

**PROCEDURAL GUIDELINES FOR THE ADMINISTRATION OF
MEDICINES BY STAFF IN COMMUNITY HEALTH SERVICES**

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Contents

Contents

1.0.	Introduction	4
2.0.	Accountability and Responsibility	4
3.0.	The Role of Health Care Professionals in the Safe Administration of Medicines:.....	6
4.0.	Prescribed Medicines	6
5.0.	Verbal Authorisation	7
6.0.	Supplies of Medicines.....	8
7.0.	Custody, Storage and Transportation of Medicines	8
8.0.	Disposal of Medicines.....	9
9.0.	Administration.....	9
10.0.	Supervision of Self Administration.....	10
11.0.	Use of Multi Compartment Compliance Aids (MCA).....	10
12.0.	Recording Administration	11
13.0.	Adverse Drug Reactions and Medication Errors.....	11
14.0.	Controlled drugs	12
15.0.	Treatment of Anaphylaxis	12
16.0.	Complementary and Alternative Therapies	13
17.0.	Covert Administration of Medicines	14
18.0.	Patient Group Directions.....	Error! Bookmark not defined.
19.0.	Monitoring.....	14
	Appendix 1: Competency Assessment of Drug Administration Community Nursing/In-Patient Areas	14
	Appendix 2: Sample Drug Calculations for Adult Nursing.....	17
	Appendix 3- Medicines Returned for Destruction Receipt	19
	Appendix 5 - Practice considerations for the use of MCA.....	22
	References	26

1.0. Introduction

- 1.1. The principles contained within this guideline are based on the Royal Pharmaceutical Society Professional Guidance on the Safe and Secure Handling of Medicines. Dec 2018 and the Professional Guidance on the Administration of Medicines in Healthcare Settings. Jan 2019
- 1.2. For the purpose of this guideline, the term “medicines” refers to all of the following:
 - All products designated as ‘prescription-only’ (POM) medicines ‘pharmacy’ (P) medicines, and ‘general sales list’ (GSL) medicines.
 - Products such as vaccines medical gases and X-ray contrast media.
 - Controlled Drugs (CDs), as defined within the Misuse of Drugs Act, 1971 as amended.
 - Complementary medicines, e.g. aromatherapy oils, herbal remedies and homeopathic preparations.
 - Medicated dressings, disinfectants, reagents and similar products.
- 1.3. The term Nurse is used in its generic form and applies to all Registered Nurses with the exception of Nursing assistants. When reference is made to other healthcare workers, the term “**healthcare professionals**” will be used.
- 1.4. It is acknowledged that the responsibility for administering medicines in the patient’s home and its associated conditions differ considerably from those within the in-patient setting and therefore different guidance must apply. For the purposes of this guideline these settings will be referred to as “**community**”.
- 1.5. This guideline also applies to In-patient settings, Day Hospital and Clinics.
- 1.6. The guideline and principles contained therein applies to all staff handling medicines in Community Health Service.
- 1.7. The guideline covers the principles involved in the administration of medicines by all routes.
- 1.8. This guideline should be read in conjunction with the following and all other relevant Trust policies:
 - The Safe Management of Patient’s Own Controlled Drugs in a Domiciliary Setting
 - Procedure for the Transcribing of Medication for the Purpose of Recording Administration in Community Health Services
 - Community Health Services Injectable Medicine Guideline
 - Community Health Services Guideline for the Safe Use of Insulin
 - Protocol for the Delegation of Administration of Insulin in Community Health Services
 - Infection Prevention and Control Guideline
 - Waste Management Guideline
- 1.9. Account must be taken of the patient’s rights and freedom.
- 1.10. Specialist advice concerning medicines is available from pharmacists (local community pharmacists, acute trust pharmacists and the Trust Pharmacy Department).

2.0. Accountability and Responsibility

- 2.1. All staff are accountable for their own actions in the administration of medicines. They must be prepared to exercise professional judgement in any situation and be able to substantiate their actions/inactions. They must:

- Be aware of the indications, action(s), usual dosage, usual route(s), side effects, interactions, contra-indications and correct storage of the medicines to be administered.
 - Ensure they are competent to administer medicines, maintain competence and address any deficits in their knowledge/skills.
 - Be aware of their limits and know when to refer for further advice
 - Nurses are deemed competent to administer medicines by virtue of their qualification. The safe administration of medicines is an essential competence for admission to the Nursing and Midwifery Council register. Additional training and competence assessments are required for intravenous and cytotoxic medicines, as well as Syringe Driver Use.
- 2.2. All staff are responsible for ensuring that they adhere to this Guideline, their Professional Codes of conduct and manufacturer's guidance.
 - 2.3. It is accepted that within the community setting, medicines may be administered by one person only without being checked by a second person.
 - 2.4. In the In-patient setting and Day Hospitals, controlled drugs (CDs) and all injectable medication must be checked by two Nurses.
 - 2.5. The Nurse must make an assessment of the patient in their care and decide whether the responsibility for assisting with/administering medication can be transferred to another healthcare professional. If administration/assistance is delegated, the nurse delegating retains responsibility for safe administration.
 - 2.6. Care should be taken to ensure the delegation of the administration of the following medications in particular is only to healthcare professionals who are trained and assessed as competent:
 - Controlled drugs, including patches containing controlled drugs
 - Enemas and rectal foam preparations
 - Injectable medicines. This must be covered by a specific Trust guideline/protocol.
 - Any drug given on a reducing dose
 - Vaginal preparations
 - 2.7. An up to date specimen signature sheet of any staff directly involved in the administration of medicines, including agency staff, must be available; an up to date copy of which is to be kept by Team Leads. In the Community an up-to-date record of signatures of the staff who administer medicines should be kept in the patient folder.
 - 2.8. Records of training and competency assessment should be held by Team Leads and Service Managers. These should also be captured in individual staff personal/management file.
 - 2.9. Where family / informal carers are observed as competent and have agreed to participate in the administration of medicines to a patient, the nature and scope of that agreement should be accurately recorded in the patient's home notes, electronic records and on the Medicine Administration Record Chart (MAR). The family/carers should be instructed to record the medications given on the MAR.
 - 2.10. Healthcare Professionals must NOT administer any medicines for which they have not received training and been assessed as competent to administer.
 - 2.11. The Student Nurse (pre- registration) is not permitted to prepare or administer medicines to a patient unless under the direct supervision of a Nurse. All drugs

administered by the Student must be countersigned by the Nurse. They must not participate in any aspect of administration or preparation of intravenous, intra-articular and intradermal therapy, and must remain in an observing capacity throughout the process.

- 2.12. Wherever possible, the actions of prescribing, dispensing/supply and administration are performed by separate healthcare professionals. Exceptionally, where clinical circumstances make it necessary and in the interests of the patient, the same member of staff can be responsible for the prescribing and supply/administration of medicines. Where this occurs, an audit trail, documents and processes must be in place to limit errors.

3.0. The Role of Health Care Professionals (HCPs) in the Safe Administration of Medicines:

- 3.1. Transcribe medicines for administration unto a Medicines Administration Record Chart (MAR), **where assessed as competent to do so**, for the purpose of documenting administration. Refer to Transcribing Guideline for further details.
- 3.2. Document allergy/drug sensitivity status of the patient on the MAR chart and in the electronic records. Information on allergy must include the reaction to the medicine/substance where known; the date of documentation and the signature of writer. If no allergies and/or sensitivities are known, "no allergies known" /NKDA should be written. This ensures that, should a patient later develop an allergy/sensitivity, the MAR chart provides evidence that the allergy was not known or declared at the time.
- 3.3. Supply or administer medicines against a Trust approved Patient Group Direction (PGD) **where competent and authorised to use the PGD**. Supply or administration via PGD must be documented in the patient's electronic records. Only the HCP who made the original assessment of the patient may administer/supply the medication under a PGD. In the case where a supply of medication was given to the patient using the PGD, the patient may self-administer if he/she is able to do so. Refer to the PGD guideline for further details.
- 3.4. Organise the provision of medication support for patients who have difficulties e.g. reminder charts, large print labels or multi compartment aids, see section 11 for more details on multi compartment aids.
- 3.5. Monitor the compliance, efficacy, any adverse effects of medication and report any findings.
- 3.6. Check for out of date medicine(s); check if the patient still requires the medication and secure a fresh supply as appropriate.
- 3.7. Obtain the patient's consent to safely dispose of out-of-date/no longer required medicines.
- 3.8. Liaise with other agencies about arrangements and responsibility for the collection of repeat prescriptions and supplies of medicines.
- 3.9. Liaise with the GP/ other Prescribers for regular reviews of the medications.

4.0. Prescribed Medicines

- 4.1. Prescribed medicines are those which have been obtained against a prescription for a specific person. These medicines are the property of the patient/client to whom the prescription was issued.

- 4.2. In order to administer such medications in the community, a member of staff who has achieved competency in transcribing or a Non-Medical Prescriber must write the prescribed medicines clearly in the patient's care plan and on a MAR chart.
- 4.3. In the In-patient setting medicines are prescribed by the medical or a non-medical Prescriber on a prescription chart which serves as both the prescription and the administration record.
- 4.4. The name, strength, form/formulation, dose, route of administration and frequency of the medicine to be given must be recorded on the MAR chart.
- 4.5. Full names must be used not abbreviations e.g. isosorbide mono nitrate (not ISMN). Frequency and dose must be written in full e.g. 'to be taken twice daily' (not BD), 'micrograms' (not mcg), units (not 'u'), nanograms (not ng).
- 4.6. For patients recently discharged from hospital, the most current prescription issued by the General Practitioner (GP) or discharge summary letter issued by the hospital Doctor (whichever is the most recent) should take precedence and be complied with.
- 4.7. The hospital discharge summary/ GP summary (containing the current prescribed medicines) will be kept in the patient home records.
- 4.8. Medicines must not be discontinued without confirming with the Prescriber that it is no longer required. This includes creams and medications for the skin even when the skin appears to have healed.

5.0. Verbal Authorisation

- 5.1. In exceptional circumstances, where a change or addition to the administration details is required and a delay in administering a medicine (other than a Schedule 2 CD e.g. morphine, diamorphine, fentanyl) would compromise patient care, verbal authorisation/instruction to administer can be taken.
- 5.2. The prescriber requesting the changes must provide a prescription/ other authority to administer/amend the prescription chart with the new administration details as soon as possible (ideally within 24 hours, 72 hours maximum if Bank Holiday or weekend).
- 5.3. If the prescriber is unable to issue a new authorisation to administer or amend the drug chart the changes must be communicated by an appropriately secure electronic method e.g. entries on patients' electronic records, emails etc.
- 5.4. The patient's records must be updated to reflect the changes so authorised and the documentation made in the patient's electronic notes. The electronic instructions received must be stapled to the patient's existing prescription chart/ MAR chart.
- 5.5. Verbal authorisation can only be taken by Nurses. It is the Nurse's responsibility to ensure that the verbal order is followed up by a new prescription/ other authorisation to administer confirming the changes.
- 5.6. **Where a medication has not been prescribed before, verbal authorisation is not permitted. The patient must be assessed by the prescriber before a new medication is prescribed.**
- 5.7. For patients where the prescriber has prescribed symptom-control medication in a defined range giving a minimum and maximum dose and frequency (e.g. palliative care or insulin), the dose can be varied within this defined range without seeking further authorisation from the prescriber. All such actions must be clearly recorded in the patient record.

6.0. Supplies of Medicines

- 6.1. In the community, it is the responsibility of the Nurse initially making the assessment for the patient's ongoing care to ensure arrangements are made through the patient, carers, General Practitioner or other authorised prescribers to obtain an adequate and ongoing supply of medicines. Where a nurse is not involved in the care of the patient e.g. Re-ablement teams, the Team Lead is responsible.
- 6.2. In In-patient settings, it is the responsibility of the Nurse and the appropriate pharmacy department staff to ensure that medicines are available and to take all reasonable steps to remedy any shortfall.
- 6.3. In the event that medicine supplies are inadequate in the community, all reasonable steps should be taken to ensure an adequate supply is obtained and the actions taken documented in the patient's electronic record to ensure good communication and continuity of care.
- 6.4. Where staff in the community become involved in collecting or returning prescribed medicines for patients, they must be aware of their responsibility for safe transit to/from the patient's home. Medicines should be taken straight from the Pharmacy to a patient's home and vice versa.
- 6.5. In the event that a medicine is not available and the patient does not receive the prescribed medication, the Prescriber must be advised and a DATIX form completed.
- 6.6. Patients have the right to choose any community pharmacy for the dispensing of their medicines. Staff must not direct patients to any particular pharmacy except on the basis of services offered. Most community pharmacies will collect prescriptions from surgeries and do home deliveries for house bound patients. This is an unpaid service and must be reserved for those patients who are genuinely unable to make alternative arrangements for collection of their medicines.
- 6.7. **Delivering to or removing medicines from the patient's home and carrying or storing them is discouraged except where absolutely necessary.**

7.0. Custody, Storage and Transportation of Medicines

- 7.1. In the In-patient setting medicines must be kept securely, in a locked cupboard (see CD guideline in respect of CDs) and access restricted to Nursing and Pharmacy staff only. Medicines must be stored in accordance with the manufacturer's instructions as contained in the Summary of Product Characteristics and in accordance with any instruction on the label. External preparations must be stored separately from internal preparations.
- 7.2. In the community setting patients should be encouraged to store medicines safely and appropriately e.g. out of the reach of children and pets and not in hot steamy rooms e.g. bathrooms. Some medicines require storage in the fridge. It is useful to record in the patient's records where medicines are normally kept so they can be easily located.
- 7.3. It must always be remembered that in the community, medicines are the property of the patient concerned and must be kept in the patient's home setting. In extreme cases where there are concerns about the possible misuse of medication by the patient/relatives, reasonable steps should be taken to control access to the medicine in the home but only if this is considered to be in the patient's best interest. Full records should be kept of what action is taken to restrict access and why.
- 7.4. For In- patient areas where medicines have been dispensed on a named patient basis, these must be stored in the individual patient's drug locker where available.

- 7.5. Where patients are having medicines administered in the health centre or clinic, the patient must be advised to bring their medicine to the centre.
- 7.6. Vaccines must be transported in the appropriate cold bags as recommended by the Infection Control Specialist Nurses.

8.0. Disposal of Medicines

- 8.1. **Refer** to the “The Safe Management of Patient’s Own Controlled Drugs in a Domiciliary Setting” for controlled drugs disposal in the Community setting.
- 8.2. Unwanted prescribed medicines should be returned to a pharmacy for destruction. **Medicines which are no longer required by the patient should not be disposed of down sinks or toilets.**
- 8.3. When drugs are discontinued or are out of date in In-patient areas, these must be returned to the Pharmacy Department for destruction. The Pharmacist must be contacted in respect of controlled drugs that are no longer required/out of date. The Nurse returning the drugs must record the name, date, and quantity of the drugs being returned in the controlled drugs register book and both the pharmacist and the Nurse will sign the CD register. The Pharmacist is responsible for ensuring the safe return of CDs to the Pharmacy Department
- 8.4. When a medicine is no longer required by the patient in the Community for whatever reason (e.g. change of strength, end of treatment, and death of patient) the patient/carer/family should be encouraged to safely dispose the medicines by returning them to the community pharmacy.
- 8.5. All cytotoxic/cytostatic (e.g. finasteride and goserelin) medicine waste should be disposed of in purple lidded bins. See Appendix 4 for sample list of hazardous medicines. Purple lidded bins can be obtained from the same source as the sharps bins.
- 8.6. In the event of a medicines spillage in the community, normal household precautions need to be taken e.g. in case of broken glass. Disposable material must be used in cleaning up the spill and depending on the size of the spillage, must be disposed of in a sharps box labelled with the drug that was spilled. In the case of vaccines, please **refer** to the Infection Prevention and Control Guideline and the CD domiciliary guideline for CD spillage.
- 8.7. When medicines are returned to the local community pharmacy, in instances where return by relatives or next of kin is not practical or possible, the Medicines Returned for Destruction Receipt Record in Appendix 3 must be completed and scanned into the patient’s notes as well as documenting return in the electronic records.
- 8.8. Prescribed drugs, including CDs, are the property of the patient and remain so even after death. Relatives/carers should be advised that it is illegal to possess the CDs and that all CDs should be returned to a Community Pharmacy for safe destruction. A written note in the patient’s record must be made of the advice given to the carer/family on disposal of medicines.

9.0. Administration

- 9.1. Before the administration of any medicine the following must always be checked:
 - The patient’s identity
 - The prescription or other direction to administer – must meet legal requirements, be unambiguous and include all information required for safe

administration i.e. medicine name, form, strength, route, dose, frequency and review date where applicable.

- Allergy status
- The dosage, strength, form / formulation, timing and route of administration are appropriate
- The patient's condition - does it warrant withholding the medicine
- Indication – should be appropriate for the patient's condition
- Contra-indications
- Consent – consider Issues around consent
- Expiry date, where present, on the medication containers.
- Medicine has been appropriately stored.
- Where medicine dosages are based on weight, the patient's weight is recorded and the dose is appropriate.
- That the dose has not already been administered by someone else (including patient or carers)
- The patient is not experiencing undesirable side effects from the medication

- 9.2. Any ambiguities or concerns regarding the direction for administration of the medicine must be raised with the prescriber or a pharmacy professional without delay. The prescription or label on a medicine dispensed by a pharmacist must be clearly written and unambiguous.
- 9.3. All reasonable precautions to protect from any harm resulting from preparation or administration of the medicine, e.g. medicines that should not be directly handled, needle stick injury, contact dermatitis, must be taken.
- 9.4. It is unacceptable to prepare substances for injection in advance of their immediate use or to administer medication drawn into a syringe or container by another person in the absence of the staff who is to administer the medicine.
- 9.5. In exceptional circumstances (e.g. insulin drawn up in advance) it may be necessary to draw up a substance for the patient to administer at a later time. This course of action can only be taken following a MDT meeting with the patient and relevant professionals. A full risk assessment must be carried out signed and dated by all parties. The outcome must always be in the patient's best interest. See Guideline on the Safe Use of Insulin for more details on Insulin drawn up in Advance.
- 9.6. Some medicine administrations require calculations, in these situations, it may be necessary to obtain a second check for the calculation, where practicable, in order to minimise the risk of error. The use of calculators to determine the volume or quantity should not act as a substitute for arithmetical knowledge and skill.

10.0. Supervision of Self Administration

- 10.1. It is acknowledged that some patients/families do not need their medicine to be given by a HCP, but may need help and supervision with self-administration and preparation for self-administration. Wherever possible, to promote independence and re-ablement, patients should be encouraged and educated to self-administer their medicines. However, this must be allowed only after a thorough assessment of risk has been done and evidence of competence has been observed.

11.0. Use of Multi Compartment Compliance Aids (MCA)

- 11.1. MCA may be of value to help some patients who have difficulty managing their medicines and maintaining independent healthy living, they are not the best intervention for all patients and many alternative interventions are available. The

evidence-base indicates that MCAs should not automatically be the intervention of choice for all patients.

- 11.2. Patients who need support with taking their medicines should have their needs individually assessed and where assessment indicates an MCA is the intervention of choice, it is important that this is supported with the provision of information, appropriate counselling and follow up for the patient and that staff are aware of the legal, professional and practice considerations. (See Appendix 5 for details).
- 11.3. Only MCAs that have been supplied by Pharmacies can be used to administer medicines to minimise risks associated with MCAs.
- 11.4. Only Pharmacy staff can fill MCAs all other Staff should not in any circumstances fill in Multi Compartment Compliance Aids.
- 11.5. Patients who fall under the Disability Discrimination Act have a right to receive reasonable support from their Community Pharmacist to support them in taking their medicines e.g. printed charts stating what medicines to be taken at what time of the day or large printed labels.

12.0. Recording Administration

- 12.1. Accurate records of medicines administered must be in the MAR Charts/Drug Chart. This must include the date and time of administration, route, frequency, site of administration and dose given. Staff must legibly sign the record. (Batch numbers and expiry date should also be recorded for vaccines).
- 12.2. If for any reason the patient declines the medication or the staff decides not to administer the medicine, including vaccinations / immunisations, the prescriber must be informed as soon as possible (the same day) and the reasons/implications discussed with the patient/carer to ensure their understanding. Staff must clearly document the name of the Prescriber that he/she has informed, the discussion with the patient/carer, the reason for the omission and the outcome in the patient-held record, and/or electronic records.
- 12.3. Non-administration of medicine must be recorded in the MAR Chart/Drug chart, using appropriate codes for stating the reason.
- 12.4. Records must be completed at the time of the administration/refusal or as soon as possible thereafter and must be clear, legible and auditable.
- 12.5. Any changes or discontinuations to medicines must be authorised by the prescriber with written evidence of the same.

13.0. Adverse Drug Reactions and Medication Errors

- 13.1. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. All Patient Safety Incidents should be reported on DATIX regardless of whether harm was caused to the patient or not.
- 13.2. As part of the ongoing evaluation of the patient's care and treatment, the effects of medicines on the patient must be observed and documented. The effects and side effects of the treatment and any variances to expected outcomes must be reported to the Prescriber/MDT and on DATIX.
- 13.3. Where adverse drug reactions are experienced advice should be sought from the prescriber/ out of hours services/pharmacy on management. Details of the reaction

should be documented in the patient records, reported on DATIX and through the Yellow Card system.

- 13.4. Any error in the administration or supervision of medicines must be recorded in the patient records, reported immediately to the Prescriber and the Senior Nurse or Senior HCP on duty.
- 13.5. Appropriate action must be taken to ensure patient safety.
- 13.6. The patient/relative/carer must be advised of the error and the patient's condition monitored and recorded as appropriate.

14.0. Controlled Drugs

- 14.1. In In-patient areas, Controlled Drugs must be checked and administered by two Nurses.
- 14.2. In the In-patient area a stock check must be carried out daily by two Nurses, or a registered nurse and other HCP, and recorded in the appropriate section of the CD Register. Medication counters, if available, must be used when counting tablets in bottles. Quantities of liquids should be estimated as accurately as possible.
- 14.3. In the Community administration of Controlled Drugs may be carried out by one member of staff.
- 14.4. In the Community the stock of Controlled Drugs must be checked, counted, reconciled and clearly recorded at the time of every administration and preferably by the patient or carer, where appropriate, if no other authorised witness available. Medication counters if available must be used when counting tablets in bottles. Quantities of liquids should be estimated as accurately as possible.
- 14.5. If a discrepancy in the number or volume of a CD is found this must be reported to the Senior Manager and Pharmacist immediately so that an investigation can be carried out. A DATIX form must be completed.
- 14.6. **Refer to** The Safe Management of 'Patient's Own' Controlled Drugs in a Domiciliary Setting Guideline and the Trust Controlled Drug Guideline for more details.

15.0. Treatment of Anaphylaxis

- 15.1. All staff involved in the administration of medicines by injection must undergo annual training in the treatment of anaphylaxis. It is the responsibility of Staff (with the exception of HCPs administering insulin and other subcutaneous injectable medicine) to ensure they have immediate access to an in-date adrenaline pack at all times.
- 15.2. Prior to the administration of vaccines, subcutaneous, intramuscular or parenteral medicines, a detailed history must be available which should include:
 - Current medication – to check for possible drug interactions
 - History of previous drug reactions
 - History of allergic reactions e.g. hay fever, asthma, eczema, nettle rash (hives)
- 15.3. If there is any doubt concerning the advisability of carrying out the procedure, the medicine should be withheld and immediate advice/clarification sought.
- 15.4. It is advisable for the patient to be observed for 10-15 minutes following an injection,

particularly after the first, second and third injection.

15.5. ACTION - In the event of anaphylaxis:

- Call for immediate assistance – dial 999 as the patient requires immediate medical attention. If in the In-patient setting, also ensure the on-call doctor is informed immediately.
- Lay patient in recovery position – ensure airway is clear
- Administer **intramuscular** adrenaline injection 1 in 1000 (1mg/mL) as per the table below.
- The best site for IM injection is the anterolateral aspect of the middle third of the thigh.
- The needle used for injection needs to be sufficiently long to ensure that the adrenaline is injected into muscle. Use a suitable syringe for measuring small doses for children under 6 years.
- Do not leave the patient unattended. Record vital signs as soon as possible (consciousness level, airway, pulse, blood pressure, respiratory pattern, pulse oximetry, ECG). This will help monitor the patient's response to adrenaline. Monitoring of conscious level, airway, pulse, blood pressure, respiratory pattern and pulse oximetry must be recorded at least every fifteen minutes and an incident form must be completed.
- If there is no improvement in the patient's condition in 5 minutes, repeat the administration of the IM adrenaline dose. Further doses can be given at about 5-minute intervals according to the patient's response.

AGE	DOSE	VOLUME OF ADRENALINE (EPINEPHRINE) 1 IN 1000
Adult and adolescents (over 12)	500 micrograms	0.5 mL
if child/adolescent is small or prepubertal	300 micrograms	0.3 mL

16.0. Complementary and Alternative Therapies

- 16.1. Complementary and alternative therapies are increasingly used in the treatment of patients. Complementary therapies encompass a variety of non-systemic therapies such as aromatherapy, body massage, reflexology, head massage, etc. These therapies are intended to be used alongside (i.e. to complement) conventional medical and psychological therapies.
- 16.2. In contrast, the term alternative therapies is used to describe treatments that are used instead of conventional approaches, e.g. homeopathy. Any staff member wishing to use an 'alternative' therapy instead of conventional treatments must seek prior authorisation from the Trust Medicines Committee.
- 16.3. Staff who use complementary /alternative therapies must have successfully undertaken training and be competent in this area. Staff must assess the appropriateness of the therapy based on the condition of the patient and any co-existing treatment and should discuss the use of any complementary and alternative therapies with their Line Manager and the patient's GP. It is essential that this information is discussed with the patient and informed consent is obtained and documented. The therapy must be an integrated part of the individual patient's care plan.
- 16.4. The pharmacist should also be contacted for advice on any possible drug interactions.

17.0. Covert Administration of Medicines

- 17.1. Medicines must only be administered covertly to people who actively refuse their medication, and who are considered to lack mental capacity, in accordance with an agreed management plan. The plan must be agreed by the MDT.
- 17.2. Where considered necessary, covert administration of medicines must be carried out within the context of existing legal and best practice frameworks.
- 17.3. Please refer to the Trust Covert Administration of Medicine Guideline for more details in In-Patient settings.

18.0. Monitoring

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Actions on recommendations and leads	Change in practice and lessons to be shared
How the Organisation makes sure that all prescription charts are accurate	Chief Pharmacist	Audit	Annual	The Chief Pharmacist receives the audit	The Team Leads will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit.	The Medicines Committee will Receive and Discuss the report and Monitor the action plan.

Appendix 1: Competency Assessment of Drug Administration

INTRODUCTION

This assessment is for use when concerns about the ability of a registered nurse to safely administer medicines have been raised.

The NMC Code (2008) (Standards of conduct, performance and ethics for nurses and midwives) states that 'you must have the knowledge and skills for safe and effective practice when working without direct supervision...You must recognise and work within the limits of your competence'.

The safe administration of medicines is an essential competence for admission to the NMC register. The administration of medicines is not a task to be carried out solely in accordance with a prescription; it requires Nurses to exercise their professional judgement in determining whether it is appropriate that the patient receive a medicine.

Nurses are accountable for their actions and omissions.

Assessment of a Registered Nurse may only be made by an experienced Registered Nurse with a recognised teaching/assessing qualification. Direct observation of administration to a minimum of 12 patients is required to assess competence.

ASSESSMENT TOOL FOR MEDICINES ADMINISTRATION

Name of Candidate:

Date of Assessment:

Name & Signature of Assessor:

Criteria	Achieved			Comments
	Yes	No	N/A	
Clearly explains and demonstrates the correct process for storage of medicines				
Attends to hand hygiene as per policy before, during and after administration of medicines to each patient				
Retrieves the correct chart for the correct patient; checks patient identity				
Check allergy status and takes action accordingly				
Checks which medicines are due and that they have not already been administered				
Confirms prescription is legible, dated, signed by authorised prescriber and that dosage, route and timings are correct,				
Articulates the therapeutic uses of the medicines to be administered, normal dose, route, side effects, precautions and contra-indications				
Articulates knowledge of the patient's condition and care plan				
Makes appropriate decision to administer/withhold the medication in the context of patient's condition.				
Contacts the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable				
Gains patient consent for administration				
Selects appropriate medicine, correct dose,				

correct formulation (tablet/ liquid/ injection etc.), expiry date				
Explains medicines/gives appropriate education to the patient;				
Ensures patient takes medicines				
Is able to explain why it is unacceptable to leave medicines on table/locker/ unsecured.				
Makes a clear, accurate record of medicines administered, intentionally withheld or declined by the patient, ensuring the signature is clear and legible and that appropriate action follows if medicine withheld/declined.				
Demonstrates clear understanding of what to do if a patient has an anaphylactic reaction				
Clearly explains what constitutes a drug error				
Demonstrates clear understanding of the steps to take in the event of a drug error				
Able to demonstrate the correct process for storage, administration and documentation of controlled drugs				
Demonstrates clear understanding of what to do if written error occurs in CD book				
Demonstrates the correct process for managing patient's own CD				
Takes correct action if prescription is not correct/clear/appropriate				
Shows clear understanding of the need to countersign student Nurse signature when teaching and supervising student in drug administration				
Shows clear understanding of the role of the Pharmacist and works in collaborative manner with Pharmacy department				
Shows clear understanding of how to order all types of medicine and how to obtain medicines 'out of hours'				
Has successfully completed drug calculation test paper				

ASSESSOR COMMENTS:

.....

In the event that the Nurse does not demonstrate competence, an action plan must be outlined above and re-assessment made within 2 weeks of completion of actions. Failure to achieve competence following reassessment will require referral to the capability route.

Assessor: I certify that has demonstrated competence in drug administration in line with the above criteria/has not demonstrated competence and requires a development plan

Name & signature of Assessor..... Date.....

Nurse: In line with the above criteria, I confirm that I am competent to administer medicines. Should my level of proficiency fall, I will seek immediate remedial action and support and advise my Manager

Name & Signature of Nurse.....Date.....

Appendix 2: Sample Drug Calculations for Adult Nursing

Refer to the Queens University Belfast website for further calculation samples on:

<http://www.qub.ac.uk/elearning/public/NumeracySkillsforDrugCalculations/Year2ChildExamples/IntermediateDrugCalculations/>

1. How many mgs in a gram?
2. How many mcg in 1mg?
3. How many mls in a litre?
4. Change 0.78 grams to mg
5. Change 34 mgs to grams
6. Change 0.086mg to mcg
7. Change 50ml to litres

8. Change 0.25mg to mcg
9. Calculate the amount of distilled water which must be added to 350ml of stock solution to make 2 1/2 litres of diluted solution
10. An injection of 8mg of morphine is prescribed. The ampoule you have contains 10mg in 1ml. What volume would you draw up?
11. Pethidine 85mg is prescribed IM. Stock ampoules contain 100mg/2ml. What volume do you draw up?
12. How many 30mg tablets of codeine phosphate are required for a dose of 0.06g?
13. A patient is prescribed 375mg of penicillin orally. Stock tablets are 250mg. How many tablets should the patient have?
14. How many drops of blood per ml does a blood infusion set administer?
15. How many drops of crystalloid fluid does a standard infusion set administer?
16. One litre of normal saline is prescribed for administration over 10 hours. How many drops per minute should be given?
17. A unit of whole blood is prescribed over 4 hours. The unit contains 480mls of blood. How many drops per minute should be administered?
18. 75 mg of aspirin is prescribed. Stock tablets are 300mg. How much of the tablet would you administer?

Drug Calculation Questions Answers

1. 1000
2. 1000
3. 1000
4. 780mg
5. 0.34g
6. 86mcg
7. 0.05L
8. 250mcg
9. 2150ml
10. 0.8ml
11. 1.7ml
12. 2
13. 1.5
14. 15
15. 20
16. 33 drops per min... volume X drops of giving set / time in minutes 1000 X
20/600 = 33
17. 30 drops per min.... 480/240 x 15
18. 0.25 or 1/4

Paediatric Drug Calculations

Paediatric dose calculation is usually based on either body surface area (mg/m²) or body weight (mg/kg) of the child. Body weight is used more frequently for ease of calculations.

The calculation of body surface area (BSA) used to require both weight and height. In 1998, the UK Chemotherapy Standardisation Group (UKCCSG) approved the use of the estimation of body surface area in infants and children based on weight alone.

To calculate drug doses, use the following formula:

Dose required / Present Standard Quantity of Drug X Present Quantity of Liquid in which

Standard Quantity of Drug is Dissolved

In other words:

What you want / What you have X What it is in (dilution)

Example 1: A child is prescribed 90mg of Paracetamol and the medication supplied is 120mg of Paracetamol in 5mls:

$$90 / 120 \times 5 = 3.75\text{mls}$$

Example 2: A child is prescribed oral solution of Ranitidine 60mg. medication supplied is 75mg in 5mls:

$$60 / 75 \times 5 = 4\text{mls}$$

Example 3: A child is prescribed intravenous injection of Teicoplanin 180mg. A vial of Teicoplanin 400mg with diluent of 4mls:

$$180 / 400 \times 4\text{mls} = 1.8\text{mls}$$

Consider the displacement value to determine volume after dilution. Some intravenous injections or infusion may need further dilution before administering IV, follow instructions written on the drug chart, check the paediatric formulary/BNF or use Trust guidelines.

Medication errors arising from poor mathematical skills of nurses are an ongoing problem (Preston, 2003).

To ensure safety:

- Take time working out calculations
- Recheck answers
- Do not be rushed by colleagues/patients/parents/ carers
- Answers that look wrong probably are wrong and an initial mental estimate of the dose may be useful.

The use of calculators should never be used as a substitute for arithmetical knowledge and skills. The use of calculators has caused much debate but it is acknowledged it is safe to use calculators as part of the checking process (Preston, 2003).

Appendix 3- Medicines Returned for Destruction Receipt

MEDICINES RETURNED FOR DESTRUCTION RECEIPT
NAME and ADDRESS OF PHARMACY:

QUANTITY	ITEM	CD	INITIALS	
			PHARMACY	RETURNEE
<i>I CONFIRM THAT I HAVE RETURNED THE ABOVE ITEMS TO THE PHARMACY INDICATED ABOVE</i>		NAME:		
		SIGNATURE:		
		DATE:		
<i>I CONFIRM THAT I HAVE RECEIVED THE ABOVE ITEMS</i>		NAME:		
		SIGNATURE:		
		DATE:		

Appendix 4: Sample List of Cytotoxic and Cytostatic Medicines

Non-chemotherapy cytotoxic / cytostatic drugs	Cancer chemotherapy drugs
Anastrozole	Aldesleukin
Azathioprine	Alemtuzumab
Bicalutamide	Amsacrine
	Arsenic trioxide

Chloramphenicol – classified as a category 2A carcinogen and as such will include eye drops with a concentration of 0.1% (the legal threshold in waste legislation)	Asparaginase
Ciclosporin	Bleomycin
Cidofovir	Bortezomib
Coal tar containing products	Busulphan
Colchicine	Capecitabine
Danazol	Carboplatin
Diethylstilbestrol	Carmustine
Dinoprostone	Cetuximab
Dithranol containing products	Chlorambucil
Dutasteride	Cisplatin
Estradiol	Cladribine
Exemestane	Cyclophosphamide
Finasteride	Cytarabine
Flutamide	Dacarbazine
Ganciclovir	Dactinomycin
Gonadotrophin, chorionic	Daunorubicin
Goserelin	Dasatinib
Interferon containing products (including peginterferon)	Docetaxel
Leflunomide	Doxorubicin
Letrozole	Epirubicin
Leuprorelin acetate	Estramustine
Medroxyprogesterone	Etoposide
Megestrol	Fludarabine
Menotropins	Fluorouracil
Mifepristone	Gemcitabine
Mycophenolate mofetil	Gemtuzumab
Nafarelin	Hydroxycarbamide
Oestrogen containing products	Idarubicin
	Ifosfamide
	Imatinib mesylate

Oxytocin(including syntocinon and syntometrine)	Irinotecan
Podophyllin	Lomustine
Progesterone containing products	Melphalan
Raloxifene	Mercaptopurine
Ribavarin	Methotrexate
Sirolimus	Mitomycin
Streptozocin	Mitotane
Tacrolimus	Mitoxantrone
Tamoxifen	Oxaliplatin
Testosterone	Paclitaxel
Thalidomide	Pentamidine
Toremifene	Pentostatin
Trifluridine	Procarbazine
Triptorelin	Raltitrexed
Valganciclovir	Rituximab
Zidovudine	Temozolomide
	Thiotepa
	Topotecan
	Trastuzumab
	Vidaradine
	Vinblastine
	Vincristine

Appendix 5 - Practice considerations for the use of MCA

The following practice considerations support the best use of MCA, following an individual patient assessment that an MCA is the intervention of choice.

<p>Protecting Children</p> <p>Counsel patients and carers about the potential risks of MCA to children.</p>	<p>It is important to understand that MCA packaging is extremely unlikely to be child resistant and may not be tamper evident. This is a potential risk, particularly to children, so patients and carers should be informed of this risk and advised to take particular care with the storage of their medicines.</p>
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<p>Packaging considerations</p> <p>Do not repackage MCA by inclusion of the original strip or blister packaging.</p>	<p>Medicines should not be repackaged within MCA in their original strip or blister packaging as there have been reports of patients swallowing the medicine and its packaging resulting in gastric perforation¹⁻³ or pelvic abscesses.⁴ The MCA package should be sealed as soon as possible after filling.</p>
<p>Medication changes</p> <p>Counsel patients not to attempt to make changes to the contents of an MCA and to instead contact the pharmacy.</p>	<p>Patients and carers should be advised not to attempt to make any changes to the contents of an MCA as this could place the patient at risk due to the difficulties in identifying medicines. Instead they should be advised to contact the pharmacy where the MCA was dispensed.</p> <p>Due to the potential complexity of adding or removing medicines mid-cycle, the safest, most effective and efficient way to achieve this should be agreed through local discussion between the pharmacist, the patient, the care provider and the prescriber. In some instances it may be more practical to action changes at the end of a supply cycle depending on the urgency of the changes proposed.</p>
<p>Spillage</p> <p>Counsel patients on steps to take if the content of the MCA is spilled.</p>	<p>When MCA are supplied, pharmacists should advise patients or carers on the steps they should take in the event of medicines spillage. If the contents are spilled, the patient or carer should not try and put the medicines back into the MCA, but should be encouraged to return the packaging and the medicines to the pharmacy where they were dispensed for arrangements to be made for resupply. Depending upon the circumstances this may require a new prescription or an emergency supply.</p>
<p>Understanding Accountability</p> <p>Be aware of potential accountability and liability for repackaging medicines outside of their original packaging.</p>	<p>Prescribers, pharmacists and other stakeholders must understand the potential liability issues when requesting or supplying a medicine in an MCA. Removing a medicine from the manufacturers packaging, which has been designed to provide the required protection and repackaging the medicine in an MCA is activity which would not be covered within the marketing authorisation.</p> <p>The consequences of this are that such removal would result in responsibility for the stability of the repackaged medicines transferring from the manufacturer to the prescriber, pharmacist and other stakeholders, with the relative liability depending on the individual circumstances. When making a professional judgment it is important that pharmacists ensure that the best interests of the patient, the available evidence and an integrated assessment and care plan are at the heart of the decision-making process. The decision-making process relating to this should be documented with the appropriate signed agreement and consent.</p>
<p>Controlled drugs</p> <p>Be aware that controlled drug legislation applies to controlled drugs stored or supplied within MCA.</p>	<p>Medicines containing controlled drugs should be assessed in the same way as other medicines (see appendix 2) before deciding whether or not to repackage within an MCA. In situations where the controlled drug requires safe custody and has already been repackaged within the MCA with other medicines, the whole MCA must be stored in a controlled drug cabinet prior to collection. If an entry in the controlled drug register is necessary, this should be made at the time of supply. The addition of a controlled drug to an MCA is unlikely to be appropriate in situations where the dose and strength of the preparation may need to change rapidly to accommodate the patient's condition, e.g. palliative care.</p>

<p>Identifying medication within an MCA</p>	<p>It is commonplace for different proprietary (branded) medicines or generic medicines with the same active ingredient to be available for use within a pharmacy. This creates problems if these are repackaged into MCA as the physical appearance of proprietary and generic versions of medicines containing the same active ingredient can vary.</p> <p>Many people using MCA have multiple morbidities with many routinely taking between ten to fifteen medicines. When presented in the same compartment in an MCA, it can be difficult to distinguish or identify each medicine, even if descriptors are available.</p> <p>There are inherent difficulties in identifying medicines repackaged within an MCA. This can lead to loss of independence and cause confusion to patients and carers (formal and informal) when they are trying to identify medicines, e.g. if they are choosing not to take a medicine at a specific time for life style reasons (such as with a diuretic). This also provides a challenge for care providers who must be able to identify the medication when they are administering medicines.</p> <p>This problem can also lead to waste and delay when the person transfers from one care setting to another, where to reduce costs the patient's own medicines are being used wherever possible e.g. into hospital or care home. Staff may be unhappy to continue to use the MCA if they cannot guarantee that the accuracy of the medicines in the same way that they can with an original pack.</p> <p>An accurate description of the appearance of each medicine accompanying an MCA can be useful for patients, carers and healthcare professionals to identify the medicines prescribed, dispensed and administered. We are aware that with the use of some MCA systems, this may not always be possible in practice.</p>
<p>Expiry Date</p> <p>Be aware of stability issues and expiry of repackaged medicines.</p>	<p>There is a lack of published data to demonstrate the stability of medicines in MCA which could be used to determine appropriate expiry dates.</p> <p>In the absence of applicable data and in order to support practice, RPS recommends a maximum interim expiry date of eight weeks for products in sealed MCA. This pragmatic decision was taken to support pharmacists in their practice and was based on current practice rather than having any scientific basis. However, it should be recognised that there may well be circumstances where an expiry date of less than eight weeks is used for a product in a sealed MCA if this is recommended by the medicines manufacturer or indicated by published scientific studies. With regard to unsealed MCA, it has been common practice since 1987 to store medicines in daily dose reminders for up to seven days. This seven day expiry date for unsealed MCA is an arbitrary timescale which reflects what typically happens in practice as, in most cases, unsealed MCA have sufficient space for seven days medication.</p> <p>Arbitrary expiry dates suggested for MCA are generally kept as short as possible in recognition that there are often little or no data to support these periods. However, as with all arbitrary shelf lives, there will be medicines that have specific stability issues where the appropriate expiry date is shorter than the suggested arbitrary life.</p>

<p>Record Keeping</p> <p>Keep appropriate supporting documentation to maintain an audit trail and to support decisions.</p>	<p>The provision of an MCA should be viewed as a package of care, with the appropriate supporting documentation which should be recorded and retained where available e.g. patient assessment documentation, decisions and reasons for medicines inclusion/exclusion, follow up, note of changes to medicines and who requested change, note of when medicines are collected or delivered, carer details and appropriate clinical information. This supports both patient care and helps to justify decisions made.</p>
<p>Hygiene and contamination</p> <p>In all circumstances, the pharmacy must ensure that the MCA is filled ensuring that poor hygiene, microbial contamination or cross contamination do not present a risk to the patient.</p> <p>Medicines must only be supplied in an MCA that is suitable for use.</p> <p>Medicines must not be handled with bare hands.</p>	<p>The risks of microbial contamination and of cross contamination by medicines, especially from uncoated tablets must be minimised to prevent risk to patients at all stages of filling the MCA.</p> <p>If the MCA or any part of the packaging system is not disposable, then it must be thoroughly cleaned before reuse in accordance with advice of the manufacturer of the MCA.</p> <p>Depending upon the circumstances, the responsibility for ensuring MCA are maintained in an acceptable state of hygiene will, by agreement, rest with the patient, carer or pharmacy.</p> <p>However, in all circumstances the pharmacy must only supply medicines within an MCA that is suitable for use.</p>
<p>Delivery</p>	<p>Patients who live alone are particularly vulnerable. Consider and mitigate the risks of delivery of MCA to these patients as there is a reduced ability to review how well the patient is managing their medicines.</p>
<p>Frequency of supply</p>	<p>Agree the frequency of supply with the prescriber, patient and pharmacy ensuring that arrangements are in place to manage the risks if multiple packs are available at the same time. There must be appropriate communication between health and social care professionals so that supply requirements or restrictions are understood.</p>
<p>Labelling</p> <p>Be aware of the importance of labelling information and provide accurate descriptions.</p>	<p>Legislation requires that a dispensing label should be prepared for each item dispensed into an MCA and attached directly to the packaging each time the medicine is dispensed.</p> <p>With some MCA, there is insufficient space to accommodate all the medicine labels and as a pragmatic solution, the labels are often attached to a separate card which accompanies the MCA. In this case, systems should be in place to ensure the card with the up-to-date medicine labels is linked to the MCA tray containing the medicine and there is no risk of separation.</p>

<p>Patient information leaflets</p> <p>Be aware of the importance supplying information about medicines to patients and legal requirements in relation to patient information leaflets.</p>	<p>When medicines are dispensed into an MCA, it remains a legal requirement that a patient information leaflet (PIL) is supplied for every dispensed medicinal product included. The RPS believes that patients and carers should always have access to a PIL for every medicine and should always be able to identify the medicine to which the PIL relates. We recognise that in practice, with patient and carer consent, a safe outcome can be achieved by sensible and pragmatic alternatives to supplying a PIL on each and every occasion and this view has been included in the RPS responses to the Medicines Act consolidation and review consultation in 2012. However, it still remains a legal requirement to supply a PIL with all medicines and pharmacists should carefully consider the implications of not supplying one.</p>
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