be confirmed. For further information, see the Council of Australian Therapeutic Advisory Group [*Guiding Principles for the use of Complementary and Alternative Medicines in Hospitals*](http://www.catag.org.au/wp-content/uploads/2012/08/150518_CAM-Position-statement-final.pdf)

Nursing staff will not be involved in the administration of complementary medicines, unless prescribed on the NIMC by an authorised prescriber.

### Methadone and Buprenorphine for Opioid Maintenance Therapy

#### Supply to Inpatient Areas

Due to security and safety issues, methadone oral liquid and oral buprenorphine tablet or film preparations Subutex® and Suboxone® (with naloxone) for the management of opioid dependence should be supplied to patient care areas from the CHS Pharmacy Service as pre-packed, individually labelled, separate daily doses. The exception to this is the Alcohol and Drug Service in-patient Withdrawal Unit, which is an authorised imprest stock holding site for Suboxone films.

Patient’s own (‘take-away’) supplies should be handed over to the inpatient area, on admission, and not administered to inpatients at the CHS. Any medications handed over by the patient on admission must only be returned to the patient on discharge, when both the patient’s Opioid Treatment Program prescriber and dosing point have been advised accordingly.

#### Opioid Treatment Service Clinic

Methadone oral liquid and / or oral buprenorphine tablet or film preparations Subutex® and Suboxone® (with naloxone) for the management of opioid dependence should be supplied to patients via a computerised dispensing and recording system.

Patient’s own (‘take-away’) supplies of Opioid Treatment Program medications handed over by the patient on admission must only be returned to the patient on discharge when both the patient’s Opioid Treatment Program prescriber and dosing point have been advised accordingly.

## Prohibited Substances – Schedule 9

Prohibited substances are substances to which the medicine and poison standard Schedule 9 applies. Schedule 9 substances are generally illegal substances that are subject to misuse such as heroin, cannabis (including seeds, extracts and resins) and MDMA (ecstasy).

The decriminalisation of cannabis in certain circumstances has not resulted in a reclassification of its scheduling in accordance with the SUSMP. It remains a prohibited substance and should be handled in accordance with the Prohibited Substance Management Procedure

*Medicinal* Cannabis products are classified as either Schedule 4 or Schedule 8 controlled substances and should be handled in accordance with the Medication Handling Policy. For advice on the scheduling of a substance please contact Pharmacy on extension 42421.

Continued use of a suspected prohibited substance by a consumer whilst under clinical treatment:

1. Has a risk of significant injury or complication (e.g., interaction with prescribed medicines) and possibly death; and
2. Presents a risk to other consumers and visitors if the substance is found and used by them.

Suspected prohibited substances found at the Canberra Hospital or the University of Canberra Hospital campus may not be returned to the patient, as the return of suspected prohibited substances constitutes supply and is contrary to criminal law.

Management of a consumer’s useof a suspected prohibited substance and processes for the removalof a suspected prohibited substance from a consumer are outlined in the Responding to Consumer Use of Alcohol and/or Other Drugs (AOD)

CHS staff are not under any obligation to remove a prohibited or suspected prohibited substance if this would place them at risk.

Suspected prohibited substances may be willingly surrendered to staff.

Under a permit issued by the Chief Health Officer under section 861 of the Medicines, Poisons and Therapeutic Goods Regulation 2008, the CHS Executive Director of Nursing and Midwifery, the Director of Pharmacy and the Deputy Director of Pharmacy (Operations) are authorised to deal with suspected prohibited substances within Canberra Hospital in accordance with the Prohibited Substance Management Procedure.

At the University of Canberra Hospital, the CHS Director of Pharmacy and the University of Canberra Hospital Assistant Director of Nursing are authorised to deal with suspected prohibited substances in accordance with the Prohibited Substance Management Procedure.

Through their delegation, and in accordance with the Prohibited Substance Management Procedure, staff may assist in the removal of prohibited substances by performing the following actions:

The following table outlines the delegations and the actions allowed:

|  |  |
| --- | --- |
| **Staff with delegation** | **Actions Allowed** |
| **Nursing staff**:   * Executive Director of Nursing and Midwifery * University of Canberra Hospital Assistant Director of Nursing * Director of Nursing (DON) * Assistant Director of Nursing (ADON) * Clinical Nurse Consultant (CNC), including After Hours CNC | * Receive a suspected prohibited substance from a consumer with their consent and store the substance in a drug safe in the patient care area * Surrender a suspected prohibited substance to a pharmacist listed in this table - this surrender must occur in the patient care area where the substance was stored * Surrender a suspected prohibited substance to ACT Policing or a Medicines and Poisons Inspector – this surrender must occur in the patient care area where the substance is stored |
| **CHS Pharmacy staff:**   * Director of Pharmacy * Deputy Director of Pharmacy Operations (Canberra Hospital only) * Pharmacist in charge of shift | * Receive a suspected prohibited substance, or remove the suspected prohibited substance from a drug safe in a patient care area and transfer the substance to the pharmacy drug Surrender a suspected prohibited substance to ACT Policing or a Medicines and Poisons Inspector – this surrender must occur in the area where the substance is stored |

## Patient care areas – Additional Considerations

* The regular review of requests for non-imprest medications by the registered nurse / registered midwife in charge of the unit with the registered pharmacist and attending authorised prescribers, for the purpose of additional medications being included on the imprest list, and
* Medication safety risk assessment and evaluation for risk of medicine selection errors by a registered pharmacist prior to the addition of a new imprest medications into stock, and
* Unused patient-labelled medications being returned to the CHS Pharmacy Service as per Section 3.15.1, and
* A registered nurse / registered midwife checking all stock on receipt to identify any variation from the current medication packs, pack sizes or proprietary names, and
* Notification to staff when new medications, or variations to existing medications, are introduced, and
* A regular review of medication storage units to confirm the suitability (including size and design) for the unit’s purposes. The physical design, layout and choice of medicine storage equipment and technology must be conducive to safe selection, storage and preparation of look-alike sound-alike medicines.

## Pharmaceutical Representatives and Medical Samples

* All supply arrangements and offers must be part of the contracted supply with the CHS Pharmacy Service.
* Supply of free or bonus stock or as part of a purchasing arrangement is not permitted at an individual level.
* Medication samples must be delivered to CHS Pharmacy Service and not to specific patient care areas or prescribers.
* Access to medicines via a compassionate program must have prior approval from the DTC and then be delivered to and distributed through the CHS Pharmacy Service.

## Radiopharmaceuticals

Nuclear Medicine Departments must be licensed under the requirements of *The Radiation Protection Act (ACT)* 2006 and *Regulation* 2007 which regulate the use of radioactive substances and radiation equipment in ACT.

Please note Poisons Standard allows for exemptions of radiopharmaceuticals.

## After-Hours Inpatient Medication Store Supplies

The After-Hours Cupboard may be used to access medications for inpatient use that are unavailable in a patient care area when the CHS Pharmacy Service is not open. The After-Hours Cupboard is managed by the After-Hours CNC. It is the expectation that in all but exceptional circumstances, medications will be ordered from CHS Pharmacy during pharmacy business hours.

The After-Hours Cupboard will be stocked by the CHS Pharmacy Service with a limited range of medications, either in the manufacturers' original packs, or re-packed and labelled by a registered pharmacist for inpatient use. The After-Hours Cupboard must not include Schedule 8 or Schedule 4D medications.

Any removal of stock from the After-Hours Cupboard must be recorded, including:

* The date and time, and
* The name, strength, form and quantity of the medication removed, and
* The name of the patient, and
* The name of the patient care area where the medication was used, and
* The name of the staff member removing the medication.

To access the After-Hours Cupboard, the RN on the ward must call the After-Hours CNC, and may be required to attend the After-Hours Cupboard to collect the required medication.

## After-Hours Dispensing by Authorised Prescribers

To accommodate situations when the CHS Pharmacy Service is unavailable, certain areas within CHS should have access to medication stocks of essential medications for supply to a patient by an authorised prescriber.

The medications dispensed by an authorised prescriber must be recorded in full in the patient’s medication record.

The authorised prescriber must [label](http://www.legislation.act.gov.au/sl/2008-42/current/pdf/2008-42.pdf) the medication as per Section 3.10 with:

1. The name of the person for whom the medicine is dispensed, and
2. The medicine’s approved name and brand name, and
3. The form, strength and the quantity dispensed, and
4. If the package of the dispensed medicine is not a manufacturer’s pack – the relevant expiry date for the medicine
5. The date of dispensing, and
6. The name, address and telephone number of the ward area from which the medicine is dispensed, and
7. The initials or other identification of the dispensing prescriber
8. Directions about the use of the medicine that are adequate to allow the medicine to be taken or administered safely, including any warning statement in the [Medicines and Poisons standard, Appendix K](http://www.comlaw.gov.au/Details/F2015C00043) (Drugs required to be labelled with a sedation warning) applying to the medicine, and
9. The words ‘KEEP OUT OF REACH OF CHILDREN’, and
10. If the substance is intended for external use only, the words ‘FOR EXTERNAL USE ONLY’ or the word ‘POISON’ in red on a white background, and
11. Any ancillary label / s required for the particular active ingredient / s with the associated warning statement.

## Medication Kits for Home Visits

A patient care area such as a community health centre or clinic may hold a range of medications in a locked bag or box (‘medication kit’) that can be taken for domiciliary care services such as ‘Hospital in the Home’, then immediately returned to the patient care area.

Maintenance of the stock levels in the medication kit is the responsibility of the registered nurse / registered midwife in charge of the patient care area. The kit must be kept in a locked room or cupboard at the centre or clinic when not in use, and which may be with other non-Schedule 4D medications.

If the medication kit needs to be kept in the car during a home visit, this should be locked in the boot of the car. The potential for the medications to be subjected to temperatures in excess of that stated on the medication packs must be considered and storage in an insulated container (such as an esky) should be used accordingly.

The medication kit must not include Schedule 4D medications or Schedule 8 medications. Where these medications may be required for a particular patient visit, they may be added to the kit from the stocks held at the health facility on a visit-by-visit basis, then returned to the respective patient care area’s storage unit(s). CHS areas are required to retain a record of the transfers, as well as the associated administration of Schedule 4D and Schedule 8 medications procured for the kit. Entries documenting Schedule 8 medication transfers, supplies and administrations must be recorded in a separate Schedule 8 drug register maintained for each kit. Corresponding entries documenting the Schedule 8 medication transfers to the kit must also be recorded in the patient care area’s Schedule 8 drug register.

Medications administered from the kit must follow the principles of safe administration (Section 5.6) and may either be nurse-initiated medications (see Section 5.5) or ordered by an authorised prescriber either on a medication chart or as a telephone, fax or email order to the staff member (see Section 5.3). The administration must be recorded on the medication chart (as applicable) as if the medication was administered in a patient care area.

Medications must not be collected from patients during home visits for return to and disposal at the patient care area, but instead be taken by the patient or patient’s carer to a community pharmacy for disposal. Where there is an urgent need to protect the patient / client from medicines in the home, staff may exercise discretion and remove the medicines. These should be taken to the closest community pharmacy for disposal.

## Major External Disaster

The provision of medication in a major external disaster is governed by Code Brown (External Disaster Policy).

## Discharge Medications and return of Patient’s Own Medications at Discharge

A registered nurse / registered midwife, authorised prescriber or pharmacist may supply medications to a patient, or the patient’s carer, on the patient’s discharge from the patient care area as:

1. Discharge medication, either previously dispensed by the CHS Pharmacy Service, or labelled and recorded by an authorised prescriber and / or
2. The patient’s own medications if surrendered by the patient to the patient care area on admission. This includes any Patient’s Own Schedule 8 medications stored in the ward Schedule 8 storage unit.

**Note**: An enrolled nurse or assistant in nursing cannot provide discharge medication to a patient.

The availability of patients own medicines on hand at admission can facilitate Medication Reconciliation (i.e. ensuring that patients receive al intended medicines) and assist in identifying any medication related problems. These medications should be stored securely during the hospital admission and be reviewed prior to discharge to determine whether they should be reissued, relabelled or confiscated and destroyed. Patient or carer’s consent must be obtained prior to confiscation or disposal of patients own medicines. Where consent is not granted by the patient or carer, the matter should be escalated to a medical practitioner suitably qualified to assess the patient’s continuing risk of self-harm (where relevant) and decision-making capacity.

Consideration should be also given to the following points in regard to patient discharge:

* Planning for a patient’s discharge, temporary leave, or transport to another point of care, including the arrangement of medication supplies during the CHS Pharmacy Service opening hours, so that an adequate quantity of medication is dispensed to ensure continuity of care until the patient is able to obtain future supplies.
* Where a dispensed supply from the CHS Pharmacy Service has not been arranged and the CHS Pharmacy Service is closed, an authorised prescriber may provide the patient with a PBS prescription for any medication required for discharge, (or see Section 4.9 Medication Store Supplies for After-Hours Dispensing);
* Medication Reconciliation (on transfer of care);
* The dispensing registered pharmacist taking into account the individual needs of the patient, for example those with visual impairment or may experience difficulty in opening certain containers, and
* The prescriber reviewing the patient’s medication prior to authorising discharge medication in conjunction with the Medication Reconciliation Form (MRF) and the NIMC where appropriate;
* Accurate information on the patient’s full medication regimen being communicated to the patient’s general practitioner (or primary care provider as applicable) as soon as possible, and
* Written information being provided to all patients that require an understanding of how to take their medication when they go home and of any changes to their medication regimen since admission. This may include a medication(s) Consumer Medicines Information and / or locally published information pertaining to the treatment.

## Patient Care Area Schedule 8 Drug Register

### Records in the Schedule 8 Drug Register

The registered nurse / registered midwife in charge of the patient care area is responsible for ensuring that a record is kept of all Schedule 8 medication transactions in a drug register. The drug register must have consecutively numbered pages that cannot be removed or replaced without trace.

A separate page must be used for each form and strength of Schedule 8 medication.

A ‘signature register’ should be maintained by the registered nurse / registered midwife in charge of the patient care area with (where possible) the names and signatures of the authorised persons eligible to access the Schedule 8 medication safe. The signature register should be kept under the control of the registered nurse / registered midwife in charge of the patient care area and apart from the Schedule 8 drug register. Authorised persons could include a registered nurse / registered midwife or authorised prescriber assigned to the patient care area or a registered pharmacist.

An authorised person must include the following details relevant to each Schedule 8 medication transaction in the drug register:

* The date and time of day, and
* In the case of medications received into stock, the name of the source (for example the CHS Pharmacy Service), the requisition number and the quantity received, and
* In the case of a medication which is supplied or administered to a patient, the patient’s name, UR number, the name of the prescriber, and the amount supplied or administered as:
* For liquids, in millilitres (mL), or
* For solid dosage forms, as discrete units, for example 1 or 0.5 with tablets (if the medication is suitable to be given as a part tablet), or
* For ampoules, as discrete units, (for example 1 or 0.5) *OR* as the dose (for example 10mg or 5mg), and
* For patient’s own Schedule 8 medications, enter one drug per patient per page, and
* The amount discarded, where only a portion of the medication (tablet or injection) is administered, as above, and
* The full and legible signature of the witness to the transaction, as described in Section 4.13.3
* The balance remaining in the drug register after the transaction.
* The full and legible signature of the person making the entry, either receiving, administering, discarding, destroying, or carrying out a balance check.

The authorised person making an entry in a patient care area drug register:

* Must not make any false or misleading entry, and
* Must not make any alterations, obliterations or cancellations. That is, no lines may be drawn through entries, no entries scribbled out or crossed out in any way, nor numerals altered. If a mistake is made, the entry must be left as it is, marked with an asterisk, rewritten as corrected on the next line (and countersigned by the second person) with a note explaining the error (signed and dated by both staff members) also marked with an asterisk.

### Management of Schedule 8 or Schedule 4D Oral Liquids

All S8 and S4D (controlled medicines) oral liquid bottles should be fitted with a blue Adapta-Cap®. These caps allow for accurate measurement of oral accountable liquid medications.

During routine use of oral liquid medicines, there are some expected losses of liquid through the dead space of the oral syringe. Before a new bottle of oral liquid controlled medicine is opened, an end of bottle balance reconciliation must be conducted to account for these losses.

**End of bottle balance reconciliation**

Steps to conduct an end of bottle balance reconciliation:

On withdrawing the last dose or part dose from a S8 or S4D oral liquid medicine bottle, the actual volume is to be reconciled with the stated volume balance in the S8 or S4D register.

1. The exact amount of liquid remaining is to be measured using a standard dose measurement technique, such as an oral dispenser.
2. A new entry titled “end of bottle balance reconciliation” is to be made in the S8 or S4D register which accurately adjusts the register balance to reflect actual balance.
3. The balance reconciliation and actual volume measured is to be witnessed by a second authorised person and both persons are to sign the register entry.

If there is a discrepancy at the end of bottle reconciliation of less than or equal to 4% of the original bottle volume and no other irregularity exists then no further action is required.  If the discrepancy at the end of bottle reconciliation is greater than 4% of the original bottle volume, then a review of the register should be conducted since the last balance reconciliation.

If the discrepancy is unable to be resolved then Section 4.16 of this policy must be followed. A registered pharmacist may advise that a Measured Balance Check is conducted to determine the acceptable discrepancy volume due to loss from the dead space of the syringe.

For example: An end of bottle reconciliation is conducted on removing the last dose from a bottle originally containing 250mL. The register states the balance is 15mL but the actual volume on measurement is 2mL. This is a discrepancy of 13ml (15mL – 2mL) or 5.2%. An acceptable discrepancy is 4% or less of the original bottle i.e. 10mL. In this case the discrepancy of 13mL is more than 4% and section 4.16 of the policy must be followed. The Director of Pharmacy or a registered pharmacist may ask you to conduct a Measured Balance Check. This will allow the number of doses administered since the last accurate balance check and the corresponding dead space to be calculated.

**Measured Balance Check on advice of a registered pharmacist**

Measurement of a controlled medicine liquid at any time other than at the end of a bottle, is to be on the advice and assistance of a registered pharmacist as unnecessary volume measurement leads to further measurement loss, altered shelf life and potential contamination.

Steps to conduct a measured balance check of the volume:

If a balance check is conducted which is not an end of bottle reconciliation, the acceptable discrepancy volume will need to be calculated.

1. Count the number of doses administered from the bottle since the last accurate measured balance check (this may be an end of bottle balance reconciliation or a measured balance check).
2. Multiply the number of doses administered by 0.2mL (the dead space of the oral dispenser, which is the expected loss during ordinary use). This is the acceptable discrepancy volume.
3. A new entry title “Measured balance check” is to be made in the S8 or S4D register and the actual measured volume recorded. The calculated acceptable discrepancy should be recorded in the comment section.
4. The measured balance check is to be witnessed by a second authorised person and both persons are to sign the register entry.

If the discrepancy is less than or equal to the calculated acceptable discrepancy volume and no other irregularity exists, then no discrepancy report is required. If the discrepancy is greater than the calculated acceptable discrepancy volume then then a review of the register should be conducted since the last end of bottle balance reconciliation or measured balance check.

If the discrepancy is unable to be resolved then Section 4.16 of this policy must be followed.

For example: A measured liquid balance check is conducted on the advice of a registered pharmacist whilst the bottle is in use and is not part of an end of bottle reconciliation. The register balance states the volume remaining is 100mL but on actual measurement the volume is 95mL. A total of 20 doses have been administered since the last reconciled balance check.

The acceptable discrepancy can be calculated as follows, 20 x 0.2mL= 4 mL

The actual discrepancy is 5 mL and therefore unacceptable. A review of the register should be conducted and if the discrepancy is unable to be resolved then Section 4.16 of this policy must be followed.

### Witness to Schedule 8 Medication Transactions (administration and discarding)

The following people are able to act as a witness in relation to the administration or discarding of a Schedule 8 medication:

1. if the medicine is administered by an intern doctor – a doctor, dentist, midwife, nurse, nurse practitioner or pharmacist
2. if the medicine is administered by a person who is not an intern doctor –
3. a doctor, dentist, midwife, nurse, nurse practitioner or pharmacist; or
4. an intern doctor or enrolled nurse

**Note:** Intern Dentists, Intern Pharmacists, and Undergraduate Student Nurses are not allowed to act as a witness to S8 medication transactions (administration and discarding).

The witness must be present during the entire procedure, that is:

* The review of the patient’s prescription including dose, route and frequency/timing
* The removal and replacing of the medication from the Schedule 8 medication storage unit, and
* The preparation of the medication (as applicable), such as drawing up into a syringe, and
* The discarding and rendering unusable any unused portion of the medication (as applicable).
* The recording in the Schedule 8 drug register, and
* The transfer to the patient, and
* The administration to the patient.

**Note**: Enrolled Nurses are not permitted to witness the discarding of a Schedule 8 medicine unless involved in the preparation process, and if no other discarding witness is reasonably available

### Balance Checks in the Schedule 8 Drug Registers

The registered nurse / registered midwife in charge of the patient care area (or appropriately legislated delegate) must ensure that the balance of

* Schedule 8 medications recorded in the drug register is checked against the physical balance in the Schedule 8 medication storage unit at the change of each shift.
* Schedule 4D medications recorded in the drug register is checked against the physical balance in the medication storage unit once in a 24 hour period.

The registered nurse / registered midwife in charge of the incoming shift is accepting responsibility for the contents of the Schedule 8 medication storage unit, therefore they (or their appropriately legislated delegate) must be in involved in checking the balance of the Schedule 8 medication storage unit with the registered nurse / registered midwife in charge of the outgoing shift (or their appropriately legislated delegate).

Each routine balance check must be carried out by a registered nurse / registered midwife with an authorised witness (Section 4.13.3) and recorded in the drug register on the relevant page for each Schedule 8 or Schedule 4D medication. The entry must state the quantity of medication actually held at the time of the balance check.

Where Patient’s Own Schedule 8 medications are being stored, the seal on the package must be checked to ensure that it has not been tampered with, and the register signed.

Where there is a discrepancy between the drug register balance and the physical balance in the Schedule 8 safe this must be recorded and reported in accordance Section 4.16 of this policy.

### Schedule 8 Register Audits

In addition to balance checks, audits of patient care area Schedule 8 drug registers and Schedule 4D drug registers must be conducted at least every 6 months. These audits are to confirm records are meeting legislative and policy requirements and also to detect any possible misappropriation.

Where an area of non-compliance or concern is revealed, this must be escalated to the Executive Director of Nursing Midwifery and Patient Support Services.

Audits should:

* Be performed by a person independent of the patient care area.
* Include checks of entries recording stock received against the patient care area and

CHS Pharmacy Service records, and

* Check and verify signatures for the purpose of detecting forgeries, and
* Verify the ‘carried forward’ balances, and
* Verify that the routine balance checks, and
* Verify that the Schedule 8 medications that have been found to be lost or stolen, including broken ampoules, have been reported and recorded in accordance with Section 4.16 of this policy, and
* Review the frequency of broken ampoules and discarded portions of ampoules and tablets, and
* Review the presence of altered, obliterated and cancelled entries, and
* Include a random selection of patient medication chart checks against the respective Schedule 8 drug register entries.

## Additional Accountable Medication Recording in a Register

The additional Schedule 4 medications listed in Section 2.3.3 must be recorded in the Schedule 4D medication register as if it were a Schedule 8 medication Section 4.2.3.

## Removal of Expired, Unwanted or Unusable Medications

### Removal of Medications – General Requirements

Unwanted medications in patient care areas include:

* Expired, unusable, contaminated or damaged medication,
* Patient-own medications unable to be returned to the patient, and
* Partly used packs of medications no longer required when a patient is discharged or treatment is discontinued.
* Unwanted general and cytotoxic pharmaceutical waste must be disposed of as per the Waste Management Plan for ACT Health DGD-024.
* Clinical trials medication should be returned to CHS pharmacy for disposal
* Unwanted Schedule 8 medications must be disposed of as per Section 3.15.2-3.

### Return of Unwanted Controlled Medications to CHS Pharmacy

Criteria for returning controlled medicines to CHS pharmacy. The item;

* Is not expired
* Is marked with a batch number and expiry date
* Has not left the hospital grounds
* Is in a usable condition
* Is not an oral liquid

If the above criteria are not met then destroy the medication on the ward following the procedure in 3.15.2-3.

A requisition form should be completed by the registered nurse signing the controlled medication out of the storage unit on the patient care area. The medication should be signed out of the controlled drug register as “return to pharmacy” by the registered nurse / registered midwife AND a registered pharmacist. The requisition number should be included in the register entry to ensure traceability of the movement of controlled medicines at CHS. The pharmacist receiving the controlled medication for return to pharmacy must also sign the register and the corresponding requisition. The white copy of the requisition should be returned with the controlled medications to the CHS pharmacy immediately.

### 4.15.3 CHS Pharmacy Returns Box

When a patient is discharged from a patient care area, the contents of the storage receptacle containing their medicines can be emptied into the ‘Pharmacy Returns Box’. These medicines are regularly sorted by pharmacy staff; medicines deemed to have sufficient integrity will be returned to the imprest shelf in the patient care areas and those that cannot be reused are returned to pharmacy for disposal. Where confident to do so, nursing staff are also able to return medicines deemed to have sufficient integrity to the imprest shelf of the patient care area.

Non-imprest medicines dispensed from pharmacy are to be placed in the Pharmacy Returns Box when the patient is discharged or when treatment ceases. These medicines must not be kept in the patient care area for use by other patients.

Pharmacy Returns Boxes:

* Are available in each patient care area, and
* Are regularly emptied by Pharmacy staff, and
* Facilitate sorting and recycling of medicines where appropriate, and
* Prevent hoarding of non-imprest medicines in patient care areas, and
* Contain stock that is not to be administered by nursing or midwifery staff unless it has been reviewed by a Pharmacist or Pharmacy Technician, and in the case of individually dispensed medicines, it will be relabelled for the patient by the pharmacy.

## Reporting Lost or Stolen Accountable Medications

This section applies to the loss, theft or deficit of an accountable medication that is accounted for in a CHS controlled medicines register.

The person who detects the loss, theft, or deficit of an accountable medication must:

* Immediately report this fact to the registered nurse / registered midwife in charge of the patient care area, and
* Complete and submit a RiskMan report through the clinical incident register.

This includes all medication that cannot be supplied or used such as:

* Loss of liquid by spillage, and
* Loss in broken or damaged bottles and ampoules, and
* Loss is believed to be attributed to the irretrievable amount retained in the measuring apparatus used (such as the repeated measuring of small dosing using a syringe which is associated with discarding of a small quantity in the ‘dead space’ of the syringe).

The person who detects loss, theft, or deficit of an accountable medication must also immediately record the physical balance on hand in the drug register in accordance with Section 4.13.3 with a witness as described in Section 4.13.3, with an explanatory note highlighting the deficit from the arithmetical balance.

Following the receipt of a verbal report (in the first instance) of the loss, theft or deficit of an accountable medication the registered nurse / registered midwife in charge of the patient care area must immediately (and within 24 hours) report the loss, theft or deficit to the Director of Pharmacy, as well as the appropriate Director of Nursing in addition to submitting a RiskMan report.

The Director of Pharmacy must then immediately notify ACT Health Chief Health Officer, or their delegate, in writing. Where there is suspicion that the accountable medication has been stolen, the Director of Pharmacy must notify ACT Policing within 24 hours.

Other required actions by the appropriate Director of Nursing are:

* Ensuring that a full investigation of the loss, theft or deficit of the medication is conducted.
* With regard to a confirmed or suspected theft, report the event to the local police.
* With confirmed misappropriation by a staff member, report the matter to the particular health practitioner’s national registration board and to ACT Health Chief Health Officer.

Where there is no apparent loss of medication, but a concern exists of possible, or admitted, misappropriation of medication by a staff member, this must similarly be reported through to the appropriate director of nursing for further appropriate action, as detailed above.

## Reporting a Lost, Destroyed or Tampered Controlled Medicines Register

A registered nurse / registered midwife or designated officer at a patient care area who detects that a drug register appears lost, destroyed, has had removed pages, or has tampered entries or pages must immediately report the matter to the registered nurse / registered midwife in charge of the patient care area.

The registered nurse / registered midwife, or designated officer in charge of the patient care area must immediately:

* Complete and submit a RiskMan report through the clinical incident register, and
* Notify the Director of Pharmacy and the appropriate Director of Nursing.
* The Director of Pharmacy must then immediately (and within 24 hours) notify ACT Health Chief Health Officer in writing immediately detailing the known circumstances of the loss, destruction or tampering.

A balance check of all Schedule 8 medications stock must be performed and entered in a new drug register in accordance with the detail included in Section 4.13.1 with a witness as described in Section 4.13.3.

**Note**: The disposal of a Schedule 8 drug register after the required retention period of two years is not reportable.

## Retention of Records

The following retention periods apply to records relating to the procurement, prescribing, administration and supply of medications in patient care areas.

* Two years for medication charts, medication requisitions and purchase orders, receipts and records of medication deliveries, inventory control records and accountable drug registers.

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| Section 5 – Administering Medication |



## Who May Administer Medication?

The Chief Operating Officer (COO) CHS must ensure that currently employed CHS staff members administering medications have appropriate qualifications, training, and demonstrated current competency. Responsibility for ensuring appropriately qualified and trained clinicians rests with the lead clinician in each department.

Competency to administer medications is included in the qualifications of medical practitioners, dentists, nurse practitioners, midwife practitioners, registered nurses, enrolled nurses and registered midwives, in accordance with any practice conditions imposed by the person’s place of employment and the endorsements, notations and conditions on the person’s AHPRA registration.

Registered Nurse and Enrolled Nurse Transition to Practice Program (TTPP) participants complete mandatory Medication Safety eLearning, including an on-line test, at the commencement of their TTPP year. Additional Medication Competency Assessments may be requested by clinical areas during the 12-month program.

Other appropriately trained and accredited staff members may be authorised to administer certain medications and / or diagnostics agents within their context of practice, and in alignment with any legislative restrictions, include:

* Dental Hygienists
* Dental Therapists
* Nuclear Medicine Technologists
* Optometrists
* Orthoptists
* Pharmacists
* Physiotherapists
* Podiatrists
* Radiographers
* Speech Pathologists
* Health care employees to non-inpatients for the purpose of assisting the patient to self-administer the medication.

The accreditation of such staff should be competency based and professionals should be annually revalidated.

An unregistered trainee or student must be directly supervised by the appropriate authorised registered person when administering any medication or diagnostic agent.

### Administration of Medicines by Enrolled Nurses

As an employee of CHS, an EN may only provide a nursing service under the supervision (direct or indirect) of a Registered Nurse / Registered Midwife (RN / RM).

ENs are responsible and accountable for their own actions and may notdelegate the administration of medications to other ENs or to other health care workers.

Any medication or intravenous (IV) therapy, which requires checking prior to administration, mustbe checked with a RN / RM or Medical Officer (MO).

See Attachment 2 *–* Reference Guide for EN (Scope of Practice) with Medication and IV Administration.

#### **Limitations to medication administration for EN**

It is outside the current scope of practicefor an EN to administer fluids or medications via the following devices:

* Arterial lines
* Central venous catheters
* Endo-tracheal
* Epidural
* Femoral lines
* Implanted devices
* Intrathecal (spinal)
* Intra-ventricular (i.e. into the ventricles of the brain) and
* Peripherally Inserted Central Catheter (PICC) lines.

An EN may care for a patient with these devices, but the EN is not allowed to interact with the devices once connected to the patient.

#### **Records of Scope of Practice**

Supervising staff should refer to the AHPRA online National Register for records of scope of practice.

**Note**: when an EN has not completed the requirements to administer medications, the AHPRA register will include the statement: *‘Does not hold Board-approved qualifications in administration of medicines’.* AHPRA removes this notation when an EN provides evidence of having successfully completed the Board-approved units in medication administration.

#### **Requirements for expanding EN scope of practice to include medication administration**

1. *Oral and non intravenous medication*

An EN may onlyadminister oral and other specified non-intravenous medications on successful completion of the recognised National Health Training Package (HTP) medication administration units.

When these training packages are completed the EN may administer specific medication via the following routes:

* Aural
* Dermal / transdermal
* Enteral (via nasogastric tube or enteral feeding tube)
* Eyes
* Inhalations / nebulisers
* Intramuscular
* Nasal
* Oral
* Rectal
* Sublingual
* Subcutaneous
* Transurethral
* Vaginal

1. *Intravenous (IV) medication*

To administer intravenous medications the EN will also be required to successfully complete:

* The recognised National HTP units which include the administration and monitoring of intravenous medications, and
* CHSs Enrolled Nurse Intravenous Medication Administration and Monitoring Competency Package.

NOTE: Enrolled Nurse Transition to Practice Program participants will complete the IV medication competency assessment as part of the 12 month program.

EN Limitations related to IV fluid management

| **Activity** | **Has AHPRA Medication Restriction**  **Notation**  **“Does not hold Board-approved qualifications in administration of medicines”** | **Does Not Have AHPRA**  **Medication Restriction**  **Notation**  **“Does not hold Board-approved qualification in administration of medicines”** | **Authorised to Administer IV Medication within the Canberra Health Services** |
| --- | --- | --- | --- |
| Commence, change, titrate  IV infusions | NO | Once infusion has been checked and commenced by RN / RM, the EN can titrate and change further IV infusions under supervision of RN / RM | Once infusion has been checked by RN / RM, the EN can commence, titrate and change IV infusions under supervision of RN / RM |

#### **Role of the EN in specialised settings**

Specific medications may require additional training regardless of the clinical setting. Administration of specific medications must be consistent with clinical area guidelines.

Settings include but may not be limited to:

* Paediatrics
* Cancers and Ambulatory Services
* Haemodialysis
* Operating theatres

Enrolled nurse knowledge base and skill must be sufficient to administer medications competently and safely.

## Medication Administration Orders

A medication prescription written by an authorised prescriber authorises the administration of unscheduled, Schedule 2, Schedule 3, Schedule 4, and Schedule 8 medications to a patient.

This prescription may be in the form of:

* A prior written prescription on an individual patient’s medication chart, anaesthetic record or other approved form
* An approved electronic prescription , or
* A verbal, telephone, fax or email medication prescription in accordance with Section 5.3 or,
* A standing order in accordance with Section 5.4.

In some circumstances, such as embedding an externally received order into an electronic patient record, it may be necessary to transcribe a medication order. A transcribed medication order is not a medication order but represents an original medication order in an electronic medication record. Medication must be administered from the original order in accordance with the principles described in Section 5.7, and documented in the MAR.

## Administering from a Verbal or Telephone Medication Prescription/Order

In an emergency, an authorised prescriber may provide a verbal prescription/medication order for a patient. The verbal prescription/order must be given separately and in full (for verification and safety) to a minimum of two of any of the following staff:

* Enrolled nurse (The EN must check with a RN / RM not another EN)
* Registered midwife
* Registered nurse
* Pharmacist

An exception to this is in the community setting where a second person is not available at the site of care delivery. The principles for safe administration from a verbal or telephone medication order as described below will still apply, but with a single, appropriately qualified clinician.

Both staff members must repeat the prescription/order back to the prescriber. Due to the risk of misinterpretation, all orders received by telephone must be read back to the prescriber, with numbers in figures and words (for example: 50mg: fifty milligrams, five zero milligrams), and recorded on the patients medication chart.

It is legislated that the prescriber countersigns the prescription/order with 24 hours of providing the verbal prescription/order.

All telephone prescription/orders will be recorded using standard practice for medication orders in the “telephone orders” section of the NIMC.

In addition, the record will also include clearly:

* The words “telephone order”
* The name and position of both staff taking / administering the prescription/order

Where a prescriber's telephone instruction is to cease a medication, the person receiving the instruction may endorse the medication chart prescription accordingly with the words ‘ceased as per phone order’, the prescriber’s name, the staff member’s name and signature, and the date and time. A corresponding entry should also be made in patient’s clinical record by the staff member, including the prescriber’s reason(s) given for ceasing the order.

## Administering medication where the original order has been transcribed to an electronic medical record

In instances where a medication order originates from a source outside the patient electronic record, the order may be transcribed into the electronic Medication Administration Record (MAR), in accordance with processes described in Section 2.6.7.

A medication order that has been transcribed will be clearly identified as having been transcribed by an annotation in the MAR.

Clinicians must not administer a medication from a transcribed order, but rather from the original order that it represents. The medication may be administered from the original order in accordance with the principles described in Section 5.7, and documented in the MAR.

Any orders that are identified as incorrect, will be amended in the electronic patient record.

## Medication Standing Orders

Medication Standing Orders provide authorisation by an authorised prescriber, the “clinical sponsor”, for the administration (or supply for administration where applicable) of medication without a patient-specific prescription/written order in specific clinical and emergency situations. CHS deems senior medical officers to be able to act as clinical sponsors.

All Medication Standing Orders must comply with all ACT legal requirements and be prepared on the approved Medication Standing Order Template available via the DTC homepage on the intranet.

All Medication Standing Orders must be consistent with the respective medication’s approved Product Information and evidence-based clinical practice guidelines. All standing orders must be reviewed by the clinical area and approved by DTC every two years.

A Medication Standing Order must include the following particulars:

* States the clinical area to which the order applies
* States the clinical circumstances in which the medication may be administered
* The medication name, form and strength
* The medication dose and route of administration
* The frequency of administration, if applicable
* A unique approval number provided by the DTC
* Bear an expiry date no longer than two years after the date of effect.

The registered nurse / registered midwife administering the medication according to a Medication Standing Order must record administration in the patient’s clinical record, preferably on the NIMC under ‘once only’ orders and identify the order as a standing order, recording the Medication Standing Order approval number. In addition, the date and time of administration must be recorded.

**Note**: An EN is not permitted toadminister medications from a Medication Standing Order with the exception that ENs are permitted to administer COVID-19 vaccinations at a CHS operated vaccine clinic under Notifiable Instrument NI2021-506 Medicines, Poisons and Therapeutic Goods (COVID-19 Vaccine Administration) Approval 2021 (No 1 ). EN’s should not be prevented from administering COVID-19 vaccinations on the basis of a standing order.

### Medication Standing Orders for Walk-In Centres

The Chief Health Officer (CHO) is authorised to issue a Medication Standing Order for the supply and administration of a medication at a walk in centre as per the Medicines, Poisons and Therapeutic Goods Regulation (ACT) 2008.

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### 5.4.2 Vaccines delivered through Women’s, Youth, Children’s Community Health Program

The administration of vaccines from Medication Standing Ordersis prohibitedfor Enrolled Nurses, Undergraduate Registered Nursing and Midwifery (direct entry) students as in accordance with the *Medicines, Poisons and Therapeutic Regulation* (2008).

Under the [*ACT Medicines, Poisons and Therapeutic Goods (Nurse and Midwife Immunisers) Direction 2020 (No 1)*](https://www.legislation.act.gov.au/di/2020-290/)a nurse or midwife is authorised to administer a vaccine to a person without a supply authority (prescription or standing order) if the nurse or midwife administers the vaccine in accordance with the ACT Registered Nurse and Midwife Vaccinations Standards as set out in Schedule 1 of the instrument.

## Nurse / Midwife Initiated Medication (NIM)

Nurses and midwives at Canberra Hospital may administer a single dose of an authorised medication, for a minor ailment, not related to the reason for admission to hospital, without a prescriber’s authorisation.

The list of nurse / midwife initiated medications that can be administered is approved by the DTC. The list must not include any Schedule 4 or Schedule 8 medications. See Attachment 3 for nurse / midwife initiated medication list.

To alter the list of nurse / midwife initiated medications, written correspondence should be directed to [dtc@act.gov.au](mailto:dtc@act.gov.au) detailing the nature of the request.

A written protocol for the nurse / midwife initiated medication must accompany this list and provide sufficient detail to nursing and midwifery staff to make informed decisions prior to administration.

The registered nurse / registered midwife administrating the medication must record administration in the patient’s medical record, in the ‘once only, pre-medication, telephone order and nurse-initiated medicines’ section of the NIMC, recording the NIM order approval number. In addition, the date and time of administration must be recorded.

It is important for nursing and midwifery staff to remain aware that:

* Minor ailments may be symptoms of other more serious diseases or may be adverse reactions to medication already prescribed, and
* Nurse-initiated medication may interact with the patient’s prescribed medication, and
* The maximum daily recommended dose of the medication must not be exceeded.

A nurse-initiated medication should not be administered on a continual and / or ongoing basis unless it is reviewed and prescribed/ordered by an authorised prescriber. A prescriber must be contacted to obtain a telephone order/prescription for any subsequent doses.

An EN cannot administer nurse-initiated medication. An EN may only administer medication on the written instruction of a medical officer (Medicines, Poisons and Therapeutic Drugs Regulation, 2008 Schedule 1, part 1.6, item 3).

## Principles for Safe Medication Administration

Safe and accurate medication administration requires the 5 Rights (the 5 R’s):

* The Right Patient, and
* The Right Drug, and
* The Right Dose, and
* The Right Time, and
* The Right Route.

Medication Storage and Administration is governed by a set of principles as agreed upon by Standard 4 Medication Safety Committee, the Pharmacy Service and the Directors of Nursing and Midwifery. These principles are described below and attached as an appendix to this document for ease of reference.

The following principles should be observed on every occasion that an appropriately authorised staff member administers a medication:

* Medication administration processes are to be inclusive of the patient.
* Patients are partners in their care and can provide an additional safeguard against medication errors.
* The staff member administering the medication must refer directly to the prescription on the medication chart, which must be clear, legible and not open to misinterpretation.
* The staff member ensures the weight of the patient is documented on the medication chart.
* If the staff member considers a prescription/medication order is unclear or ambiguous or is concerned that the prescription/order may be incorrect or inappropriate for the particular medical condition, the staff member must contact the prescriber for clarification before administering the dose.
* Medication administration tasks are to be undertaken at the patient’s bedside, or other area where patients take their medicines.
* At the bedside a strict process is to be followed for verifying the identity of the patient. Three unique identifiers must be used. The patient’s allergies / previous adverse drug reactions must also be confirmed.
* At the bedside, the same person should select, prepare, administer and record the administration of the medicine
* When administering an oral dose form this involves:
* Transferring the storage receptacle containing the patient’s medicines from the medication stock trolley to the bedside with the medication order, and
* Reading the medication order and selecting the correct medication from the storage receptacle
* Confirming the dose, (for paediatrics patients verify all dose calculations and the specified dose in accordance with the patient’s weight by 2 RNs or 1 RN and 1 EN, one of whom must be a regular paediatric staff member) form and route of administration of the medication and the time for administration, and
* Involving the patient in discussion of their medicines as appropriate; for example confirming the medicine name or indication and checking for adverse effects, and
* Preparing the medication directly from the container provided by the CHS Pharmacy Service in the presence of the patient. This includes confirming the medication’s name, strength, form, route of administration and expiry date against the medication order, and
* Administering the medication to the patient via the correct route of administration
* Documenting the administration of the medication, and
* Collecting all medication containers from the bedside, returning them to the storage receptacle and replacing it on the medication stock trolley for secure storage.
* When preparing medications for administration, care must be taken to minimise the risk of occupational exposure to hazardous agents.
* Doses must be prepared for only one patient at a time, directly from packaging supplied by CHS Pharmacy Service immediately before the intended administration. Where appropriate, this is to take place at the bedside in the presence of the patient. Exceptions include administration of controlled medicines, and medicines requiring complex manipulation.
* Injections must not be shared between patients (‘multi-dosed’).
* Unwanted portions of ampoules and tablets must be discarded appropriately at the time the dose is prepared.
* Oral dispensers are to be used at all times for administration of all oral or enteral liquid medicines that require accurate dosing. These dispensers are for sole use only.
* Where possible, a collapsible squeeze tube / bottle or a pump pack should be used to dispense lotion or cream from a multi-dose container. Where used, the pump pack should be disposed of with the container.
* Open multi-dose lotion or cream in tubes / pots / containers must only be used for an individual patient.
* Unless in immediate use, medication storage areas and medication trolleys must not be left unlocked
* The inclusion of a second person check before certain medications are administered – see Section 5.8
* Medication orders must be regularly reviewed by an authorised prescriber in accordance with a timeframe that is appropriate in the particular circumstances.
* Clinical handover must include details of administration of medication history.
* Injectable medications and associated lines and catheters must be labelled as outlined in the ACSQHC [National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines](https://www.safetyandquality.gov.au/publications/national-standard-for-user-applied-labelling/).
* Community nurses do not administer the first dose of each course of treatment with the following medications:
* Biological modifiers
* Chemotherapy agents
* Injectable anticoagulants
* Insulin
* Intravenous medications, including intravenous antibiotics
* For community based patients, refer to Australian Pharmaceutical Advisory Council [Guiding Principles for Medication Management in the community.](https://www1.health.gov.au/internet/main/Publishing.nsf/Content/EEA5B39AA0A63F18CA257BF0001DAE08/$File/Guiding-principles-for-medication-management-in-the-community.pdf)

## Documentation

Documentation of administration of medication for inpatients must be in accordance with the ACSQHC [NIMC User Guide](http://www.safetyandquality.gov.au/wp-content/uploads/2014/07/NIMC-User-Guide.pdf) or guidelines associated with the proper use of all relevant electronic systems.

## Second Person Checks Prior to Administration for inpatients of CHS

An authorised second person is:

* An enrolled nurse
* A medical officer
* A registered pharmacist
* A registered midwife
* A registered nurse

A second person check should be used prior to administration where:

* Doses are administered by injection, and
* Doses are administered to children up to their 16th birthday, and
* Chemotherapeutic agents are being administered, and
* All Schedule 8 medications, with the second person being the ‘witness’ described in Section 4.13.3.
* When removing medication i.e. patches, syringe driver

The second person checking the preparation and administration of a medication is responsible for:

* Confirming the identity of the patient, and
* Confirming the selection of the correct medication, route and fluid (where applicable), and
* Confirming that the dose is appropriate and the calculations are correct, and
* Confirming that a rate limiting device such as an infusion pump with medication safety software has been correctly set, and
* Countersigning the administration on the medication chart against that of the administering person.

### Second Person Checks for Domiciliary Care and Patient Transfers

When medications for injection are to be administered by a nurse / midwife to a patient in a domiciliary care setting such as ‘Hospital in the Home’, or when a patient is in transit from a health facility, the second person check should occur within the health facility. The person administering an injection must re-check the medication against the prescription/medication order at the time of the administration.

Community nurses administering patient’s own medications in the patient’s home may ask the patient or carer to check the medication prior to administration if they do not have an authorised second person available. In this circumstance the registered nurse must be satisfied that the second person understands and checks the 5 Rights of medication administration. When Schedule 8 medications are administered by community nurses, the second person check is to be done with an authorised person, i.e. another community nurse, either at the patients’ home or at a health facility prior to visiting the patient. If it is not practical to obtain an authorised second person check in the community then it may be appropriate to ask the patient or carer to check the medication prior to administration.

### Reconstituting Medicine (Break through Medications)

In the ‘Home Based Palliative Care Setting’ HBPC, the Community Nurse may be required to reconstitute and prepare break through medication to be administered by patient, family and care providers. This must be done in accordance with section 4.5.4 of the[Caring @ Home – Guidelines for the handling of palliative care medicines in community services](https://www.caringathomeproject.com.au/Portals/13/Documents/NPS-Palliative-Care-Guidelines-v25-jg260620-ACC.pdf) **.**

An excerpt from these guidelines follows:

*Medicine is left in the container as supplied by the community or hospital pharmacy (for example, medicine box or dose administration aid) and administered to the 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’ medicine if the patient’s carer is unable to do so. This medicine may need to be stored in a fridge in a child-resistant and appropriately labelled container for the carer to administer to the patient at a later time. Each syringe should be individually labelled with the following:*
* *medicine name and dose*
* *date*
* *signature of the registered nurse who prepared the medicine.*

*Manufacturers vary according to the recommended length of time that a particular medicine, in a prefilled syringe, can be stored before administration. Further, there are no recommended times for some of the medicines used for symptom control in the last few weeks of life. Consensus-based practice is that pre-filled syringes, drawn up under aseptic conditions and secured with a bung, can be stored for 24 hours. This time may need to be extended to 48 or 72 hours for terminal palliative patients who may be geographically or otherwise isolated, to ensure symptom control and quality of life. Clinical judgement needs to be exercised when determining the risk-benefit balance between unlikely microbiological contamination and patient comfort.*

### Second person checks in Women’s, Youth, Children’s Community Health Program immunisation services

All vaccines must be checked by two RN/RMs(includes the drawing up and mixing of all multi component vaccines) to ensure:

* Right Client
* Right Vaccine
* Right Dose
* Right Route
* Right Timeframe according to the National Immunisation Program (NIP) schedule

## Medicines Information

When administering certain medicines (e.g. injected medicines), additional considerations should be taken into account. In most circumstances, approved and preferred references are available to guide practice. Specific Medication guidelines may be developed when there is insufficient existing information to support the safe administration of medications. Medication guidelines must be developed following the approval process defined by the CHS Policy Committee.

### Administration by Injection

The Australian Injectable Drugs Handbook (AIDH) offers concise, referenced information for nurses and registered pharmacists preparing medicines for administration by injection. The AIDH must be available in all patient care areas.

Access to the electronic [AIDH](http://aidh.hcn.com.au/browse/about_aidh), (must be from a hospital computer, using Google Chrome, when first registering so that it can recognise the hospital IP address).

### Subcutaneous Syringe Driver

* Medication for use in a syringe driver should be prescribed by a Medical Practitioner on a medication chart as a dose in mass (e.g. micrograms, milligrams or grams) over 24 hours.
* A maximum of three medications may be combined in a syringe driver. Compatibilities must be checked before mixing two or more drugs together.
* The pH and concentration of medicines influence compatibility, therefore regular monitoring of the contents and the tubing must be undertaken to detect evidence of physical incompatibility e.g. precipitation, colour change.
* Syringes must be changed every 24 hours.

### Options for Patients Unable to Swallow Solid Oral Medicines

The Australian *Don’t Rush to Crush* Handbook offers concise, referenced information for health practitioners investigating options for patients who are unable to swallow solid oral medicines. The Australian Don’t Rush to Crush Handbook must be available in all patient care areas either in hardcopy or electronic access via MIMs.

### Administration of Epidural Anaesthesia or Analgesia

* An epidural infusion must be commenced by an anaesthetic registrar or anaesthetist
* Only registered nurses / registered midwives / enrolled nurses who are competent in epidural analgesia management may monitor patients on epidural infusions
* Two registered nurses / registered midwives who are competent in epidural analgesia management may load and program the epidural pump
* Two registered nurses / registered midwives must complete any rate changes or loading doses on an epidural pump.

### Single Use Products

A number of products are available in individual use forms. These include injections, eye preparations (e.g. minims), nebules and other products.

When these products are used and only a portion of a dose is required for a patient, the unused balance must be discarded. The discarding of part doses of Schedule 8 injections is detailed in Section 3.15.3.

Sole use products must not be used for treatment of multiple patients.

### Multi-dose injections

Medications supplied in multi-dose ampoules or vials must only be used exclusively for a single patient and labelled accordingly with their addressograph.

### User-applied Labelling of Injectable Medications and Associated lines

Injectable medications and associated lines and catheters must be labelled to identify the correct route of administration in accordance with the [Australian Commission on Safety and Quality in Health Care National Standard for User-Applied Labelling of Injectable Medicines, Fluids and Lines.](default.aspxhttps://www.safetyandquality.gov.au/publications/national-standard-for-user-applied-labelling)

### Additions to Intravenous Fluids

Additions of medications to intravenous fluids should be made under controlled environmental conditions where possible, or else prepared immediately prior to administration using aseptic technique.

Medications must not be added to blood or blood products, parenteral nutrition solutions, commercially prepared solutions, or admixture infusions prepared in CHS Pharmacy Service. The exception to this is the addition of opioids to commercially prepared bags of bupivacaine 0.125% and adrenaline 2 microgram / mL in 0.9% sodium chloride which are specifically purchased for use in Patient Controlled Epidural Anaesthesia.

No more than one admixture should be added to any IV fluid unless alternative advice is provided by CHS Pharmacy. Compatibility should be checked with the ([AIDH](http://aidh.hcn.com.au/browse/about_aidh)).

Infusions must run for no longer than 24hours.

Where infusion pumps are used, smart pumps with medication safety software should be used for all intravenous infusions.

### Administration by Nebuliser

Use of nebuliser therapy is a consultant Medical Practitioner decision and only indicated for:

* upper airway obstruction and severe bronchospasm in the absence of pneumonia; and
* other specialised therapy administered via nebulisation (e.g. nebulised adrenaline for croup)

Nebuliser therapy should be undertaken in a negative pressure room or a single room to prevent the spread of airborne infection to hospital staff and patients.

Chronic Obstructive Pulmonary Disease (COPD) patients should not receive nebulisation therapy with oxygen. If indicated, simultaneous oxygen therapy may be administered via nasal cannula.

### Considerations Specific to Administration of Cytotoxic Medications

Cytotoxic medications for injection must be prepared, administered and disposed of by appropriately accredited staff members. Where available, reference should also be made to the Clinical Oncology Society of Australia (COSA) guidelines and Work Health and Safety Regulation 2011 (ACT).

#### *Venous access*

The chemotherapy nurse will determine if the venous access is appropriate and safe for the administration of cytotoxic medications. Patients requiring cannulation by a Medical Practitioner for the administration of chemotherapy, cytotoxic medications and targeted therapy must be attended in a timely manner.

#### Central Venous Access Device (CVAD)

Central Venous Access Devices:

* Must be appropriate to the protocol ordered and must be inserted in a timely manner for use for the administration of chemotherapy, cytotoxic medications and targeted therapy.
* The precise location of the tip of the CVAD must be documented in the patient’s clinical record before any intravenous treatment will be given.
* If patency of a CVAD cannot be confirmed by the chemotherapy registered nurse, chemotherapy, cytotoxic medications and targeted therapy will not be administered until a full review of the CVAD has occurred.

#### CHS Oncology Pharmacy

CHS Oncology Pharmacy should receive electronic chemotherapy orders by 1400 hours on the day prior to administration, or by 1100 hours on the morning of proposed treatment at the latest, to enable chemotherapy nurses to administer chemotherapy, cytotoxic medications and targeted therapy in a safe and timely manner. Urgent treatment will be managed as requested.

The CHS Pharmacy does not provide a chemotherapy compounding service on weekends, unless it is a life threatening situation. Chemotherapy for the weekend can be ordered by lunchtime on a Friday and will be pre-prepared for the weekend. Chemotherapy can only be ordered and commenced on a weekend after consultation between the specialist and a senior oncology pharmacist as to the urgency of the request.

#### Chemotherapy Administration

Administration by CACHS chemotherapy registered nurses will occur when:

* All appropriate blood tests and investigations are ordered and results reviewed by the treating medical team.
* Valid prescription
* The treating medical team confirm that the patient is to proceed with treatment, with documentation in the clinical record.
* The patency of an intravenous cannula (IVC) or CVAD is confirmed.
* There is optimal medical cover (during business hours) should an adverse reaction, hypersensitivity or anaphylactic reaction occur:
* The 1st dose of any chemotherapy, cytotoxic medications and targeted therapy should be completed by 1700 hours (excluding cytarabine and cyclophosphamide which may be part of a twice daily (BD) dosing regimen),
* First dose of rituximab must be commenced by 1200 hours, due to considerable risk of hypersensitivity reactions,
* Cytotoxics known to cause hypersensitivity reactions must be commenced by 1500 hours.

Chemotherapy will not be administered overnight due to significantly reduced medical cover and chemotherapy registered nurses.

## Discarding Partly Used Schedule 8 Medicines

Discarding partly used Schedule 8 medications in a patient care area by an authorised person, must be witnessed by a second authorised person as described in Section 3.15.2.

### Tablets or Ampoules

Where only a portion of a dose form of a Schedule 8 medication is required for administration, the unused portion must be rendered unusable and discarded in the presence of the witness to the administration.

A separate entry recording the discard must be made in the drug register on the next available line following the record of the administration.

Any unused portion of an injectable medication must not be discarded in the original container/ampoule but drawn up into a syringe and the contents expelled into a drug disposal bin for liquid medicines (refer to 3.15.3) in the presence of the witness.

The discarding of any unused portion of a Schedule 8 medication by an anaesthetist must also be recorded in the patient’s anaesthetic record.

### Infusions

All records of disposal of a partially used Schedule 8 medication infusion must be kept in the register specific to the medication involved except in the circumstance where initial administration of infusions have occurred in an operating theatre and removal and disposal of residue occurs on a ward. In this circumstance, the disposal must be recorded in the ‘Discard’ register.

For a syringe driver device, the syringe graduations provide for the measurement of the discard. For an infusion device it is accepted that only the arithmetically calculated amount can be recorded as discarded. However, if there is an apparent discrepancy between the arithmetic amount and the physical residue, the registered nurse / registered midwife must report this to the registered nurse / registered midwife in charge of the patient care area for further appropriate action.

### Transdermal Patches

Special attention must be applied to the discarding of Schedule 8 (fentanyl, buprenorphine) transdermal patches that have been removed from a patient’s skin.

Fentanyl patches, even after being used or when expired, contain sufficient fentanyl to cause life-threatening respiratory depression if absorbed. If in the disposing of fentanyl patches the active layer come into contact with the skin or other body surface, immediately wash off thoroughly with soap and water.

Particular care must be taken to ensure that a Schedule 8 transdermal patch is not left in the patient’s clothes / bed linen or dropped onto the floor, thereby providing the opportunity for someone, such as a child, to swallow the patch.

The used transdermal patch must be removed in the presence of a witness, even if the patch is not to be replaced.

Discarded transdermal patches must be folded in half so that the medication is trapped within the adhesive surface, then disposed of in a ‘sharps’ container. The time of the discarding must be recorded in the patient’s health care record, signed and dated by the registered nurse / registered midwife and countersigned and dated by the witness to the procedure.

Where a Schedule 8 transdermal patch is found to be missing from the patient, this must be treated as a loss and reported immediately in accordance with Section 3.16.

### Fentanyl Lozenges

Partially used fentanyl lozenges must be disposed of by a registered nurse / registered midwife in the presence of a witness, in a ‘sharps’ container or as for other solid oral dose forms. The discarding should be recorded in the patient’s health care record, signed and dated by the administering registered nurse / registered midwife and countersigned and dated by the witness.

## Time-Critical Medications

Time critical medications are those where early or delayed administration may cause harm or result in sub-optimal therapy or pharmacological effect and include:

| **Medication Category** | **Examples of Medicines** | **Examples of Possible Outcomes** |
| --- | --- | --- |
| Anticoagulants | heparin, warfarin, enoxaparin, apixaban, dabigatran, rivaroxaban | Deep vein thrombosis, pulmonary embolism |
| Anticonvulsants | diazepam, phenytoin, sodium valproate, levetiracetam, | Seizure activity, especially if omitted peri-operatively |
| Antidotes (usually STAT order) | naloxone, digoxin-specific antibody, sodium polystyrene sulfonate, protamine, calcium folinate, acetylcysteine | Toxicity, overdose related events |
| Antimicrobials | Intravenous antibiotics, antivirals, antifungals | Sepsis, prolonged infection |
| Intravenous and oral corticosteroids | prednisolone, cortisone | Acute asthma attack, delayed symptoms control. |
| Cytotoxics | methotrexate, cyclophosphamide, etoposide, thalidomide | Incomplete remission, prolong hospital stay to finish course, exacerbation of symptoms. |
| Hypoglycaemic agents | Immediate release sulfonylurea, e.g. glibenclamide, insulin | Ketoacidosis, hyperglycaemia |
| Immunosuppressants | cyclosporin, tacrolimus | Transplant rejection, exacerbation symptoms. |
| Anti-Parkinson’s medications | levodopa combinations, bromocriptine, cabergoline | Exacerbation of symptoms, rigidity, falls |

Staff administering these time-critical medications must ensure that they take necessary steps to ensure that these medications are administered as per the prescription/medication chart and within best practice guidelines.

## Non-Inpatient Day Centres

Staff may assist a patient self-administering the patient’s own medications in a non-inpatient day centre, further to the authorised prescriber who completes the medication chart confirming that:

* The medication is current, and
* The dosage stated on the pharmacy dispensing label is current.

If there is any doubt, the original prescriber must be contacted to clarify the medication and dosing instructions.

## Dose Administration Aids (DAA)

Dose administration aids may be used for the routine administration of medications, in Correctional Health facilities, for Direct Observational Treatment (DOT) programmes, by patients of the Mobile Intensive Treatment Team (MITT) and a range of community health teams.

Dose administration aids may comprise blister packs, plastic ‘packettes’ (sachets), but not unsealed compartmentalised containers e.g. ‘dosette boxes’.

Dose administration aids may be used in patient care areas to train, assess a patient’s ability to self-medicate, or, in the community setting, to assist self-administration.

Nurses must not fill DAA.

The packing and labelling on a DAA, with the inclusion of the required warning and precautionary labels, must be checked by a registered pharmacist prior to the supply for patient administration. Detail on the requirements relating the supply of dose administration aids by registered pharmacists is included in the Pharmacy Board of Australia ‘Pharmacy Guidelines on specialised supply arrangements’ available at <http://www.pharmacyboard.gov.au/Codes-Guidelines.aspx>

In the community, partly used DAA should be returned to a community pharmacy for safe disposal.

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| Evaluation |

**Outcome**

* Medications at CHS will be managed as per this Policy.

**Measures**

* Annual review of clinical incident reports related to medication error
* Annual review of consumer feedback related to medications
* Annual review of clinical audits related to medications

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Enrolled Nurse Scope of Practice Pilot Project
* Health Practitioner Credentialing and Scope of Practice
* Incident Management - Clinical
* Clinical Records Management
* High Risk Medicines
* Informed Consent (Clinical)

**Procedures**

* Credentialing and Scope of Clinical Practice for Nurse Practitioners (NPs) and Endorsed Midwives (EMs)
* Credentialing and Defining the Scope of Clinical Practice for Senior Medical and Dental Practitioners
* Management of Recalls Alerts and Product Corrections
* Discharge Summary Completion Procedure
* Information and Communications Technology Resources Acceptable Use
* Incident Management - Clinical
* Patient Identification and Procedure Matching
* Clinical Records Management
* Clinical Handover

**High-Risk Medicine Standards**

* High-Risk Medicine Standard – Insulin
* High-Risk Medicine Standard – Neuromuscular Blocking Agents (NMBA)
* High-Risk Medicine Standard – Opioids
* High-Risk Medicine Standard – Vincristine
* High-Risk Medicine Standard Concentrated Potassium and other Electrolytes
* High-Risk Medicine Standard Heparin and other Anticoagulants

**Guidelines**

* National ACSQHC Labelling Recommendation for User-applied Labelling of Injectable Medicines, Fluids and Lines.
* ‘Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines’
* Council of Australian Therapeutic Advisory Group (CATAG) *Guiding Principles for the quality use of off-label medicines*.
* National Health and Medical Research Council ‘National Statement on Ethical Conduct in Research Involving Humans’.
* NIMC User Guide
* CATAG Principles for the use of Complementary and Alternative Medicines in Hospitals
* Society of Hospital Pharmacists of Australia Standards
* Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)
* ACT Opioid Maintenance Treatment Guidelines 2012
* Australian Commission on Safety and Quality in Health Care 2020, User Guide for Medication Management in Cancer Care

**Legislation**

* *Medicines, Poisons and Therapeutic Goods Act* 2008
* Medicines, Poisons and Therapeutic Goods Regulation 2008
* *Health Practitioner Regulation National Law Act* 2010
* Health Regulation 2004
* *National Health Act* 1953 (Commonwealth)
* *Mental Health Act* 2015
* *Therapeutic Goods Act* 1989
* Therapeutic Goods Regulations 1990
* *Radiation Protection Act* 2006
* Radiation Protection Regulation 2007
* *Children and Young People Act* 2008
* *Health Act* 1993

**Other**

* Australian Charter of Healthcare Rights

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|  |
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| References |

1. ‘ISMP Medication Self Assessment for Automated Dispensing Cabinets’
2. Chapter 18 ‘Security in Pharmacies’ of NSW Health Policy Manual ‘*Protecting People and Property; NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies*’.
3. Standard for the Uniform Scheduling of Medicines and Poisons.
4. Therapeutic Goods Order No. 80 Child-Resistant Packaging Requirements
5. Therapeutic Goods Order No. 80A Amendments to Therapeutic Goods Order No. 80
6. Child-Resistant Packaging Requirements for Medicines (TGO 80A)
7. TGA Poisons Standard 2014 (SUSMP5)
8. Rethinking Medicines Decision Making: Guiding Principles for the quality use of off-label medicines November 2013
9. Achieving Effective Medicines Governance: Guiding Principles for the roles and responsibilities of Drug and Therapeutics Committees in Australian public hospitals November 2013
10. COSA Safe Prescribing Guidelines
11. EviQ Cancer Treatment Online: Cancer Institute NSW.

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|  |
| --- |
| Definition of Terms |

Refer to Attachment 4 for an alphabetical list of acronyms used throughout this document.

**Accountable medication** All Schedule 8 medications and or Schedule 4 medications,

as well as any other Schedule 4 medication directed by the CEO of CHS (or delegate) to be accounted for in a register.

**Adverse drug reaction (ADR)** An action which is noxious and unintended, and which occurs at doses normally used for the prevention, diagnosis or treatment of disease or for modification of a physiological function.

**Authorised person** A staff member authorised to conduct a particular task at CHS in accordance with endorsements, notations and conditions on the person’s registration as a health practitioner (where applicable) and the person’s confirmed competence to complete the task.

**Authorised prescriber** A person approved by law to prescribe medications, but only in

accordance with any endorsements, notations and conditions on the person’s health practitioner registration, as:

* A medical practitioner registered by the Medical Board of Australia.
* A dentist registered by the Dental Board of Australia as a dental practitioner.
* A nurse registered by the Nursing and Midwifery Board of Australia with endorsement as a nurse practitioner, and also authorised under the *Medicines, Poisons and Therapeutic Goods Act 2008*
* A midwife registered by the Nursing and Midwifery Board of Australia with endorsement as a midwife practitioner, and also authorised under the *Medicines, Poisons and Therapeutic Goods Act 2008*
* An optometrist registered by the Optometry Board of Australia with endorsement to prescribe or supply a limited range of Scheduled medications.
* A podiatrist registered by the Podiatry Board of Australia with endorsement to prescribe or supply a limited range of Scheduled medications.

**CHS Pharmacy Service** The service administered by the Director of Pharmacy which is responsible for the procurement, distribution, preparation and dispensing of medications as well as the delivery of clinical and other services as defined by the Society of Hospital Pharmacists of Australia. Includes a principal medication supply service (that is also not part of a patient care area) at a facility where no registered pharmacist is employed or contracted for whom the responsibility of the distribution of medications is assigned to the director of nursing or medical superintendent of the patient care area.

**Enrolled Nurse** An enrolled nurse licensed under the Australian Health Practitioner Regulation Agency (AHPRA) without notation who has successfully completed the required National Health Training Package (HTP) medicine administration units.

**Medication** Used singularly throughout this Policy to describe a drug, medicine, pharmaceutical preparation (including a compounded preparation), therapeutic substance, complementary and alternative medicine, vaccine, diagnostic agent for patient administration, medicated dressing and a fluid for intravenous use. Includes Scheduled medication and unscheduled medication.

**Medication Management** The prescribing, dispensing, supply, administration, storage, manufacture, compounding and monitoring the effects of medications.

**Must** Indicates a mandatory action requiring compliance by staff at public health

facilities, in accordance with a legislative requirement and / or an ACT Health policy.

**Patient care area** Any area, clinic or unit in a hospital, health facility, health institution, healthcentre, health service or health support service where patient treatment or care may be carried out. Includes a hospital ward, operating theatre, specialised treatment unit (for example haemodialysis, oncology, radiology, dental), day surgery unit, community health centre, domiciliary service, day centre, and facilities at which Justice Health & Forensic Mental Health Network provides health services.

**Relevant Delegate** (for approval of medication not on formulary) - The relevant delegate is the Head of Department and/or the Executive Director for the Division where the medicine requested is to be used (depending on the financial delegation required for the cost of treatment), or the Chief Executive Officer or Chief Operating Officer if the cost of treatment and financial delegations require this.  Where there is a conflict of interest caused by the applicant being the relevant delegate, the application must be approved at a level of governance higher than their position (e.g. for a Head of Department, it must go to the Executive Director, for an Executive Director, the application must be considered by the COO or CEO).

**Section 19A medicine.** This is a medicine that is not on the Australian Register of Therapeutic Goods (ARTG) but has been approved for import and supply because there is a shortage of a medicine registered in Australia and the medicine is needed in the interest of public health

**Schedule 4D medications** The subset of Schedule 4 medications that are known to be liable toabuse or misuse, and as such within CHS require additional requirements for storagein patient care areas. These medications include benzodiazepines (except aSchedule 8 benzodiazepine), anabolic-androgenic steroids, ephedrine,phentermine, phenobartitone, thiopentone, and amylobarbitone andpentobarbitone when packed and labelled for injection. See Section 2.3.3. These requirements, and the medicines designated as Schedule 4D, are set out by CHS and are not legislated in the ACT.

**Scheduled medication** A medication containing a substance in the SUSMP as;

* Schedule 2 ‘Pharmacy Medicine’ (pharmacy ‘over the counter‘ medication),
* Schedule 3 ‘Pharmacist Only Medicine’ (pharmacist controlled ‘over the counter’ medication),
* Schedule 4 ‘Prescription Only Medicine’ (also known as a ‘restricted substance’), or,
* Schedule 8 ‘Controlled Drug’ (also known as a ‘drug of addiction’).
* Schedule 9 ‘Prohibited Substances’.

**Should** Indicates a recommended action to be followed, unless there is a sound reason for taking a different course of action.

**Tall Man Lettering** Tall Man lettering is a typographic technique that uses selective capitalisation to help make look-alike, sound-alike (LASA) medicine name pairs easier to differentiate. The Australian Commission on Safety and Quality in Health Care developed the List to help clinicians reduce the risk of medicine selection errors for medicines with LASA medicine names.

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|  |
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| Search Terms |

Medication, Drug, Medication Management, Dispensing, Prescribing, Administration, Medication Storage, Scheduled Medication, Adverse Drug reaction, Reconciliation, Medication handling, Cold chain, Immunisation, Fridge, Storage, Administering, Pharmacy, Schedule, Dangerous drugs, Buprenorphine, Opioid, Methadone, standing order, infusions, controlled,

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| Attachments |

Attachment 1: Medications where trade name should be used

Attachment 2: Reference Guide for EN (Scope of Practice) with Medication and IV Administration

Attachment 3: List of Nurse / Midwife Initiated Medications

Attachment 4: Alphabetical List of Acronyms

Attachment 5: Principles of Medication Storage and Administration

Attachment 6: Registered Nurse Transcription workflow

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*Policy Team ONLY to complete the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval* |
| *26 June 2022* | *Complete Review* | *Ashwin Swaminathan, Acting ED-MSG* | *CHS Policy Committee* |
| *11 November 2022* | *Nurse transcription information added* | *Jo Morris ED RACS*  *Daniel Lalor Director Pharmacy* | *CHS Policy Committee Chair* |
| *08 December 2023* | *Section 5 TTPP requirements to administer medication* | *Daniel Lalor Director of Pharmacy - MSG* | *CHS Policy team* |

*This document supersedes the following:*

|  |  |
| --- | --- |
| *Document Number* | *Document Name* |
| *CHHS17/172* | *Medication Handling Policy* |
|  |  |

## Attachment 1: Medications where trade name should be used

|  |  |
| --- | --- |
| Oxycodone (Oxycontin®) or  Morphine (MS Contin®) products | Pentavite® liquid or Ferroliquid® |
| Combination inhalers  (e.g. Seretide®, Symbicort®) | Insulin products  (e.g. Actrapid®, Novorapid®, Novomix 30® ) |

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## Attachment 2: Reference Guide for EN (Scope of Practice) with Medication and IV Administration

| **Activity** | **Has AHPRA Medication Restriction**  **Notation**  **“Does not hold Board-approved qualifications in administration of medicines”** | **Does Not Have AHPRA**  **Medication Restriction**  **Notation**  **“Does not hold Board-approved qualifications in administration of medicines”** | **Authorised to Administer IV Medication within Canberra Health Services** |
| --- | --- | --- | --- |
| Initiate a phone order | NO | NO | NO |
| Confirm a phone order/prescription for medication | NO – unless completed Canberra Health Services eLearning for medication checking | Yes with RN or RM only | Yes with RN or RM only |
| Check Medications | NO – unless completed Canberra Health Services eLearning for medication checking | Yes with RN / RM / MO only | Yes with RN / RM / MO only |
| Issue requisition for S4D or S8 medicines | NO | NO | NO |
| Obtain S4D or S8 medicines on requisition | NO | NO | NO |
| Administer medication as per a standing order | NO | NO | NO |
| Administer Nurse Initiated Medications | NO | NO | NO |
| Supply discharge medication to patient | NO | NO | NO |
| Transfer S8 and pharmacy restricted medication between theatres | NO | NO | NO |
| Carry the S8 drug keys | NO | NO | NO |
| Check IV Infusions | NO – unless completed Canberra Health Services eLearning for medication checking | Yes with RN / RM / MO only | Yes with RN / RM / MO only |
| Commence, change, titrate  IV infusions | NO | Once infusion has been checked and commenced by RN / RM, the EN can titrate and change further IV infusions under supervision of RN / RM | Once infusion has been checked by RN / RM, the EN can commence, titrate and change IV infusions under supervision of RN / RM |
| Flush an IV cannula with sodium chloride 0.9% | NO | NO | Yes – with sodium chloride 0.9% and under the direct / indirect supervision of a RN / RM / MO |
| Give medication via an IV Cannula | NO | NO | Yes under the direct / indirect supervision of a RN / RM / MO and as described in? section 5.1.1.3 |
| Check Epidural Infusion | NO - unless completed the Canberra Health Services eLearning and annual Epidural Workshop Competency Requirement and under the direct supervision of an RN / RM | Yes - once completed the Canberra Health Services eLearning and annual Epidural Workshop Competency Requirement and under the direct supervision of an RN / RM | Yes - once completed the Canberra Health Services eLearning and annual Epidural Workshop Competency Requirement and under the direct supervision of an RN / RM |
| Commence, change,  titrate Epidural Infusion | NO | NO | NO |
| Check Patient Controlled analgesia (PCA) / Narcotic Infusion | NO - unless completed the Canberra Health Services eLearning for medication checking and attended annual PCA theory and Practical Test and under the direct supervision of an RN / RM / MO | Yes - once completed the Canberra Health Services eLearning and attended annual PCA theory and Practical Test and under the direct supervision of an RN / RM / MO | Yes – once completed the Canberra Health Services eLearning and attended annual PCA theory and Practical Test and under the direct supervision of an RN / RM / MO |
| Commence, change, titrate PCA Narcotic Infusion | NO | NO | NO |
| Check cytotoxic | NO | NO | NO unless has completed the CRCS Chemotherapy Program + 100% accuracy on BSA / GFR + AUC Drug Calc Worksheet = Yes  And only in CRCS: 14A, 14B and Radiation Oncology |
| Commence, change, titrate cytotoxic | NO | NO | NO |
| Check PRN and variable doses of medication | No – unless completed Canberra Health Services eLearning for medication checking | Yes with RN / RM / MO only | Yes with RN / RM / MO only |
| Give PRN and variable doses of medication | NO | Yes with RN / RM / MO only | Yes with RN / RM / MO only |

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## Attachment 3: List of Nurse / Midwife Initiated Medications

|  |
| --- |
| Aluminium / magnesium / simethicone liquid (Mylanta®) |
| Docusate and senna tablets |
| Glyceryl trinitrate sublingual tablets |
| Hypromellose eye drops |
| Ibuprofen tablets / liquid |
| Loratadine tablets / liquid |
| Paracetamol tablets / liquid |
| Psyllium Powder (Metamucil®) |
| Salbutamol metered dose inhaler |
| Sodium citrotartrate sachets (Ural®) |
| Zinc oxide and cinchocaine ointment (Rectinol®) |

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## Attachment 4: Alphabetical List of Acronyms

ACHS: Australian Council of Health Standards

ACSQHC: Australian Commission on Safety and Quality in Health Care

ACT: Australian Capital Territory

ACTPAS: ACT Patient Administration System

ADON: Assistant Director of Nursing

ADR: Adverse Drug Reaction

ADRRC: Adverse Drug Reaction Reporting Committee

AHPRA: Australian Health Practitioner Regulatory Agency

AIDH: The Australian Injectable Drugs Handbook

AMHU: Adult Mental Health Unit

ARTG: Australian Register of Therapeutic Goods

AUC: Area Under the Curve

BSA: Body Surface Area

CACHS: Cancer, Ambulatory and Community Health Service

CCTV: Closed Circuit Television

CHS: Canberra Health Services

CHO: Chief Health Officer

CNC: Clinical Nurse Consultant

COP: Chronic Obstructive Pulmonary Disease

COSA: Clinical Oncology Society of Australia

CPMS: Clozaril Patient Monitoring System

CRCS: Capital Region Cancer Services

CVAD: Central Venous Access Device

CVC: Central Venous Catheter

DAA: Dose Administration Aid

DDG – CHS: Deputy Director-General – Canberra Health Services

DMA: Deputy Medical Administrator

DON: Director of Nursing

DOT: Direct Observational Treatment

DTC: Drug and Therapeutics Committee

EMM: Electronic Medicines Management

EN: Enrolled Nurse

GFR: Glomerular Filtration Rate

HPS: Health Protection Service

HTP: National Health Training Package

IPU: Individual Patient Use Application

ISMP: Institute for Safe Medication Practices

IV: Intravenous

IVC: Intravenous Cannula

MAP: Medication Access Programs

MDAAC: ACT Health Medical and Dental Appointment Advisory Committee

MHJHADS: Mental Health, Justice Health, Alcohol and Drug Service

MITT: Mobile Intensive Treatment Team

MO: Medical Officer

MRF: Medication Reconciliation Form

MMC: Medication Management Committee

MOSCETU: The Medical Officer Support, Credentialing, Employment and Training Unit

NICU: Neonatal Intensive Care Unit

NIMC: National Inpatient Medication Chart

NSSC: National Standards Steering Committee

OCMA: Office of the Chief Medical Administrator

PBS: Pharmaceutical Benefits Schedule

PCA: Patient Controlled Analgesia

PFP: Patient Familiarisation Program

PIE: Practitioner Information Exchange

RM: Registered Midwife

RN: Registered Nurse

S8: Schedule 8 Medication SARA: System for Australian Recall Actions

SAS: Special Access Scheme

SCN: Special Care Nursery

SHPA: The Society of Hospital Pharmacists of Australia

SOH: Surgery and Oral Health

SUSMP: Standard for the Uniform Scheduling of Medicines and Poisons (Poisons Standard)

TGA: Therapeutic Goods Administration

TGO: Therapeutic Goods Order

WhoG: Whole of Government

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## Attachment 5: Principles of Medication Storage and Administration

Medicines are the most common intervention in healthcare and their use helps millions of people. A significant proportion of nursing and midwifery time is dedicated to administering medicines. Because of the large number of medicines administered in the hospital, there are many opportunities for errors to be made. These errors can have wide ranging consequences. They could have little to no effect on the patient, but they can also be catastrophic.

To support nursing and midwifery staff in safely administering medicines, the systems for storage, supply and administration of medicines across Canberra Health Services are being reviewed and standardised.

The following principles govern the design of systems for the storage, supply and administration of medicines.

**Principle 1**

Medication administration processes are inclusive of the patient.

**Rationale**

Patients are partners in their care and provide an additional safeguard against medication errors. By including patients in the medication administration process, nursing and midwifery staff provide the opportunity for patients to ask questions about their medicines, provide feedback on medication treatment and its effects and to be educated about their medication regimen.

**Action**

Medication administration tasks are undertaken at the patient’s bedside, or other area where patients take their medicines. With the exception of controlled medicines, and medicines requiring complex manipulation, medicines for the patient are taken to the bedside in their packaging and dispensed for administration in the presence of the patient.

**Principle 2**

The model of medication storage and administration reduces the time nurses and midwives spend in motion.

**Rationale**

Nursing and midwifery staff time is valuable and there are many competing demands for their attention. A system that helps get medicines to where nurses and midwives need them to be, when they need to administer them, limits time spent searching for medicines and travelling back and forth between medication stores and the patient.

**Action**

All patients cared for across CHS will have a storage receptacle that contains all of the medicines that they are taking (with the exception of controlled medicines, some injectable medicines and medicines with special storage requirements). This receptacle will contain packets of medicines from imprest supply (not loose strips) and items that have been dispensed for that patient by the Pharmacy. This receptacle will be labelled, at all times, with the patient’s identification details.   
  
This receptacle will be able to be taken to the bedside, or other area in which patients are administered medicines.

**Principle 3**

Medicines are stored in a way that reduces the opportunity for medication errors.

**Rationale**

The way in which medicines are stored can significantly increase the opportunity for error. When compared to lose strips or individual ampoules, medicines stored in the manufacturers packaging contain visual prompts of what the medicine is.

**Action**

Medicines stored in the imprest area will be stored according to legislative requirements and organised in a consistent manner that reduces opportunity for error. The setup of the imprest area will be agreed upon between the Clinical Nurse Consultant/Clinical Midwife Consultant, or other nurse or midwife in charge of the treatment area, and the Pharmacy Department. Wherever possible, medicines will be stored in alphabetical order to facilitate ease in finding them.   
  
Medicines supplied in boxes by the Pharmacy Department will be labelled with drug and/or patient details on at least two opposing faces.   
  
Medicines will be stored in manufacturers’ packaging or pharmacy provided medication boxes, not as loose strips, or individual ampoules.

**Principle 4**

Medicines that are individually dispensed for a patient by the Pharmacy Department are used exclusively for that patient and returned to Pharmacy when the patient is discharged, or if treatment is discontinued.

**Rationale**

Ward imprests are created so that they have medicines that are frequently needed on the ward within easy access. Medicines that are used rarely, are obtained from Pharmacy. In addition, items that have a high level of risk are dispensed from Pharmacy. This ensures that prescriptions for these medicines are reviewed for safety and appropriateness before they are administered. By hoarding non-imprest medicines in ward areas, this safe-guard is avoided, providing opportunities for error and patient harm.

**Action**

Pharmacy returns bins are to be made available in each patient care area and regularly emptied by Pharmacy staff.   
  
Once items are no longer in use for the patient that they have been dispensed for, they are to be placed in the Pharmacy return bin.   
  
Stock in the Pharmacy return bin is not to be administered by nursing or midwifery unless it has been reviewed by a Pharmacist or Pharmacy Technician, and in the case of individually dispensed, it will be relabelled for the patient. Nursing staff may reuse imprest stock from the return bin once assessing that it is suitable for use. They may also return this to imprest stock.   
  
Medicines individually dispensed for a patient are transferred with them if treatment is ongoing at the time of their transfer between care areas within CHS.

**Principle 5**

Canberra Health Services is constantly moving towards medication administration processes that support a closed-loop medication management process.

**Rationale**

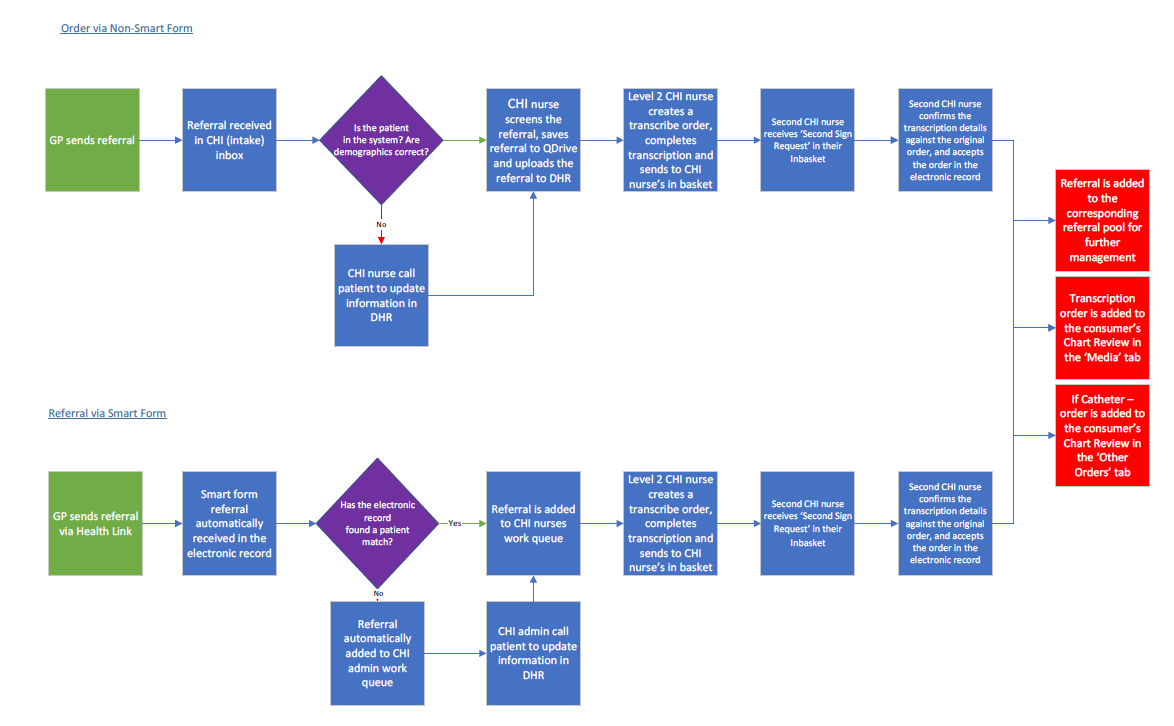
Information technology has been employed to enhance the accuracy of all medication management processes, including administration. Through the use of barcode medication administration, systems can be created whereby barcode verification is used to compare medicines administered to a patient against electronic orders that have been placed for them. In this way, the electronic medication management system can alert nurses to possible errors in patient selection or medicine selection.   
  
To facilitate the implementation of these processes, any manual system for medication administration should be applying principles that can easily be adapted to the electronic environment.

**Action**

Manual systems for medication administration are designed in a manner that would enable direct application of electronic solutions. This includes patient inclusive medication administration where medicines are dispensed at the bedside, or other area where medicines are administered from a patient specific receptacle.

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## Attachment 6: Registered Nurse Transcription workflow



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