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**GUIDE TO THE HANDLING OF MEDICATION  
IN NURSING HOMES IN NSW**

This Information Bulletin encloses the attached document which **supersedes** the NSW Health Department's *Guide to the Poisons and Therapeutic Goods Regulation; Private Hospitals, Day Procedure Centres and Nursing Homes* (TG 115) in respect of **nursing homes only**.

The attached guide applies only to residential aged care facilities that are licensed as nursing homes in NSW under the Nursing Homes Act 1988. The guide has been developed to consolidate recent amendments to the Poisons and Therapeutic Goods legislation, which are specific for nursing homes only, and to provide best practice principles for the handling of medication in nursing homes.

The guide should be used by each nursing home as a basis for the development of detailed local policies and procedures for the handling of medication in their facility.

**This guide does not apply to aged care "hostels" in NSW, i.e. residential aged care facilities that are not licensed nursing homes.**

Hostels should instead refer to NSW Health Department **Circular 97/10**, *Guidelines for the Handling of Medication in Community-Based Health Services and Residential Facilities in NSW*, **Section 4, 'Residential Facilities'**, for guidance on best practice in these facilities. Copies of Circular 97/10 are available from the Better Health Centre on phone: (02) 9816 0452, or on the Internet at [www.health.nsw.gov.au](http://www.health.nsw.gov.au) under Publications & Reports.

This Information Bulletin is available on the Internet at [www.health.nsw.gov.au](http://www.health.nsw.gov.au) under Publications & Reports. For further information contact the Duty Officer, Pharmaceutical Services Branch, NSW Department of Health, on phone: (02) 9879 3214 or fax: (02) 9859 5165.

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

**NSW DEPARTMENT OF HEALTH**

**GUIDE TO THE HANDLING OF MEDICATION  
IN NURSING HOMES IN NSW**

This Information Bulletin **supersedes** the NSW Health Department's *Guide to the Poisons and Therapeutic Goods Regulation; Private Hospitals, Day Procedure Centres and Nursing Homes* (TG 115) in respect of **nursing homes only**.

The guide has been developed to consolidate recent amendments to the Poisons and Therapeutic Goods legislation, which are specific for nursing homes only, and to provide best practice principles for the handling of medication in nursing homes.

The guide was prepared following wide consultation with aged care organisations, the Commonwealth Department of Health and Ageing, and pharmacy, medical and nursing professional organisations.

A separate guide is being prepared for private hospitals and day procedure centres. Until a revised bulletin is issued for those facilities, TG 115 will remain current as a guide for private hospitals and day procedure centres and can be accessed on the Pharmaceutical Services Branch website at [www.health.nsw.gov.au/public-health/psb](http://www.health.nsw.gov.au/public-health/psb). Alternatively, contact the Branch on phone: (02) 9879 3214 to request a copy.

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## 1 INTRODUCTION

The term *nursing home* in this document means a residential aged care facility that is licensed as a nursing home in NSW under the Nursing Homes Act 1988.

The term *chief nurse* in this document means the Director of Nursing (however named) of the nursing home.

This Information Bulletin provides a guide to:

- a. The **legal requirements** for the handling of medication of the Poisons and Therapeutic Goods Act 1966, the Poisons and Therapeutic Goods Regulation 2002 (P & TG Regulation 2002; the Regulation) and the Nursing Homes Regulation 1996, as they apply to **nursing homes** in NSW. In the case of legal requirements, reference to the relevant legislation is given throughout the guide.
- b. **Best practice principles** for medication handling in nursing homes, as advised by the NSW Department of Health, in the interests of residents' safety.

**The guide is designed to assist nurses, pharmacists and medical practitioners in their legal and best practice obligations in regard to the handling of medication for nursing home residents.**

**Each nursing home in NSW should have in place its own detailed policies and procedures that are developed using this guide as a basis (Refer 3).**

**Note:** This guide does **not** apply to residential aged care hostels (that are not licensed nursing homes). Staff employed in hostels should instead refer to Section 4, "Residential Facilities", of NSW Health Department Circular 97/10, *Guidelines for the Handling of Medication in Community-Based Health Services and Residential Facilities in NSW*.

Copies of Circular 97/10 are available from The Better Health Centre on (02) 9816 0452 or look up Circulars under Publications & Reports on the NSW Health website at: [www.health.nsw.gov.au](http://www.health.nsw.gov.au).

Both nursing homes and hostels should refer to the Australian Pharmaceutical Advisory Council document, *Guidelines for medication management in residential aged care facilities*, (the APAC guidelines). For copies contact 1800 020 613.

## 2 POISONS SCHEDULES SUMMARY

Medicines are classified into different schedules in the NSW Poisons List according to the degree of control to be exercised over their availability to the public, in the interest of public safety.

The labelling on the manufacturer's pack is an indication of the schedule listing of a medicine, as outlined below.

**Unscheduled** – Over-the-counter medicines sold in supermarkets or pharmacies.

**Schedule 2** - Over-the-counter medicines sold in pharmacies only; labelled **PHARMACY MEDICINE**.

**Schedule 3** - Medicines sold in pharmacies only, directly handed to a customer by a pharmacist with advice if required; labelled **PHARMACIST ONLY MEDICINE**.

**Schedule 4** - Prescription only medicines other than Schedule 8 drugs; labelled **PRESCRIPTION ONLY MEDICINE**.

**Schedule 4 Appendix D** - Those Schedule 4 medicines listed in Appendix D to the Poisons and Therapeutic Goods Regulation 1994 due to their abuse potential (eg benzodiazepines, ephedrine, ketamine, anabolic androgenic steroids); labelled **PRESCRIPTION ONLY MEDICINE**. Special separate storage requirements apply to these drugs.

**Schedule 8** - Drugs of addiction; labelled **CONTROLLED DRUG**. Special separate storage and recording requirements apply to these drugs.

**Note:** Lists of Schedule 4 Appendix D and Schedule 8 drugs are available on the Pharmaceutical Services Branch website at [www.health.nsw.gov.au/public-health/psb](http://www.health.nsw.gov.au/public-health/psb). For copies phone the Duty Officer on (02) 9879 3214.

### **3 MEDICATION ADVISORY COMMITTEE**

In order to facilitate the quality use of medicines, each nursing home should establish, or have access to, a committee that is the responsible body for considering all aspects of medication use in the nursing home.

The committee, usually termed the *Medication Advisory Committee*, should include representation from medical practitioners, nurses (including the chief nurse) and pharmacists who are directly involved in the care of residents in the facility. Consideration should also be given to the inclusion of a representative(s) of the residents or their relatives/carers.

All decisions and policies determined by the Medication Advisory Committee should be effectively communicated to all relevant health professionals and nursing home staff. The chief nurse has the responsibility to ensure that the Committee's policies are put into practice.

For further advice on Medication Advisory Committees refer to the APAC guidelines. (Refer 1 INTRODUCTION).

## 4 OBTAINING SUPPLY OF MEDICATION

### 4.1 Individual Resident Prescriptions

'Prescription only' medication for the treatment of individual residents may only be obtained on the prescription of a medical practitioner, dispensed and labelled by a pharmacist for that individual resident.

Section 10 (4) (c), Poisons and Therapeutic Goods Act 1966.

An arrangement must be made between the nursing home management, the attending medical practitioners and the pharmacist/s to ensure that prescriptions are readily available in order to allow for the continuity of supply of medication to residents. Prescriptions must be available to the pharmacist **prior to** dispensing of the medication.

In the interests of residents' safety, it is essential that pharmacists supply medications to individual residents only on the basis of written prescriptions or **direct** communication by telephone with prescribers. There is no provision for pharmacists to dispense medication for individual residents on the order of a nurse or other staff member, whether this is by telephoned requests or prepared lists, unless the pharmacist holds a current prescription for that resident's medication.

Additionally, pharmacists should not supply medication for individual residents solely on the basis of medication chart orders written by residents' medical practitioners. If no prescription is available, the medical practitioner must confirm the prescription directly to the pharmacist by phone, fax or e-mail (providing other details that are not included on the chart, such as quantity to be supplied, number of repeats and repeat intervals if applicable, medical practitioner's name, designation and surgery address) and send the original prescription to the pharmacist without delay.

### 4.2 Exceptions to Obtaining Medication on Individual Prescription

#### 4.2.1 Emergency morphine and pethidine

The Regulation allows the chief nurse of a nursing home to hold an emergency stock of morphine and pethidine provided it is used only for the emergency treatment of residents on the authority of a medical practitioner. The emergency stock must not exceed:

5 ampoules of morphine sulfate containing 30mg or less per ampoule; and  
5 ampoules of pethidine containing 100mg or less per ampoule.

This stock may be obtained from a retail pharmacist on the signed written order of the chief nurse of the nursing home.

Clauses 102, 103, P & TG Regulation 2002.

#### 4.2.2 Emergency medications approved by the Director-General of Health.

A limited range of medications, as determined from time to time by the Director-General, may be held at a nursing home for the emergency treatment of residents on medical practitioners' authority, at times when pharmacy services are not immediately available.

The approved list of medications is as follows:

adrenaline injection  
antibiotics oral (all oral forms)  
atropine sulfate injection  
diazepam injection  
frusemide injection  
metoclopramide injection  
prochlorperazine injection

This medication may only be obtained and used in accordance with the following:

- Apart from morphine and pethidine, only those medications included in the list approved by the Director-General, as in force from time to time, may be obtained for emergency use. Other prescription only medications required may only be obtained on prescription for an individual resident.
- The Medication Advisory Committee (however named) of the nursing home is to determine which of the approved medications are needed for emergency use at that nursing home. A nursing home may only need to keep some of the medications included in the approved list. The committee should develop written drug information on the emergency medications for reference by nursing staff.
- Supply of the medication is to be obtained from a retail pharmacist on the signed written order of the chief nurse of the nursing home. The pharmacist must supply the medication as a whole manufacturer's original pack. The pharmacist is *not* required to apply a pharmacy label to the pack. The cost of the medication is to be borne by the nursing home.
- Nursing home facilities must ensure that appropriate stock rotation, expiry date checking and ordering systems are in place to maintain the integrity of emergency stock.
- The medication may only be used to treat a resident of the nursing home and only on the authority of a medical practitioner.
- The medication is to be removed from storage as a whole pack and doses administered to residents directly from that pack. Single blister strips should not be removed due to the risk of mix up when the strip is returned to storage.

- Where the medical practitioner has prescribed a course of medication or on-going medication (that is, more than one or two doses), this should be obtained on prescription as soon as possible from a retail pharmacist as a dispensed supply, labelled for that resident. Refer 8.2.2.
- On receipt of the resident's labelled supply, the emergency pack must be withdrawn from use and placed back in storage. Other than removal of a few doses, the emergency pack must remain unaltered so that the remainder may be held in stock for future use. Residents' dispensed supplies of medication must not be used to replace emergency stocks.

Note that antibiotic mixtures, once reconstituted with water, must be stored in the refrigerator and have a limited shelf-life.

- The resident's dispensed supply is to be used until the prescribed course of medication is completed.

Clauses 17(4), 46, P & TG Regulation 2002.

### 4.2.3 Drug Licence.

Due to the ability to obtain residents' medication on prescription and the provisions in place for emergency medication, nursing homes are rarely issued with a 'Drug Licence'.

Such a licence, issued under the Poisons and Therapeutic Goods Act 1966, is required by any private health care facility that wishes to purchase stock medication from a pharmaceutical wholesaler. 'Drug Licences' are generally only required by private hospitals and day procedure centres for the purpose of holding bulk stocks of anaesthetics and injectable medications.

To obtain a 'Drug Licence', application must be made to the Pharmaceutical Services Branch, NSW Health Department. An inspection of the facility is then arranged. An annual licence fee applies. For information telephone the Duty Officer, Pharmaceutical Services Branch on (02) 9879 3214.

Clause 161, P & TG Regulation 2002.

If a nursing home is issued with a 'Drug Licence', orders to a wholesaler for supply of drugs of addiction must be in writing and be signed by the nurse nominated on the licence. Orders that are telephoned, faxed or e-mailed to the wholesaler must be followed up by signed written confirmation from the nurse nominated on the licence within 24 hours.

Clause 95, P & TG Regulation 2002.



## 5 STORAGE OF MEDICATION

### 5.1 Responsibility

The chief nurse of a nursing home is responsible for ensuring that all medication is correctly stored at the nursing home whether brought in by residents on admission or whether obtained from a pharmacist either on prescription for individual residents or on signed orders for emergency use.

The registered nurse in charge of a ward area is responsible for the day-to-day storage of all medication in that ward area. He/she must ensure that the drugs are stored in accordance with the legal requirements outlined below and that the correct conditions are met in relation to security, storage temperature and stock rotation (expiry checking).

Clauses 30, 73, P &TG Regulation 2002.

### 5.2 Ward Area Storage Requirements

#### 5.2.1 Storage of General Medication

All general 'prescription only' medication (Schedule 4) and all non-prescription medicines in a ward area must be stored out of resident and visitor access in either:

- a **locked cupboard** securely attached to a part of the premises; or
- a **locked room** (on a shelf); or
- a **locked medication trolley**; or
- a **locked drawer** of a resident's bedside locker.

The cupboard, trolley, room or bedside drawer **must be kept locked** when not in immediate use and the **keys kept on the person of** the nurse in charge of the ward, or his/her delegate, who must be a registered nurse.

In the case of residents who are deemed to be capable of self-administering their medication, each resident may hold a key to his/her own bedside drawer. Note that bedside storage of medication that is self-administered by residents must be inaccessible to other residents or visitors. Keys held by residents must not be capable of opening other residents' bedside drawers.

Keys to drug storage must be held separately from other nursing home keys in order to ensure that access to medication is by authorised persons only.

Refrigerators for the storage of medication in ward areas are not required to have locks fitted, as long as they are in an area out of public access. Note that only that medication requiring refrigeration, i.e. below 8 degrees Celsius, as indicated on the label, should be stored in a refrigerator.

All medication is to be stored in ward areas in the same container/carton in which it was received from the pharmacy. Nursing staff **must not** remove medication from these packs until immediately before administration to a resident.

Clause 28, P & TG Regulation 2002.  
Clause 43, Nursing Homes Regulation 1996.

### 5.2.2 Storage of Schedule 4 Appendix D Drugs (S4D)

S4D drugs are those Schedule 4 medicines listed in Appendix D to the Poisons and Therapeutic Goods Regulation 1994 due to their abuse potential (for example: benzodiazepines, ephedrine, ketamine, anabolic androgenic steroids). A list of S4D drugs is available on the Pharmaceutical Services Branch website at [www.health.nsw.gov.au/public-health/psb](http://www.health.nsw.gov.au/public-health/psb). For copies phone the Duty Officer on (02) 9879 3214.

S4D drugs must be stored apart from all other medication (except Schedule 8 drugs) in a **separate** sturdy cupboard, **preferably a metal safe**, which is securely attached to a wall or to the floor, and kept locked when not in immediate use.

**No other goods**, including keys, cash or documents may be kept in this cupboard/safe.

These storage requirements apply equally to all S4D drugs **in any form**, including injectable and oral drugs. For example, diazepam ampoules must be stored in the same manner as oral diazepam. S4D medication labelled for individual residents and S4D medication obtained for emergency use must both be stored in the S4D cupboard.

The **key** to the S4D cupboard must be **kept separate** from all other keys, except an S8 safe key, and be kept **on the person** of the registered nurse in charge of the ward or his/her delegate, who must be a registered nurse.

It should be noted that S4D drugs do not have to be recorded in a ward register, unless the nursing home determines otherwise. When determining policy on whether to maintain a register record of S4D medication, consideration should be given to the legal requirement that any loss of an S4D drug must be reported to the Director-General of Health – refer section 6.1.4.

Clause 29, P & TG Regulation 2002.

### 5.2.3 Storage of Schedule 8 Drugs

A list of Schedule 8 (S8) drugs is available on the Pharmaceutical Services Branch website at [www.health.nsw.gov.au/public-health/psb](http://www.health.nsw.gov.au/public-health/psb). For copies phone the Duty Officer on (02) 9879 3214.

The registered nurse in charge of a ward area is responsible for the storage of all S8 drugs in that ward.

S8 drugs must be stored apart from all other medication (other than S4D drugs) in a **separate** sturdy cupboard, **preferably a metal safe**, securely attached to a part of the ward and kept securely locked when not in immediate use. The lock should be a five-lever key lock (or a lock that provides at least equivalent security).

**No** keys, cash, documents or other goods may be kept in a ward S8 drug cupboard/safe.

The **key** to the S8 safe must be kept **separate** from **all** other keys (except an S4D cupboard key) and **on the person** of the registered nurse in charge of the ward, or his/her delegate, who must be a registered nurse.

Clause 74, P & TG Regulation 2002.

**Notes:** There is **no** legal requirement for the S8 safe to be placed within another cupboard nor for the lock to have a key-retaining feature. The use of S8 drugs must be recorded in a drug register. Refer 6.1.

In the case of a **bulk storage safe** maintained by the chief nurse of a nursing home for the storage of S8 medication, the following applies:

- Such a safe might be in use at a nursing home that has been issued a Drug Licence, for storage of bulk S8 stock (purchased from a wholesaler), prior to distribution of the stock to the ward areas. The safe would normally be located in the office of the chief nurse or his/her deputy.
- Schedule 8 medication may be stored in this safe together with cash or documents, as long as the safe can only be accessed by the chief nurse or registered nurse delegate (such as the deputy chief nurse). No other drugs or goods, other than cash or documents, may be stored together with S8 drugs in this safe.
- The safe must be fixed to the premises and comply as a minimum with the specifications given in clause 75, P & TG Regulation 2002. In summary, this means it must be a secure metal safe, bolted to a wall or to the floor, with a key lock and/or other locking mechanism of equivalent security.
- A drug register must be kept to record the receipt and supply of the drugs held in this safe.

Clauses 72, 73, 75, 111,112, P & TG Regulation 2002.

### **5.2.3.1 Delivery of S8 medication from pharmacy to nursing home**

When a pharmacy employee delivers an S8 medication to a nursing home, the person should hand the medication directly to a registered nurse.

The delivery person should obtain a signed & dated receipt from the registered nurse confirming that the S8 drug has been delivered. The delivery person should then return this receipt to the pharmacist. The receipt could be in the form of a signed receipt or a signature and date on the resident's prescription.

The registered nurse who received the medication must immediately place the medication into the S8 safe, in the presence of a witness, and make a record in the ward drug register. The witness must be a person who is fully familiar with the procedure and who understands their legal responsibilities in this role.

Under clause 107, Poisons and Therapeutic Goods Regulation 2002, where the delivery of an S8 medication is made by a contracted carrier, the pharmacist must keep written evidence of consignment of the drug and the carrier must obtain a signed receipt on delivery to the nursing home and deliver this receipt back to the pharmacist.

## 6 SCHEDULE 8 DRUG PROCEDURES

### 6.1 Ward Register

The registered nurse in charge of a ward area is responsible for ensuring that a record is kept of all Schedule 8 drugs in that ward in a register of drugs of addiction, termed a "**ward register**".

A ward register must be in the form of a **bound book** (whose pages cannot be removed or replaced without trace), with **consecutively numbered pages**.

Clause 115, P & TG Regulation 2002.

No drugs other than S8 drugs are required to be recorded in this way by the Poisons and Therapeutic Goods Regulation 2002. However, a nursing home may consider keeping a record of other drugs, such as S4D drugs, in a ward register at that nursing home. Refer 5.2.2.

**Note:** Ward registers may be obtained from the NSW Government Printing Service, phone (02) 9743 8777. Refer NSW Health Information Bulletin 95/7, *Drug Registers (H31 and H32)*. (A ward register is an H32 register).

#### 6.1.1 Entries in Ward Registers

The Regulation requires that a separate page is used for each drug, each form of a drug and each strength of a drug. Nursing homes must record each resident's own medication on a separate page. On-going supplies of the same medication for a resident may continue to be recorded on the same page for that resident.

The record must be legible and must be made on the day of the transaction.

The record must show the following details (as are relevant to that transaction):

- date
- time of day
- resident's name, in the case of a drug which is administered to a resident
- amount administered, in the case of administration of a medication to a resident. This amount should be recorded in the 'Amount given' column.
- amount discarded, in the case of only part of an ampoule or tablet being administered to a resident (refer 6.1.2) – recorded in the 'Amount given' column. In this case the balance remains the same.
- amount received, in the case of receipt of drugs from a pharmacy. The entry should state, *Received from.....Pharmacy* and the amount recorded in the 'Amount received' column.
- amount destroyed, in the case of the destruction of a medication which has become unwanted (refer 6.2) – recorded in the 'Amount given' column.
- balance of the medication remaining. An entry stating a balance check has been done should state *Balance check* or *Balance on hand* and the actual balance found recorded in the 'Balance' column.
- signature of the person making the entry
- signature of the person witnessing the transaction. **All entries must be countersigned** by a witness who is *present* during the entire transaction. Refer 6.1.2.
- name of the prescriber.

**Notes:**

- (i) The **person administering** a Schedule 8 medication must be a **registered nurse** or a **medical practitioner**.
- (ii) The record of the **discarding** of any unused portion of a medication must be made on a **separate line** to the record of the amount administered, preferably on the next line.
- (iii) Signatures in registers must be **full signatures** so that the person signing can be identified.

Clauses 115 (3), 116, P & TG Regulation 2002.

A person making an entry in a ward register

- (i) must not make any false or misleading entry, and
- (ii) must not make any alterations, obliterations or cancellations. That is, **no** lines may be drawn through entries, no entries scribbled out or crossed out in any way, no numerals altered.

If a mistake is made, **it must be left as it is**, marked with an asterix, the entry re-written as appropriate, and a note explaining the error must be made in the margin or at the foot of the page, initialled and dated.

Clause 173, P & TG Regulation 2002.

### 6.1.2 Witness to Administration and Discarding

On **each occasion** that a registered nurse administers a Schedule 8 medication to a resident of a nursing home, another person must be present to witness the procedure.

The witness **must be present** during the **entire procedure**, ie:

- removal of the medication from the cupboard,
- recording in the ward register,
- transfer to the resident,
- administration to the resident, **and**
- discarding of any unused portion of the medication.

Clause 116, P & TG Regulation 2002.

The witness to administration and discarding should be a person who is fully familiar with the procedure, preferably a registered nurse. If no registered nurse is available, the witness may be an enrolled nurse or an assistant in nursing as long as they are familiar with the procedure and understand the legal responsibilities of their role as a witness.

**No** person is to sign a ward register as a witness to administration or discarding of a Schedule 8 drug unless that person was present during the administration or discarding of that drug.

Where half a tablet is administered from a whole tablet of a Schedule 8 medication, it is best practice to discard the unused half, due to the difficulty in keeping the

remainder. The discarding must be done in the presence of a witness and a separate line entry made.

### 6.1.3 Balance Checks

- The registered nurse in charge of a ward area must ensure that the balance held of all Schedule 8 medication in that ward is checked as a minimum once a week.

It is recommended, however, that more frequent balance checks are done, where this is possible, such as daily or at change of shift, particularly when the regular registered nursing staff are not on duty.

- A balance check must be carried out by a registered nurse and another person. The second person should be a person who is fully familiar with the balance check procedure, preferably a registered nurse. As in 6.1.2, if no registered nurse is available, the second person may be an enrolled nurse or assistant in nursing as long as he/she is familiar with the procedure.
- The balance check must be recorded by an entry in the ward register on the relevant page for each medication. It is **not** sufficient to make a single entry on one page of the register to cover checks of all medication.
- The entry must state the **quantity of medication actually held** at the time of the balance check, the date and time the check was made and be signed by the two persons carrying out the check. The wording *Balance on hand* is recommended.
- When the persons checking the balance find a **discrepancy** that cannot be accounted for by an error in calculation, they must **immediately** notify the registered nurse in charge of the ward, who then must follow the procedure as described in 6.1.4.
- Regular balance checks must be carried out of any morphine or pethidine ampoules held as emergency stock and any S8 medication that has been set aside in the safe for destruction. These balance checks must be recorded in the register on the relevant page.
- When a new nurse takes over the role of registered nurse in charge of a ward area for one month or more, the nurse must, immediately on assuming control, perform a full balance check and record the balance in the ward register.

Clause 117, P & TG Regulation 2002.

#### Notes:

In regard to **morphine mixture**, it is sufficient to use the volume gradations provided on most proprietary bottles of morphine to check the balance remaining during the time that the bottle is in use.

However, an apparent balance discrepancy should not be carried over when a new bottle of mixture is opened. That is, an accurate check should be made when near the end of a bottle and the actual balance on hand recorded. If it is considered that an accurate measure of the volume is needed using a metric measure, the nursing home should seek the assistance of a community pharmacist or alternatively, purchase an accurate cylinder measure for the nursing home's on-going use.

#### **6.1.3.1 Audits of Registers and Schedule 8 Stock**

Audits of ward registers and stock balances should be carried out for the purpose of monitoring that records are being kept in accordance with legislative requirements and to detect any possible misappropriation of the drugs. Persons who are **independent** of that ward area's nursing staff should do these audits, such as the chief nurse or his/her registered nurse delegate, or a pharmacist.

In addition to balance checks, these audits should include:

- checks of entries recording medication received. Where necessary, these should be checked against pharmacy records.
- identification of staff signatures for the purpose of detecting forgeries. Signatures in the register must be full signatures and be identifiable.
- review of the frequency of broken ampoules or discarded portions of ampoules.
- review of the presence of altered or crossed out entries.

**The chief nurse of a nursing home can pro-actively prevent misappropriation of S8 and S4D drugs in the home by ensuring that nursing staff adhere to legislative requirements and to nursing home policies and procedures.**

#### **6.1.4 Loss of a Schedule 8 or a Schedule 4 Appendix D Drug**

The registered nurse in charge of a ward must **immediately** report the loss or theft of an S8 or S4D drug to the chief nurse of the nursing home who must then immediately (during normal business hours) notify the Director-General of Health by contacting the Duty Officer, Pharmaceutical Services Branch on phone: (02) 9879 3214 or fax: (02) 9859 5165.

Clauses 66 (1), 122, P & TG Regulation 2002.

When there is no apparent loss of drugs, but concern exists of possible or admitted misappropriation of drugs by a staff member, this should similarly be reported to the Pharmaceutical Services Branch. Failure to do this may result in possible harm to a resident or to the member of staff, particularly where a possibility exists that this staff member is drug dependent or is impaired.



Similar reporting requirements apply to the loss of S8 or S4D drugs from a bulk storage safe that is maintained by the chief nurse.

### **6.1.5 Loss of a Ward Register**

The registered nurse in charge of a ward must **immediately** report the loss or destruction of a ward register to the chief nurse of the nursing home, who then must notify the Director-General of Health **in writing** of that fact and of the circumstances of the loss.

The notification should be addressed to:

Chief Pharmacist  
Pharmaceutical Services Branch  
NSW Health Department  
PO Box 103  
GLADESVILLE NSW 1675

The notification may be faxed on (02) 9859 5165. For advice, telephone the Duty Officer on (02) 9879 3214.

The nurse in charge of the ward where the register was lost must immediately carry out a balance check of all S8 drugs held in stock and enter the particulars in a new ward register.

Clause 118, P & TG Regulation 2002.

A ward register must be kept at the nursing home premises for a minimum of 2 years from the date of the last entry made in it. (Note: Disposal of a ward register after this period does not have to be reported to the Director-General of Health).

Clause 172, P & TG Regulation 2002.

Similar requirements apply to the loss or destruction of a drug register that is kept by the chief nurse to record the receipt and supply of S8 drugs held in a bulk storage safe.

## **6.2 Destruction of Unwanted Schedule 8 Drugs**

The term *unwanted Schedule 8 drugs* refers to any Schedule 8 medication that is no longer in use for a resident or that is deemed unsuitable for use for whatever reason. This could include, for example:

- a deceased resident's medication;
- a resident's medication that has been ceased by their medical practitioner;
- medication that has expired, is contaminated or damaged;

- resident's own medication brought into the nursing home on admission that is determined to be unsuitable for use.

All unwanted S8 medication must be destroyed **on the premises** of the nursing home under the supervision of a person authorised under the Regulation. No unwanted S8 medication is to be returned to the supplying retail pharmacy.

A retail pharmacist (proprietor or registered pharmacist staff) who is **engaged in the supply** of Schedule 4 or Schedule 8 medication to a nursing home or to a resident of a nursing home, is authorised to destroy unwanted Schedule 8 drugs **on the premises of that nursing home**, in the **actual presence of the chief nurse** of the nursing home.

The pharmacist must **record the destruction** by signing an entry in the nursing home's drug register. The chief nurse must **countersign** this record.

The drugs must be destroyed in a manner that does not cause environmental or public harm and in such a way that the drugs are unable to be recovered.

Clause 125, P & TG Regulation 2002.

Other persons who are authorised to supervise the destruction of S8 drugs in nursing homes are authorised inspectors of the NSW Health Department's Pharmaceutical Services Branch (Phone: (02) 9879 3214) or police officers.

**Note:** A pharmacist who is carrying out medication reviews in a nursing home, but who is not supplying medication to the nursing home, is **not** authorised to destroy unwanted drugs of addiction at that nursing home.

## 7 DISPOSAL OF OTHER (NON S8) MEDICATION

Medication that is no longer in use for the resident for whom it was dispensed **must not** be kept for administration to another resident.

Arrangements should be made with the supplying pharmacist for the return of general prescription only medication (S4) and non-prescription medicines to the pharmacy for appropriate disposal via a pharmaceutical waste system. The *Return of Unwanted Medicines* program provides for appropriate disposal of unwanted medicines via community pharmacies.

Where a nursing home is maintaining a record of S4D medication in a drug register, any unwanted S4D medication should be destroyed in a similar manner to that described in 6.2 for S8 medication, on the premises of the nursing home by the supplying pharmacist in the presence of the chief nurse.

Where no register record is being maintained, the S4D medication may be returned to the pharmacy for disposal, as described above for general S4 medication.

**Note:** No medication that is returned to a pharmacy may be re-dispensed by the pharmacist for another resident of the nursing home or for any other person. (This does not preclude a pharmacist re-dispensing a blister pack for the same resident where the doctor has altered the resident's dosage regimen). Under the World Health Organisation (WHO) guidelines, as adopted by the Australian Pharmaceutical Advisory Council, no medication that has been supplied to one person is to be re-supplied to another person. Similarly, under the WHO guidelines, expired medication should not, under any circumstance, be collected for donation for humanitarian relief.

## 8 AUTHORISATION OF MEDICATION

- Medication that is to be administered to a resident of a nursing home must be authorised in writing by a medical practitioner or a dentist (for dental treatment only), on an individual resident's **medication chart**, which must bear the name of the nursing home.

Clauses 57, 119, P & TG Regulation 2002.

- The prescriber must write a separate **prescription** for supply of the medication by a pharmacist. A pharmacist must not supply a prescription only medication to a resident of a nursing home unless he/she holds a valid prescription or has received an emergency order for that resident **directly from the medical practitioner** by telephone, facsimile or electronic mail. (Refer 4.1, 8.2.2).

Section 10 (4) (b), P & TG Act 1966.  
Clauses 35, 80, P & TG Regulation 2002.

Nursing staff and pharmacists must remain alert to any discrepancies between the prescription and the medication chart order, such as a circumstance where there is an existing chart order but a new prescription has been written or vice versa.

### 8.1 Medication Chart

A medication chart in a nursing home should be so designed that it provides **adequate space**, in the one document, for the following to be recorded:

- ❑ name of the nursing home;
- ❑ resident's full name and adequate identifying information (a recent photograph of the resident is of benefit);
- ❑ known allergies/adverse drug reactions. These may be entered by the resident's medical practitioner or by a registered nurse or a pharmacist;
- ❑ medication orders which are handwritten (or provided in any other manner approved by the Director-General of Health), signed and dated by the resident's

medical practitioner. Separate sections should be provided for the prescribing of 'prn' and once-only doses of medication;

- ❑ annotations by pharmacists of any special instructions;
- ❑ record of administration of each dose of each medication, **directly adjacent** to the medical practitioner's medication orders. The record of administration must be signed (initialled) by the administering person, showing the date and time of administration;
- ❑ record of administration of medication in accordance with a medical practitioner's telephone order (refer 8.2.1);
- ❑ record of any 'nurse-initiated' medications administered in accordance with the policy of the nursing home, as determined by the nursing home's Medication Advisory Committee (refer 8.3); and
- ❑ record of any medication reviews carried out by medical practitioners. Space for recording pharmacists' medication reviews should also be provided. These records may alternatively be made in residents' clinical notes. Refer 8.1.2.

### 8.1.1 Prescribing on Medication Charts

When prescribing medication on a resident's medication chart, the medical practitioner should ensure that all medication orders are **clear, legible and unambiguous**.

The medical practitioner **must** include the following particulars:

- **resident's full name and other identifying particulars** (such as their date of birth, medical records number and/or address).

The resident's identifying particulars may be entered by applying a resident identity label ("addressograph label"). It is the medical practitioner's responsibility to ensure that the patient for whom they are prescribing is correctly and unambiguously identified on the medication chart.

- **allergies/adverse drug reactions** reported by the resident to the medical practitioner that have not been entered by other persons.
- **name of the medication**
- **strength** of the medication, where applicable
- **form** of the medication (eg. suppositories), where applicable

- **dose, route and frequency of administration** (written in full – ‘as directed’ or ‘prn’ alone are **not** sufficient).
- **date of cessation, total number of doses or finite time period** of administration, **where applicable** (eg. antibiotics). In the case of on-going medication, there is no need to specify a ‘stop date’. The duration of the chart is sufficient limit in this case as long as regular medication reviews are carried out.
- **medical practitioner's signature and date.**
- **medical practitioner's name printed**, at least once, for identification.

Clauses 57, 119, P & TG Regulation 2002.  
 Clause 44, Nursing Homes Regulation 1996.

In order to ensure that their instructions are interpreted as intended, medical practitioners should adopt the following **principles** when prescribing on nursing home medication charts:

- When a medical practitioner wishes to change any of the above particulars, he/she should **cease** the original order and write a new order.
- To **cease** a medication order the medical practitioner should **draw a line** across the area of the chart where administration is recorded (after the last entry) and **sign and date** adjacent to this line. The original medication order should not be obliterated. (A line may be drawn through the order, if desired).
- If a medication is **not to be given on certain days**, the medical practitioner should **cross out those days** on the medication chart, in order to prevent the drug being administered in error on those days.
- Also, where treatment is to cease on a stated date, the medical practitioner should cross out the following days' spaces on the chart.
- All medication ordered by the medical practitioner is to have **specific** directions for use indicated on the medication chart including dose and frequency. ‘As directed’ type directions alone are not sufficient, nor is ‘prn’ alone - it should be qualified. For example:  
*Paracetamol 500mg tabs 2 tabs 4 hourly prn for pain. Max 8 tablets in 24 hours.*
- To avoid errors in dosage calculation, the dosage of oral liquid preparations should be expressed as .. mg (.. mL). For example, Morphine mixture 5mg/mL, Give 10mg (2mL) twice a day.
- To avoid errors in interpretation, **abbreviations should be avoided**. An abbreviation used by a prescriber may mean something quite different to nurses

that are reading the medication order. A few examples of abbreviations that may be **misinterpreted** include:

- U or I.U. for *Units*. For example, a dose of insulin should be written as 4 Units, not 4U (which may be misread as 40 Units or 44 Units) or 4 I.U. (which may be misread as 41 Units).
  - µg or mcg for *micrograms* - may be misread as mg (milligrams). *Micrograms* should be written in full.
  - x 1/7 meaning *for 1 day* - may be misinterpreted as "for 1 week". Directions should be written in full as: *for one (or 1) day*.
  - 6/24 meaning *every 6 hours* - may be misinterpreted as "6 times a day" - write in full as: *every 6 hours*.
  - "1 alt.d" meaning *one every second day* – write this in full.
- Always place a zero before a decimal point. For example, 0.5mg ( $\frac{1}{2}$  mg) should never be expressed as .5mg since this may easily be misread as 5mg.

### 8.1.2 Periodic review of medication orders

The Nursing Homes Regulation 1996 requires that residents' medication orders in nursing homes are reviewed at least every three months. The resident's medical practitioner must make a record of the results of this review, signed and dated. It is preferable that the medical practitioner makes this record on the resident's medication chart. Alternatively, the record could be made in the resident's clinical notes.

As long as a record is made of the medical practitioner's review of the medication, the medication orders on the chart do not have to be re-written at this time.

Note, however, that the re-writing of a resident's medication orders on a medication chart at three months suffices as the medical practitioner's record of a three monthly review of the medication.

Clause 45, Nursing Homes Regulation 1996

## 8.2 Emergency Medication Orders

When a resident requires a dose of a medication but the resident's medical practitioner is unable to attend the resident (deemed "an emergency"), he/she may give a medication order:

- (i) by telephone; or
- (ii) by facsimile (fax) or electronic mail (e-mail).

In the case of telephone orders, the person at the nursing home who **receives** a telephone order for medication from a medical practitioner should be a registered nurse (or a pharmacist or another medical practitioner).

Due to the risk of misinterpretation of drug names and dosages over the telephone, all medication orders received by telephone should be **read back** to the medical practitioner (in figures and words – eg 50mg: fifty milligrams, five 0 milligrams – to distinguish the order from fifteen mg). As a further check, where possible, the medical practitioner should **repeat** the medication order to a **second nurse**.

The registered nurse should make a full record of the medication order received, including the medical practitioner's name, and any other relevant details regarding the resident's condition in the resident's clinical record. The nurse must also record the administration of the medication as described in 8.2.1.

In the case of a **telephone order** the medical practitioner **must confirm** the order by **EITHER**

- (i) **counter-signing** the nurse's record of administration, as soon as is practicable, and in any case **within 24 hours** of ordering; **OR**
- (ii) **sending written confirmation** of the order to the nurse **by fax** or **by e-mail**, as soon as is practicable, and in any case **within 24 hours** of ordering. The fax or e-mail should include all relevant details of the medication order as specified in 8.1.1 including the medical practitioner's signature.

In any event, the medical practitioner giving the medication order **must attend to review the patient**, as soon as he or she considers it appropriate **in the circumstances of the case**.

Clauses 57, 119, P & TG Regulation 2002.

Where the prescribing medical practitioner is not able to attend the nursing home within 24 hours, he/she must follow-up a telephone medication order by written confirmation to the nurse either by fax or by e-mail, no later than 24 hours. This confirmation is imperative due to the risk of misinterpretation of medication orders over the telephone.

The fax must be able to be received on dry paper, or otherwise a photocopy kept, so that the image does not fade with time. In the case of a medical practitioner confirming the order by e-mail, a printed copy must be made at the nursing home.

The medical practitioner's fax or printed e-mail copy should be attached to the medication chart for reference by the nurses **each time** a dose of that medication is administered according to the emergency order.

**Note:** If the medical practitioner ordered the medication by fax or e-mail in the first instance, rather than by telephone, there is no need to send a second fax or e-mail as confirmation.

### **8.2.1 Administration record of emergency medication orders**

The record of administration of medication according to an emergency order may be achieved in different ways. All such records must be made either on the resident's medication chart or be kept firmly together with the chart.

The following alternatives are satisfactory:

- (i) The medical practitioner may fax confirmation of his/her medication order on the nursing home's medication chart.

The fax sheet may be utilised to record administration of the medication, as long as the fax is attached to the resident's original medication chart (say by staple), and a system is in place to ensure nurses are aware of the order and any need for further doses to be administered of that medication.

- (ii) The medical practitioner may fax confirmation of the medication order on his/her letterhead. This should be attached to the original medication chart for reference. The administration record may be made by the nurse directly on the resident's original medication chart.

This record must be written in ink in some place on the chart **other than** the section for on-going regular, or prescribed 'prn' medication, preferably in a section of the chart dedicated for the recording of telephone orders. If not recording in a dedicated section for telephone orders, the nurse should indicate in his/her record that this was an emergency telephone order.

The record must include the date and time of administration, the medication name and dose, the prescriber's name and the nurse's signature.

**On each occasion that a dose is given, the nurse should refer to the medical practitioner's fax or e-mail that is attached to the chart.**

**In the case of ongoing medication**, the medical practitioner must, at the time of next attending the nursing home, write an order in the regular medication or 'prn' section of the chart, as the case may be, for the medication to continue to be administered on an ongoing basis. The faxed or e-mailed order is sufficient as authority to administer until the medical practitioner attends the nursing home and writes up the ongoing order (as soon as possible).



### 8.2.2 Emergency prescriptions

In an emergency, when supply of medication for a resident is required from the pharmacy, the medical practitioner must telephone, fax or e-mail a prescription **directly to the pharmacist** and then send the **original** prescription without delay (and in any case within 24 hours) to the pharmacist.

Clauses 35, 80, P & TG Regulation 2002.

There is **no** provision in the Regulation for a pharmacist to supply prescription only medication for an individual resident in a nursing home on the order of a nurse or other staff member, unless the pharmacist holds a current prescription for that medication for that resident. (Refer 4.1).

### 8.2.3 Medication on Admission

When residents are admitted to a nursing home, or return after a period of absence such as a stay in hospital, their medical practitioner should provide written medication orders as soon as possible to confirm the residents' current medication.

If written orders are not available before medication is to be administered, the nurse should telephone the resident's medical practitioner to confirm the resident's current medication. This should be treated as an emergency telephone order and procedures followed as described in 8.2.

Alternatively, in the case of return from hospital, a clear discharge summary, written and signed by a medical practitioner at the hospital, detailing the resident's medication at the time of discharge, is sufficient as a direction to administer the medication until the resident's medical practitioner writes up the medication chart orders (as soon as possible).

Any doses of medication administered must be recorded on the nursing home's medication chart.

Clauses 57, 119, P & TG Regulation 2002.

## 8.3 Nurse-Initiated Medication

Medication that may be administered by a registered nurse without a medical practitioner's authorisation is usually termed 'nurse-initiated medication'. Any considerations for the use of 'nurse-initiated' medication in a nursing home must be by consultation between nursing administration, medical practitioners and pharmacist/s.

A nursing home's Medication Advisory Committee may approve certain medications as 'nurse-initiated' in that nursing home, provided that:

- ❑ the medication is **not** a prescription only drug (Schedule 4 or Schedule 8). Only medicines for minor ailments should be considered for inclusion as 'nurse-initiated' medication; and
- ❑ appropriate **written protocols** for the use of **each** medication are developed by the Committee. These protocols must provide sufficient detailed information about **each** medication, so that nursing staff can make informed decisions as to when and when not to administer a medication.

When setting policy and developing written protocols on nurse-initiated medication, it is important that the following are considered for inclusion by the Committee:

- Nurse-initiated medication may **interact** with a resident's prescribed medication. Written protocols should include any contraindications to the administration of each nurse-initiated medication, taking into account those prescribed medications that the nurse-initiated medication may interact with.
- Minor ailments may be symptoms of other more serious diseases or they may be adverse reactions to medication already prescribed.

When a nurse administers a dose of a nurse-initiated medication to a resident, the nurse must:

- record the name and dose of the medication in ink on the resident's medication chart;
- record the date, time of administration and any other relevant details; and
- sign the entry.

The record should be made in an appropriate section of the chart, such as an area dedicated to nurse-initiated medication or the 'stat' (once only) section.

Clause 44, Nursing Homes Regulation 1996

'Nurse-initiated' medication should **not** be administered on an **ongoing** basis without a medical practitioner's review. Limits on the number of doses of nurse-initiated medication that may be given and policy on when to contact a resident's medical practitioner should be part of the nursing home's general policy on the use of nurse-initiated medication.

If, on the medical practitioner's review of the resident, he/she decides the medication is to continue, the medical practitioner must write a medication order on the resident's medication chart, and, if a dispensed supply from pharmacy is required for the resident, the medical practitioner must write a prescription.

## 9 ADMINISTRATION OF MEDICATION

### 9.1 Record to be Kept

On each occasion that any medication is administered to a resident, a record must be made on the resident's medication chart, signed and dated. The record must be made at the time the medication is administered to the resident. Medication administration records must be accurate and include all required details.

Clause 44, Nursing Homes Regulation 1996.

### 9.2 Principles for Safe Administration of Medication

As part of a nursing home's quality improvement programs, systems and procedures should be established that are designed to ensure safe administration of medication to residents and prevent the possibility of medication errors.

**All** areas of medication handling should be examined for their potential for error or for contributing to error. These areas include:

- Prescribing
- Obtaining supply
- Storage
- Administration.

The following principles should be observed **on each occasion** that a nurse administers medication to a resident in a nursing home:

- Nurses administering medication must refer **directly** to the medical practitioner's instructions on the medication chart.
- Nurses must follow a strict protocol for checking the identity of the resident on each occasion that medication is administered. The Medication Advisory Committee should develop this protocol.
- The residents' allergies/ previous adverse drug reactions should be checked before administering any medication.
- The same nurse that selects a resident's medication should administer the medication and record its administration. The nurse must record administration of the medication **at the time it is administered** to the resident.
- Nurses must administer each dose of medication to residents **directly** from the container supplied by the pharmacy. They **must not**, under **any** circumstance, transfer medication from one container to another or relabel a pack. Medication for several residents must not be placed into other containers, such as egg cartons, prior to a medication administration round, for convenience purposes.

This practice, commonly termed 'pre-dispensing', carries a high risk of medication and resident mix up.

- To avoid selecting the wrong medication, it is emphasised that the nurse **must carefully read the pharmacy label** on the container and check:
  - the name of the resident;
  - the name and strength of the medication against the medical practitioner's order on the medication chart. If dispensed by pharmacy in the manufacturer's pack, check the medication name and strength on the pharmacy label against that on the manufacturer's pack.
  - the expiry date and physical appearance of the medication.
  - any warning statements on the label, such as, *Do not use on broken skin. Wash hands thoroughly after use.*
  - in the case of mixtures, such as morphine mixture, take great care to check the strength of the medication and to administer the correct dose according to the medical practitioner's order, which may be specified in milligrams or millilitres.
- If there is any doubt regarding the medication or the medication order, contact the medical practitioner or the pharmacist before administering the medication.
- If a nurse is administering a medication on the verbal order of a medical practitioner who is present, the medical practitioner should also check the medication before it is administered.
- Injectable medication should only be drawn up into a syringe for **immediate administration**. Injections should not be prepared for later use, due to the risks of contamination, instability and mix-up, and additionally, in the case of Schedule 8 drugs, for security reasons.
- To avoid the mix up of medication and the risk of administration to the wrong resident, prepare and administer medication for the one resident only at any one time. In the case of injectable medication, do not prepare and administer more than one injection at any one time. Take care when using a syringe to measure oral medication that this medication is not administered in error by injection.
- Where only a portion of an oral tablet is required for a resident, it is best practice to discard the unused balance.
- Certain tablets or capsules are formulated in such a way that they should only be swallowed whole - they should not be crushed, broken or chewed. A comprehensive list of such products and information on the administration of oral dose forms ("Do Not Crush List") is available from the Wollongong Hospital Pharmacy Department, phone (02) 4222 5340.

- Due to the danger of inadvertent access to medication by visitors or other residents, trolleys must not be left unlocked unless in immediate use (or unless stored within a locked room).

Medication should not be left by a resident's bedside to be taken later by the resident due to the risk of another resident or a visitor consuming the medication.

### 9.3 Medication on Day Outings

In order to reduce the need for medication to be administered to residents during outings, it is recommended that, where possible, due doses of medication are administered to residents at the nursing home prior to, and after returning from, an outing.

If a dose is required while a resident is out, the **original dispensed pack** of medication that has been dispensed by a pharmacist should be sent with him/her from which to administer the medication. The medication **should not** be provided as a few doses re-packed into another container, such as an envelope or a 'box' medication compliance aid (unless the latter is dispensed by a pharmacist).

Where the administration of medication during outings cannot be avoided, the pharmacist dispensing the resident's prescription could be consulted as to the possibility of providing a small pack, appropriately labelled for the purpose of taking on day outings.

Some dose administration aid packaging systems allow the removal of a single packaged dose of medication whilst still retaining full labelling of that dose.

## 10 MEDICATION INCIDENT REPORTING

Nursing homes should have in place policies and procedures for medication incident reporting, as determined by the Medication Advisory Committee (MAC).

All incidents involving medication error should be immediately reported to the chief nurse of the nursing home or his/her delegate. Any medication incident that may adversely affect a resident must be immediately reported to the resident's medical practitioner. Notification of incidents to residents and relatives/carers should occur in accordance with the policy developed by the MAC and any requirements of the Nursing Homes Regulation 1996 (refer 10.1).

Nurses should be encouraged to report any medication incidents or "near miss" incidents for the **purpose of identification of system and process deficiencies**. Staff should be informed that the reason for reporting is to remedy system problems and to avoid similar incidents occurring in the future, **rather than** to punish individuals.

All types of medication incidents should be included for **review by the Medication Advisory Committee**. Medication administration errors, dispensing errors, prescribing errors and any interventions that serve to prevent an incident occurring (“near miss” incidents) should also be included in this reporting with the object of systems and quality review.

Where an error has resulted from lack of following policy and procedures, the staff concerned should be provided education to ensure that they are aware of their obligations in this regard in the future.

## **10.1 Reporting of Incidents involving Injuries, Transfers and Deaths**

Any incidents, whether these involve medication or other accidents, that result in any injury requiring medical intervention and/or transfer of a resident to hospital or that involve the death of a resident, **must** be reported to the Director-General of Health, under the requirements of the Nursing Homes Regulation 1996.

These reports must be sent to the Department’s Private Health Care Branch.

Refer to the regulation for further detail or for advice concerning this reporting contact the Private Health Care Branch on (02) 9816 0425.

Clause 41, Nursing Homes Regulation 1996.

## **10.2 Reporting of Suspected Adverse Reactions to Medication**

Any suspected adverse reactions to prescription medicines, vaccines, over the counter medicines, or complementary medicines should be reported to the Adverse Drug Reactions Unit, a unit of the Commonwealth’s Therapeutic Goods Administration.

All reports are assessed by a health professional and entered into the Australian Adverse Drug Reactions System. Reports involving serious reactions or recently marketed drugs are reviewed by the Adverse Drug Reactions Advisory Committee (ADRAC). This committee assesses the information that has been collated to date about a particular medicine and decides whether any action needs to be taken in order to safeguard the public.

Medical practitioners, pharmacists and nursing staff that suspect a resident has experienced an adverse reaction to a medication should report the suspected reaction to the Adverse Drug Reactions Unit.

Reports can be made by

- (a) using the “Blue Card” prepaid reporting form, available from the Adverse Drug Reactions Unit or at the front of the Schedule of Pharmaceutical Benefits book;
- OR

(b) reporting electronically via the TGA website ([www.tga.health.gov.au](http://www.tga.health.gov.au)).

Further information can be obtained from the TGA website or by contacting the Adverse Drug Reactions Unit, as follows:

E-mail: [adrac@health.gov.au](mailto:adrac@health.gov.au)

Phone: 1800 044 114

Fax: (02) 6232 8392.

For further information or advice on this guide contact the Duty Officer, Pharmaceutical Services Branch, NSW Department of Health, by telephoning: (02) 9879 3214 or faxing: (02) 9859 5165.

The Branch's website address is: [www.health.nsw.gov.au/public-health/psb](http://www.health.nsw.gov.au/public-health/psb). This site includes a copy of this guide (see Publications) and also provides a link to the Poisons and Therapeutic Goods Regulation 2002 (see Legislation).