United Kingdom Central Council for Nursing, Midwifery and Health Visiting

# ADMINISTRATION OF MEDICINES

A UKCC Advisory Paper

## A framework to assist individual professional judgement and the development of local policies and guidelines

UKCC



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# INTRODUCTION

1 **The framework which is set out in this document should be considered against the background of the extracts from Statutory Instrument 1983 No. 873 (The Nurses, Midwives and Health Visitor Rules) and the UKCC Code of Professional Conduct for the Nurse, Midwife and Health Visitor which are reproduced for convenience, and of the definitions given for the terms 'professional judgement' and, 'professional responsibility'.**

2 It is intended for practitioners of nursing, midwifery and health visiting wherever they are practising. The main body of the text relates to 'normal' circumstances. Guidelines in respect of exceptional circumstances are set out in an Appendix to the main document.

3 **The relevant primary legislation concerning the administration of medicines is the Medicines Act, 1968, and the Misuse of Drugs Act, 1971.**

4 The term "medicine" refers to controlled drugs and "prescription only" medicines as defined in those Acts. It includes "General Sales List" medicines in those settings where they are normally subject to prescription.

5 **Wherever in this paper the word 'practitioner' is used it refers to a practitioner of nursing, midwifery or health visiting.**

6 This advisory document is released following helpful consultation with the General Medical Council and the Pharmaceutical Society.

# BACKGROUND

1 **Rule 18 of Statutory Instrument 1983 No. 873 states:–**

Courses leading to a qualification the successful completion of which shall enable an application to be made for admission to Part 1, 3, 5 or 8 of the register shall provide opportunities to enable the student to accept responsibility for her personal professional development and to acquire the competencies required to:–

(a) advise on the promotion of health and the prevention of illness;
(b) recognise situations that may be detrimental to the health and well-being of the individual;
(c) carry out those activities involved when conducting the comprehensive assessment of a person's nursing requirements;



(d) recognise the significance of the observations made and use these to develop an initial nursing assessment;
(e) devise a plan of nursing care based on the assessment with the co-operation of the patient, to the extent that this is possible, taking into account the medical prescription;
(f) implement the planned programme of nursing care and where appropriate teach and co-ordinate other members of the caring team who may be responsible for implementing specific aspects of the nursing care;
(g) review the effectiveness of the nursing care provided, and where appropriate, initiate any action that may be required;
(h) work in a team with other nurses, and with medical and para-medical staff and social workers;
(i) undertake the management of the care of a group of patients over a period of time and organise the appropriate support services;

related to the care of the particular type of patient with whom she is likely to come in contact when registered in that Part of the register for which the student intends to qualify.

Courses leading to a qualification the successful completion of which shall enable an application to be made for admission to Part 2, 4, 6 or 7 of the register shall be designed to prepare the student to undertake nursing care under the direction of a person registered in Part 1, 3, 5 or 8 of the register and provide opportunities for the student to develop the competencies required to:–

(a) assist in carrying out comprehensive observation of the patient and help in assessing her care requirements;
(b) develop skills to enable her to assist in the implementation of nursing care under the direction of a person registered in Part 1, 3, 5 or 8 of the register;
(c) accept delegated nursing tasks;
(d) assist in reviewing the effectiveness of the care provided;
(e) work in a team with other nurses, and with medical and para-medical staff and social workers;

related to the care of the particular type of patient with whom she is likely to come into contact when registered in that Part of the register for which the student intends to qualify.'

2 **The different but quite specifically stated competencies in Rule 18(1) for the nurses whose names appear in the first level parts of the register (i.e. Registered General Nurse, Registered Mental Nurse, Registered Nurse of the Mentally Handicapped, Registered Sick Children's Nurse), and in Rule 18(2) for the nurses whose names appear in the second level parts of the register (i.e. Enrolled Nurse, General; Enrolled Nurse, Mental; Enrolled Nurse, Mental Handicap; Enrolled Nurse) should be noted.**

3 In relation to the administration of medicines, the midwife has the same responsibility as the first level nurse.

4 The UKCC Code of Professional Conduct for the Nurse, Midwife and Health Visitor contains the following important statements:–

**Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the interests of society, and above all to safeguard the interests of individual patients and clients.**

**Each registered nurse, midwife and health visitor is accountable for his or her practice, and, in the exercise of professional accountability shall:**

(i) act always in such a way as to promote and safeguard the well being and interests of patients/clients;

(ii) ensure that no action or omission on his/her part or within his/her sphere of influence is detrimental to the condition of safety or patients/clients;

(iii) take every reasonable opportunity to maintain and improve professional knowledge and competence;

(iv) acknowledge any limitations of competence and refuse in such cases to accept delegated functions without first having received instruction in regard to those functions and having been assessed as competent;

5 For the purpose of this advisory paper the following definitions are drawn to your attention:–

(i) **Professional Judgement in health care is personal judgement based on special knowledge and skill, and always and above all is exercised in the best interests of the patient/client.**

(ii) **Professional Responsibility in health care is personal responsibility based on special knowledge and skill for actions, attitudes and policies always and above all directed to the best interests of the patient/client.**





# THE FRAMEWORK

## 1 TREATMENT WITH MEDICINES

The treatment of a patient with medicines for therapeutic, diagnostic or preventative purposes is a process which involves prescribing, dispensing, administering and receiving.

The word 'patient' is used since any person receiving a prescribed medicine is the patient of that prescriber at the time of prescription.

## 2 PRESCRIBING (THE DOCTOR'S ROLE)

(a) This involves obtaining a patient's consent (commonly this is implicit) based on an understanding of the treatment, and issuing a prescription written legibly, indelibly and dated. The prescription must ensure accurate patient identification, specify the preparation to be given and where appropriate its form (e.g. tablets, capsules, suppositories, etc) and strength, the dose, the timing and frequency of administration and the route of administration. In the case of patients for whom a prescription is provided in the Out-Patient or Community setting, the number of dose units or total course must be stated.

(b) In the case of controlled drugs, the dose must be written in words and figures and in the Out-Patient or Community setting the total dose or number of dose units in both words and figures to be supplied, the whole being in the prescriber's own handwriting.

(c) Prescriptions must be signed and dated by the prescribing doctor.

(d) There are certain situations (e.g. in Registered Nursing Homes) where a medicine will have to be administered against a prescription which is no longer available. Unless the prescription was very specific the container will probably bear the instruction to administer 'as directed' only. In such circumstances the prescribing doctor should produce a written order against which medicines can be checked.

(e) Any practitioner faced with a prescription not satisfying the above criteria should withhold administration and request the doctor concerned to write a full and correct prescription. (See paragraph 4(c) on page 7).

(f) The administration of medicines on verbal instruction except in emergencies does not satisfy acceptable criteria.

(g) Instruction by telephone to a nurse to administer, even in an emergency situation, a hitherto unprescribed drug cannot be supported. This practice is unreliable and involves a nurse in a procedure which is potentially hazardous to the patient. This paragraph must, however, be read in the context of the supplementary advice set out in the appendix to this document on pages 11 and 12.

(h) Where it is the wish of the doctors that nursing staff be authorized to administer certain medicines such as mild analgesics, laxatives and topical applications a local protocol which satisfies the general criteria of the appendix to this paper should be agreed between the medical, nursing and pharmaceutical professionals involved.

(i) The exemptions for midwives and occupational health nurses under the terms of the Medicines Act 1968 and the Misuse of Drugs Act 1971 and subsequent regulations are referred to in paragraph 4(l) on page 9.

## 3 DISPENSING (THE PHARMACIST'S ROLE)

(a) This involves checking that the prescription is written correctly to avoid misunderstanding or error, appropriate in the circumstances, and that any newly prescribed medicine will not dangerously interact with or nullify the effect of any previously prescribed medicines or food.

(b) In addition the pharmacist is involved in determining quality, advising on security and storage conditions, compounding the medicine in a form suitable for administration to the relevant patient, providing relevant additional information on container labels and annotating the prescription to render it accurate.

(c) Still further the pharmacist is involved in monitoring the adverse side effects of medicines, and should therefore be sent any information which the administering practitioner deems relevant.

(d) **It should be noted that amendments to a prescription which are made and signed by the pharmacist after consultation with the prescribing doctor are acceptable.**

(e) When the pharmacist is satisfied on all appropriate points, his/her role further involves clear labelling, insertion into an appropriate container and secure delivery.



## 4 ADMINISTERING (THE ROLE OF THE NURSE, MIDWIFE AND HEALTH VISITOR)

(a) **The exercise of professional judgement (which involves the application of his/her knowledge and experience to the situation faced) will lead the practitioner to satisfy himself/herself that he/she is competent to administer the medicine and prepared to be accountable for that action. Once that decision has been made, the practitioner follows a sequence of steps to ensure the safety and well being of the patient, and which must as a prerequisite be based on a sound knowledge of the patient's assessment and the environment in which care is given.**

(b) **Correctness**

This involves interpretation of the prescription and container information in terms of what has been prescribed. Illegibility and lack of clarity of the instruction must be questioned. It also involves ensuring that the medicine is to be administered to the patient for whom it has been prescribed, and in the form and by the method prescribed.

Certain of these points do not usually apply in the context of a patient's home where the patient is receiving medicines from a personalised container. The visiting practitioner does, however, have a responsibility to assist the patient's understanding and help ensure safe administration.

Where a patient is in possession of a range of medicines in containers which are not labelled with precise instructions, and the danger of over or under administration exists, it may be necessary for the practitioner to advise the prescribing doctor so that he/she may consider whether any action is required.

(c) **Appropriateness and the possible need to withhold**

This involves checking the expiry date of the medicine, careful consideration of the dosage and the method, route and timing of administration in the context of the condition of each specific patient.

It may be necessary or deemed advisable at the time when a medicine is due to be administered to withhold it in order to seek further verification from the prescribing doctor, or confirmation from the responsible senior nurse that it should be given.

Where, in the opinion of the administering nurse or responsible senior nurse, (i.e. the nurse on duty to whom the administering nurse is in line responsibility at the time) contra-indications to the administration of the medicine are observed the prescribing doctor should be contacted without delay.

(In respect of this point and that at (b) above the advice of the relevant pharmacist will often be helpful in those situations where the prescribing doctor or an appropriate alternative doctor cannot be contacted.)

(d) **Reinforcement**
The positive effect of treatment may need to be reinforced by the nurse. Every occasion on which a medicine is administered is an opportunity for such reinforcement and for reassurance. In the community particularly it is also an opportunity to help ensure avoidance of misuse of self-medication, and the misuse of the prescribed drugs by others who reside in or are visiting the household.

(e) **Recording/Reporting**
As part of the ongoing process (not solely at the times of administration of medicines) the effects and side-effects of the treatment should be noted. Taking appropriate action in relation to side-effects is essential. Positive and negative effects should be reported to the appropriate doctor and recorded.

(f) **Record of Administration**
Where a practitioner is involved in the administration of medicines thorough and accurate records of the administration must be maintained. In hospital settings this will normally be achieved by initialling the appropriate box on a treatment record at the time of administration. Otherwise the date and time of administration, together with the administering practitioner's signature are essential minimum requirements, and all must be legibly written.
If (as a result of consideration as in 'c' above) a medicine is not administered a record to that effect should be made.

(g) **The UKCC is of the view that practitioners whose names are on the first level parts of the register, and midwives, should be seen as competent to administer medicines on their own, and responsible for their actions in so doing. The involvement of a second person in the administration of medicines with a first level practitioner need only occur where that practitioner is instructing a learner or the patient's condition makes it necessary or in such other circumstances as are locally determined. Where two persons are involved responsibility still attaches to the senior person.**

(h) **The UKCC is totally opposed to the involvement of personnel who are not professionally registered such as nursing auxiliaries or assistants in the administration of medicines since it gives a false sense of security, undermines true responsibility, and fails to satisfy points (c) and (d) of this section.**



(i) **Given the wording of Rule 18(2) of Statutory Instrument 1983 No. 873, the UKCC is opposed to the use of a second level practitioner for the administration of medicines other than under the direction of a first level nurse. It is recommended that employers adopt the same stance unless:–**
**(1) they have provided additional instruction relevant to the medicines likely to be encountered in a particular setting;**
**(2) they have undertaken an assessment of the individual's knowledge and competence to perform the task; and**
**(3) they are prepared to accept the responsibility for any errors that are consequential upon using a second level practitioner beyond the role for which training prepared him/her. (See BACKGROUND 1 and 2 of this paper).**

(j) **The principles enunciated in this section are equally applicable to a medicine round or to the administration of medicines within individual care.**

(k) **The responsibility of the nurse varies in the setting of a patient's home,** where he/she needs to be cognizant of the 'freedom' of the patient in his own setting, and the implications of self-medication and the possession of 'over the counter' medicines. Where a nurse working in the community becomes involved in obtaining prescribed medicines for patients he/she must recognise his/her responsibility for their safe transit and correct delivery.

(l) **In accordance with the requirements of the Medicines Act 1968 and the Misuse of Drugs Act 1971 and subsequent regulations there are specific arrangements for midwives working in the community, and occupational health nurses, to obtain and administer medicines.** Those relating to midwives are contained in the UKCC Midwife's Code of Practice and those to occupational health nurses in the Royal College of Nursing Society of Occupational Health Nursing Information Leaflet No. 11 dated November 1983. Also in pursuance of Regulation 10(3) of the Misuse of Drugs Regulations 1973 specific "Group Authority" is given to certain registered nurses employed at places of work.

## 5 RECEIVING (THE PATIENT'S ROLE)

The patient's role is as participant. The point of receiving provides the opportunity for:–

(a) **Validation**
Ensuring that the patient understands the treatment, the need to complete the prescribed course and has consented to receiving it.

(b) **Education/Instruction**
Assessing and promoting the patient's knowledge and understanding regarding his/her medication, and reinforcing safety; this is essential before the patient can progress to independence. The role of the relatives and other informal carers is an important consideration in the rehabilitation of the patient.

(c) **Self-Administration**
Monitoring the patient's self-administration of prescribed medicines (where the practice is established) or preparing the patient for self-administration at home or in hospital as part of a planned programme towards independence. At home and at work account must be taken of the possibility of self-medication with non-prescribed medicines.

6 **THE LEGISLATIVE ASPECT**

Medicinal products are subject to legislative controls relating to their manufacture, prescription, sale, handling, storage and custody. The nurse therefore operates within a legal framework in respect of:–

(a) **Supplies.** Proper procedures should be employed for ordering. Checking deliveries and maintaining records are key factors. Orders should not be such that stocks will be excessive and wastage likely.

(b) **Storage.** As well as being kept in a secure place as required by legislation, drugs should be stored in the appropriate environment as instructed by the respective manufacturers.

(c) **Stocktaking.** This involves recording, checking stocks and disposing of unwanted medicines according to legislation. Discrepancies in stocks must be reported and investigated.

Collaborative working with the Pharmacist will ensure that appropriate systems are developed in respect of these three important aspects of the process aimed at safe administration of medicines.



## Supplement suggesting variations which should apply where the specific framework is not appropriate

(a) **There are certain situations in which practitioners are involved in the administration of medicines where specific factors within the preceding framework are difficult to apply or could not be applied without introducing dangerous delay and its consequent risk to patients.**

(b) These will include occupational nursing settings in industry, small hospitals with no resident medical staff and possibly some specialist units within larger hospitals and a variety of community settings.

(c) **In any situations in which practitioners may be expected or required to administer "prescription only" medicines to patients which have not been directly prescribed for those patients by a medical practitioner who has examined and made a diagnosis, it is essential that a clear policy be determined which enables action to be taken in the patients' interests and to protect the practitioners from risk of complaint which might jeopardise their employment or professional status.**

(d) It is therefore recommended that, in any situation where practitioners might be called upon or expected to administer "prescription only" medicines which have not been directly prescribed as a result of examination, the following principles should be agreed and set down in a local policy which is known to all practitioners likely to be involved.

(i) It should first be agreed and then set down in writing by all the doctors working within a particular setting that there are circumstances in which particular "prescription only" medicines may be administered in advance of examination by a doctor. Where frequent staff changes make this impractical one senior doctor should be appointed by his/her colleagues to establish such policies on their behalf, with them undertaking to honour his/her decision. A review of such policies must take place annually.

(ii) The particular circumstances in which a particular "prescription only" medicine (and its form, route, etc.) could be administered must then be the subject of specific and well documented agreement, which must have similar support.

Wherever possible agreements should, in the

particular organisation to which they apply, satisfy the needs likely to emerge in paragraph 2(g) on page 6.
(iii) Except where there is an appropriate senior nurse to provide this instruction it must be the responsibility of one of the doctors working in the setting (acting on behalf of all the doctors) or, where appropriate, a pharmacist to undertake instruction of any practitioner who will be expected to administer any "prescription only" medicine which has not been specifically prescribed, this instruction to encompass information concerning the medicine, the indications for its use, its effects and side-effects, and any contra-indications. Where an appropriate senior nurse is available for this purpose he/she must not hesitate to call upon the services of the doctor, especially in relation to aspects of diagnosis, pharmacology and prescribing.
(iv) The above instruction should conclude with an assessment of knowledge and competence which is a necessary prelude to the preparation of the written document authorising a particular practitioner to administer a particular "prescription only" medicine without a specific prescription in a particular set of circumstances.
(v) No practitioner should be expected to accept the responsibility for administering such medicines against his/her will, and those who do accept the responsibility must remember the requirements of the UKCC Code of Professional Conduct that they acknowledge any limitations in their competence and seek appropriate instruction.

(e) **Practitioners who engage in the administration of "prescription only" medicines which have not been specifically prescribed for a particular patient following medical examination and diagnosis in any situation where the above 5 criteria have not been fully met are rendering themselves extremely vulnerable. However, where these criteria are fully satisfied the nurse would normally be protected from the consequences of his or her actions even if made the subject of a complaint to the Statutory Regulating Bodies.**