Continuing Professional Development
Professional accountability

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Administration of medicines
part 1: the law and nursing

The aim of this article is to outline the legal and professional consequences for nurses of failing to adhere to the law relating to administration of medications. Safe administration also requires consideration of biological variables, such as drug formulation, and drug/food interactions, and this will be discussed in part 2 next week.

After reading this article, you should be able to:

I Explain the role of qualified nurses in the administration of medicines prescribed by appropriate practitioners.
I State the requirements for valid consent before administering medicines.
I Describe current best practice for managing clinical risk when administering medicines.
I Outline factors contributing to drug errors.

Administration of medicines is a key element of nursing care. Every day some 7,000 doses of medication are administered in a typical NHS hospital, with thousands more self-administered by patients in their own homes (Audit Commission 2002a).

However, some 10,000 serious adverse drug reactions are reported each year in the UK (DoH 2000) and cases such as Thalidomide (S v Distillers Co (Biochemicals) Ltd [1970]) and Opren (Nash v Eli Lilley [1993]) highlight that medicines can have serious adverse effects. A fifth of all clinical negligence litigation in the UK stems from errors in the use of prescribed medicines (Audit Commission 2002b).

Public safety is further focused on the administration of medicines where considerable concern has been expressed over the giving of unprescribed medicine and the widespread practice of crushing tablets and opening capsules (Wright 2002). These concerns are reflected in the strict legal framework that regulates the supply and administration of medicines to others.

The law requires that medicines are given to the right person, at the right time, in the correct form, using the correct dose, via the correct route. To achieve this, the legal framework draws together four separate areas of accountability to protect patients from the harmful effects of medicines while allowing them to benefit from their therapeutic properties (Figure 1). Four key areas of law bind nurses when administering medicine. They regulate the right to administer medicine and the standard required when giving medicine. They can mutually or collectively demand that actions are justified and apply sanctions if those demands are not satisfied. It is vital, therefore, that administration practice is informed by reference to the law in each area of accountability.

The right to administer medication

The law

Introduction

Aim and intended learning outcomes

Richard Griffith BN, LLM, PGDL, DipN, CPE, RMN, RNT, CertEd, is a Lecturer; Howard Griffiths RN, BSc, MSc, PGCE (FE), RNT, is a Clinical Practice Tutor; and Sue Jordan MB, BCh, PhD, PGCE (FE), is a Senior Lecturer, School of Health Science, University of Wales, Swansea.

Email: S.E.Jordan@swansea.ac.uk

Summary

The authors outline the legal and professional consequences for nurses of failing to adhere to the law relating to the administration of medications. Part 2, next week, will look at the biological consequences for patients of non-adherence to drug administration schedules.

Key words

Drug administration
Law
Nursing

These key words are based on subject headings from the British Nursing Index. This article has been subject to double-blind review.

Multiple-choice questions and submission instructions

Practice profile assessment guide

A reader’s practice profile


CONTINUING PROFESSIONAL DEVELOPMENT

**Professional accountability**

**Figure 1. Accountability and drug administration – the four areas**

- In the right form of the drug
- At the right time
- To the right patient
- At the right dose

**Box 1. The Consumer Protection Act 1987 and Medicines Act 1968**

These acts require that in accordance with the directions of an appropriate practitioner, medicines are administered to patients. The secretary of state for health has a duty, under section 58A of the Medicines Act 1968, to place on the prescription sheet produced by the drug company. It is essential, therefore, that trusts take great care to keep accurate supply records of medications received and ensure that drugs are kept securely to avoid such liability.

**Figure 2. Liability principle**

In the European Union, the European Medicines Agency (EMA) develops a list of medicines that represent a danger to patients if their use is not supervised by an appropriate practitioner. The Medicines Act 1968 requires that those administering medicines to others are aware of the licensed uses of the product. The product does not have to be sold for profit to society through the civil law. The conviction of those products the risk would materialise, it would be liable under the 1987 Act (A v National Blood Authority [2001]). This would be the case if the product had been administered carelessly (Veedfald v Århus [2001]). Where a producer, knowing the existence of a possible defect, continues to supply products even though it was unable to identify in which batch or order the defect was present, it would be liable under the 1987 Act.

**Figure 3. Strict liability**

Strict liability (or liability without fault) makes a producer liable for damage caused by a defective product. The producer of the product must always be identifiable. Generally this would be the manufacturer or importer of the product into the European Union. However, where the manufacturer is unknown (because of a break in tracing the supply chain), the last person identified in the supply chain will be deemed the producer and liable for the damages. It is essential, therefore, that trusts provide evidence of their supply chain. The EMA is a public body, its purpose is to improve the quality of life in the European Union by means of actions and measures taken in accordance with the provisions of the various international conventions and agreements on foodstuffs, drugs, and cosmetics. The EMA is responsible for the adoption of guidelines and standards for human and veterinary medicinal products. The EMA also monitors the implementation of international conventions and agreements on foodstuffs, drugs, and cosmetics, and issues guidelines and standards for these areas.

**Figure 4. Medication received and ensure that drugs are kept securely to avoid such liability.**

- Medication received and ensure that drugs are kept securely to avoid such liability. Medication received and ensure that drugs are kept securely to avoid such liability. Medication received and ensure that drugs are kept securely to avoid such liability.
given in the absence of a valid consent in the per-

ability, then the principle allows medication to be

unconscious or has a more permanent incapac-

sion is binding. If not, they may be treated in what

treatment (Box 3).

make a decision whether to consent to or refuse

mental functioning renders the person unable to

capacity if some impairment or disturbance of

(determined by a test of understanding (Re MB

a presumption that can be rebutted. Capacity is

adult is presumed to have that capacity, but it is

own fate presupposes a capacity to do so. Every

right to decide one's

caring for the person must respect that right. In

has a right to refuse the medication and those

medicine is in place, the medicine can only be given

or care, those responsible for patients' care must

have effect to patients' wishes, even though they

do not consider it to be in the patients' best inter-

give effect to patients' wishes, even though they

have a right to accept or decline medical treatment.

'reight to determine' means that a person has the

determination is long established in law and its

duty to be careful when administering medicines

standard of administration

the event of an adverse reaction.

they would be required to justify their actions in

cases. Two key principles of common law apply to

developed from the decisions of judges in decided

developed through the common law, or rules of law

administration. These standards have been devel-

the standard of administration

and respiratory distress. He also vomited on several

Mr Evans, aged 91, was frail

lived in his own home with his

Mr Evans, aged 91, was frail

have a continuing power

Act 2000 allows persons with a continuing power

uni

controlling drugs is required in all nursing homes and

Medicines for internal use should be stored in a locked trolley, cupboard or room.

A locked refrigerator should be available in nursing homes and hospitals, but this requirement is subject to local guidelines for residential homes in England and Wales.

should be available.

should be used to monitor the refrigerator temperature daily (RPS 2003).

with manufacturers' instructions and national guidelines (BNF 2002, McKenry and

Cytotoxics and associated spillages or patient excreta are handled in accordance

iodine. Therefore gloves should be worn when handling these medicines.

substances, such as anaesthetic gases, radiopharmaceuticals and malathion. These should be used with great care and knowledge of their hazards. Gloves should be worn when handling these medicines.

substances, such as lanolin or tars (Kelly 2000). A few substances can be absorbed through the

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skin, including antiseptics, topical corticosteroids and some antibiotics. The nurse should wear gloves when handling any substance that may be absorbed through the skin. Cleaning and disinfecting hands is critical when handling these medicines.

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Nursing standard

Out 2

has undisturbed sleep.

Alternative strategies should be adopted to ensure Mrs. Evans is able to sleep.

Covert administration is likely to be justified.

Hypnotics in older people should be censored against the use of sedation.

Indeed the BNF no.45 p.167 suggests night sedation is not directly in patients' best interests.

If Mr. Evans refuses, it would be in his best interests either to admit him to hospital for parenteral administration. However, the patient was told about the risks involved and gave consent.

The patient was told about the risks involved and gave consent.

The community pharmacist was consulted about the safety issues involved in seeking alternative products available, such as liquid preparations.

There were alternative products available, such as liquid preparations.

The doctor, pharmacist and those that have to assist a person with swallowing difficulties and he was able to hide or crush the medication in his food to enable drug administration.

TIME OUT 3

The form of the drug is safe to use covertly.

Medication, especially in tablet form, will usually be crushed or a capsule opened to permit administration.

If medication is crushed or a capsule opened to permit administration.,

...
Since the Nursing & Midwifery Order 2002, the NMC is able to investigate a nurse's competence as well as his or her conduct. The number of 'striking off' orders issued by the NMC since its creation in 2002 has risen dramatically (NMC 2002b).

Failing to administer medication properly, failing to prepare a drugs trolley correctly and failing to work in a collaborative manner in relation to medication have all been misconduct charges that have recently led to nurses being removed from the professional register.

The practice of crushing tablets and opening capsules is one that has the potential to endanger public safety and thereby breach legal and professional requirements. It must not be done where there is a safer alternative, such as a liquid preparation (Wright 2002). Where there is no alternative, practitioners must demonstrate that they have fully considered safety issues by consulting the prescriber, pharmacist and patient and administer the medication in accordance with a practice accepted by a responsible body of professional opinion and the drug's product licence. In that way the practitioner will avoid liability and the patient will safely continue to benefit from the medication.

Clinical governance is the framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in health care will flourish (DoH 1998). Clinical governance entails corporate responsibility and accountability to central government for the quality and safety of care being delivered by NHS service providers.

It is acknowledged that there has been little systematic learning from previous adverse events and service failures (DoH 2000). Subsequently, the National Patient Safety Agency has been established with a remit to instigate a mandatory reporting system to (DoH 2001a):

I Identify adverse events in health care, including specified near misses.
I Gather information on their aetiology.
I Analyse and synthesise this information.
I Learn and act to prevent similar events occurring.

The agency encourages staff to report near misses and incidents via its internet site.

Errors can arise in drug selection, prescribing, dispensing, administration and therapeutic monitoring

**Managing risk**

**TIME OUT 4**

**Figure 2. Factors affecting drug errors**


**Education**

I Lack of knowledge or information
I Failure to record allergies
I Lack of training for administration device
I Poor drug calculation skills (nurses and doctors)
I Checking drugs can become ritualistic, giving a false sense of security

**Pressure of work**

I Failure of dose and identity checking
I Poorly written or confusing prescription
I Attention slips, for example, errors in units or decimal points
I Unfamiliar work environment
I Poor communications, for example, failing to take a history of non-prescription drug use

**Systems**

I Absence of standardisation for doses and regimens
I Absence of prescription review, for example, by pharmacists or computers checking drug interactions
I Terminology changing or inconsistencies between manufacturers
I Poor stock keeping
I Poor feedback following identification of errors
I Incident reporting not anonymised
I Incident documentation not sufficiently detailed for future learning
I Failure to support staff who make errors
CONTINUING PROFESSIONAL DEVELOPMENT

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Access to patient information in care
services for patients in hospital and the community.

I

Pharmacist-led medication Strategies include:

Automated medication This aims to increase the availability of pharmacists for advising patients

Automated bedside A randomised controlled trial on a 32-bed surgical ward over 14 days

Computerised database In this cohort study, 24 per cent of 24,266 alerts triggered and

Computerised A time series analysis indicated a reduction in number of prescribing

Computerised A randomised controlled trial with a sample of 75 patients found that

Computerised A first class

Use of joint formularies This promotes effective use of medicines (Audit Commission 2002b).

Use of original medicine This assures the integrity of the medicines, improves quality, and

Use of medicines outside their licensed

Use of medicines This is a recall programme for medicines that are unsafe or have been withdrawn from the market.

Use of original medicine This is a programme for ensuring the integrity of the medicines, improving quality, and reducing the risk of medication errors.

Use of medicines outside their licensed

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Kohn L, Kelly J (2000) may come to rely on this, and fail to ensure that their checking is thought to reduce errors, practitioners automation and additional checks (Table 1). Although errors have been proposed, including increased 1999). Several strategies to reduce the rate of drug drug is distracted by other events on the ward (O'Shea and failing to check the patient's identity. These are most likely to arise if the nurse administering the wrong drug or wrong dose, using the wrong route or route of failing to abide by standards will be liability in professional standards. Consequences for nurses of failing to abide by standards will be liability in professional standards. Consequences for nurses and common law, by implied contract terms and statutory standards at all times responsibility for ensuring that clinical risk is minimised. The right to administer medication and the standards of administration are regulated by statute. The liability is not mutually exclusive. Where the Offences Against the Persons Act 1861 or for the nurse may face criminal charges under the employment contract. In the most serious cases, offences, professional misconduct and breach of conscience, professional misconduct and breach of standards of drug administration. In Mallett J, Dougherty L (Eds) Medication Review: the Agenda for General Hospital. London, NMC. Conclusion


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Fijin 2002). Drug errors are attributed to many underlying the occurrence and Interacting factors, largely unrelated to the individual. They reflect failure of education programmes, including increased checking itself may be ritualistic, allowing errors to be overlooked (Anderson and Webster 2001). Should an adverse consequence for patients and in Box 1 and the possible in each of the procedures listed Consider how errors could arise TIME OUT 5

TIME OUT 6


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