# Policy and Procedures on the Administration of Medication

## DOCUMENT CONTROL

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<td>Sean Abbott, Head of Client Services</td>
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<tr>
<td>Bernadette O’Sullivan Head of Homes &amp; Community 2/Director of Nursing</td>
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## DOCUMENT REVIEW HISTORY

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1.0 Introduction

1.1 Cope Foundation is based in over 60 locations within Cork City and County.

1.2 Medications for individual clients are prescribed by his/her personal GP and dispensed by a Pharmacist.

1.3 On 1st May 2007, primary legislation was put in place by the Minister for Health & Children to provide for prescribing by nurse and midwives in Ireland. Legal regulations to support this practice include:


- Misuse of Drugs (Amendment) Regulations 2007, Statutory Instruments No. 200 of 2007,


1.4 This legislation, along with new rules, requirements and professional guidelines approved by An Bord Altranais provides for the implementation of prescriptive authority for suitably qualified nurses/midwives.

1.5 Nurse prescribing has been introduced into some areas of Cope Foundation. These areas will be listed in the Cope Foundation Policy and Guidelines to Support Nurse Prescribing.
2.0 Purpose of Policy

The purpose of this policy is to detail "best practice" in the administration, storage, ordering, receipt and return of medication. Local protocols will detail arrangements for the receipt and return of unused/out of date medication and the documentation of all such actions.

3.0 Terminology

3.1 The term medication(s) is used in this policy as the descriptor for medications or medical preparations utilised by registered nurses in the delivery of nursing interventions.

3.2 Any reference to medication(s) for the purpose of this policy implies any medically prescribed substance or medical preparation.

3.3 In this policy, the term "MP Chart/CR 21" refers only to the Client Medication Prescription (MP) Chart (CR 21).

4.0 Audit

4.1 The audit of "best practice" in the administration, storage, ordering receipt and return of medication is required and should be carried out at least quarterly or more frequently where indicated.

4.2 Audits should be carried out routinely and should detail both findings and actions.

4.3 In addition to internal audits, the dispensing pharmacy carries out audits in areas they supply.
## 5.0 List of abbreviations used by Registered Medical Practitioners when prescribing medications.

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Meaning</th>
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| B.D. Bis (In) Die | Twice daily.  
This usually means morning and evening. Always check times with Prescribing Medical Practitioner and ask him/her to write times on the client’s Medication Prescription Chart (MP Chart/CR 21) |
| T.D.S. Tere Die Sumendum | Three times daily.  
Always check times with Prescribing Medical Practitioner and ask him/her to write times on the client’s Chart |
| T.I.D. Ter (In) Die | Three times daily.  
Always check times with Prescribing Medical Practitioner and ask him/her to write times on the client’s Chart |
| Q.D.S. Q.I.D. Quater (In) Die | Four times daily.  
Always check times with Prescribing Medical Practitioner and ask him/her to write times on the client’s Chart |
| S.O.S. Si Opus Sit | If necessary (once only). |
| P.R.N. Pro Re Nata | PRN means as necessary/required.  
PRN medication must be administered strictly in accordance with the written instruction of the medical practitioner who has prescribed it. This instruction must include the purpose of the PRN medication and the circumstances when it must be used. The dosage to be administered initially, the frequency of the repeat dosage (i.e. 10 minutes) and the maximum dosage in 24 hours and the action that must be taken if the symptoms persist after the medication has been administered. |
| Nocte | At night.  
Always check actual time (2000 hrs or 2200 hrs) with Prescribing Medical Practitioner and ask him/her to write time on the client’s chart |
<p>| Mane | In the morning. |</p>
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<td>Always check actual time with Prescribing Medical Practitioner and ask him/her to write time on the client's chart</td>
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| **P.R.**  
  *Per Rectum* | By the rectum. |
| **P.V.**  
  *Per vagina* | By the vagina. |
| **I.M.**     | Intramuscularly. |
| **I.V.**     | Intravenously. |
### 6.0 Definition of terms employed in this Policy.

The following terms are used throughout this document in relation to medication preparation management.

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Administration</strong></td>
<td>To give an individual dose of medicinal product (tablet, capsule, liquid, injection) either to oneself or to a client via the appropriate route (oral, rectal, intramuscular).</td>
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<td><strong>Chart</strong></td>
<td>In this policy the term &quot;MP Chart/CR 21&quot; refers only to the Client Medication Prescription (MP) Chart.</td>
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<td><strong>Covert Administration</strong></td>
<td>Covert administration of medicines involves the administration of a medicine disguised in food or drink to a resident who resists it when given openly.</td>
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<td><strong>Controlled Drug</strong></td>
<td>For the purpose of this policy, controlled medications refer to MDA Schedule 2 and MDA Schedule 3 medications only (for a list of the more common MDA Schedule 2 and MDA Schedule 3 medications see Appendix 3).</td>
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<td><strong>Delegated Staff Member</strong></td>
<td>A Cope Foundation employee working in a specified setting who has been directed to administer medications to clients under his/her supervision.</td>
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<td><strong>Medical Preparation</strong></td>
<td>A substance which is sold under propriety designation and which may be used for the prevention or treatment of any human ailment, infirmity, injury or defect. Any other prophylactic, diagnostic or therapeutic substance, which may be used for the prevention or treatment of any human ailment, infirmity, injury or defect. Any drug or preparation intended to prevent pregnancy. Other preparation used for restoring, correcting or modifying physiological function in human beings (Health Act, 1947, No. 28, Section 65) Family Planning (Amendment) Act 1992 (No. 20, Section 7). (See Section 3.0 Terminology).</td>
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<tr>
<td><strong>Medication</strong></td>
<td>A substance which when taken into a tissue, organ or body system modifies its structure and function. (See Section 3.0 Terminology).</td>
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<td><strong>Medication errors</strong></td>
<td>Any preventable event that may cause or lead to inappropriate medication use or patient/client harm while the medication is in the control of the health care professional, patient/client encounter or consumer. These events may be associated with professional practice, health care products,</td>
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<tr>
<td>Term</td>
<td>procedures and systems. This includes prescribing; order communication; product labelling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use (National Coordinating Council for medication Error Reporting and Prevention, 1998). ¹</td>
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<td>Near Miss</td>
<td>Is an event or situation where the error does not reach the patient/service user and no injury results (e.g., incorrect dose is prescribed but is recognised and adjusted before the medication is administered). An Bord Altranais, 2007, p. 27)</td>
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<tr>
<td>Registered Nurse</td>
<td>A woman or man whose name is currently entered in the An Bord Altranais Register (Nurses Act, 1985)</td>
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<td>Registered Nurse Prescriber</td>
<td>A Nurse who is registered with An Bord Altranais as a Registered Nurse Prescriber (RNP) and has the authority from the Health Service provider who employs them to prescribe a range of medications within their scope of practice.</td>
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<tr>
<td>Pharmacist</td>
<td>A person keeping open shop for the dispensing or compounding of medications or for the sale of poisons under the Pharmacy Act, 1975 - 1977. It also includes a registered pharmaceutical chemist and a registered druggist (Misuse of Drugs Act, 1977).</td>
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<tr>
<td>Practitioner</td>
<td>Registered Medical Practitioner, Registered Dentist (Misuse of Drugs Regulation, 1988)</td>
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<tr>
<td>Prescription</td>
<td>A prescription issued by a registered medical practitioner for the medical treatment of an individual, by a registered dentist for the dental treatment of an individual (Misuse of Drugs Regulation, 1998)</td>
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<td>Self-Administration</td>
<td>The selection and use of a medication by clients to treat symptoms/conditions or illness. This may include the use of prescribed or over the counter medications or alternative medicines.</td>
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**Note:**
A Glossary of terms is available in “Guidance to Nurses and Midwives on Medication Management” (July 2007, An Bord Altranais)

¹ National Council for the Professional Development of Nursing and Midwifery (June, 2005) Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products, Dublin: National Council for the Professional Development of Nursing and Midwifery
7.0 Scope of policy

7.1 This policy applies to all Registered Nurses/delegated staff members charged with the responsibility of ordering, storing, dispensing and administration of medications.

7.2 This policy applies to Student Nurses who dispense and administer medications under the supervision of a Registered Nurse. The Registered Nurse retains accountability for the administration of medical products (An Bord Altranais, 2007, p.11)

7.3 This policy covers:
   a) Residential Services
   b) Day Services
   c) Short Breaks/Respite Services
   d) Home Support Services
   e) Community Settings.

7.4 This policy applies to Registered Nurses/Delegated Staff members who support clients to self-medicate/administer their own medication.

7.5 Recognising that Registered Nurses have a statutory responsibility in this regard, Cope Foundation’s policy complies with current An Bord Altranais requirements, while at the same time protecting all parties (clients, families and staff) in the implementation of a safe, practical, operational policy.

Administration of medication in community settings

7.6 The administration of medication in the community setting by staff other than nurses/nurse prescribers falls within the scope of this policy.

7.7 The administration of medication should in as far as reasonably practicable be carried out by staff who have completed the medication management course.

7.8 All aspects of this policy with reference to the administration of medication must be complied with.
The administration of medication in centres that provide short breaks to people we support.

7.9 The administration of medication in centres that provide short breaks must comply with this policy.

7.10 When a person is being admitted for a short break period, a current prescription is furnished every 6 months or at change of medication. A Cope Foundation drug administration record can be supplied by the short break centre to parent/guardian for completion by family GP on each admission and it is sent home with client at the end of each short break.

7.11 It is the responsibility of parent/guardian to keep the record up to date at all times. The record has to be reviewed and signed by the GP at six month intervals if not required previously.

7.12 Only medication as prescribed can be administered by the Nurse/ delegated staff member. All medications are supplied by the parent/guardian and returned at the end of each short break.

7.13 In the event of crisis/emergency admission all efforts will be made to gain the up to date prescription and medication. In situations where the admission occurs and the prescription and medication is not made available every effort will be made to gain sufficient information to enable the Manager/Person in charge to contact the prescribing General Practitioner. South Doc/out of hours GP service/GP on call can be contacted if there are concerns that cannot be addressed.

7.14 Protocols for the transfer of medication between short break and schools or day services, for example, should be drawn up locally.
8.0 Administration of Medication by Delegated Staff Members

8.1 In a number of Cope Foundation community homes the administration of medicines is delegated to care staff. It is Cope Foundation policy that delegated staff members working in community homes are required to undertake the training programme 'Responsible & Safe Medication Management'. This programme is on-going to meet the training needs of both current and new staff in safe medication management.

8.2 This 2 day programme is delivered by staff nurses who have undertaken specific training and will give designated staff the knowledge and skills required to competently take on the responsibility inherent to the role.

8.3 The programme is divided into 6 modules:
   1) Policy, role and responsibility
   2) Relevant legislation
   3) Medication
   4) Obtaining, storing and disposing of medication
   5) Reporting and recording practices
   6) Clinical skills in safe administration.
   Also included is training for administration of oral, eye/ear/nasal and topical medications. Both the theory examination and onsite assessments must be passed by participants.

8.4 The 'Responsible & Safe Medication Management' Training Programme for designated staff members requires updating every 2 years.

8.5 Designated staff members are responsible for their own practice with regard to medication management and must adhere to Cope Foundation's 'Policy & Procedures on the Administration of Medications'.
9.0 Staff self-administration of medication from the service supplies

9.1 On no account must any member of staff take for him or herself, or give to another staff member any medication from the service supplies.

9.2 Staff members must not bring medication for personal use into the workplace unless the medication is essential (e.g. inhaler). This medication must be stored in his/her personal locked locker. It must not be kept on the person, or stored in any of the organisation’s drugs storage systems. Access must be restricted to the staff member prescribed the medication.
10.0 Policy for medication prescriptions

10.1 Medications must be prescribed by registered Medical Practitioners / Dental Surgeons/Registered Nurse Prescribers (RNP) only.

10.2 In areas where the Registered Nurse Prescriber is permitted to prescribe medications it is the responsibility of each individual nurse working in that area to ensure that he/she is knowledgeable regarding the contents of the Cope Foundation Policy, Guidelines & Protocols to Support Nurse Prescribing. This policy applies to all Registered Nurse Prescribers whose names appear on the current register for Nurse Prescribers with An Bord Altranais.

10.3 The Registered Nurse Prescriber will use prescriptive authority in a safe, effective manner in accordance with the Collaborative Practice Agreement (CPA). Prescriptive practice extends only to those drugs normally used in the named clinical area, and of these, only for categories of medicinal products or named medicinal products contained on the CPA endorsed by the Cope Foundation Drugs and Therapeutics Committee and allowed under current legislation.

10.4 In all areas where there is a visiting Medical Practitioner or Registered Nurse Prescriber, medications prescribed must be clearly identified in black ink on the client's MP Chart/CR 21 (Appendix 2) stating:

i. Name of the person (in full) for whom the medication is prescribed.

ii. Client's Date of Birth

iii. The date of prescription.

iv. The name of the medication prescribed.

v. The dosage.

vi. The times of administration.

vii. The route of administration.

viii. The duration of treatment and stop date.

ix. The doctor's signature/Registered Nurse Prescriber's signature.
10.5 The client's MP Chart/CR 21 must be reviewed by the Medical Practitioner every 6 months. In the event that the prescribed medication is changed, cancelled or the therapy regime is completed then:

i. A line must be drawn through the prescribed medication on the client's MP Chart/CR 21.

ii. It must be dated and signed by the medical practitioner in order to give a clear indication that the medication regime is complete, has been changed or is cancelled.

10.6 In areas where there is no visiting Medical Practitioner, medications prescribed must be clearly identified on either:

- A registered Medical Practitioners prescription docket;
- A GMS prescription;
- A prescription written on a registered Medical Practitioner's headed paper.
- Medications that are being brought in by persons from home must be in current, clearly labelled containers as filled by his/her pharmacist. (See Appendix 1 i Letter to Parents/Guardians)

10.7 The Registered Nurse/delegated staff member must not accept written or verbal requests from families/guardians regarding the commencement or change in a client's medication regime.

10.8 Only registered Medical Practitioners/Registered Nurse Prescribers will discontinue medication prescriptions.

10.9 In the event of medications that are prescribed for a defined period (e.g. antibiotics) the prescription must indicate the duration of the prescription, for example: 1 week, 3 days, etc. A stop date must be entered into the client's MP Chart/CR 21.

10.10 Oxygen must be prescribed by a Registered Medical Practitioner. If used in Basic Life Support/Emergency situation, it must be charted in the client's MP Chart/CR 21 by a Medical Practitioner as soon as possible.
10.11 Where the Medical Practitioner is required, he/she must be requested to attend. Where it is not possible for the Medical Practitioner to attend, and the client is in need of immediate treatment, the medication may be prescribed by sending in the prescription by facsimile. A prescription for controlled drugs must adhere to the requirements of the Misuse of Drugs Acts of 1977 and 1984 and the Misuse of Drugs Regulations, 1988, 1993 and 2007. A prescription therefore must be handwritten in its entirety for it to be dispensed by a pharmacist and subsequently administered by a registered nurse.

10.12 In the instance where medications are prescribed by facsimile the following conditions apply:
   i. The original prescription must be provided by the Medical Practitioner and placed in the client’s file as soon as possible.
   ii. The facsimile must be placed in the client’s file.
   iii. The Medical Practitioner must update the client’s MP Chart/CR 21 and notes as applicable on his/her next visit. The Registered Nurse/Delegated staff member must inform the Clinical Nurse Manager on Duty.

10.13 Adherence to this policy must be ensured through systematic audit.

10.14 An Bord Altranais guidelines state the only acceptable time a **verbal or telephone order for medication** should be taken from a medical practitioner is in an emergency situation where there is an immediate unplanned client need.

10.15 A nurse accepting a verbal medication order should repeat the order to the medical practitioner for verification. The medical practitioner should repeat the medication order to a second nurse. This should be followed by both nurses confirming the medication order between them. A record of the verbal/telephone medication order should be documented in the client’s notes and Verbal/Telephone Medication Order (Appendix 6)
10.16 The Medical Practitioner is responsible for documenting the written order on the prescription sheet/medication administration record/medical notes as soon as possible within but not later than 72 hours after the order has been received.
11.0 Dispensing of Medications

11.1 The Registered Nurse/delegated staff member, family member or bona fide representative will bring the medications to the community setting and the Registered Nurse/delegated staff member will place it in the designated locked medication cupboard.

11.2 Medications dispensed in blister packs/medication pouches must have a typed label detailing:

i. Client name and location.
ii. Name of each medication contained in each blister/pouch.
iii. Strength/dosage of each capsule/tablet in the blister/pouch.
iv. Name of the dispensing Pharmacy.
v. Date of prescription.
vi. Date and time medication is to be administered.

11.3 Blister packs/medication pouches are used mainly for oral solid dosage medications (An Bord Altranais, 2007).

11.4 Reference resources must be readily accessible for the registered nurse to confirm prescribed medication in the blister pack or medication pouch with identifiable drug information, e.g. physical description of the medication (i.e. reg. oblong, or a colour photograph of the tablet, An Bord Altranais, 2007). The registered nurse is responsible for checking that the medications in the blister packs/medication pouches are correct and must place them in the medication press/trolley.

11.5 Registered Nurses must document each administration via blister pack / medication pouch in the same way as medications administered from the original dispensed container (i.e. it is not acceptable to document ð0800 hrs. blister pack/medication pouch given in client notes).
12.0 Prescription and administration of Stesolid®

12.1 A client who is prescribed PRN Stesolid must have a current MP Chart/CR 21 clearly stating:

i. The circumstances when it is to be used.

ii. The initial dosage.

iii. The timing of respective doses.

iv. The maximum dosage in a 24-hour period.

12.2 If a second dose of Stesolid® is prescribed, then the prescription must state the period of time after administration of the 1st dose in which the 2nd dose can be administered.

12.3 Stesolid must only be administered by:

i. Registered Nurse or Registered Medical Practitioner.

ii. Delegated staff members who have successfully completed a specific training programme on epilepsy and the administration of Stesolid to specific clients.

iii. Student nurses under the supervision of a Registered Nurse.
13.0 Prescription and administration of Buccal midazolam

13.1 Clients who are prescribed PRN Buccal midazolam must have the following information on their Medication Administration Record MP Chart/CR 21:

i. The circumstances when it is to be used.
ii. The initial dosage.
iii. The timing of respective doses.
iv. The maximum dosage in a 24-hour period.
v. Action to be taken if symptoms persist.

This information may also be contained in a protocol which has been placed in the client’s support plan.

13.2 Buccal midazolam must only be administered by:

i. A Registered Nurse or a Registered Medical practitioner.

ii. A delegated staff member who has completed training on the administration of Buccal midazolam.

iii. Student Nurses under the supervision of a Registered Nurse.
14.0 Storage of medications

14.1 All medications must be stored in a locked cupboard and in the appropriate conditions as indicated on the label or packaging of the medication or as advised by the Pharmacist. This includes all injectable preparations that are sensitive to light.

14.2 Some medications may require storage in a refrigerator. It is best practice that this refrigerator must not be used for any other purpose and must be kept locked. Daily temperature checks should be carried out and recorded. Such temperature recording should be in the range 2-8°C.

14.3 Cupboards and refrigerators must be large enough to store medications and must be kept clean and tidy. Refrigerators must be defrosted regularly (see manufacturer’s instructions).

14.4 All controlled medications (MDA Schedule 2 and MDA Schedule 3) will be stored in a separate, locked cupboard within the locked cupboard.

14.5 Clients who wish to self-medicate must be provided with a secure storage facility.

14.6 Mobile Medication Trolley’s must be secured to a wall when not in use. Emergency boxes should be locked.

14.7 The Registered Nurse/delegated staff member responsible for administering medications in an area will carry the medication keys on his/her person throughout his/her shift of duty.

14.8 Medication keys must not be attached to a key ring, which is used for general domestic purposes. Keys to the controlled medication press/trolley must always be kept in the custody of a Registered Nurse and no other medication keys must be kept on the controlled medication key ring.

14.9 Lost or mislaid medication keys must be reported to the Clinical Nurse Manager/person in charge immediately. In the event of the medication keys not being found the maintenance officer must be contacted to change the locks. The staff member involved must complete an Incident Form (CR 53), and it must be dated and signed by the Clinical Nurse Manager/person-in-charge and the Registered Nurse/delegated staff member involved in the incident (See
Appendix 5). An evaluation of this incident must take place to ensure all efforts are made to reduce the possibility of reoccurrence.

14.10 In any area of the service where there are oxygen cylinders, these will be kept in a clearly identified "NO SMOKING" area. A "NO SMOKING" sign must be clearly displayed beside the cylinder. Each cylinder must be checked at least once a month; however, the frequency of these checks must reflect the frequency of use. A record of this check must be maintained and empty cylinders are to be returned to suppliers immediately.

14.11 Medical Oxygen cylinders have a collar label with the product name and fill and expiry date of the contents. The label should be checked prior to administration. Portable Medical oxygen cylinders have a sticker on the body of the cylinder; this should be checked for the fill and expiry date prior to administration.

14.12 Medications must never be removed from its original container until it is being administered (must not be transferred from one container to another).

   i. Blister packs/medication pouches must never be cut down to size.
   ii. Tops of boxes and or packages that accompany medications must not be defaced or torn off.

Storage of medications during staff accompanied vacations:

14.13 Place the required amount of client medication in a locked box. This box is placed in a locked press/safe area upon arrival at destination where possible. The Registered Nurse/delegated staff member must retain possession of keys to both box and cupboard where applicable.
15.0 Administration of Medications

Administration involves assisting clients in the ingestion, application, inhalation, injection, insertion and self-management of medications according to the direction of the prescribing medical practitioner.

15.1 Only Registered Nurses, Student Nurses under supervision and delegated staff members in designated areas must administer medications. The person who administers the medication must record its administration.

15.2 The Registered Nurse must know the therapeutic uses, normal dosage, side effects, precautions and contra-indications of the medications that they are administering.

15.3 Staff members who administer medications must know the reason why a client is receiving a particular medication and its potential side effects.

15.4 Only Registered Nurses, Registered Medical Practitioners or Student Nurses under the direct supervision of a Registered Nurse are permitted to administer parenteral injections (Intra-muscular, subcutaneous or intradermal).

15.5 Medication may be withheld from a client where, in the professional judgement of the Registered Nurse, there may be a clinical indication which contradicts the administration of the medication.

15.6 It will be necessary to consult with a Medical Practitioner, Pharmacist or Clinical Nurse Manager with regards to withholding medication.

15.7 Accurate and contemporaneous documentation should be made for any medicinal product withheld.

15.8 Should a medication need preparation before it is to be administered to a client, the same Registered Nurse/delegated staff member must perform the complete process.
15.9 The Registered Nurse/delegated staff member who removes the medication from the container/package/blister pack/pouch must be the person who administers the medication to the client.

15.10 The person administering the medication must check the medication prescription to confirm:

i. That the date of prescription and signature of the Medical Practitioner/Registered Nurse Prescriber is present;

ii. Name of the person (in full) that the medication is to be given to;

iii. Date of birth of client.

iv. The medication that is to be given;

v. The dosage to be given;

vi. The route that it is to be given by;

vii. The time of administration.

viii. Check the expiry date of the medication to be administered.

ix. If administering IM injections the batch number and expiry date must be checked and documented.

15.11 The person administering the medication must ensure that it is given to the person for whom it is prescribed.

15.12 Medications must only be administered from clearly labelled containers/pouches.

15.13 Medications must always be administered from their original dispensing container/package/blister pack/pouch.

15.14 It is preferable to handle medications minimally when administering them.

15.15 The Registered Nurse/delegated staff member must pay full attention to the preparation, administration and recording of the medication í no other activity is to be engaged in simultaneously.

15.16 If a client is unable to take a prescribed medication in tablet form, without the prescribed tablet being crushed, the
Registered Nurse must first consult with the Registered Medical Practitioner and the Pharmacist to discuss alternatives for the client.

15.17 If the GP agrees that this tablet may be crushed, this must be stated on the Prescription Chart.

15.18 In the event of spillages of medical products, the Registered Nurse/delegated staff member must:
- Clean up any spillages as soon as possible.
- Inform the senior Clinical Nurse Manager on duty of the spillage.
- Complete an Incident Form (CR 53) and send to the Safety Officer.

15.19 In the event of medications being mislaid/lost the Registered nurse/delegated staff member must:
   i. Search the area where the item was last seen. This action must also be taken in the event of a client spitting, removing or hiding an administered medication.
   ii. Place any spoiled medications in the Spoiled medications container in the medication press.
   iii. Make a clear and accurate written account using the Incident Form (CR 53) of the medications misplaced, the actions taken and the outcome of the event.

15.20 If a client vomits or regurgitates following the administration of his/her prescribed oral medication, the Registered Nurse/delegated staff member must:
   i. Note the time of medication administration
   ii. Note the time of vomiting/regurgitation.
   iii. If one hour has elapsed since the medication has been administered no action is necessary. If in doubt check with the medical practitioner.
   iv. If less than one hour has elapsed, the medical practitioner must be contacted. He/she may advise that the medication is to be re-administered. A clear and accurate account of the information given and the actions taken must be recorded in the client's notes.
16.0 Administration of medications via enteral tubes.

17.0 Self-Administration of Medications by Clients

Self-administration of medicines involves the independent use of a medication(s) by a client in accordance with his/her wishes and preferences.

17.1 Cope Foundation is committed to supporting and facilitating opportunities to individual clients who express a desire to administer his/her own medicines.

17.2 Individual clients who wish to administer his/her own medication must be assessed as able to do so without compromising his/her safety or that of other clients.

17.3 An inter-disciplinary approach must be adopted to determine the viability of the client to self-medicate, and the conditions under which it takes place. This will involve assessment of capacity, competence, cognitive function and manual dexterity. An individual risk assessment must be completed to inform the decision-making process at all times.

17.4 This Self-Medication Assessment will establish client’s level of ability and any risk, resources, supervision and supports required to support his/her goal to self-medicate (Appendix 7).

17.5 The differing levels of administrative support a client may require are:

i. Partial Self-Administration is if the client is only able to self-administer some medicines. For example, the client may be able to self-administer his/her oral medicines but not any creams or ointment, or he/she may be able to use his/her inhalers, but may require assistance with oral medicines.

ii. Client administers the medicines, with the Nurse/Designated staff member providing supervision

iii. Client administers the medicines using augmentative communication tools or adaptive devices, with Nurse/Designated staff member providing supervision and/or assistance
iv. Client administers the medicines independently and/or utilises augmentative communication tools or adaptive devices (without any supervision).

17.6 The client must be monitored over an agreed period of time and must demonstrate an ability to medicate with accuracy.

17.7 The level of support/supervision required by the client regarding drug administration must be documented in his/her Care Plan. The self-administration plan will be evaluated and reviewed at identified timeframes or as clients’ needs and circumstances change e.g. change in medical needs.

17.8 Appropriate, safe and secure storage of medicines for self-administration should be based on an individual risk assessment and access limited to the client and/or nurse/designated staff member. For example, secure container in the communal drug press, secure locker in day service or bedroom.

17.9 To comply with An Bord Altranais guidelines the practice of self-administration must be audited at regular intervals. (Guidance to Nurses & Midwives on Medication, July 2007).
18.0 Administration of PRN Medications

Definition: "When required" (PRN) medication is administered when the client presents with a defined intermittent or short-term condition i.e. not given as a regular daily dose or at specific times e.g. medication rounds.²

18.1 When a client is prescribed a PRN medication, the evidence supporting the need for this prescribed medication should be identified in the care plan and medical records (which demonstrates that the client's intermittent or short term condition has been assessed and reviewed by the medical practitioner). When the uses of PRN medications are considered, they are part of the clients integrated care plan and outcomes should be evaluated on an on-going basis.

18.2 When PRN medication is prescribed for a client, it is essential that clear instructions are received from the Medical Practitioner/Nurse Prescriber describing the circumstances when PRN medication should be given (i.e. signs, symptoms), the medication to be given, dose to be given, time interval between doses, maximum dose that can be given in 24 hours. This information must be documented.

18.3 The Medical Practitioner/Nurse Prescriber must check what regular medication the client may be taking daily before prescribing PRN medication, to safe guard the client from receiving excessive amounts of similar medications or a combination of medications that are contra indicated.

18.4 The Medical Practitioner must review PRN medications every 6 months, initial and date on a client's medication chart and record in client's medical notes. The medical Practitioner must review and rewrite all a client's PRN medications every 12 months in the client medication chart/medical notes.

18.5 PRN medications are neither prescribed nor dispensed to cover holiday periods while the client is at home. A client who is going on holidays should have their needs reviewed in a timely manner and with written instructions from their Medical Practitioner to cover the specific holiday period.

² ("Good Practice guidance medication prescribed to be taken ‘when required’ (PRN) in Care Homes” Copeland, Cumbria Clinical Commissioning Group, NHS)
18.6 Should the PRN medication not have the desired effect the prescribing Medical Practitioner/Nurse Prescriber where appropriate, should be contacted. In the event of out of hours, the out of hours GP service/South Doc/Doctor on call service should be contacted. The prescriber will authorise any changes which should be documented in the client’s medication chart/medical notes.

18.7 Clients prescribed psychotropic medication must have at least a 6 monthly review with a psychiatrist or more frequently where requested by a psychiatrist.

18.8 PRN medication(s) may fall into any drug classification, and may include but are not limited to the following:

* Analgesics (medications used for pain – e.g. Paracetamol)
* Anti-inflammatory drugs (medications used for inflammation and pain – e.g. Ibuprofen)
* Gastrointestinal tract drugs (medications used for heartburn, constipation, etc., i.e. Senna or Pepcid)
* Sedatives or hypnotic (medications used for sleep, e.g. Loazepine)

Administration of PRN Medication

18.9 PRN medication must be administered strictly in accordance with the written instruction of the medical practitioner/nurse prescriber who has prescribed it.

18.10 All PRN prescription must include the following criteria:
   i. The date of prescription and signature of the medical practitioner/nurse prescriber is present
   ii. Name of the client (in full).
   iii. Date of birth of client
   iv. Name of medication that is to be given
   v. The dosage to be given
   vi. The route that it is to be given by
   vii. The time of administration
   viii. The minimum time intervals between doses
   ix. Check expiry date of the medication to be administered
   x. The purpose of the PRN medication
   xi. The circumstances when it should be used
   xii. The total daily dose of the clients regular and PRN medication, so as to not to exceed the maximum (BNF) recommended dose
   xiii. The maximum dose in 24 hours
   xiv. Action to be taken if symptoms persist
18.11 All PRN medications administered must be recorded in the client's CR23 nursing notes, and signed and dated in the client's medication chart.

18.12 Clients must be closely monitored following the administration of PRN medication to assess whether the medication has had the desired effect.

18.13 If a PRN medication is being administered regularly/frequently by Registered Nurses/Delegated Staff Member this must be brought to the attention of the Medical Practitioner as it may be an indication that a review of that client's regular medication is required.

18.14 Where PRN psychotropic medications are used they must be part of the client's agreed pro-active strategy in the management of escalating deterioration of mental health, in accordance with instructions from a psychiatrist.

18.15 In areas where a nurse is not available to administer PRN medication the delegated person must contact a staff nurse/nurse manager in another area before administering this medication. A local protocol will give guidance as to the area and/or person to contact.

18.16 The responsibility for the safe administration of PRN medication (s) lies with the person who administers it.

18.17 Excessive stocks of PRN medication needs to be avoided by only stocking essential medications as identified in PRN charts and care plans. Check stock before ordering.

18.18 Shared PRN medications (e.g. Paracetamol) should be limited to a central stock in each area. This stock is recorded in a special stock log held on the unit.

18.19 PRN medication should be supplied in its original package as this enables the expiry date to be checked and reduces unnecessary medication waste.

18.20 If PRN medication is offered and refused by a client, then staff must document this in the clients' Medical Chart/CR23 Nursing Notes.
19.0 Controlled Medications

19.1 A controlled medication is one whose use, storage and distribution are tightly controlled by the Misuse of Drugs Acts 1977, 1984 and the Misuse of Drugs Regulations 1988 to 1993 and 2007. The legal term for these drugs is the abbreviation 'MDA' followed by the appropriate Drug Schedule Number (1 to 5). (See Appendix 4).

19.2 For the purpose of this policy, controlled medications refer to MDA Schedule 2 and 3 medications only (for a list of the more common MDA Schedule 2 and 3 medications see Appendix 3).

19.3 Any MDA Schedule 2 or 3 medications may be administered by, or in accordance with, the direction of a Medical Practitioner. It is unlawful for a Medical Practitioner to issue, or for a pharmacist to dispense, a prescription for a MDA Schedule 2 or 3 medication unless it complies with the following requirements:

i. The prescriber must be satisfied as to the identity of the client and check the client's name and date of birth.

ii. The prescription must:

a) Be in black ink (or otherwise indelible) and be signed by the Practitioner issuing it with her/his usual signature and dated by her/him.

a. Clearly indicate the name of the Medical Practitioner issuing it and, except in the case of a General Medical Services prescription (GMS), specify her/his address.

b. Specify (in the prescriber's handwriting (the name and address of the person for whose treatment it is issued (in the case of a client in Cope Foundation or resident in Cope Foundation), the address of the client need not be specified, provided the prescription is written in the client's case notes).

c. Specify a telephone number at which the prescriber may be contacted.
d.
e. Specify (in the prescriber’s handwriting):

- The dose to be taken,
- The form, in the case of medications,
- The strength (when appropriate) and in both words and figures, either the total quantity of the medication or Medical Preparation or the number of dosage units to be supplied.
- Route.

19.4 The Clinical Nurse Manager in charge of the area may be supplied with a controlled medication, solely for the purpose of administration to a client in that area, in accordance with the directions of a registered Medical Practitioner or dentist.

19.5 On return to the relevant area, the Registered Nurse must transfer the controlled medication to the controlled medication cupboard. In relation to MDA Schedule 2 medications, the transfer will be witnessed by a second person (It is desirable that this is a Registered Nurse), who will also confirm the identity of the person that the medication is prescribed for and the amount present. A record of this will be made in the appropriate controlled medication book on the unit and both staff members will sign this.

19.6 All controlled medications (MDA Schedule 2 and MDA Schedule 3) will be stored in a separate, locked cupboard within a cupboard.

19.7 The Registered Nurse responsible for administering medications must carry the medication cupboard keys on his or her person at all times. The keys to the controlled medication cupboard must be kept separately on its own keyring.
20.0 Administration of controlled medications

20.1 When a MDA Schedule 2 controlled medication is administered, the following procedure applies:

i. MDA Schedule 2 controlled medication is administered by a Registered Nurse who conducts the procedure (including checking, preparation, administration and documentation) and a witness, preferably also a Registered Nurse, who observes the complete process.

ii. The prescription must be read carefully and the date and doctor’s signature checked.

iii. The time of last administration must be checked.

iv. The controlled medication required must be selected and its label checked to ensure it corresponds with the prescription.

v. The amount of the controlled medication present must be checked to ensure that the balance corresponds with the balance recorded as being supplied in the controlled medication book.

vi. The controlled medication must be prepared for administration by a Registered Nurse in the presence of the witness who must verify the prescription, the controlled medication and its expiry date, the calculation (if any), the measured dose, the name of the person receiving it and the route of administration.

vii. The controlled medication must be taken to the person for whom it is prescribed and administered in the presence of the witness.

viii. The details must then be entered in the controlled medication book, together with the signatures of the person who has administered it and the witness. N.B. the book must be signed following administration of the controlled medication.
ix. A prescription is incorrect if the doctor does not specify the total number of doses of a controlled medication that are to be administered, and in this case the doctor must be contacted to amend the prescription before administration.

x. Any spillage of a controlled medication must be clearly documented and signed by the person administering the medication, and their signature witnessed in the controlled medication book. An Incident Form (CR 53) must be completed and sent to the Safety Officer.

xi. Should the amount of controlled medication present not equate to the amount that must be present according to the controlled medication book, the Clinical Nurse Manager on duty must be contacted and informed. An Incident Form (CR 53) must be completed and sent to the Safety Officer. The Nurse Manager must inform the Director of Nursing.

20.2 Community care involving MDA Schedule 2 drugs.
Registered Nurses must follow the guidelines given in the An Bord Altranais Guidance to Nurses and Midwives on Medication Management, July 2007, p. 24).
21.0 The procedure to follow where a client refuses to take their prescribed medications/medications.

21.1 Where a client refuses to take his/her prescribed medications the delegated person/staff nurse should offer the medications again **2 further times at 15 minute intervals**. If after reasonable encouragement, the client does not take his/her medication this refusal must be noted in their notes and in his/her MP Chart/CR 21 and advice obtained from a medical practitioner as soon as possible. Any reason(s) for refusal must also be documented. This record must be dated and signed by the Registered Nurse/delegated staff member involved. The medication which has been refused must not be transferred back into its original container; it must be stored in a marked container with the stock to be returned to the supplying Pharmacy.

21.2 If a client attending on a daily basis refuses to take his/her medication a family member/guardian must be informed and **this must be** documented in the client’s notes.

21.3 Where persistent refusals occur, or where administration poses a difficulty, this must be addressed within a case review. All relevant people must be present at this review, where an agreed plan of care must be drawn up to address the problem.
22.0 Covert Administration of Medications

When Medicine may be given in food

22.1 Crushing medication and/or mixing medicines with food or drink to make it more palatable or easier to swallow when the client has consented to this - does not constitute covert administration of medications.

22.2 Crushing medication and/or mixing medicines with food or drink for clients unaware they are receiving medicines because he/she lack the capacity to consent or withhold consent, does not constitute covert administration of medicines.

22.3 The suitability of the medicine to be given in this way must be checked with the Registered Medical Practitioner/Pharmacist and documented in the client's care plan/to be kept with the medication prescription chart.

22.4 Clients receiving medication administered in food or drink must be supervised until the medicine has been consumed.

Procedure to be followed where medications are administered covertly to clients

Definition: "Covert administration of medicines involves the administration of a medicine disguised in food or drink to a resident who resists it when given openly."

22.5 Medicines should not be administered to a client without his/her knowledge (covert administration) if the client has the capacity to make decisions about his/her treatment and care.

22.6 Cope Foundation recognises the right of individual clients to refuse to take medication. However there are certain circumstances in which covert medication may be necessary or appropriate, that is, in the case of clients who actively refuse medication but who are judged not to have the capacity to understand the consequences of his/her refusal, or to prevent clients missing out on essential treatment.

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3 (NHS Oxfordshire Clinical Commissioning Group 2013).
22.7 In such circumstances and in the absence of informed consent, a case review is necessary to discuss covert administration of medication if:
   i. All attempts at conventional methods of administration of medication have been unsuccessful
   ii. The client to receive the medication cannot or will not give consent
   iii. It may be necessary to save life
   iv. It may be necessary to ensure the improvement and/or maintenance of the client's physical well-being
   v. It may be necessary to ensure improvement and/or maintenance of the client's mental well-being
   vi. It may be necessary to ensure safety of others.
      - The case review should include: GP/psychiatrist, manager, family and any other members of the multi-disciplinary team if required

22.8 The decision to administer medication covertly should not be considered routine but as a last resort, and should be client specific and should be reviewed on a regular basis (at least 6 monthly intervals). Any decision to do so be must be reached after discussion with Registered Medical Practitioner, Clinical Nurse Manager, Registered Nurses, carers, client's family and/or advocate (or after case review).

22.9 The covert administration of medicine must be documented in the client's Medication Administration Chart/ CR 23 Nursing Notes/CR 19 Medical Notes.

22.10 The method of administration of medicines should be agreed with the pharmacist, on whether a particular medicine can be given with food or drink, and documented in the client's Medication Administration Chart/ CR23 Nursing Notes/Care Plan.

22.11 Clients receiving medication administered covertly in his/her food must be supervised until medication is consumed.
23.0 **Procedure to follow in the event of an accident with medications (medication errors/near misses)**

23.1 A medication error may involve the:
- administration of incorrect medication,
- administration of an incorrect dose,
- administration at incorrect time,
- omission of the administration of a prescribed medication,
- administration of a medication to the incorrect client,
- administration of out of date medication,
- Administration by incorrect route.

23.2 **All errors/near misses must be reported immediately to the Clinical Nurse Manager on duty and to the relevant Medical Practitioner.**

23.3 The client must be observed closely and any Medical advice given must be followed.

23.4 The incident must be documented on an **Incident Form (CR 53)** and this must be sent to the Clinical Nurse Manager/Manager of the Unit/Area, who in turn must send this to the Safety Officer. The purpose of reporting of errors/near misses is to learn about their causes, improve the system for the administration of medications and thereby improve the quality of service and the well-being of the client.

23.5 In the case of day attendees, the client's family must be contacted and informed of the situation and any action that may be required at home.

23.6 In the event that prescription and medication containers/bottles do not match, the Registered Nurse/delegated staff member must withhold the medication and immediately request either:
   i. The prescribing medical practitioner to re-write the prescription
   ii. The pharmacist to dispense the medication according the medical practitioners prescription.
   iii. Inform the Clinical Nurse Manager on duty.
24.0 **Medications that must be returned to the Dispensing Pharmacy**

24.1 Unused medications must be returned to the Dispensing Pharmacy.

24.2 Spoilt medications must be returned to the dispensing Pharmacy for safe disposal.

24.3 Staff must check expiry dates of medications on a weekly basis and return unused and out-of-date medications.

24.4 All medications returned to a dispensing Pharmacy must be recorded and signed for in the returns recording sheet supplied by the pharmacist.

**Note – USE OF OUT OF DATE MEDICATION IS AN OFFENCE.**
25.0 Adverse reactions to medications

25.1 An adverse medical reaction is a response to medication that is noxious and unintended and occurs at doses normally used in man for prophylaxis, diagnosis or therapy of diseases or for the restoration, correction or modification of physiological function (2001/83/EC).

Guidelines to identify Adverse Drug Reactions (Adapted from World Health Organisation (WHO) 2008).

1a) Should any adverse reaction be noted in a client’s condition following administration of any medication it must immediately be reported to the relevant medical practitioner to seek further advice and guidance. The senior clinical nurse manager on duty must also be informed.

1b) Establish that the medical preparation prescribed is the medication received and taken by the correct client in the correct dosage, at the correct time, and in the form prescribed.

1c) Ascertain that the suspected adverse medication reaction signs and symptoms were not present prior to administration of the medication.

1d) An accurate record of the suspected adverse medication reaction and actions taken must be recorded in the client’s notes. The client’s parents/guardians must be informed.
26.0 Recording and administration of medications.

26.1 Recording is an integral part of the Administration of medications. Cope Foundation uses Medication Administration Prescription Charts (client MP Chart/CR 21) as part of this policy (See Appendix 2).

26.2 When a medication is administered, the Registered Nurse / delegated staff must detail the time given, the date and his/her initials on the relevant clients MP Chart/CR 21. When supervising a Student Nurse in the administration of medications, the Registered Nurse must clearly countersign the signature of the Student Nurse.

   a) In the event of the Registered Nurse/Delegated staff making an error on the client's MP Chart/CR 21, they must cross out the error once - then initial and date it.

   b) Medications must never be recorded prior to administration. The Registered Nurse/delegated staff member's signature establishes accountability for medication administration.

26.3 When PRN medications are administered, the dosage, reason for administration and effect of the medication on the client must also be documented in that client's notes.

26.4 A record of known medication allergies must be clearly visible on the client's file (with a red triangle on the outside) and on his/her MP Chart/CR 21. There is a mutual responsibility on Registered Nurses/Delegated Staff to inform parents/guardians of any allergies.

26.5 Each area must hold a current list of signatures and initials for each registered nurse/delegated staff.

26.6 The responsibility for documenting a client's medication in the client's MP Chart/CR 21 is the registered medical practitioner/nurse prescriber.

27.0 Alternative medications (Vitamin supplements / homeopathic medications and essential oils)
27.1 There are occasions where clients will bring alternative medications from home. It is essential that prior to administration of these medications the registered nurse/delegated staff member receives a note from the person's Medical Practitioner confirming the suitability of this treatment.

27.2 Alternative medications received from family members of clients must state on the container/packet/box:

i. Client's name.
ii. Name of alternative medication.
iii. Dosage to be given.
iv. Route to be used.
v. Time of administration.
vi. Expiry date.
28.0 The administration of over the counter Medications (i.e. items purchased without prescription)

28.1 Medications, including for example: Panadol, Paracetamol, Calpol, cough mixtures and cold remedies must be prescribed.

28.2 It is very important to ensure that the recommended daily dose of these medicines is not exceeded and that close monitoring of these medications takes place (including any use at home or in other settings) prior to their administration.

28.3 Where clients use these medications on a regular basis a review with the person's Medical Practitioner must occur.

28.4 For this reason it is imperative the dosage is closely monitored through effective communication between all parties involved in administering such medication (i.e. staff in day/residential services and the client's family).

29.0 General Notes

Each area must have the following documentation for consultation:
- MIMS
- Resource book on Medications
- “Guidance to Nurses and Midwives on Medication Management” (July 2007, An Bord Altranais)

This policy will be reviewed annually. The next review of this policy is due in May 2015.

Local area/residence specific protocols/procedures maybe developed but at all times must adhere to this Policy.
30.0 References:


British National Formulary (BNF) British Medical Association, BMJ Publishing Group Ltd or PS publishing, London. This is a joint bi-annual publication of the BMA and Royal Pharmaceutical Society of Great Britain (www.bnf.org).


National Council for the Professional Development of Nursing and Midwifery (June, 2005) Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products, Dublin: National Council for the Professional Development of Nursing and Midwifery
Dear Parent/Guardian,

To ensure the safe administration of medications to your son/daughter while attending Cope Foundation, the following guidelines must be adhered to:

1) All medications supplied by you must be in a current, clearly labelled container, filled by a pharmacist.

2) Staff at the centre/school must be informed of any changes to medications and a new, current prescription for the medication change must be supplied to the centre.

3) Cope Foundation staff must be informed if your son/daughter has had any known allergies to any medications.

We look forward to your co-operation in this matter.

Yours sincerely

Bernie O’Sullivan
Head of Homes & Community 2/
Director of Nursing

12 May 2014
Appendix 1(a) – Letter to Parents/Guardians re short break.

A letter to parents/guardians whose relative avails of short break should be sent annually or more frequently if needed

Date: _______

Dear Parent/Guardian

We are delighted to welcome ________to stay with us in ____________.

So that we can provide the best service to ________during his/her stay with us we require the following:

- If your son/daughter/next of kin is prescribed medication(s), the prescription supplied or on file must be up to date.

- All prescriptions must be within a six month period after which time a new prescription must be furnished to us.

- The medication prescribed must be sent in to us in the original packaging/blister pack as dispensed by your pharmacist.

- Please find enclosed the Cope Foundation Administration Record. Your GP must write in any prescribed medications and review every 6 months or sooner if there are any changes to medications.

- We are unable to administer analgesics, for example paracetamol, cough bottles, multivitamins, unless these have been prescribed by the Doctor and listed on the prescription. Please advise us of any allergy that your son/daughter/next of kin may have.

Failure to comply with this request will cause your short break allocation to be delayed until the above can be processed. We are happy to discuss/advise on any concerns you may have in relation to the prescription and supply of medication.

Yours sincerely

Nurse Manager/Person in Charge
Appendix 2 – Client Medication Prescription Chart(s) – MP Chart/CR 21’s

1) CR.21 Medication Prescription Chart ï Short Term

2) CR.21 Medication Prescription Chart ï Long Term

3) Cope Foundation - Medication Prescription Chart (PRN medications, Short Term medications)

Note:

In centres where medication administration records are supplied by individual dispensing pharmacies, these differ in presentation to the above, for example MARS recording sheets.
<table>
<thead>
<tr>
<th>Drug Approved Name</th>
<th>Route</th>
<th>Start Date</th>
<th>Stop Date</th>
<th>Date of Administration</th>
<th>DOCTOR:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use approved names and BLOCK CAPITALS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Discontinue a Drug by drawing a line</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NURSE:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Check entries to avoid omissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If a Drug is not given please enter &quot;x&quot; in the appropriate box.</td>
</tr>
</tbody>
</table>
### Appendix 3 - The more common MDA Schedule 2 & MDA Schedule 3 Medications

#### Common MDA Schedule 2 Medications

<table>
<thead>
<tr>
<th>Class of Controlled medication</th>
<th>Proprietary Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alfentanil</td>
<td>Rapifen</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>Temgesic</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td></td>
</tr>
<tr>
<td>Dexamphetamine</td>
<td>Duxedrine</td>
</tr>
<tr>
<td>Dextromoramide</td>
<td>Palfium</td>
</tr>
<tr>
<td>Dihydrocodeine</td>
<td>DF118, DHC Continus</td>
</tr>
<tr>
<td>Dipipanone</td>
<td>Diconal</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Sublimaze</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Tussionex</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Dilaudid</td>
</tr>
<tr>
<td>Levorphanol</td>
<td>Dromoran</td>
</tr>
<tr>
<td>Medicinal Opium (this includes Papaveretum and Opium Tincture BP)</td>
<td>Omnopon</td>
</tr>
<tr>
<td>Methadone</td>
<td>Physetone</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Ritalin</td>
</tr>
<tr>
<td>Morphine</td>
<td>Cyclimorph, Morstel SR, MST Continus, Oramorph Conc., Sevredol Cesamet</td>
</tr>
<tr>
<td>Nabilone</td>
<td>Operidene</td>
</tr>
<tr>
<td>Pethidine</td>
<td>Seconal, Tuinal</td>
</tr>
<tr>
<td>Pholocodine</td>
<td>Sufentanil</td>
</tr>
<tr>
<td>Phenoperidine</td>
<td></td>
</tr>
<tr>
<td>Quinalbarbitone</td>
<td></td>
</tr>
<tr>
<td>Sufentanil</td>
<td></td>
</tr>
<tr>
<td>Class of Controlled Medication</td>
<td>Proprietary Products</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Amylobarbitone</td>
<td>Amytal, Sodium Amytal</td>
</tr>
<tr>
<td>Butobarbitone</td>
<td>Soneryl</td>
</tr>
<tr>
<td>Cyclobarbitone</td>
<td>Phanodorm</td>
</tr>
<tr>
<td>Diethylpropion</td>
<td>Apisate, Tenuate Dospa</td>
</tr>
<tr>
<td>Flunitrazepam</td>
<td>Rohypnol</td>
</tr>
<tr>
<td>Mazindol</td>
<td>Teronac</td>
</tr>
<tr>
<td>Meprobamate</td>
<td>Equagesic, Equanil</td>
</tr>
<tr>
<td>Methylphenobarbitone</td>
<td>Prominal 200mg</td>
</tr>
<tr>
<td>Methohexitone</td>
<td>Brietal</td>
</tr>
<tr>
<td>Pentoxocine</td>
<td>Fortral, Fortagesic</td>
</tr>
<tr>
<td>Pentobarbitone</td>
<td>Gardenal Sodium 200mg</td>
</tr>
<tr>
<td>Phenobarbitone</td>
<td>Duromine, Ionamin</td>
</tr>
<tr>
<td>Phentermine</td>
<td>Euhypnos, Normison, Nortem, Tenox.</td>
</tr>
</tbody>
</table>
Appendix 4 - Schedule of Controlled Medicinal Products

MDA Schedule 1
A special license is required for any activity in respect of these drugs. In practice, such activities are strictly limited to scientific research or forensic analysis. Examples of these drugs are: cannabis, coca leaf, raw opium and the major hallucinogenic drugs (LSD, Mescaline, and Psilocin).

MDA Schedule 2
A license is required for the import and export of these drugs and those entitled to produce, supply or possess them are listed. Possession without an appropriate authority is an offence. A pharmacist may supply to a patient only on the authority of a prescription written in the prescribed form. Record-keeping requirements (including MDA register) apply in full. Destruction must be witnessed and safe custody maintained. Examples of Schedule 2 drugs are opiates (morphine and heroin), amphetamines and synthetic narcotics (pethidine, methadone, hydrocodone).

MDA Schedule 3
Less strict controls apply to this schedule of drugs. Record keeping requirements in a MDA register does not apply. Destruction of the drug does not need to be witnessed. The safe custody provisions are applicable to these drugs as are the controlled drug prescription writing requirements. Most barbiturates, some potent analgesics, minor stimulants and two benzodiazepines – flunitrazepam and temazepam – are examples.

MDA Schedule 4
Control of these drugs is minimal and in practice they should be supplied in accordance with the Medicinal Products (Prescription and Control of Supply) Regulations, 2003. Record keeping in a controlled drugs register, the retention of invoices and the safe custody regulations do not pertain to drugs in this schedule. Most benzodiazepines, phenobarbitone, methylphenobarbitone preparations containing less than 100mg and Selegiline are examples.

MDA Schedule 5
This schedule lists medicinal products exempt from most restrictions under the regulations. Invoices regarding these products must be retained for two years. The list includes:

a) Preparations (not injections) containing codeine, nicocodine, nicodidocidine, norcodeine, acetyldihydrocodeine,
ethylmorphine pholcodine mixed with other substances and containing less that 100mg per dosage unit or not more than 2.5% in undivided preparations.

b) Preparations of dihydrocodeine (not being injections) containing not more than 10mg per dosage unit of dihydrocodeine as base and, in the case of undivided preparations, not more than 1.5% as base.

c) Preparations of cocaine containing not more than 0.1% calculated as cocaine base.

d) Preparations of medicinal opium or morphine, containing not more than 0.2% as calculated as anhydrous morphine base.

e) Preparations of diphenoxylate containing not more than 2.5mg of diphenoxylate calculated as base and a quantity of atropine sulphate equivalent to at least 1% of the dose of diphenoxylate (e.g. Lomotil).

f) Preparations for oral administration containing not more than 135mg of dextropropoxyphene (e.g. Distalgesic, Doloxene Co.).

“Guidance to Nurses and Midwives on Medication Management” (July 2007, An Bord Altranais)
Appendix 5 – Incident Form CR 53

Please complete this Section and Section D in all cases, and complete Section A, or B, or C, as appropriate

Incident Form
An incident means an unplanned event, with the potential to lead to an accident

Name of the person(s) directly affected by incident.

Address

Telephone Number

Date of Birth

Position/Title

Date and time of Incident

Nature of the incident: (Please tick one of the following)
A Medication/Medical Administration error
B Exposure to Blood/Body Fluids
C Other (e.g. Absconding, near misses)

Please complete the following relevant Section A or B or C
AND IN ALL CASES

Please ensure that Section D is completed in full
Section A

Medication/Medical Administration Error

Name of Client who was administered Medication/Medical Preparation in error: ____________________________

Name of the medication/Medical preparation administered in error: ____________________________

Dose: ____________________________ Route administered: ____________________________

Time: ____________________________ Date: ____________________________

Name of the person who administered medication/Medical preparation in error: ____________________________

Is the person who received this medication/Medical preparation prescribed any other medications/Medical preparations? Yes ☐ No ☐ (please tick ☐ clearly)

If "Yes" please outline this regime:

What medication had been administered up to the time of this incident? (Please include all medications given on the day)

Please describe any observed adverse reaction(s) if any:

________________________________

________________________________
Section B

Exposure to Blood / Body Fluids

Nature of Incident: 

Date and Time of exposure: DATE: _______ TIME: _______

Has Hepatitis B vaccine course been completed? Yes ☐ No ☐ (please tick ☑ clearly)

If “YES” - date of last dose: DATE: _______________________

Current Hepatitis B Status/ Level of Antibodies of person exposed: ______________________________________________________

Source Details: ____________________________________________

Source Reference: _________________________________________
- Client Number: __________________________________________
- Employee Number: _______________________________________
- Visitor’s Name: __________________________________________

Hepatitis B surface antigen status of source: Negative ☐ Positive ☐ (please tick ☑ clearly)
Section C

Other Incident

(E.g. Absconding, Ingestion of foreign objects or substances, near miss event or any other incident.)

Name of Person(s) involved in this incident

Nature of the incident / near miss

Where did this incident occur?

Date and time of incident
Section D

This Section is to be completed in all cases

Please outline the circumstances of the incident:

Was the incident witnessed?  YES ☐ NO ☐ (please tick clearly)

If “Yes” please give details:

Describe the action taken following the incident:

Name of the Senior person who was contacted re incident:

Date and time of contact  Date: Time:

Name of the person who made such contact:

What action was taken to prevent recurrence of such an incident:

Signature: Title:

Date:
Appendix 6 - Verbal/telephone medication order form

VERBAL/TELEPHONE MEDICATION ORDER FORM

Client name:__________________________  D.O.B. ________________

Client I.D. __________________________ Location: ______________________

Date:________________

Time:________________

Doctor Name___________________________

Contact Details________________________

Clinical emergency:

<table>
<thead>
<tr>
<th>Date: ____________________</th>
</tr>
</thead>
</table>

Medication Order:

<table>
<thead>
<tr>
<th>Date: ____________________</th>
</tr>
</thead>
</table>

Nurse 1 _______________ Date: _______________

Nurse 2 _______________ Date: _______________
Appendix 7. Self-Administration of Medication(s) by Clients.

To enable people we support to self-administer medication(s) prescribed for them, please complete the following Assessment Tool.

Section A - Client

<table>
<thead>
<tr>
<th>1. Details of Client Self-Administering:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of client:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Current Day Service:</td>
</tr>
<tr>
<td>Residential Service:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. List of Current medication(s) (include route i.e. liquid, tablets etc.):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Name</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Details of prescribing GP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Surgery Address:</td>
</tr>
<tr>
<td>Telephone No. : (Surgery)</td>
</tr>
<tr>
<td>Mobile:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Who currently administers the medication? (Please list all people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>Relationship:</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>Relationship:</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>Relationship:</td>
</tr>
</tbody>
</table>
5. Please state the reason(s) why medication is necessary:

6. Does the person we support have any allergies? Please Tick Yes or No ☑
   Yes ☐ No ☐
   If Yes, please list:

7. Does the person you support have any other physical/medical condition that may affect medication regimes?
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary (i.e. coeliac, eating problems)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Respiratory (asthma)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Other</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>
   If Yes, please list:

8. Are there any factors that will impact on his/her ability to self-medicate?
   Yes ☐ No ☐
   If Yes, please explain:

9. Does the person you support want to participate in self-medication?
   Yes ☐ No ☐

10. Does the person have a history of self-medicating reliably?
    Yes ☐ No ☐
**Section B – Cognitive Skills for Self-Administration of Medication(s)**

**Literacy Skills**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Can the person we support read?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please give reading age equivalent: R.A.:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Can the person recognise their name as typed on the medication container?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numeracy Skills**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the person able to recognise written numbers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• (Test on sample instructions such as “take 2 tablets 3 times a day”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Can the person count?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please tick beside number to how high they can count</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Size**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the person discriminate by size?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• (Test by presenting a “little” and “big” tablet and ask the person to show you the small and large tablet over a number of trials)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Colour**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the person readily identify colour?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• (Test colour reliability on at least 4-5 different colour tablets e.g. white, pink, yellow, blue, two tone by matching coloured cards to colour tablet, or by asking the person to point to the named colour, repeating this 2-3 times to ensure consistency)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Shape**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the person discriminate by shape of medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• (to Test, present tablet/pill and capsule in round and oval format and ask the person to point to the correct shape when named)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Liquid**

If the person is on liquid suspension show the person two or more bottles and ask the person to pick their bottle.

If the liquid suspension has to be measured out, does the person demonstrate an ability to prepare the current dosage?  

| Yes | No |

**Section C – Communication Skills**
### Expressive Language
1. Can the person talk freely?  
   - Yes  
   - No
2. Does the person initiate communication with others?  
   - Yes  
   - No
3. Does the person ask for help when they need it?  
   - Yes  
   - No

### Receptive Language
1. Can the person follow simple one-step instructions?  
   - Yes  
   - No
2. Can the person follow complex (two or more step) instructions?  
   - Yes  
   - No

### Time
1. Can the person relate time to daily events (e.g. meal times)?  
   - Yes  
   - No
2. Does the person know what time to take his/her medication?  
   - Yes  
   - No
3. Can the person recognise and explain the written time on medications? (e.g. 8.00am, 1800pm etc.)  
   - Yes  
   - No
4. In the case of P.R.N., can the person deduce the next dosage time? (e.g. every four hours)  
   - Yes  
   - No

### Physical Barriers
1. Can the person get and open medication?  
   - Yes  
   - No
2. Can the person choose and put away medication?  
   - Yes  
   - No
   - (have the person demonstrate this skill; check what adaptations/assistive technology can be used to diminish physical barriers e.g. placing medications in one unit container)
3. Does the person wear eye glasses or contact lenses?  
   - Yes  
   - No
4. Is the person visually impaired?  
   - Yes  
   - No
5. Does the person wear a hearing aid?  
   - Yes  
   - No
6. Is the person hearing impaired?  
   - Yes  
   - No
7. Can the person get a drink to take with the medication?  
   - Yes  
   - No
8. Does the person have any difficulty swallowing?  
   - Yes  
   - No
### Health Self-Maintenance

1. Does the person know basic first aid?  
   - Yes ☐ No ☐

2. Does the person know the desired effect of each medication?  
   - Yes ☐ No ☐

3. Does the person know the possible adverse effects of each medication?  
   - Yes ☐ No ☐

4. Does the person recognise an emergency situation?  
   - Yes ☐ No ☐

5. Does the person know what to do in an emergency?  
   - Yes ☐ No ☐

6. Can the person use a telephone or mobile phone?  
   - Yes ☐ No ☐

7. Can the person state his/her name?  
   - Yes ☐ No ☐

8. Can the person state his/her address?  
   - Yes ☐ No ☐

9. Can the person state his/her phone number/mobile phone number?  
   - Yes ☐ No ☐

---

Thank you for taking the time to complete this assessment tool. Please tick the conditions under which a named service user can self-medicate:

- Is competent to self-medicate without supervision  
  - Yes ☐

- Is competent to self-medicate with supervision  
  - Yes ☐

- Is competent to self-medicate with verbal/physical prompts  
  - Yes ☐

- Is not capable of self-medication at the present time, but might do so given training  
  - Yes ☐

- Is not capable and is unlikely to do so at any stage  
  - Yes ☐

---

N.B. It will be necessary to reassess a person(s) capacity to self-administer their medication(s) at regular intervals.

---

<table>
<thead>
<tr>
<th>Name of Person Completing this form (block letters)</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of this Review:___________</th>
<th>Date of Next Review: __________</th>
</tr>
</thead>
</table>