Administration Of Medication Procedure	Procedure Number *WCDHB-PN-0037*	Version Nos: 7

1. Purpose

This Procedure is performed as a means of ensuring the safe administration of therapeutic medication to patients in accordance with all legislative and regulatory requirements.

2. Application

This Procedure is to be followed by all nursing staff throughout the West Coast District Health Board (WCDHB).

3. Definitions

For the purposes of this Procedure:

Prescribing medications is the responsibility of the Doctor;

Dispensing medications is the role of the Pharmacist;

Administration of medications is undertaken by nurses.

4. Staff Authorised To Perform Procedure

This Procedure shall be performed by a:

i) Registered nurse(RN)/midwife; or

ii) Enrolled nurse / nurse assistant; or

iii) Student nurse under RN supervision.

5. Resources Required

This Procedure requires:

i) prescribed medication;

ii) kidney dish;

iii) syringe packs;

iv) drug treatment sheet.

6. Process

1.00 Introduction

Medication may only be administered with:

(a) reference to the prescription;
(b) knowledge of the health status of the patient, including allergies and/or adverse reaction status;
(c) knowledge of the action of the medication, its recommended dosage and any precautions associated with the medication;
(d) knowledge of service-specific practices.

2.00 Administration Of Oral Medications (Tablets, Pills, Capsules and Liquid Medications

2.01 Review written prescription for the medication

2.02 Prepare medication as per the written prescription (for liquids, invert bottle to ensure mixing)

2.03 Have the medication checked as per the requirements of the WCDHB Medication Policy.

2.04 Correctly identify patient.

2.05 Check for any notification of medication allergies/adverse reactions.

2.06 Explain Procedure to patient.

2.07 Obtain informed consent from patient. If the patient refuses to give consent, then the nurse is required to:
(a) notify the doctor who prescribed the medication;
(b) document the outcome.

2.08 Remain with patient until patient swallows medication.

2.09 Immediately after administering the medication, document the administration and sign in the patients medical record (as per the *WCDHB Clinical Documentation Procedure*).

2.10 Monitor and record the patient's response to the medication.

2.11 If the patient starts to exhibit side effect or problems after the administration of the medication, the prescribing doctor is to be notified immediately.

3.00 Intramuscular Injections

3.01 Review doctor's order and check with another nurse.

3.02 Wash hands and collect appropriate equipment/resources.

3.03 Correctly identify patient.

3.04 Obtain informed consent from patient.

3.05 Explain Procedure to patient.

3.06 Ensure privacy of patient by closing curtains around bed or closing door to room.

3.07 Select appropriate injection site (See GUIDELINES)

3.08 Gently tap injection site to stimulate nerve endings and minimise pain

3.09 Clean skin at site using antiseptic wipe.

3.01 Position syringe at 90º angle to skin surface.

3.11 Inform patient that they will feel a pricking sensation as the needle is inserted through the skin.

3.12 Quickly and firmly thrust the needle through the skin and subcutaneous tissue into the muscle.

3.13 Support the syringe with the non-dominant hand and pull back on the syringe with the dominant hand.

3.14 If no blood appears, slowly inject the medication into the muscle. There should be little or no resistance against the force of the injection.

3.15 If blood appears in the syringe as aspiration, the needle is in a blood vessel. Stop the injection, withdraw the needle and prepare another injection site using new equipment and inject into another site.

3.16 Gently but quickly remove the needle at a 90º angle to skin surface.

3.17 Cover the injection site immediately and apply gentle pressure. Unless contraindicated for the medication injected, massage the muscle to help distribute the medication.

3.18 Inspect the injection site for any signs of active bleeding or bruising. If bleeding continues apply pressure to the site. If bruising develops, apply ice to the area.

3.20 Dispose of equipment (including gloves) according to standard precautions.

3.21 Wash hands.

3.22 Document in patient's clinical case notes procedure and its outcome.

3.23 Immediately after administering the medication, document the administration and sign in the patients medical record (as per the *WCDHB Clinical Documentation Procedure*).

3.24 Monitor and record the patient's response to the medication.

3.22 If the patient starts to exhibit side effect or problems after the administration of the medication, the prescribing doctor is to be notified immediately.

4.00 Hypodermic/Subcutaneous Injections

4.01 These are given into the highly vascular subcutaneous tissue immediately beneath the epidermis.

4.02 No more than 1ml should be given into any one site, unless specified by the Doctor.

4.03 The administration of medications by this method is the same as for 3.00, except that:
(i) a 25/26 gauge needle should be used;
(ii) do not rub the injection site;
(iii) the needle is inserted on a 90° angle with the skin pinched between the thumb and forefinger.

5.00 Instillation Of Eye Drops

5.01 Wash hands and collect appropriate equipment/resources.

5.02 Correctly identify patient.

5.03 Explain Procedure to patient.

5.04 Obtain informed consent from patient.

5.05 Ensure privacy of patient by closing curtains around bed or closing door to room.

5.06 Check directives to ensure correct eye is treated.

5.07 Wash hands and uncap medication dispenser

5.08 Encourage patient to tilt their head back slightly, and using forefinger gently pull lower lid (conjunctival sac) down.

5.09 Encourage patient to look upwards

5.10 Drop prescribed amount of medication into centre of lid.

5.11 Instruct patient to slowly close their eyes, but not to squeeze/rub them, and then open them.

5.12 Wipe away excess solution with gauze.

5.13 Recap dispenser

5.14 Remove equipment and wash hands.

5.15 Document the Procedure in the patient's clinical record.

6.00 Instillation Of Ear Drops

6.01 Wash hands and collect appropriate equipment/resources.

6.02 Correctly identify patient.

6.03 Explain Procedure to patient

6.04 Obtain informed consent from patient.

6.05 Ensure privacy of patient by closing curtains around bed or closing door to room, and ensure adequate lighting.

6.06 Check directives to ensure correct ear is treated.

6.07 Wash hands and uncap medication dispenser

6.08 Encourage patient to turn their head with affected ear in an upward position

6.09 Straighten the auditary canal by holding aurical upwards and backwards

6.01 Instil prescribed amount of medication

6.11 Instruct patient to remain in that position for 5-10 minutes. Support their head with a pillow if necessary.

6.12 Wipe away excess medication on external ear with gauze.

6.13 Remove equipment.

6.14 Wash hands

6.15 Document the Procedure in the patient's clinical record.

7.00 Vaginal Suppositories

7.01 Wash hands and collect appropriate equipment/resources.

7.02 Correctly identify patient.

7.03 Explain Procedure to the patient.

7.04 Obtain informed consent from the patient.

7.05 Ensure privacy of patient by closing curtains around bed or closing door to room.

7.06 Position patient on their left side with knees drawn up

7.07 Put on disposable gloves

7.08 Lubricate index finger and tip of suppository

7.09 Insert suppositories gently, approximately 5cm upward and backward into the vagina.

7.10 Make patient comfortable

7.11 Discard used disposable equipment appropriately.

7.12 Document the results of the Procedure in the patient's clinical record.

8.00 Rectal Suppositories

8.01 Wash hands and collect appropriate equipment/resources.

8.02 Correctly identify patient.

8.03 Explain Procedure to the patient.

8.04 Obtain informed consent from the patient.

8.05 Ensure privacy of patient by closing curtains around bed or closing door to room.

8.06 Position patient on their left side with knees drawn up

8.07 Put on disposable gloves

8.08 Lubricate index finger and tip of suppository

8.09 Insert suppositories gently beyond the internal anal sphincter

8.10 Wipe anal area and encourage patient to rest

8.11 When required, assist patient to the toilet.

8.12 Discard used disposable equipment appropriately.

8.13 Document the result of the Procedure in the patient's clinical record.

7. Precautions And Considerations

- ➔ Review written prescription for the medication prior to administration
- ➔ Have the medication checked as per the requirements of the WCDHB Medication Policy
- ➔ Check for any notification of medication allergies/adverse reactions prior to administration
- ➔ If the patient starts to exhibit side effect or problems after the administration of the medication, the prescribing doctor is to be notified immediately.

8. References

Code of Health and Disability Services Consumers' Rights (1995)
Health Practitioners Competence Assurance ACT 2003
New Zealand Nursing Council Code of Conduct for Nurses and Midwives (1995)
Health Act (1956)
Hospitals Act (1957)
Hospitals Regulations (1993)
Medicines Act (1981)
Medicines Regulations (1984)

9. Related Documents

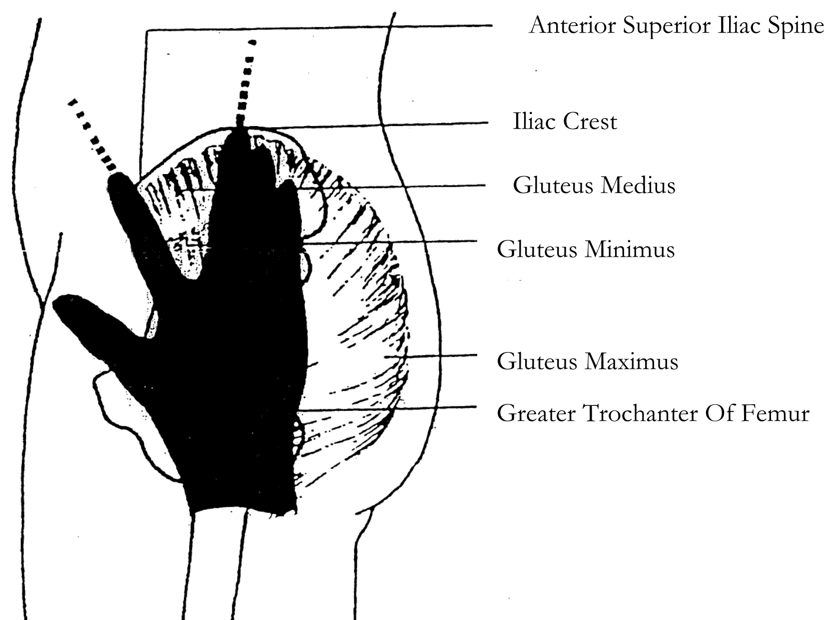
WCDHB Administration of Medications by Students Procedure
WCDHB Controlled Drugs Procedure
WCDHB Emergency Orders and Verbal Orders Procedure
WCDHB Medication Errors Procedure
WCDHB Medication For On-Leave Patients Procedure
WCDHB Medication Policy
WCDHB Nurse Initiated Medication Procedure
WCDHB Nursing Policy
WCDHB Nursing Standards
WCDHB Practice Development Programme
WCDHB Refusal of Medications by Patients Procedures
WCDHB Self-Medicating Patients
WCDHB Storing and Labelling Medications Procedure
WCDHB Use of Traditional and Alternative Medications Procedure

10. Guidelines

Siting Of Gluteal Intramuscular Injections

The recommended position for siting of gluteal injections is into the ventrogluteal muscle as this site poses less risk of damage to the sciatic nerve:

- landmark with patient lying on side, prone or supine
- patient is to flex leg of injection site to relax muscles
- landmark as in diagram below
- inject into centre of "V"



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