PRACTICE STANDARD

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
THE STANDARD OF CARE.

Medication, Revised 2008

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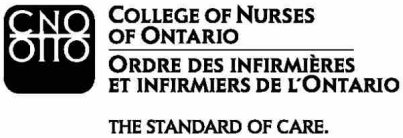

OUR MISSION is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.

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Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— College of Nurses of Ontario

Introduction

Safe, effective and ethical medication practice is an important component of client care. As with any nursing procedure, administering, recommending and/or prescribing[1] a medication requires knowledge, technical skills and judgment. Nurses[2] need the competence to assess the appropriateness of a medication for a client, manage adverse reactions, understand issues related to consent and make ethical decisions about the use of medications. As well, client care environments need systems and structures that support and facilitate safe medication practice.

The College of Nurses of Ontario's (the College's) practice standards apply to all nurses regardless of their role or practice area. Nursing practice standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses.

College practice standards, along with the *Regulated Health Professions Act, 1991* (RHPA) and *Nursing Act, 1991,* provides a framework for nursing practice.[3]

Medication, Revised 2008 replaces the 2003 *Medication* practice standard and includes four standard statements with indicators that describe nurses' accountabilities for medication practice. Administering a medication is one component of a continual process that goes beyond the task of giving a medication to a client. Nurses must apply their knowledge about the client and the medication when assessing, planning, implementing and evaluating the process. The College advocates for the same nurse performing all administration steps to minimize the chance of error and clarify individual accountability. This document applies to prescription drugs as well as other substances, including over-the-counter medications and herbal preparations. The decision tree on page 14 can help nurses decide about medication administration and determine if administering a specific drug is within their individual nursing role.

Nursing education

As a result of differences in basic nursing education, the foundational knowledge of RNs and RPNs is different. Both categories study from the same body of nursing knowledge, which includes pharmacology. However, RNs study for a longer period of time, allowing for a greater depth and breadth of knowledge. Those who apply for College registration must meet basic RN and RPN competencies for medication administration. Nurse Practitioners (NPs) demonstrate additional competencies associated with their authority to prescribe a drug.[4] To determine the category of nurse most appropriate to administer a medication in a particular context, the needs of the client, the knowledge, skill and judgment of the nurse, and the features of the practice environment need to be reviewed.[5]

In practice, nurses may need to administer medications by routes and methods that were not included in the experiences of their basic educational program. While nurses will have learned the competencies associated with safe medication practices, they may need additional knowledge to competently assume these responsibilities. You can acquire such knowledge and skill in continuing education courses or in-service education. As well, you need to become familiar with the policies and procedures provided

[1] Nurse Practitioners have the additional authority to prescribe a drug or category of drugs designated in the regulations.

[2] In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

[3] For more information on the legislation governing nursing practice, see Appendix A on page 17.

[4] For more information, refer to the College's *Nurse Practitioners* practice standard at www.cno.org/publications.

[5] For more information, refer to the College's *Utilization of RNs and RPNs* practice guideline at www.cno.org/publications.

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by an employer. Nurses are accountable for assessing their competencies and related skills in providing care related to medications. Even nurses who do not administer medications must still understand the actions (for example, purposes, risks and potential side effects) when caring for clients who receive medications as part of their treatment plan.

Standard Statements

There are four standard statements, each with accompanying indicators, that describe a nurse's accountabilities related to medication practice. The standard statements describe broad principles that guide nursing practice and are listed in a manner that reflects the steps of the nursing process. The standard statements have been organized for clarity; however, the process is not a linear progression. For example, it is expected that assessment will occur throughout all phases of medication administration and not solely as the first step in the process. The indicators are broad statements that nurses can apply to their particular practice environment.

1) Assessment

Nurses use their knowledge, skill and judgment in the assessment of the client, the medication and the practice supports prior to administering medication.

Indicators

The nurse meets the standard by:

a) accepting **authorizing mechanisms**[6] only from prescribers with ordering authority (for example, physicians, NPs, dentists, chiropodists and midwives);
b) accepting a medication order that is complete and includes the order date, client name, medication name, dose in units, route, frequency, purpose (for example, a research or PRN medication), and prescriber's name, signature and designation (the prescription label is the order);
c) accepting an outpatient or community order[7] for medication that includes all of the above information as well as the amount to be dispensed, the duration of therapy and the number of repeats or refills;
d) withholding the medication and following up with a prescriber in a timely manner in the event that a medication order is incomplete, unclear, inappropriate or misunderstood;[8]
e) requesting written orders when the prescriber is present, or only accepting electronic orders when there is a secure system in place (for example, via a secure fax or e-mail);
f) accepting a **verbal order** only in an emergency situation or when the prescriber cannot document her or his orders (for example, in the operating room or during a code);
g) recognizing that **telephone orders** should be limited to situations requiring direction for client care when the prescriber is not present;
h) ensuring that verbal and telephone orders are repeated in their entirety for accuracy;
i) documenting verbal and telephone orders as well as the prescriber's name and designation in the client's record (the nurse is not responsible for ensuring that such orders have been signed by the prescriber);[9]
j) assessing her or his own knowledge, skill and judgment to competently carry out medication administration, use medication equipment and intervene during an **adverse reaction**;

[6] Bolded words are defined in the glossary on page 9.

[7] Clients in the community may not be regularly assessed by a health care provider or have pharmaceutical supports in place to promote client safety. Limiting the amount of medication and the time the medication is available helps ensure that clients receive an appropriate course of therapy.

[8] For more information, refer to the College's *Disagreeing With the Plan of Care* practice guideline at www.cno.org/publications.

[9] For more information, refer to the College's *Documentation, Revised 2008* practice standard at www.cno.org/publications.

[10] For more information, refer to the College's *Consent* practice guideline at www.cno.org/publications.

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k) verifying that informed consent[10] has been obtained from the client or the client's substitute decision-maker;
l) assessing the appropriateness of the prescribed medication for the client by considering the:
   - client's age, weight, pathophysiology, laboratory results, vital signs, medication knowledge, and choice or preference,
   - expected benefits and potential risks/side effects, the possible interaction with other medications, and any foods that are contraindicated or decrease absorption,
   - client's allergies, sensitivities and previous adverse reactions, and
   - appropriate use of the medication as prescribed for the client in the particular situation (for example, a PRN medication);
m) ensuring and/or advocating for appropriate resources to monitor and intervene to manage potential adverse drug reactions (for example, having the prescriber on-site before administration);
n) performing all of the administration steps to minimize the chance of error and clarify individual accountability (for example, exercising judgment in deciding whether to involve other nurses in preparing the vaccine in a mass-immunizing campaign); and
o) identifying and advocating for systems and resources that support nurses in maintaining competency in medication practice.

2) Planning

Nurses are accountable for ensuring the accuracy, appropriateness and completeness of a client's plan of care in regards to medication order(s), and for communicating concerns about the treatment plan to other members of the health care team.

Indicators

The nurse meets the standard by:

a) transcribing medication orders as written, or validating the accuracy and completeness of the transcription when others have completed the transcribing;
b) scheduling dosing times for a medication, taking into consideration the effect of food intake on medication absorption, contraindications, required interventions before, during and after administration (for example, blood pressure), and client choice or preference;
c) refraining from accepting medication order information from those who do not have pharmacology knowledge (for example, a unit clerk);
d) communicating orders with individuals within the circle of care (for example, the health care team or client or, with consent, the family);
e) demonstrating clear, evidence-based rationale for decisions and taking appropriate steps[11] to resolve issues relating to medication administration; and
f) advocating for systems that provide a mechanism for resolution when there is disagreement among members of the health care team regarding a medication order.

[11] For more information, refer to the College's *Disagreeing With the Plan of Care* practice guideline at www.cno.org/publications.

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3) Implementation

Nurses prepare and administer medication(s) to clients in a safe, effective and ethical manner.

Indicators

The nurse meets the standard by:

a) ensuring that the client receives appropriate education about the treatment plan and current medication;
b) ensuring that the client or the client's substitute decision-maker has given consent[12] to administer the medication;
c) preparing and administering the medication according to an evidence-based rationale;
d) obtaining a new supply of medication if there are concerns about how the medication has been maintained;
e) applying principles of infection prevention and control[13] when administering medication;
f) verifying:
   - the right client,
   - the right medication,
   - the right reason,
   - the right dose,
   - the right frequency,
   - the right route,
   - the right site, and
   - the right time;[14]
g) ensuring that the client receives appropriate monitoring during and after administering the medication, and intervening if necessary;
h) documenting, during and/or after medication administration, in the client's record according to documentation standards;[15] and
i) advocating for appropriate environmental supports to ensure clients receive safe, effective and ethical care.

4) Evaluation

Nurses evaluate client outcomes following medication administration and take appropriate steps for follow-up.

Indicators

The nurse meets the standard by:

a) recognizing client outcomes following medication administration, including effectiveness, side effects, signs of adverse reactions and/or drug interactions;
b) following up with the prescriber regarding any concerns or questions about the medication;
c) referring clients to the appropriate care provider for further assessment and follow-up when necessary (for example, when the underlying problem persists despite PRN medication);
d) documenting actions taken or advice given and client outcomes according to documentation standards;
e) documenting, when appropriate, if the client is capable of self-administering the medication, including the type of assistance the client requires, if any, and the ongoing nursing assessment of the client's capacity to continue self-administration; and
f) advocating for adequate resources and systems that facilitate safe, effective administration according to standards.

[12] For more information, refer to the College's *Consent* practice guideline at www.cno.org/publications.

[13] For more information, refer to the College's *Infection Prevention and Control* practice standard at www.cno.org/publications.

[14] This is known as the rights of medication administration.

[15] For more information, refer to the College's *Documentation, Revised 2008* practice standard at www.cno.org/publications.

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Enhancing Client Safety

Nurses and employers have a shared responsibility to create safe practice environments. Quality practice settings include appropriate staff, medication systems (for example, delivery, administration, policies, procedures) and environments to facilitate safe, effective and ethical care. The following section provides information and resources to help nurses and employers work together to prevent and resolve medication issues.

Safe medication practices

To support safe medication practice, systems need to be in place to track, address and learn from any medication errors that occur in the practice environment.

Medication errors

A medication error is defined as any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication; product labelling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.[16]

Medication errors can be further classified into errors of commission (for example, giving the wrong medication) and errors of omission (for example, not administering an ordered medication), which can result in an adverse drug event resulting in harm, injury or death. Or, it could result in a "near miss." In this situation, an error does not reach the client, but had it, the client could have been harmed. (For example, a wrong dose is prescribed but is intercepted before administration.)

Preventing and reducing errors involves collaboration between the nurse, other health care professionals and the facility. Nurses can often identify and correct errors before they occur. Addressing individual accountability and using a systems-based approach to analyze errors ensures that errors are identified, and that staff participate in an interprofessional process that identifies root causes and results in corrective actions. When an error is made, the nurse must ensure the well-being of the client and limit the client's exposure to any potential harm. The plan of action will depend on the problem(s) identified. Some strategies to address problems are system modifications, in-service education, individual assistance and potential performance management.

Safe medication practice includes:

- advocating for setting-specific, accessible, current **medication information**, such as drug formularies;
- evaluating the need for a colleague to conduct an **independent double-check** on a prepared medication;
- meeting and being aware of the facility's expectations on independently double-checking preparations;
- advocating for written policies and supporting processes when the practice setting requires independently double-checking preparations;
- having knowledge of **high alert medications** for the practice setting (for example, chemotherapeutic agents);
- avoiding the use of error-prone abbreviations, dose designations and symbols, and advocating for a policy on the use of acceptable abbreviations;
- reporting all errors and near misses using formal practice-setting communication mechanisms;
- advocating for organizational systems and policies that promote continuity and safety of client medication administration during transfer of care and at transition points;
- ensuring that the client or the client's substitute decision-maker has the most complete and accurate list possible of all medications currently being taken;
- communicating to the client and appropriate

[16] (National Coordinating Council for Medication Error Reporting and Prevention, 2008)

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caregivers the current list of medications during **transfer of accountability**;
- addressing system issues that contribute to medication errors;
- advocating for and/or participating in interdisciplinary error-reporting and root cause system analysis;
- advocating for facility policies and/or procedures regarding disclosure of adverse events; and
- following legislation and/or advocating for practice setting policies and procedures regarding the storage, counting, administration and disposal of medication.

Medication reconciliation

This process is intended to prevent medication errors when a client's care is transferred. Medication reconciliation assists in reducing the risk of preventable adverse events and is an important client safety initiative. The medication reconciliation process may involve all members of the health care team.

The process involves:
- creating the most complete, accurate list of all medications a client is currently taking and the time the last medication was given (for example, a best possible medication history);
- using this list when writing admission medication orders;
- comparing the list and the admission medication orders;
- identifying any discrepancies and, if any are found, bringing them to the attention of the prescriber and making appropriate changes to the orders;
- communicating the current list of medications to the client and appropriate caregivers;[17] and
- comparing the medication history to transfer/discharge orders to ensure that the client's medications are reconciled at transfer/discharge.[18]

Institute for Safe Medication Practices Canada

The Institute for Safe Medication Practices (ISMP) Canada is an independent, national, non-profit agency committed to the advancement of medication safety in all health care settings. It works collaboratively with the health care community; regulatory agencies and policy-makers; provincial, national and international client safety organizations; the pharmaceutical industry and the public. ISMP Canada is a resource for information on how to prevent errors and identify high alert medications. It also has a list of industry accepted abbreviations. For more information, contact ISMP Canada at:

Toll-free: 1 866 544-7672
E-mail: info@ismp-canada.org
Website: www.ismp-canada.org

Adverse drug reactions

A serious adverse drug reaction (ADR) is defined as a noxious and unintended response to a drug that occurs at any dose and requires in-patient or extended hospitalization; causes congenital malformation; results in persistent or significant disability/incapacity; is life-threatening or results in death.[19] A nurse who assesses a serious ADR should report it or advocate for reporting it to the Canada Vigilance Program:

Toll-free: 1 866 234-2345
Website: www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html

[17] (Institute for Safe Medication Practices Canada, 2006)

[18] (Safer Healthcare Now, 2007)

[19] (Health Canada, 2007)

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Glossary

Adverse reaction. Undesirable physical reactions to health products, including drugs, medical devices and natural health products. Drugs include prescription and non-prescription pharmaceuticals; biologically derived products such as vaccines, serums and blood derived products; cells, tissues and organs; disinfectants and radiopharmaceuticals.[20]

Authorizing mechanism. An order, initiation, directive[21] or delegation. A means specified in legislation or described in a practice standard or guideline through which nurses obtain the authority to perform a procedure or make the decision to perform a procedure.[22]

High alert medications. Drugs that bear a heightened risk of causing significant client harm when they are used in error.[23]

Independent double-check. A process that ensures that a second practitioner conducts a verification, either in the presence or absence of the first practitioner. For example, a nurse may use this process to verify a dosage calculation. The most critical aspect is to ensure that the first health care provider does not communicate what he or she expects the second practitioner to find; this would reduce the visibility of a mistake.[24]

Medication information. Information about a specific drug such as indications, appropriate dose, precautions, contraindications, drug/food interactions, expected outcomes, potential adverse reactions, side effects and how to minimize and treat them, high alert medications, special consideration, storage and administration.

Telephone order. An order communicated via telephone by an authorizer who is not physically present to write the order. The person accepting the order must have knowledge of the client, including his or her health history and treatment plan. Ultimately, the person implementing the order is accountable for ensuring that the order is appropriate. Practice settings should establish procedures for timely sign-off by the authorizer of the telephone order.

Transfer of accountability. An interactive process of transferring client-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity of care and the safety of the client.[25]

Verbal order. An order that is communicated by an authorizer who is present in the practice environment but is unable to document the order. Verbal orders must only be used in emergency situations or when the prescriber is unable to document the order, such as in the operating room.

[20] (Health Canada, 2007)

[21] For more information, refer to the College's *Directives* practice guideline at www.cno.org/publications.

[22] For more information, refer to the College's *Authorizing Mechanisms* practice guideline at www.cno.org/publications.

[23] (Institute for Safe Medication Practices Canada, 2008)

[24] (Institute for Safe Medication Practices Canada, 2008)

[25] (Patton, 2007)

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Medication Terms

Allergy challenge testing. The administration of an allergen by oral, inhaled or other route in which a positive test is a significant allergic response (for example, anaphylactic shock). Unless delegated, nurses cannot perform allergy challenge testing.

Allergy testing and desensitizing injections. An allergy test is a prick/puncture procedure to determine allergies, if any. A positive test results in a wheal and area of erythema. A desensitizing injection is an intracutaneous injection to desensitize to an allergen. Because allergy testing and desensitizing injections carry a risk of adverse reactions, nurses must be able to recognize side effects, intervene in the event of complications (for example, difficulty breathing, rash or anaphylactic shock) and manage outcomes. If the nurse cannot manage adverse outcomes, a competent health care practitioner and appropriate environmental supports and medications must be readily available.

Controlled substance. Any type of drug that the federal government has categorized as having a higher-than-average potential for abuse or addiction. Such drugs are divided into categories based on their potential for abuse or addiction. Controlled substances range from illegal street drugs to prescription medications.[26]

The Office of Controlled Substances of Health Canada regulates the distribution of controlled substances in Canada, including those substances used by individuals and health care facilities for legitimate scientific or health reasons. The governing federal legislation includes the *Controlled Drugs and Substances Act*, the *Narcotic Control Regulations*, Part G (Controlled Drugs) of the *Food and Drug Regulations and Benzodiazepines and Other Targeted Substances Regulations*.

Under the legislation, all licensed health care facilities in Ontario, such as public hospitals, private hospitals and long-term care facilities as defined by the *Nursing Homes Act*, are required to maintain a count of controlled substances. Facilities that are not provincially licensed as defined by the *Homes for the Aged and Rest Homes Act* are not bound by the *Controlled Drugs and Substances Act* and related regulations.

Immunizing agent(s). A vaccine. The skill required to administer immunizing agents is the same as that for other injections. For more information, refer to the College's *Influenza Vaccinations* practice guideline.

Over-the-counter (OTC) medication without an order. Medications and preparations that do not require a prescription; for example, herbal therapies and acetaminophen. OTC medications are not part of the act of prescribing. In some situations, however, the nurse's role may include administering or recommending OTC medications to clients. Nurses are solely accountable for recommending OTC medications to clients and for any outcomes of those recommendations. Before recommending an OTC medication, nurses must have the knowledge, skill and judgment about the client's situation; the client's condition and medication profile; and the medication. Legislation or organizational policies may require an order from an authorized prescriber. For more information, refer to the College's *Complementary Therapies* practice guideline.

Placebo. A pharmacologically inert substance that has no physiological effect. Administering placebos to clients without their knowledge and informed consent is inappropriate and unacceptable.

Placebos may be administered:

- when prescribed with client consent because the client experiences a placebo effect; and/or
- as part of a double-blind research study in which the client has been informed, as part of the consent process, that he or she may receive a placebo.

[26] (Health Canada, 2008)

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PRN medication(s). Medications that are prescribed and administered as needed. The order includes the frequency, such as Q4H, and the purpose (for example, sleep, pain or nausea). Nurses must have current knowledge of the use and action of PRNs, as well as the competence to assess the need for PRNs and whether to administer them to a client.

Range doses. Dosages, frequencies or routes that are prescribed in ranges (for example, Gravol 50–100 mg for nausea). Most medications are not prescribed in range doses; however, range doses are used in situations in which the need for the amount of a drug varies from day to day or within the same day. Range doses give nurses the flexibility to administer the dose that best suits the assessment of the client.

Self-administration. Administrating one's own medication. Clients may self-administer their medications at home and in some agencies to develop or maintain an optimal level of functioning and independence. Clients who self-administer may be completely independent, or may require some assistance, such as reminders, help opening containers or assistive devices (for example, dosettes), or help in filling assistive devices. Nurses must ensure that medications are securely stored.

When using investigational and emergency release medications (off label). When physicians prescribe these medications, the physician or pharmacist must give the nurse a drug monograph/information. Although the nurse is not accountable for any outcomes produced by the medications, the nurse is accountable for correctly administering the drug, and is required to intervene and possibly withhold medications if severe side effects occur. After administration, the nurse monitors the client for adverse side effects.

When using medication brought from home. In some settings, such as geriatric daycare centres and children's camps, clients bring their medications from home. Nurses may administer these medications if they are in their original dispensing containers (that is, not in an envelope or assistive device for self-administration). If the information provided by the client or the client's representative is different from that on the dispensing label, the nurse needs to use her or his judgment about the appropriateness of following the directions and follow up with the prescriber when required. The nurse should document the discrepancy and her or his rationale for following the chosen directions.

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Additional Information

Administration of medication by an unregulated care provider (UCP)

Technological advances, shorter hospital stays, fiscal constraints and a general shift to community-based care have contributed to the increased use of UCPs to assist with or perform aspects of care, including medication administration, that were formerly provided by regulated care providers. Nurses may teach UCPs medication administration, including the process of administration and documentation, as required. Although administering by some routes is not a controlled act and doesn't require delegation, there is still a risk of harm when performing any procedure if it is not done competently. The nurse remains responsible for the:

- ongoing assessment of the client's needs;
- plan of care in conjunction with the health care team;
- evaluation of the client's health status; and
- effectiveness of the medication(s).

UCPs do not have the knowledge to provide this component of the plan of care. If the nurse decides it is appropriate for the UCP to administer medication(s), the nurse is accountable to ensure criteria are developed and communicated to the UCP that clearly define when the UCP needs to contact the nurse. The nurse must make provisions to ensure an ongoing assessment of the client's condition.[27]

Dispensing

Dispensing is a controlled act authorized, to various extents, to some health care professionals, including pharmacists, physicians and dentists. It involves the selection, preparation and transfer of one or more prescribed drug doses to a client or his or her representative for administration. Dispensing applies to prescription medications only, not to over-the-counter medications. Although repackaging is performed both with the delegation of dispensing and when delegation is not required, the difference lies in what medication you are repackaging.

Dispensing involves:

- receiving/reading the prescription;
- adjusting the order according to approved policy (for example, substitution), if appropriate;
- selecting the drug to dispense;
- checking the expiry date;
- reconstituting the product, if needed;
- repackaging the drug;
- labelling the product; and
- completing a final physical check to ensure the accuracy of the finished product.

Nurses do not have access to the controlled act of dispensing; however, some health care professionals can delegate the act of dispensing to nurses. Each practice setting must identify who is delegating the authority to dispense and the nurses delegated with the authority; the delegation process; and client specific orders or directives for dispensing specific types of drugs.

Therefore, delegation is required for nurses to perform any of the following activities:

- preparing/packaging leave of absence (LOA) or pass medication from a drug supply not previously dispensed to the client (for example, prescribed ward stock);
- filling a mechanical aid or alternative container from a ward stock or unit dose supply for client self-administration or for a UCP to administer;
- providing clients with several doses (from stock supply) for self-administration (for example, giving the client either the entire prescription or several doses in an emergency department, or providing oral contraceptives or antibiotics in a clinic to take home);
- repackaging large-volume ward stock into smaller containers for another alternate ward stock supply; and
- providing sample prescription drug packs.

Conversely, nurses do not require delegation to repackage a drug. Because dispensed drugs come in blister packs, vials or unit dose packages labelled with the drug name, dose, frequency and the client's

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name, it is considered repackaging, not dispensing, to do the following:

- fill a mechanical aid or alternative container from the client's own blister pack or prescription bottle to facilitate self-administration or administration by a caregiver;
- repackage and label drugs from the client's own blister pack or vial for an LOA;
- give a client LOA medications prepared by a pharmacy; or
- give a client her/his blister pack or prescription bottle to take on an LOA.

For more information on delegation, refer to the College's *Decisions About Procedures and Authority, Revised 2006* practice standard and *Authorizing Mechanisms* practice guideline.

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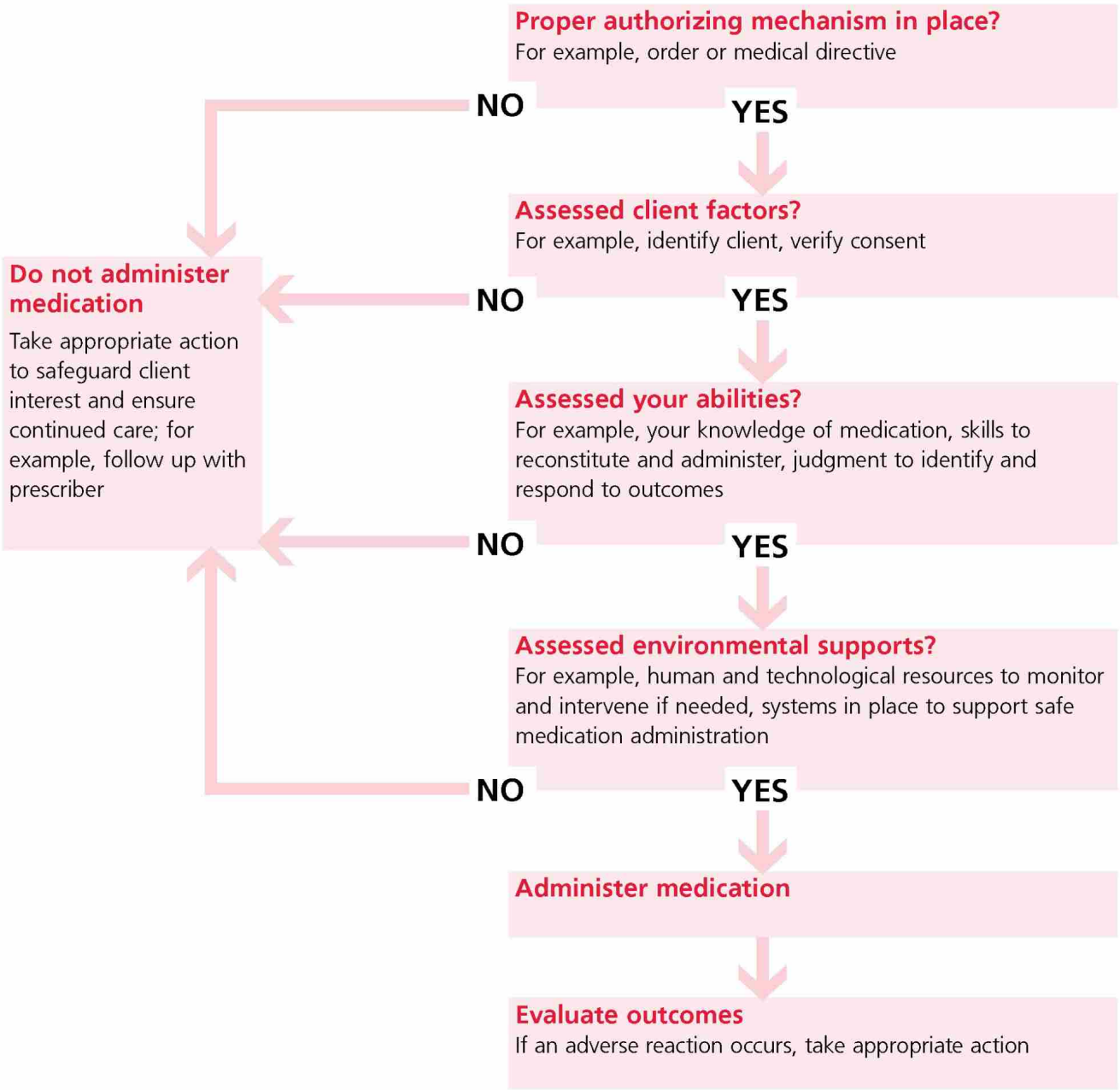
Decision Tree: Deciding About Medication Administration

Use this tool to help you determine whether or not to administer a medication. Be sure to consider all of the components of medication administration in this document.



Note: *Document during and/or after administering medication, according to documentation standards.*

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Appendix A: Legislation Governing Nursing Practice

The *Regulated Health Professions Act, 1991* (RHPA)[28] and *Nursing Act, 1991* set and guide the practice of nursing. Under these acts, nurses are given the authority to perform controlled acts and provide client care. The scope of practice statement for nursing is:

The practice of nursing is the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.[29]

Controlled acts are defined as acts that could cause harm if performed by those who do not have the knowledge, skill and judgment to perform them. A regulated health professional is authorized to perform a portion or all of the specific controlled acts that are appropriate for his or her profession's scope of practice. Because some scopes of practice overlap, certain professionals are authorized to perform the same, or parts of the same, controlled acts.

Nurses are authorized to perform three controlled acts when ordered or permitted by regulations under the *Nursing Act*:

- performing a prescribed procedure below the dermis;
- administering a substance by injection or inhalation; and
- putting an instrument, hand or finger beyond a body orifice or artificial opening to the body.

NPs can perform the controlled acts authorized to all nurses as well as additional controlled acts.[30]

Although administering medications by some routes is not a controlled act (for example, orally or topically), there is a risk of harm in performing any procedure if it is not done competently. Performing controlled acts represents only a small portion of nursing practice. It is important to note that:

- controlled acts are not the only procedures that can cause harm;
- having the authority to perform a procedure does not automatically mean it is appropriate to do so; and
- each nurse is accountable for her or his decisions and actions.

[28] For more information, refer to the College's *RHPA: Scope of Practice, Controlled Acts Model* reference document at www.cno.org/publications.

[29] From the *Nursing Act, 1991*.

[30] For more information, refer to the College's *Nurse Practitioners* practice standard at www.cno.org/publications.

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Notes:

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