Seirbhís Sláinte Nios Fearr á Forbairt | Building a Better Health Service

Office of the Nursing & Midwifery Services Director

Completion of the Medicines Request and Administration Record for Public Health Nursing Services

☐ Policy ■ Procedure ☐ Protocol ☐ Guideline

HSE National Public Health Nursing Service : Primary Care

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2.7 PART A: Outline of PPPG Steps

Title: Completion of the Medicines Request and Administration Record for Public Health Nursing Services

The steps to be taken to complete a request to the Public Health Nursing Service for the administration of a medication are;

2.7.1 Completion of the Request Form

A1.1 The authorised prescriber must complete a full assessment of the patient prior to prescribing a particular medication.

A1.2 The authorised prescriber must obtain an informed consent from the patient in relation to the recommended course of treatment and this is documented in the patient's clinical record.

A1.3 **Only** the official Health Service Executive (HSE) Medicines Request and Administration Record (MRAR) for Public Health Nursing Services is to be used. The MRAR will be available in electronic and paper format. The MRAR is completed in black ink if completed manually.

A1.4 It is recommended that the MRAR is completed by the authorised prescriber. The date of the request is clearly noted in the required section of the form.

A.1.5 All demographic information is completed providing a minimum of three unique identifier data fields (NICE, 2015).

A.1.6 Any known drug allergies are noted.

A.1.7 A full list of current medication to include prescribed, over the counter, homeopathic and herbal therapy is attached as a separate document where applicable. If the patient is on no other medications tick the "no" box.

A.1.8 The generic name (when possible) of the drug to be administered, is entered in block letters, the dose, the route of administration and the frequency of which the drug is to be administered are all stated legibly in the required data entry fields. As insulin is a high alert medication, when prescribing insulin the word "units" must be written in full. (HSE, 2010; IMSN, 2010; NPSA, 2010).

A.1.9 Use of the generic name when prescribing reduces the potential for confusion and error. The following drugs should be prescribed by brand name:

- Combination products e.g. Frumil®

- Narrow therapeutic index drugs where changing brand might affect drug levels, e.g. modified-release theophylline, lithium, anti-epileptic medication, immunosuppressant drugs (e.g. ciclosporin or mycophenolate)
- Certain modified release preparations, e.g. Dilzem®
- Controlled drug opiates, e.g. OxyContin®, BuTrans®
- Insulins
- Medication of biological origin, e.g. etanercept, pegfilgrastim, erythropoietins

A.1.10 An indication for the need and purpose of the prescribed medication is outlined.

A.1.11 The start date the medication administration is to commence is completed.

A.1.12 The period the drug is to be administered for is indicated by inserting a date in the "administer until" data field.

A.1.13 The request will be valid for a maximum of nine months* (DoHC, 2020). After the nine month period the indication for the medication is reviewed and a decision is made on whether to continue the administration of the medication or to discontinue. If the treatment is to continue a new request must be completed.

* As per temporary amendment (DoH 2020)

A.1.14 Additional relevant information should be provided as relevant by highlighting any treatment precautions. ie medical history, blood test results etc.

A.1.15 The authorised prescriber electronically or manually signs the MRAR, prints their name, includes their professional registration number and enters the date the form was completed.

A.1.16 The request remains the responsibility of the prescriber. If any part of the request is unclear the medication should not be administered by the registered nurse/midwife and the prescriber must be contacted to rewrite the request. The nurse can record an non – administration code, see section **A.1.22**

A.1.16.1 If the prescriber requests administration of medication in another format i.e. not on the MRAR, the prescriber must submit a request with all of the required fields to comply with the NMBI guidance on medicine administration (https://www.nmbi.ie/NMBI/media/NMBI/NMBI-Medication-Administration-2020.pdf?ext=.pdf) in order for the nurse to administer the medication. If the

prescriber administration request complies with all of the criteria, the request can be attached to the MRAR and the nurse can use the MRAR for an administration record. If the prescribers request does not comply with the guidance from NMBI the nurse should not administer the medication and seek clarity from the prescriber.

A.1.17 The following routes of administration are approved for use under the scope of this procedure; oral, topical, transdermal, inhaler, eye drops, sublingual, intramuscular injection, subcutaneous injection, per rectum, per vaginal, central venous access device cannula (CVAD) patency maintenance and PEG. The nurse should be familiar with the Summary of Product Characteristics leaflet that is enclosed with the medication. Syringe drivers are excluded from the scope of this procedure. Intravenous medications are excluded from this policy.

A.1.18 The following medications are excluded from the scope of this procedure; insulin sliding scale therapy, medication doses that vary based on blood results and drug cycles e.g. chemotherapy cycles.

A.1.19 The following patient categories are excluded from the scope of this procedure;

- children with complex medical needs and children with life limiting conditions
- patients requiring the administration of psychiatric medication under the care of the mental health services
- children receiving vaccinations administered as part of a school vaccinating programme.

A.1.20 Only acceptable abbreviations as listed in Part B section **1.8.1** of this procedure can be used.

A.1.21 Any amendments required to the MRAR following a review of the patient must be entered as a new request. This includes adjustments to the drug dose. Medication changes will not be accepted by alteration to an existing request.

A.1.22 In the event the medication is not administered. The reasons for non-administration codes should be used (codes 1- 6)

1. Patient did not attend/ not at home
2. Patient refused (see section **2.7.5**)
3. Medication unavailable

4. Withheld as per Doctors Instructions
5. Awaiting clarification (See section **A.1.16**)
6. Other

2.7.2 Communication processes

A.2.1 Confidentiality of patient information must be protected at all times in accordance with current data protection legislation.

A.2.2 The acceptable method of sending MRAR is by post, via the patient/family member or via secure email ie. healthmail. When emailing a request the sender should ensure a read receipt notification is applied. If faxing is utilised in the absence of established electronic communication systems, it must be through a secure confidential fax system using pre-programmed fax numbers and in accordance with locally agreed protocols. If the initial request form was sent by fax the original request form must be forwarded within the agreed local specified timeframe (NMBI, 2007). Healthlink electronic resources once fully developed and available will be the primary mode of communication of medicines administration requests.

A.2.3 Local systems should be put in place to ensure requests furnished via healthmail are accessed in a timely manner if the assigned area community nurse is on leave.

A.2.4 The patient is informed by the prescriber that a request for medicine administration has been issued to the public health nursing service.

2.7.3 Record Keeping

A.3.1 All assessments both medical and nursing in relation to the medication to be administered are recorded in the relevant patient's clinical record.

A.3.2 Electronic versions of the form must be printed as a double-sided document (120gsm paper is recommended).

A.3.3 All records are held in accordance with local caseload file management procedures.

A.3.4 Administering nurses must ensure they verify the date and time of last administration by checking both sides of the form prior to next administration to ensure a dose is scheduled/due. Additional administration recording space is available overleaf for each numbered request.

A.3.5 Additional copies of the nurse administration record if required (page 2 of the form) may be attached to the record securely in chronological order and should be clearly labelled with patient details.

A.3.6 On discontinuation of treatment or on discharge of the patient from the nursing caseload a note is recorded in the patients nursing record and all prescribing and administration documentation is filed within the patient's nursing file and archived in accordance with local procedures. The records are the property of the Health Service Executive.

A3.7 In the event a record of injection site rotation is required, a sample document is available in Appendix VII. Ensure the patients demographic details are recorded on the injection site rotation document and the document should be securely affixed to the MRAR.

2.7.4 Quality Assurance

A.4.1 Medicinal products legislation authorises the registered medical practitioner or dentist to prescribe medication through the Medicinal Products (Prescription and Control of Supply) Regulations, 2003 (Statutory Instrument (SI) 540 of 2003) and Medicinal Products (Prescription & Control of Supply) (Amendment) Regulations 2020.

A.4.2 More recently, the Irish Medicines Board Act (Miscellaneous Provisions) Act, 2006 (No. 3 of 2006), and the Medicinal Products (Prescription and Control of Supply) (Amendment), Regulations 2007 (SI 201 of 2007) give legal authority to nurses and midwives to prescribe medications. The Nursing and Midwifery Board of Ireland (NMBI) registration number (also known as the Personal Identification Number (PIN)) must be stated on the prescription of Registered Nurse Prescribers. The NMBI regulatory requirements for registered nurse and registered midwife prescribers are outlined in *Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority* (NMBI, 2019).

A.4.3 Best practice would indicate that the responsibility for completing the medication administration request is with the authorised prescriber.

A.4.4 In relation to administration "the individual nurse or midwife is responsible for undertaking relevant continuing professional development and education in order to develop and maintain their knowledge, skills and competency in medication administration" (NMBI, 2020). Medication administration should be carried out in accordance with local and national policies.

A.4.5 The request remains the responsibility of the prescriber. If any part of the request is unclear the medication should not be administered by the registered nurse/midwife and the prescriber must be contacted to rewrite the request. See section **A.1.16**.

A.4.6 There must be clear communication systems in place if the patient is receiving nursing care from more than one nursing service/provider in order to avoid duplication or omission of administration.

2.7.5 Refusal of Patient to take a medication

A.5.1 In the event a patient refuses the medication a non-administration code (section **A.1.22**) is entered on the MRAR, signed and dated by the nurse.

A.5.2. A note is entered by the administering nurse into the clinical nursing record outlining the date and time of refusal of a medication and reason for the refusal.

A.5.3 The administering nurse will contact the prescriber to inform them that the patient has declined to accept the medication administration.

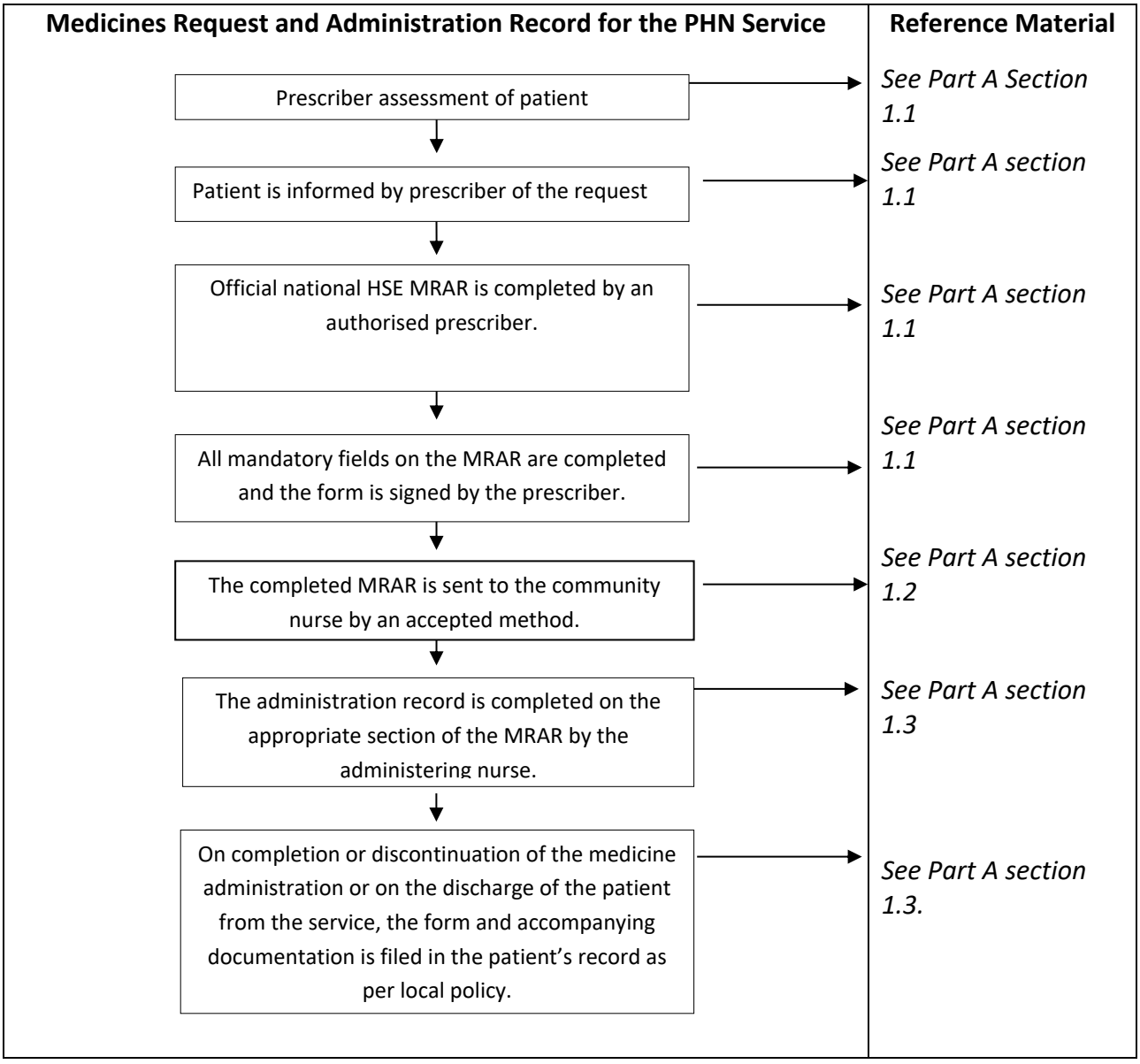
A.5.4 The patient's decision to decline a service and the patient's autonomy is respected. All health professionals involved must seek a balance in respecting the patient's rights, assessing risk and protecting the patient from harm in meeting their professional responsibilities (HSE, 2014; HIQA, 2016).

A.5.5 If a patient declines a recommended medical treatment and it is the professional's judgement (NMBI, 2015) that this patient is vulnerable requiring safeguarding, the health professional must report their concerns in writing to the safeguarding and protection team as per the HSE Safeguarding of Vulnerable Persons procedures. (HSE, 2014).

A.5.6 All concerns in relation to the care of vulnerable persons must be discussed with the relevant line manager and a risk assessment completed and escalated if required.

A.5.7 A note is entered into the patient's clinical health record outlining the professional recommendations for medication, the discussions that took place with the patient (and legal guardian as appropriate) in relation to these recommendations and that the patient has declined the treatment.

2.7.6 Process map of procedure



PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

The purpose of this procedure is;

1.1.1 To provide guidance to RPHN's, RGN's and RNP's, and doctors on the processes to issue a request to a nurse working in the PHN service to administer a prescribed medication to a patient.

1.2 Scope

The scope of this procedure identifies what will (and will not) be covered by the procedure

1.2.1 **Target users**; this procedure applies to registered nursing staff in the Public Health Nursing service nationally. This includes Directors of Public Health Nursing, Assistant Directors of Public Health Nursing, Nursing Practice Development Co-ordinators, Registered Public Health Nurses, Registered General Nurses, Registered Nurse Prescribers, Registered Midwives and locum/agency nurses working in the PHN service. It applies to GP's and Practice Nurse RNPs. It applies to Community Intervention Teams (CIT) who are governed by a DPHN. It applies to acute hospitals issuing a request to the public health nursing service for medication administration.

1.2.2 **Population to whom it applies**; this procedure applies to all patient categories receiving a clinical service within the PHN service. It does not apply to children with complex medical needs or to children with life-limiting conditions. Hospital requests will be accepted from acute general hospitals. The following hospitals are not included under the scope of this procedure; maternity, psychiatric or paediatric hospitals.

1.3 Objectives

1.3.1 To ensure the safe and effective management of prescriber requests to the PHN

service to administer medication to patients on the community nursing caseload.

1.4 Outcomes

1.4.1 Explicit, up to date written request documentation is available for all patients requiring the administration of medication by the community nursing service in that patient's health care record.

1.5 PPPG Development Group

1.5.1 See Appendix II master copy for Membership of the PPPG Development Group.

1.5.2 See Appendix III master copy for PPPG Conflict of Interest Declaration Forms.

1.6 PPPG Governance Group

1.6.1 See Appendix IV master copy for Membership of the Approval Governance Group.

1.7 Supporting Evidence

1.7.1 **Relevant Legislation:**

Department of Health and Children (2007) *Medicinal Products (Prescription and Control of Supply) (Amendment), Regulations 2007 (SI 201 of 2007)*

Department of Health and Children (2020) *Medicinal Products (Prescription & Control of Supply) (Amendment) Regulations*

Irish Medicines Board (2006) *The Irish Medicines Board Act (Miscellaneous Provisions) Act, 2006 (No. 3 of 2006)*

Department of Health and Children (2003) *Medicinal Products (Prescription and Control of Supply) Regulations, 2003 (Statutory Instrument (SI) 540 of 2003)*

Relevant PPPGs;

Health Information and Quality Authority (2015) *Medicines Management Guidance.* Dublin: Health Information and Quality Authority.

Health Information and Quality Authority (2014) *Guidance for Health and Social Care Providers: Principles of Good Practice in Medication Reconciliation*.

Nursing and Midwifery Board of Ireland (2019) Practice Standards and Guidance for Nurses and Midwives with Prescriptive Authority

Nursing and Midwifery Board of Ireland (2020) Guidance for Registered Nurses

and Midwives on Medication Administration

Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice Professional Guidance.*
Nursing and Midwifery Board of Ireland (2015) *Scope of Nursing and Midwifery Practice Framework.*
Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.*
Nursing and Midwifery Board of Ireland (2007) *Guidance to Nurses and Midwives on Medication Management*

Health Service Executive (2018) *National Nurse and Midwife Medicinal Product Prescribing Policy*
National Institute of Clinical Excellence (NICE) (2015) *Medication Optimisation: the Safe and Effective Use of Medicines to Enable Best Possible Outcomes*.

1.7.2 All samples of existing local CHO procedures on medication management informed the development of this procedure.

1.7.3 Related Legislation;

Department of Health and Children (2000) *Circular 41/2000*
Department of Health and Children, (1970) *Health Care Act*
Department of Health and Children, (1966) *Circular 27/66 District Nursing Service*
Pharmacy Act, 2007,

1.7.4 Related PPPG's:

Department of Health and Children, (2001) *Primary Care: A New Direction*
Health Information and Quality Authority (2016) *Supporting Peoples Autonomy: a Guidance Document*

Health Information and Quality Authority (2012) *National Standards for Safer Better Healthcare*

Health Service Executive (2010) Health Services Executive Code of Practice for Healthcare Records Management

Health Service Executive (2011) Risk Management in the HSE: an Information Handbook

Health Service Executive (2011) Developing and Populating a Risk Register: Best Practice Guidance
Health Service Executive (2011) Standards and Recommended Practices for Healthcare Records Management

Health Service Executive (2013) Record Retention Periods: Health Service Policy

Health Service Executive (2017) National Consent Policy

Health Service Executive (2019) Electronic Communications Policy

Health Service Executive (2019) Data Protection Guidelines

1.8 Glossary of Terms

1.8.1 Abbreviations:

ADPHN -	Assistant Director Public Health Nursing
CHO -	Community Health Care Organisation
CIT-	Community Intervention Team
CPA -	Collaborative Practice Agreement
DPHN -	Director Public Health Nursing
GP -	General Practitioner
HIQA -	Health Information and Quality Authority
HSE -	Health Services Executive
IMSN -	Irish Medication Safety Network
INN -	International Non-Proprietary Name
NMBI -	Nursing and Midwifery Board of Ireland
ONMSD -	Office of the Nursing and Midwifery Services Director
PC -	Primary Care (Community)
PEG-	Percutaneous Endoscopic Gastrostomy
PPPG -	Policy Procedure Protocol Guideline
RGN -	Registered General Nurse working in the PHN service
RM-	Registered Midwife
RNP -	Registered Nurse Prescriber
RPHN -	Registered Public Health Nurse
SPC	Summary of Product Characteristics

Medication related abbreviations;

Please refer to the HSE approved list for drug prescribing for further guidance: Section 2: Page 7 to 14.
https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/abbreviations.pdf
* Never abbreviate International Units, Micrograms, Nanograms or Units.

1.8.2 Definitions:

Administration: Giving an individual dose of a medicinal product to a patient/service-user via direct contact (e.g., orally, by injection) or by indirect contact (e.g., application of a medicated dressing) and ensuring the completion of this activity.

Dosage Strength: the strength of a drug product which indicates the amount of active ingredient in each dosage.

Drug Formulation: The drug form varies by the route of administration. E.g. capsules, tablets etc.

Indication (for a drug): the use of that drug for treating a particular disease. Drugs often have more than one indication, which means there is more than one disease for which it could be used. Indications may be diagnostic, prophylactic or for therapeutic purpose https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/abbreviations.pdfs. (Royal Marsden Manual of Clinical Nursing Procedures, 2015).

Medicine: any substance or combination of substances presented as having properties for treating or preventing disease in human beings. (Royal Marsden Manual of Clinical Nursing Procedures, 2015).

Must: Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed (NMBI, 2018).

Person: A person means an individual who uses health and social care services. In some instances, the terms 'client', 'individual', 'patient', 'people', 'resident', 'service user', 'mother', or 'baby', 'child', 'young person' are used in place of the term person depending on the health or social care setting (NMBI, 2018).
For the purposes of this procedure the term patient will be used throughout.

Prescribe: To authorise in writing the dispensing, supply and administration of a named medicinal product (typically a prescription–only medicine, but may include over-the-counter medications) for a specific patient/service-user.

Prescription: 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, or by a registered veterinary surgeon for the purposes of animal treatment or a registered nurse for the medical treatment of an individual subject to Article 3A of the Regulations (Misuse of Drugs (Amendment) Regulations, 2007).

Professional Judgement: A nurses professional judgement is based on the principles of responsibility, accountability and autonomy as outlined within her professional scope of practice (NMBI, 2015).

Should: Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, 2018).

Transcribing: the act of transferring a medication order from the original prescription to the current medication administration record/prescription sheet (NMBI, 2007).

2.0 DEVELOPMENT OF PPPG

2.1 List the questions (clinical/non-clinical)

Will a standardised written format for prescribers to request community nurses to administer medication to a patient contribute to safer medication management practice?

2.2 Describe the literature search strategy

A review of the relevant literature was undertaken for the period from 2000 to date. Based on the key question defined above a literature search strategy was developed. The main database used was CINAHL (Cumulative Index to Nursing and Allied Health). A search was performed using the following search terms "*community nurs* "*, "*medication administration*", "*drug chart*", "*district nurs* "*, "*home/domicillary*", "*safe**", "*incidents*" and "*documentation*" using AND and OR Boolean combinations to source articles of relevance. Only English language publications and articles published after 2000 were included. A number of articles specific to acute hospital inpatient medication management identified in the search process were excluded for the purpose of this procedure as were articles specific to complex medical conditions or treatments. All relevant articles were reviewed.

The search also included library searches of clinical books and online relevant statutory reports. Samples of local CHO and national procedural documentation/guidelines on medication management were sourced and reviewed specifically in relation to the request and authorisation to administer medication. Sample international guidelines were reviewed from the district nursing service in the UK (See Section 8.0 references).

In addition a search of relevant websites both in Ireland and the United Kingdom was undertaken. The following websites were accessed in January 2018 and reviewed in September 2020 to identify publications and guidelines that related to the subject area; Nursing Midwifery Board of Ireland; Health Information Quality Authority, Ireland; Health Service Executive, Ireland and the NICE guidelines website UK. Relevant documents accessed were reviewed.

2.3 Describe the method of appraising evidence

The evidence in relation to medication administration authorisation was considered. When appraising all the research evidence the following areas were considered;

- Are the results valid?
- What are the results?
- Are the results applicable to the population of the PPPG?

The evidence found consisted predominantly of medication safety audits, review journal articles and existing national, UK and NICE guidelines. One systematic review is included in the evidence gathered.

2.4 Describe the process the PPPG Development Group used to formulate recommendations

The recommendations are formulated through a formal structured process whereby the following were considered and documented:

- The evidence available to answer the clinical questions.
- The quality of the evidence.
- The applicability of the evidence to the Irish population and healthcare setting.
- The potential benefit verses harm to the population/patient.

The literature search results were limited in relation to documentation specific to the design of medication administration request documentation in the community and therefore evidence related generally to the subject was considered.

In the early stages of the Safe Administration of Medication project a decision was made by the Advisory Group to review current practice in medication administration requests issued to community nurses in the PHN service nationally. This included a review of sites that had a request form in use locally. This review produced a Summary Report with recommendations. The findings of this report in addition to evidence findings sourced on literature review were reviewed and discussed by the Advisory Group and these discussions informed the development of this PPPG.

This is a management operational procedure for the PHN service nationally and therefore Irish statutory guideline publications supported by the NICE guideline 5 predominantly informed the development of the first draft of recommendations. The draft PPPG was circulated to the Safe Administration of Medication Project Advisory Group for consultation and approval in February 2018 and the revised draft was sent in October 2020.

2.5 Provide a summary of the evidence from the literature

The following is a summary of the supporting evidence from the literature for this PPPG. The summary will focus firstly on the importance of safe medication

administration authorisation, the Irish policy documents in relation to medication management and optimisation, the challenges experienced in the community and the recommended processes to minimise adverse medication events.

Legislative frameworks, government regulations and professional regulations govern medicines management practices in Ireland. The Medicinal Products (Prescription & Control of Supply) (Amendment) Regulations, 2007; SI 201 of 2007 legislation states that only authorised healthcare practitioners can legally prescribe medicines in Ireland and outlines the medicines that require a prescription. Good medicines management is essential to assure high standards in the clinical care of patients. The HSE's multi-disciplinary Medicines Management Programme (MMP) was established in 2013 to enhance evidence-based and cost-effective prescribing and to optimise patient safety (HSE, 2016; HSE, 2018).

National and international standards on medication safety and evidence based guidelines provide recommendations on safe medication management systems. Medicines management covers all the following aspects; assessing, supplying, prescribing, dispensing, administering, reviewing and assisting people with their medicines. Medicines contribute to the health and wellbeing of people but these benefits are accompanied by risk. A "*quality use-of-medicines"* approach promotes good health outcomes (HIQA, 2012; HIQA, 2015). NICE (2013) medicines optimisation programme outline the key principles of safe medication management practices. Principle 3 of medicines optimisation includes safe processes and systems and effective communication between professionals.

Healthcare professionals have an important role in helping to ensure medication safety. An important part of this is engaging with people and discussing their medicines with them. The HSE launched a national medication safety campaign in July 2019 to promote a greater awareness of medication safety among the public and health professionals. The call for action of the campaign is **Know Check Ask**. The aim of the campaign is to encourage those taking medication and their caregivers to take an active role in managing their medication. The three key messages to individuals are; **Know**: about each of their medicines and encouraging them to keep an up-to-date medicines list, **Check**: they know how to use their medicines correctly and **Ask**: discussing medicines with the person taking them and answering any questions they may have (health professionals).

This HSE medication safety campaign has been developed in line with the World Health Organisation (WHO) Global Patient Safety Challenge *Medication without Harm* (WHO,

2017). The aim of the WHO challenge is to reduce severe avoidable harm by 50% globally over the next 5 years. Medication safety at transitions of care must involve the improvement in the quality and availability of information and identifying the most reliable information sources for verifying medication histories. These could include patient-held medication record (medication passport), information technology systems to facilitate reconciliation processes, and electronic health records to facilitate smoother transitions (WHO, 2019). Adverse Drug Events are the third most common type of adverse events in the Irish Healthcare System (Rafter et al., 2017) with 8.8% of emergency admissions being drugs related (Ahern et al., 2013). Safe prescribing at transitions of care can be particularly problematic. With traditional medication history taking, Irish research has shown that 41% of patients had at least one medication error or omission at admission to hospital (Grimes et al, 2014). In 56% cases patients experienced prescribing errors and miscommunication at the time of discharge (O' Riordan et al., 2016). People who use a memory aid, such as a medicines list, could recall their medicines accurately (65%) than those who did not (21%), providing a more reliable initial medication history (Fitzsimons et al., 2011). Health professionals may still need to verify a person's medicines list with an additional reliable source of information as no single source is complete for everyone. Such options include: contacting the community pharmacy or contacting the GP practice which are complete for 77% and 69% of people respectively (Fitzsimons et al., 2011).

An audit carried out by the UK's National Patient Safety Agency (NPSA) in 2007 provided statistics on medication incidents. This found the most frequently reported types of medication incidents involve: wrong dose, omitted or delayed medicines and the wrong medicine (NPSA, 2009). The National Reporting and Learning Service (NRLS) regularly reviews the incidents reported from the NHS in England and Wales. The NRLS has published two reports that identify risks and areas for action that aim to help ensure that medicines are used safely and prevent similar incidents from happening again. *Safety in Doses* (2007) analysed almost 60,000 incidents reported between January 2005 and June 2006. *Safety in Doses* (2009) analysed 72,482 medication incidents reported to the NRLS by frontline NHS staff in acute, mental health and primary care sectors between January and December 2007. This NPSA audit found 32% of errors occurred with prescribing and 41% with the actual administration of medication (NPSA, 2007).

The prescribing of medication is the most common form of medical intervention (Chetan et al, 2014). Medication error is the most common type of error affecting patient/service-user safety and is the most common single preventable cause of adverse events (National Medicines Information Centre, 2001). A hospital based study found that 5.9% of hospital consultants and 10.3% of trainee hospital doctors made prescribing errors in one week (Dornan et al., 2009). An estimated 1.7 million serious prescribing errors occurred in general practice (Avery et al, 2012). A study by Shah et al found that in a typical GP setting 7.5% of prescriptions contained an error (Shah et al,

2001). E-prescribing or the utilisation of electronic systems to facilitate the communication of a medicine order or prescription has been shown to reduce medication errors (Porterfield et al, 2014). In a systematic review by Reckmann et al (2009) nine out of 13 studies demonstrated a significant reduction in prescribing errors when e-prescribing was used.

There is evidence of increasing demands on community nursing to administer more medications to more complex patients as a result of changing demographics, increasing elderly population, greater chronic disease burden and earlier hospital discharges. The nurse is accountable for the safe administration of medications and it is probably the most common clinical procedure she will undertake, therefore carrying a higher level of risk. To ensure safe practice the nurse must have a sound knowledge of the therapeutic use, usual dose, side-effects, precautions and contraindications of the drug being administered (Royal Marsden, 2015). The Nursing and Midwifery Board of Ireland provides guiding principles to all nurses on responsibility, accountability and autonomy in relation to patient care. These outline expectations in meeting the standards of care of the profession and include sound professional judgement, nursing actions and omissions of care (NMBI, 2015 & 2014). NMBI's 2020 document "*Guidance for registered Nurses and Midwives on Medication Administration"* provides guidance to nurses and midwives in this specific area (NMBI, 2020).

It is important that up to date and accurate information on the patient's allergy status is available to reduce medicine related harm to patients (Cassam et al., 2014; IMSN, 2012; NMBI, 2007 pg. 12). An audit community nursing drug charts in Brent, Harrow and Ealing (UK) found low allergy box completion rates (58%). The authors acknowledged that allergy information may have been documented in the nursing notes but the drug chart is the final document checked before administration and therefore is an ideal location to document allergies. Another finding that caused concern was the absence of a second patient identifier such as Date of Birth. This increased the risk of administering medication to the wrong patient and in the absence of a hospital number/identify band is an important identifier in the community setting.

Almost 50% of administration activity involved end of life or diabetic care and the most commonly administered drug was insulin. The administration of insulin highlighted risk as the prescription failed to clearly state the word units. As insulin is considered a high alert medication the word "units" must be written in full when prescribing (Cassam et al., 2014) (www.ismp.org). The National Patient Safety Agency in the UK between August 2003 and August 2009 received 3,881 wrong dose incident reports involving insulin. These included one death and one severe harm incident due to 10-fold dosing errors from abbreviating the term 'Unit' (NPSA, 2010). The Cassam audit did highlight issues around a lack of clarity between prescribing and transcribing. The NMBI

medication guideline states that transcribing should only happen in exceptional circumstances (NMBI, 2007).

Community nursing services have come under increased strain in recent years with patients being discharged earlier from hospital, increases rates of chronic disease and more patients with complex nursing care needs. Transfer information between services can be poor particularly in relation to medication management. Community nurses are lone workers and there is an absence in most cases of a second nurse to verify queries or cross check in relation to medication administration. All of these factors increase the level of risk for medication errors and it is important that the HSE has clear processes and guidelines for medication management. A national HSE PPPG and related authorisation template containing all the required data fields will assist all health professionals involved to deliver safe practice in medication management.

2.6 Detail resources necessary to implement the PPPG recommendations

Existing resources and the further development of secure electronic communication systems ie electronic version of form, healthmail and use of health link as rolled out via the eHealth strategy.

2.7 Outline of PPPG Steps/Recommendations

An outline of the procedural steps and recommendations to be followed are in Part A Pages 4 –9.

3.0 GOVERNANCE AND APPROVAL

3.1. Outline Formal Governance Arrangements

This national procedure was sponsored by the Office of Nursing and Midwifery Services Director and the National Community Operations Division. Final approval of the procedure was issued from the sponsors and follow up reviews will be initiated from Community Operations: Primary Care Office. Refer to Appendix IV for Membership of the Approval Governance Group. This national document will be submitted to the National Central Repository Office for referencing when this office is established.

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs

The design of the form was informed by the project site evaluations completed in 2017 and as outlined in the evaluation summary report. Development of the draft procedure was undertaken with representation of key stakeholders from frontline services to identify any issues in presentation, clinical processes recommended within, recommendations for implementation and any further suggestions. The first draft of

the document was circulated to the Safe Administration of Medication Project Advisory Group for feedback. Consensus was reached by the group on whether to accept or reject suggested amendments from feedback. Subsequent changes were recorded and all feedback received is available with the master copy of the procedure. The final version of the document was circulated to the Safe Administration of Medication Project Advisory Group for recommendation for approval from National Community Operations. The PPPG Checklist (Section 3.4) was reviewed in conjunction with the final revised procedure to ensure compliance with the standards as outlined in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (2016). This completed checklist and the final draft of the procedure was submitted to the Operational Division of Community Operations and to the Office of the Nursing and Midwifery Services Director to confirm that all stages in the revision of the procedure had been completed and met the National Standards for Clinical Practice Guidance (NCEC, 2015). The procedure was approved for national implementation. A signed and dated master copy will be retained within the Office of the Nursing and Midwifery Services Director, Dr Steevens Hospital.

3.3 Attach any copyright/permission sought

No copyright or permissions are required in relation to this procedure.

3.4 Insert approved PPPG Checklist

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	**Tick ✓**
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	✓
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	✓
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	✓
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	✓
The views and preferences of the target population have been sought and taken into consideration (as required).	**X**
The overall objective(s) of the PPPGs are specifically described.	✓
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	✓

Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	✓
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	✓
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	✓
Information and support is available for staff on the development of evidence-based clinical practice guidance.	✓
There is service user/lay representation on PPPG Development Group (as required).	**X**

Stage 2 Development	**Checklist**
The clinical question(s) covered by the PPPG are specifically described.	✓
Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented).	✓
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, Limitation's and methodological quality of the body of evidence are clearly described).	✓
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	✓
There is an explicit link between the PPPG and the supporting evidence.	✓
PPPG guidance/recommendations are specific and unambiguous.	✓
The potential resource implications of developing and implementing the PPPG are Identified e.g. equipment, education/training, staff time and research.	✓
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	✓
Budget impact is documented (resources required).	**N/A**
Education and training is provided for staff on the development and implementation of evidence based clinical practice guidance (as appropriate).	✓
Three additional standards are applicable for a small number of more complex PPPG s: Cost effectiveness analysis is documented. A systematic literature review has been undertaken. Health Technology Assessment (HTA) has been undertaken.	**N/A**

Stage 3 Governance and Approval	**Checklist**
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	✓
The PPPG has been reviewed by independent experts prior to publication (as required).	✓
Copyright and permissions are sought and documented.	✓

Stage 4 Communication and Dissemination	Checklist
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	✓
Plan and procedure for dissemination of the PPPG is described.	✓
The PPPG is easily accessible by all users e.g. PPPG repository.	✓

Stage 5 Implementation	Checklist
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	✓
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	✓
Education and training is provided for staff on the development and implementation of evidence based PPPG (as required). There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	✓

Stage 6 Monitoring, Audit, Evaluation	Checklist
Process for monitoring and continuous improvement is documented.	✓
Audit criteria and audit process/plan are specified.	✓
Process for evaluation of implementation and (clinical) effectiveness is specified.	✓

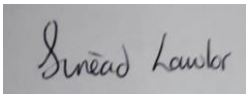
Stage 7 Revision/Update	Checklist
Documented process for revisions/updating and review, including timeframe is provided.	✓
Documented process for version control is provided.	✓

I confirm that the above Standards have been met in developing the following PPPG:

Name of PPPG: Medication Management: Completion of the Request Form to the Public Health Nursing Services for Medication Administration

Name of person signing off on the PPPG Checklist: Sinead Lawlor

Title of person signing off on the PPPG Checklist: National Practice Development Co-ordinator PHN Services/Project Lead for the Safe Administration of Medications PHN Service Project.

Signature of person signing off on the PPPG Checklist: 

Date: 15th of October 2020

This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved.

4.0 COMMUNICATION AND DISSEMINATION

4.1. Describe communication and dissemination plans

A draft of the procedure was forwarded to representatives of all key stakeholders. All feedback submissions were analysed. The final draft was submitted to the Office of the Nursing and Midwifery Services Director (ONMSD) for professional review and recommendation and to National Community Operations: Primary Care for final approval. The approved document will be circulated to all DPHNs nationally for dissemination to their respective departments and to all general practices and acute hospitals via existing established communication systems. A copy of the procedure is available on the HSE website to download at; National PHN Services: Primary Care; www.hse.ie/phn**.** Communication in relation to this procedure will clearly identify that it supports existing medication management procedures in place locally.

5.0 IMPLEMENTATION

5.1 Describe implementation plan listing actions, barriers and facilitators and timelines

As part of the exploring and preparing stage of implementation sample existing medication management procedures in place in local CHO's were reviewed in 2017 prior to preparing the first draft of this national procedure. This review assisted in identifying the existing barriers to safe practice in this area and the potential facilitator actions required for implementation.

A PPPG Development Group was established in January 2018 with membership representing key stakeholders. Feedback on the draft of the document was sought from the project Advisory Group.

On planning and resourcing consultation took place with the ICT and Healthlink teams re the current development of an electronic version of a primary care referral form (PHN services) and incorporating the medication request form into that electronic document. Existing channels of communication were utilised to inform all relevant staff of the request form and supporting documentation.

This approach ensured that all community nurses/GP's/acute hospitals understood and appreciated that the request form and associated procedure contributes to the effective and safe management of medication administration in the community nursing service.

5.2 Describe education/training plans required to implement the PPPG

To implement and operationalize the procedure a summarised document in the format of a Frequently Asked Question sheet was prepared in addition to completed samples of the form for illustrative purposes. Local induction programmes for new nurses commencing employment will include briefing on all PPPGs approved for use within the PHN service.

5.3 Identify lead person(s) responsible for the implementation of the PPPG

At national level the National Lead for Public Health Nursing and the National Practice Development Co-ordinator for PHN service will lead on the implementation of this procedure and address issues arising nationally with implementation. Within the Community Health areas the DPHN will be responsible in ensuring all nurses under her remit are aware of, have read and have signed the verification document (Appendix I) in relation to this procedure. Audit of the use of the procedure will be carried out as outlined in Section 6.1.2 of this procedure.

5.4 Outline specific roles and responsibilities

National Governance Group for Quality Improvement/Practice Development in the Public Health Nursing Services: The National Governance Group established in 2018 is responsible for developing and recommending national service PPPGs for use and submitting these PPPGs to the Primary Care Division and Director of the ONMSD for approval. On approval the Group will ensure the final approved copies are circulated to all DPHNs nationally. The Group will agree a review date for this procedure and in the event of amendments to legislation, HSE policy or other related PPPGs will initiate an earlier review as required.

Director Public Health Nursing: The DPHN is responsible for resourcing, implementing and managing and auditing this procedure within her area of responsibility. The DPHN will identify and support ongoing related educational opportunities to further enhance knowledge and skills in relation to medication management.

Assistant Director Public Health Nursing: The ADPHN is responsible for the implementation of the procedure through ensuring that current documents are available to all nurses in health centres. The ADPHN is responsible for ensuring that all community nursing staff has knowledge of the procedures to be followed within the document. The ADPHN is responsible for ensuring new nurses are informed of the procedure on induction. The ADPHN will ensure that all nurses are aware of any revisions to the procedure and ensure older versions of the procedure are removed from circulation. A database record of all nurses who has signed the signature sheet

(Appendix I) will be maintained by the ADPHN and the DPHN will be notified of any noncompliance with sign-off of the procedure.

Role of the RPHN and RGN: It is every nurse's responsibility to ensure they are working within their "Scope of Practice" at all times and that they identify their training needs to their manager to maintain standards of care (NMBI, 2015).

Each nurse is responsible for adhering to this procedure and to use it to guide their practice in the delivery of the service they provide. Each nurse is responsible for ensuring that they read and understand the document and sign the attached signature sheet. When areas of concern are identified, where legislation is known to have changed or where a health and safety risk is identified, it is the responsibility of each nurse to ensure that their ADPHN is informed in order to ensure appropriate review and amendments are made to the procedure.

Role of Nursing Practice Development Co-ordinator: The NPDC where in post support the development of excellence in the PHN service by promoting standardisation, quality assuring and evaluating nursing practice. She/he has a key role in the transfer of knowledge to frontline staff through the dissemination of current evidence based practice.

Role of Registered Nurse Prescriber: The RNP is responsible to ensure their name is entered in the Nurse Prescribers Division of the Register of the NMBI, be fully accountable and responsible for all aspects of their prescribing practice from a professional and legal perspective. They must maintain ongoing communication with members of the multidisciplinary team in order to enhance therapeutic outcomes for patients. They will issue prescriber requests for medication administration to community nurses as outlined within this procedure. When areas of concern are identified, where legislation is known to have changed or where a health and safety risk is identified in relation to the outlined procedures, it is the responsibility of each prescribing nurse to ensure that an appropriate review and amendments are made to the procedure.

Role of the Liaison Nurse The liaison nurse is responsible for adhering to this procedure and to use it to guide the delivery of the service. The liasion nurse should maintain ongoing communication with members of the multidisciplinary team in order to ensure use of the medication administration request form by GPs and acute services.

Role of Doctors: The doctor (GPs and acute hospitals) is responsible for all aspects of their prescribing practice from a professional and legal perspective. They will issue prescriber requests for medication administration to community nurses as outlined within this procedure. When areas of concern are identified, where legislation is known to have changed or where a health and safety risk is identified in relation to the outlined procedures, it is the responsibility of each prescribing doctor to ensure that an appropriate review and amendments are made to the procedure.

6.0 MONITORING, AUDIT AND EVALUATION

6.1. Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1. Monitoring of this procedure will occur by the ADPHN through professional Supervision, team meetings and documentation audit.

6.1.2. Audit of the operation of the procedure will be initiated by the DPHN in consultation with the local CHO audit lead. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012). Audit will be carried out retrospectively by the designated person appointed by the DPHN. This designated person may be the area nurse, a nursing peer, the ADPHN or other. This procedure will be the standard for audit using the attached audit tool (Appendix V). The objectives of the audit will be to provide evidence of compliance to the national procedure, identify areas for improvement, make recommendations and prioritise actions. Frequency of audit, sampling processes and timescales for completion will be determined at local level following the first initial audit in consultation with the local CHO audit lead*.*

6.1.3. Evaluation of the procedure will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings, direct patient feedback and through structured review surveys on the PHN service. Feedback from Your Service Your Say and through local formal complaints processes will be considered in any revision of the procedure.

7.0 REVISION/UPDATE

7.1 **Describe procedure for the update of the PPPG**

This procedure will be revised every three years on the date specified on the front page of the document. This review will be triggered by the National Community Operations: Primary Care office and the National Quality Improvement Governance Group/PHN Services.

7.2 **Identify method for amending PPPG if new evidence emerges**

Practitioners will assist in the revision of the procedure and also request an earlier review of this procedure where required if new evidence based practice is recommended.

7.3 **Complete version control update on PPPG Template cover sheet**

This is the revised national version of a procedure for the management of processes for prescriber requests to the PHN service for medication administration to a patient. See version control document on cover sheet for updated sections.

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9.0 APPENDICES

Appendix I	Signature Sheet
Appendix II	Membership of the PPPG Development Group (Master copy ONMSD)
Appendix III	Conflict of Interest Declaration Form Template (Master copy ONMSD)
Appendix IV	Membership of Approval Governance Group (Master copy ONMSD)
Appendix V	Audit Tool to review operation of this procedure
Appendix VI	Medicines Request and Administration Record for the Public Health Nursing Service
Appendix VII	Injection Site Rotation Document sample

Appendix I:

Signature Sheet

I have read, understand and agree to adhere to this Procedure: Completion of the Medicines Request and Administration record for the Public Health Nursing Service

Print Name	Signature	Area of Work	Date

Appendix V: Audit Tool to Review Operation of this Procedure

AUDIT TOOL FOR THE: Completion of the Medicines Request and Administration for the PHN Service

An Audit should be carried out within 9 months of implementation of this procedure using this audit tool. Frequency of audit, sampling processes and timescales for completions will be determined at local level following the first initial audit.

Please answer all questions indicating Yes or No and give a comment if applicable

	Question	**Yes**	**No**	**Comment**
1	Is the patient's full name present?			
2	Is the patient's full date of birth recorded?			
3	Is the patients address included?			
4	Is the patients contact phone number listed?			
5	Is the current request in date (i.e. requested within the last 9 months)?			
6	Is the drug allergies section completed?			
7	Are current medications listed /attached?			
8	Is the drug name written in block letters or typed?			
9	Is the indication for medication stated?			
10	Is the drug dose stated?			
11	Is the drug route stated?			
12	Is the frequency of administration stated?			
13	Is the start date for drug administration included?			
14	Is the duration of treatment included with a date entered in "*administer until*"?			
15	Is the prescriber's signature present?			
16	Is the prescriber's name (print) and registration number present?			
17	Is the date of the request recorded on the form?			
18	Is the patient aware of referral section been completed?			
19	Is the date and time (in 24 hr clock) of nurse administration completed in the appropriate administration section?			

20	Is the printed name and the signature of the nurse entered in the appropriate administration section?			
	Totals Percentage Compliance __ /20 ___ %	__ /20	__ /20	

Action Areas identified **Quality Improvement Plan:**
Date and time:
Audit completed by: **Title:**
Re-audit due date:
Primary Care/Health Centre: **CHO:**

Appendix VI: Medicines Request and Administration record for the Public Health Nursing Service

Latest Version Available at www.hse.ie/phn

Appendix VII

Injection Site Rotation Document sample

https://www.freeprintablemedicalforms.com/

Print as required

Affix label otherwise complete:
IHI:
Surname:
Forename:
DOB: dd/mm/yyyy
Address:
Eircode:

Insert the date in the appropriate box.