

Good practice in the routine, ward-based administration of medication on acute mental health units.

## Support Manual



Authors:

Joy A Duxbury, John Baker, Neil Harris

## Author contact details:

### Dr Joy A Duxbury (Principal Investigator)

Divisional Leader for Mental Health  
University of Central Lancashire  
Nursing Department  
Brook Building  
Preston  
PR1 2HE  
Email: j.duxbury@uclan.ac.uk

### John A Baker

Lecturer  
Coupland 3  
Coupland Street  
The University of Manchester  
M13 9PL  
Email: john.a.baker@manchester.ac.uk

### Dr Neil Harris

Nurse Consultant/Lecturer  
Manchester Mental Health & Social Care Trust  
Coupland 3  
Coupland Street  
The University of Manchester  
M13 9PL  
Email: neil.harris-2@manchester.ac.uk

© The University of Central Lancashire 2007

## Contents:

### SECTION ONE

Introduction	2
Background	3
Study Aims	4
Glossary	4
Study flowchart	5
Prerequisites for practice	5

### SECTION TWO

Principles of good practice for the administration of medicines	6
1. Prescription quality	6
2. Administration	7
3. Polypharmacology, efficacy and side effects	9
4. Accountability	11
5. Concordance	14
6. Information giving	16
7. Evaluation of effects	18

### SECTION THREE

Lessons Learnt – What do we know?	19
Recommendations	22
With thanks	23
References	24

### Introduction

This manual describes the good practice principles for the administration of medications in acute mental health wards.

Whilst for many these are already custom and practice, research shows that there is room for improvement in this key area of mental health practice. It is hoped that this guide will act as a further prompt for all clinicians to improve on what they already do well, maintain areas of good practice and for some staff provide additional knowledge and skills for how they administer and monitor medication.

- ▶ **Section 1** gives a brief outline of the study underpinning the production of this manual
- ▶ **Section 2** highlights good practice for the administration of medicines
- ▶ **Section 3** details lessons learnt from the study and recommendations for the way forward

### Background

Pharmacological interventions in mental health have had a profound effect since their introduction. Despite debates about the efficacy of antipsychotic medication however, its value has been established with nurses playing a central role in its administration.<sup>1,2</sup> Psychotropic medication forms the mainstay of secondary care mental health treatment, and is especially important in inpatient mental health settings.<sup>3</sup> Bowers et al (2005) identified that medication was perceived by the Multidisciplinary Team as the first intervention in acute mental health wards - 'a central task'.<sup>3</sup>

The development of skills related to medicines features in a number of documents pertaining to acute mental health care. In the Standing Nursing and Midwifery Advisory Committee<sup>4</sup> report 'Addressing Acute Concerns' two out of six recommendations focus on medication. These particularly highlight the importance of formal side effect assessment, and medicines management both of which feature in the capable practitioner document. The training and education guidance for acute mental health wards suggests that all staff should have level 1 capabilities incorporating knowledge of medications and their side effects<sup>5</sup>. Qualified staff in addition need an array of level 2 capabilities that require post basic training in medication management. Specific skills in motivational interviewing, compliance therapy, side effect management and/or knowledge in health beliefs, psychopharmacology, and effective prescribing are advocated<sup>5</sup>. Training in medication management has tended to largely focus in recent years on community settings.<sup>6,7</sup>

Research does indicate however, it is both necessary and possible to teach staff from acute mental health wards about medication, and that qualified and unqualified staff welcome such training<sup>8</sup>.

Good practice in the administration of medicines provides the foundation for improving medicines management.

With regards to medication, the nurse's role is central. Decisions about the treatment of patients with an array of psychotropic drugs are and should be at the heart of mental health nursing and embraced as a therapeutic intervention. Nurses after all are in a key position to deliver, monitor and report upon patient progress and response to treatment.

## Section One:

This manual has been developed as part of a two year research project. It is a valuable tool in that it can compliment training and/or be used as a supportive guide in practice.

### Study Aims

The aims of the study were:

1. To describe current practice in the administration of medication on an acute psychiatric unit and identify factors that influence nurses when making decisions regarding the administration of psychotropic medication;
2. To develop and evaluate a short medication management training programme for nurses using a range of service user and staff outcome measures.

Data collected involved a combination of methods including the observation of practice using the Ward Administration of Medication Scale, the administration of surveys to patients and staff and follow up interviews.

Whilst the broader findings of this study will not be reported upon here, some of the data gathered underpins the focus of this guide and pointers for the way forward.

### Glossary

**Administration:** The process by which nursing staff give medication to patients.

**Atypical:** Refers to 'new' antipsychotic medication which produces less extra-pyramidal side effects (EPSE)

**DAI** Drug Attitude Scale

**Dispensing:** The process by which pharmacy staff issue medications to the ward.

**LUNSERS:** A rating scale for antipsychotic side effects.

**MES:** Medication Engagement Scale

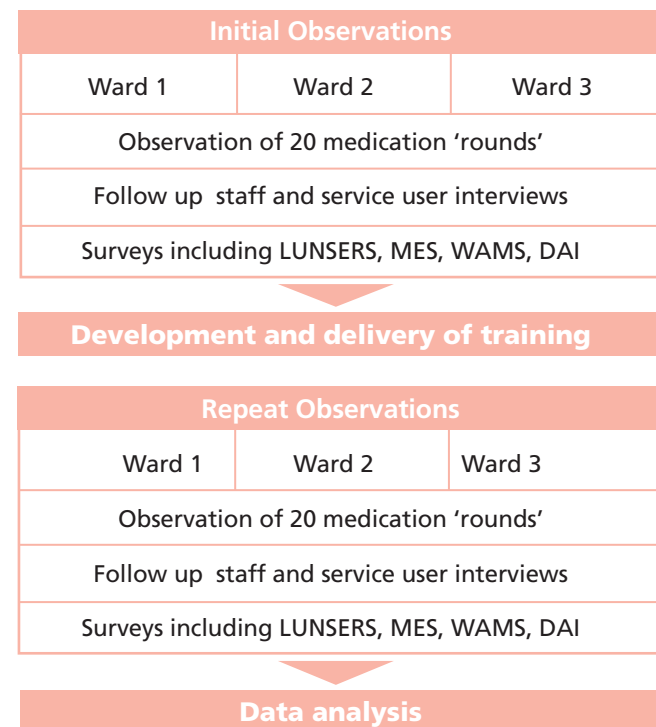
**PRN:** Pro re nata, the Latin phrase for as needed medication. This medication which once prescribed can be administered to patients at the nurse's discretion

**Polypharmacy:** Two or more antipsychotic medications at the same time.

**Psychotropic:** Medications which influence mental state<sup>1</sup>.

**WAMS:** Ward Administration of Medication Scale

### Study flowchart



### Prerequisites for practice

- ▶ This manual is designed to be used in adult inpatient mental health settings.
- ▶ It builds on existing good clinical practice and evidence drawn from staff in Manchester Mental Health and Social Care Trust as the result of the first stage of a research project.
- ▶ It should not replace clinical judgement, but is designed to enhance and support clinical practice.
- ▶ Clinicians remain professionally accountable for prescribing<sup>9</sup> or administering<sup>10,11</sup> medications.
- ▶ It is assumed that staff using the protocol are knowledgeable about the patients that they are treating.
- ▶ This manual is intended to supplement existing and related local Trust policies.

### Principles of good practice for the administration of medicines

In nursing, drug administration is a major clinical role.<sup>12</sup> Issues relating to the administration of medication account for nearly a quarter (21.7%) of all the time nurses are in contact with patients, and nearly 10% of their total time<sup>13</sup>.

*'Each Registered Nurse is accountable for his or her practice. This practice includes preparing, checking, and administering medications, updating knowledge of medications, monitoring the effectiveness of treatment, reporting adverse drug reactions and teaching patients about their drugs.'*<sup>12</sup>

*'The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement.'*<sup>10</sup>

As part of our research to date we have identified a number of principles of good practice. These 7 principles are discussed in further detail in the following pages.

#### 1. Prescription quality

Correct prescriptions form the foundations for good administration habits for nursing staff. Prescribing errors are the most common form of medication error and are often responsible for causing subsequent errors in administration.<sup>12 14 15</sup>

Prescriptions need to be correctly and clearly written (legible) with specific attention to:

**Drug name**

**Single dose (i.e. non-ranged) and within appropriate limits for example, as identified in the British National Formulary<sup>16</sup>**

**A signature**

**Calculations used to determine dose**

**Polypharmacy and/or high doses<sup>17</sup>**

Additional considerations are needed for PRN prescriptions which are often of a poorer quality<sup>18</sup> including:

- ▶ Appropriate indication for use
- ▶ Total daily dose to be administered
- ▶ Single route per prescription
- ▶ Expiry/review or stopping date

The General Medical Council, Royal College of Psychiatry and the Nursing, Midwifery Council have produced a number of good practice documents for prescribing and administration.<sup>9-11 19</sup> The British National Formulary contains additional guidance for prescribers, particularly on abbreviations, decimal points and the use of zero.<sup>16</sup> Additional information can be obtained from The Maudsley Prescribing Guidelines,<sup>20</sup> the National Institute of Clinical Excellence (NICE) (<http://www.nice.org.uk>) and the Cochrane Review (<http://www.cochrane.co.uk>).

#### Practical tip:

Doctors and nurses should work together to ensure the good quality of clear prescriptions as it saves time in the long run, and reduces the risk of medication errors.

#### 2. Administration

**The poor administration of medicines is one of the most common reasons for nurses losing their registration.<sup>21</sup>**

The Department of Health (2004) estimates that there is a 5% error rate in the administration of medicines in hospitals, although precise figures remain unknown.<sup>22</sup>

A recent study found that medicine trolleys are associated with an increased risk of administration error when compared to individual patient lockers.<sup>22</sup> Bedside lockers also increase patient privacy.<sup>23</sup>

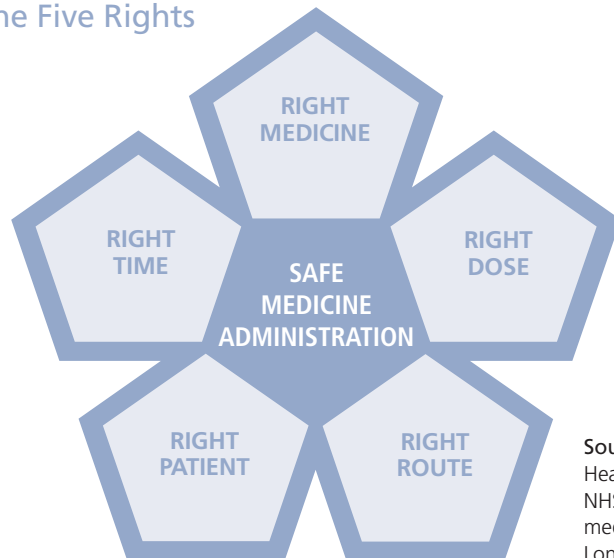
#### Practical tip:

Untidy or cluttered medicine trolleys/work stations increase the risk of mistakes. Try to make preparations for an organised work area before beginning each round.

## Section Two:

The Department of Health (2004) recommends the 5Rs for medication administration to reduce common errors.<sup>22</sup>

### The Five Rights



Source: Department of Health. Building a safer NHS for patients: Improving medication safety. London: DH, 2004, p 61.<sup>22</sup>

#### Practical tip:

Rehearse the 5Rs each time you administer a medicine.

The Nursing, Midwifery Council<sup>10</sup> recommends the following principles for administering medications:

1. Know the medications, dosage, side effects, precautions and contra-indications.
2. Be certain of the patient
3. Be aware of care plans
4. Check the prescription
5. Consider dose, route and timing for the patient
6. Check expiry date
7. Check the patient is not allergic
8. Make a clear and accurate record including those withheld or refused
9. Countersign student nurses' administrations

Our research suggests that:

- 1 It is important to establish the identity of each patient.
- 2 Irrespective of external pressures the medication round should be dedicated therapeutic time. Many nurses find this difficult due to given ward constraints.
- 3 You need to be organised before each round. This will reduce the potential for error and stress for patient and nurse alike.

### 3. Polypharmacology, efficacy and side effects

The mismanagement of medication is a recurring theme and often includes concerns regarding patient compliance, the overuse of polypharmacological approaches and insufficient knowledge of administration, interactions, preferences and side effects.<sup>7 24</sup>

Important points to note:

#### a) The more antipsychotic you give the greater the effect (high doses)

**THIS IS A MYTH!** Antipsychotic medications work by blockading Dopamine receptors; they are very effective in doing this. A recent Cochrane review for acute schizophrenia concluded that:

It would be understandable if clinicians were cautious in prescribing doses in excess of 7.5 mg/day of haloperidol to a person with uncomplicated acute schizophrenia.<sup>25</sup>

#### b) Polypharmacy / High Doses

It is estimated that 25% of inpatients are prescribed high doses of medication, often as a result of polypharmacy. PRN contributes to both of these factors<sup>17</sup>. High doses and polypharmacy should be avoided and have been attributed to poor health outcomes including premature death.<sup>17 26 27</sup>

#### c) Effectiveness of treatment regimens

Antipsychotic medication takes 1-3 weeks to work. There is no evidence that high loading has additional benefits but instead can cause increased levels of side effects.<sup>28</sup>

## Section Two:

### d) Monitoring side effects

Evidence of side effect monitoring in acute mental health settings remains scarce.<sup>29</sup>

Health care workers underestimate the problem of side effects especially those associated with weight gain and psychotropic medication.<sup>30</sup>

#### Practical tip:

Aim to complete LUNSERs for each of your patients.<sup>31</sup> A computer programme is now available in addition to hard copies of this rating scale.

Patients can sometimes hesitate to take prescribed medication because of fear of side effects. The interpersonal contact between the nurse who administers the medication and the patient is paramount.<sup>32</sup>

#### Our research suggests that:

1 The following are the most common side effects reported by patients:

- a) Physical effects - Weight gain, tiredness, dizziness and shakiness
- b) Cognitive effects - Poor concentration, difficulty with recall and depression
- c) Behavioural effects - Restlessness, sleep difficulties and feelings of tension.

This is consistent with their views on side effects as reported by them in the Drug Attitude Inventory (DAI)

2 Patients report their side effects but feel less confident in asking for medication when they feel unwell.

3 Patients indicate that whilst aware of side effects, they take medication because it often improves their mental state whilst in hospital.

## 4. Accountability

Nurses are accountable for their professional decisions and actions. According to Glover (1999) there are four areas of accountability that should inform and underpin safe nursing practice as seen in the diagram.<sup>33</sup>

You are accountable to patients in your care and have a duty of care towards them to act in their best interests and to do them no harm.<sup>11</sup>

You are accountable to the public for any actions you take and have a public responsibility as a registered nurse to protect them.

Consequently you are accountable to your professional body for both of the above and to your employers who will have local policies and guidelines that you are expected to adhere to.

When examining the principles of medication administration there are two areas in particular that will influence the decisions you make and how you manage this process. They are consent and confidentiality. Good record keeping is of course paramount and inextricably linked to both of these areas of practice. It is therefore an integral part of this manual throughout and consequently will not be dealt with as a separate item.

#### Action:

For a broader look at legal issues go to <http://www.bmj.bmjournals.com>. Then search for 'Clinical guidelines: Legal and political considerations of clinical practice guidelines' by Brian Hurwitz 1999

#### Consent

The NMC (2004) states that wherever possible the prescription and administration of medication should be based upon the patient's informed consent and awareness of the purpose of the treatment.<sup>10</sup> Usher and Arthur (1998) suggest that when establishing the consent of a patient this should be a process as opposed to a one off event.<sup>34</sup>



## Section Two:

The DoH (2001) suggest that consent can be:<sup>35</sup>

- ▶ Written
- ▶ Verbal
- ▶ Implied

### Practical tip:

With regards to medication it is good practice to check verbally with patients on every occasion that they understand about and are happy to comply with medication offered.

A patient's refusal to take prescribed medication can lead to ethical conflicts and awake feelings of frustration, fear or anger in nurses.<sup>32</sup>

In order for consent to be valid you must ensure that:<sup>35</sup>

- ▶ The patient has the capacity to consent. This means that you must feel sure that they understand the purpose, side effects and effects of not adhering to treatment.
- ▶ The patient has received and can retain sufficient information for the period of administration.
- ▶ They are not co-erced or acting under duress.<sup>11</sup>

The need for consent can be overridden if: <sup>35 10</sup>

- ▶ It is in the 'best interests' of the patient to receive medication to ensure improvement or to prevent deterioration in their mental health when consent has been withheld.
- ▶ And that this would be 'a reasonable action' to take and one that would be taken by others in a similar situation and professional position.

It is imperative when decisions of this nature are being considered that patients are informed and that consultation with colleagues is undertaken within the parameters of the law.

### Practical tip:

It is rare for a practitioner to make an independent decision of this nature. Always endeavour to seek the assistance of and discuss this with your nursing and medical team.

See: [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent)  
[www.nmc-uk.org](http://www.nmc-uk.org)

## Confidentiality

The need to safeguard the confidential information of patients about their personal circumstances is also fundamental to the relationship between them and health care professionals.<sup>36</sup>

Facilities for privacy and the maintenance of dignity are essential components of protecting and ensuring confidentiality. The administration of medication can adversely affect the patient if these are not given the attention they deserve.

### Practical tip:

Location is particularly important; offering tablets or discussing medication with patients in corridors and communal areas increases the stigma and reduces the dignity that they experience. It also makes confidential discussion and further assessment difficult.

The Department of Health (2003) recommends that:<sup>37</sup>

- ▶ Staff are fully aware of their responsibilities and the Code of Practice regarding confidentiality.
- ▶ Information is recorded accurately and consistently.
- ▶ Patient information is kept private and physically secure.
- ▶ Information must be used and disclosed with the appropriate care.

### Our research suggests that:

- 1 Nurses rarely ask questions about the patient's mental health status and effectiveness of drugs at the medication round. They feel that this is the result of concerns over keeping confidences.
- 2 Maintaining confidentiality when asking sensitive questions is imperative. This may involve or even necessitate time out after the round to discuss things further.
- 3 When it is clear that there may be difficulties with compliance, again it is important and therapeutic to work with the individual on a one to one basis. This can be difficult if wards are under-resourced.

## Section Two:

The DOH (2003) suggests that you should: <sup>37</sup>

- ▶ Check that patients are aware of the choices available to them in respect of how their information may be disclosed and used.
- ▶ Answer any queries personally or direct the patient to others who can answer their questions or to other sources of information.

### Action:

Download and read the following documents. Make them available to other colleagues in your working area.

DOH (2003) Confidentiality NHS Code of Practice, London, DH.

DOH (2001) Good Practice in Consent Implementation. London, DH.

DOH (1997) The Caldicott Committee Report on the Review of Patient Identifiable Information, London, DH.

## 5. Concordance

Medication concordance is essential for recovery. Whilst the term has been criticised by some,<sup>38</sup> it embodies the principle of informed consent.

*“Poor concordance rates are estimated to result in relapse rates of 50% within a year”.*<sup>39</sup>

However it is important to note that ‘in the real world, up to 30% of hospitalised patients do not respond to neuroleptics. Among those who do and are discharged, more than one-third relapse within the next 12 months and need to be re-hospitalised, even though they reliably take their medications.’<sup>1</sup>

Medication administration is more than giving the right pill to the right patient. It provides patients with an opportunity to communicate with their nurses.

Limited research has been conducted of patients’ perceptions and experiences associated with psychotropic medication<sup>40</sup>. However when there exists a non-coercive atmosphere, positive relationships with the care team, a regimen with minimal adverse effects and involvement in treatment decisions, patients are more prepared to accept treatment. Their perception of inpatient services is then also likely to be more positive.<sup>41</sup>

You can encourage concordance generally by doing the following:<sup>39 42</sup>

- ▶ Engage with your patient as soon as possible and then endeavour to provide information within the first 48-72 hrs of admission.
- ▶ Discuss, formulate and communicate a plan.
- ▶ Assess the patient’s mental health status on a daily basis and monitor for medication effectiveness, side effects and interactions. Review plan accordingly.
- ▶ Ask the patient! Consultation is the key even when you feel the patient isn’t able to make a decision based upon sound judgement.
- ▶ Explain decisions made and the reasons for them.
- ▶ Discuss and review again. Do not assume that any degree of incapacity is a permanent state.

### Practical tip:

Reflect upon your own interpersonal style after your next medication round and evaluate your own performance in these matters. You may want to use peer review or co-supervision.

Individuals with good medication compliance have a significantly better improvement of psychopathological symptoms during their inpatient stay.<sup>43</sup> The importance of facilitating concordance can therefore not be underestimated. The value of interpersonal contact between nurses and patients in order to encourage patients to take medication has been commented on in a number of studies.<sup>32 41</sup>

### Practical tip:

Knowing the nurse who administers the medicine makes it easier for patients to take it. This has implications for the use of temporary staff and in how they are deployed when on a shift.

### Our research suggests that:

- 1 Nurses recognise the authority of patients in medication decision making but find this hard to facilitate when making clinical judgements about capacity.
- 2 Despite feeling uncertain about the effectiveness of medication and concerned about its side effects, compliance is reportedly good. Patients in this instance recognise and appear accepting of a paternalistic approach. This does not however excuse poor information giving or limited collaborative practice.
- 3 Whilst largely conforming to treatment, patients are sometimes unsure of the rationale for the chosen medication. This may affect concordance in the long term and reflects room for improvement in this area.

It has been reported that where there is slowness by professionals to adopt a patient centred approach in mental health services this is linked to their doubts about competence and capacity.<sup>44</sup>

## 6. Information giving

Information concerning medication needs to be provided in both written and oral formats.<sup>23</sup> Nurses have a unique opportunity to provide this to patients. Although research suggests new patients are provided with information it is often assumed that those who have been on treatment for some time will know all about it. This is often not the case.<sup>24</sup>

Inadequacy of information and exclusion from discussion and decisions about treatment is a continuing complaint of service users of psychiatric services.<sup>44</sup>

The National Institute of Clinical Excellence recommends that the provision of good information is a core component of quality care and a prerequisite for users to make informed choices about their treatment.<sup>45</sup> Access to information is a fundamental right!

### Practical tip:

The provision of information sheets about the actions and side effects of medication is a very useful vehicle for communication. Reminders to patients are also imperative as are guidelines on how this information should be distributed.

### Remember

- ▶ Patients cannot exercise choice if they do not know what is being prescribed or understand the intended effects.
- ▶ Information is reassuring.
- ▶ Advanced knowledge of side effects helps patients cope better with them if they arise.
- ▶ Good communication builds better relationships with staff.
- ▶ Being actively involved in your own care means that you can take charge of your own recovery as much as possible.
- ▶ It helps patients calibrate the severity of their illness.
- ▶ Knowing about drugs encourages greater reporting by patients and safer use of medication.

### Our research suggests that:

- 1 Information giving could be better. This finding is consistent with other studies. This applies to both nurses and doctors particularly when pertaining to changes in medication.
- 2 Patients are mixed in their views about this. However, generally more information on medication and particularly changes would be welcomed.

## 7. Evaluation of effects

There is increasing evidence of the distance between service users and professionals in terms of their outcome goals and evaluation of treatment<sup>44</sup>. It is important to establish whether medication is having a positive effect on a patient's acute symptoms. Information gained from making observations and asking questions about symptoms is essential for making medication changes. Exploring the person's experience of medication in this way can provide useful insights into their attitude towards treatment and help them reflect on its value.

Our research suggests that:

- 1 Nurses infrequently made enquiries at the medication round as to the effectiveness of medication.
- 2 Nurses who do enquire as to the well-being of patients are perceived to be warm and approachable. This is valuable in that it potentially facilitates further opportunities to discuss patients' concerns about drug effectiveness and impact.
- 3 Whilst medication clearly leads to common side effects as reported using LUNERS in this instance, many patients feel there are benefits to the drugs they take.

### Practical tip:

Simply asking the patient "Is this working for you?" clarifies their progress as well as their level of understanding about the medication. This may fluctuate and as with consent, requires ongoing evaluation.

Most guidelines recommend choosing and monitoring medications on aspects of effectiveness, tolerability and patients' preferences.<sup>43</sup>

## Lessons Learnt - What do we know?

This section includes summaries of findings from data collected from stage 1 of our project which has informed the key principles outlined in this manual

### What happens at medication rounds?

The observations conducted looked at 20 medication rounds in total from 3 different acute adult inpatient wards. These covered a range of times including morning, lunchtime, evening and night time rounds.

We found that:

- ▶ Prescription quality can reportedly be poor.
- ▶ Organisation of and preparation for the round is imperative.
- ▶ Patients are more comfortable talking about side effects than their mental health status when at the trolley.
- ▶ The safety of the trolley/medication area is paramount and this can sometimes be compromised when the wards are busy or understaffed.
- ▶ Distractions can interfere with protected time for the administration of medication.
- ▶ The health status of patients and enquiries about side effects are commonly not explored and thus may go undetected if not discussed with patients and carefully monitored.
- ▶ Nurses demonstrate excellent interpersonal skills in dealing with patients, often communicating 'warmth'.
- ▶ Where **patients** instigate dialogue about their medication then nurses are very good at responding and using skills such as negotiation. However they are less likely to explore, clarify or collaborate with patients unless prompted. This may be indicative of workload, ward pressures and/or concerns around pre-empting difficulties that relate to consent. This means that opportunities to determine health status and side effects can be missed.

### What do nurses think?

- ▶ Privacy and the maintenance of confidentiality are important and nurses feel restricted in questioning patients in a public forum.
- ▶ Nurses feel that they have to rush medication rounds due to work pressures and find 'round times' very stressful.
- ▶ Medication rounds need to be better organised and there needs to be consistency in the approach used.
- ▶ There needs to be greater teamwork in making sure that this area is addressed. Communication between the MDT can be poor and effects interventions of this nature.
- ▶ There are problems in particular with the written and verbal communication between doctors and nurses regarding medication.
- ▶ Better guidelines are needed or at least their visibility and procedures need to be more consistently followed by everyone.
- ▶ Nurses feel unsure about patients' ability to consent and have mixed views about where the decision should lie when medication is required but resisted.
- ▶ Nurses would like to use tools such as LUNSERs but are sometimes not familiar with them.
- ▶ More training is needed. For example nurses would like greater input on psychopharmacology and associated drug interactions, indications and efficacy.
- ▶ There should be more opportunities for mentorship in practice and support for newly qualified staff in the management of medication to build their confidence.
- ▶ Nurses feel more time should be given to the whole issue of medication administration and feel unsupported by their organisations. Staffing and workload pressures are significant problems and can interfere with the quality of this therapeutic intervention.

### What do patients think?

- ▶ Patients believe nurses to have very good interpersonal skills in dealing with them overall.
- ▶ They commonly do not feel involved in decisions made about their treatment.
- ▶ Many patients believe that decisions based upon expertise rests with the healthcare professional as to what they should take and when.
- ▶ Patients recognise the need to take medication and often comply but would prefer not do so if given a choice.
- ▶ Information giving is variable.
- ▶ Common side effects have been reported and can be broken down into behavioural, physical and cognitive effects. Each may affect understanding and recall. This has implications for information giving, consent and recovery.
- ▶ Patients have concerns over the organisation of medication rounds which can sometimes be chaotic. They feel that time is often wasted and queuing excessive. This they find stressful.
- ▶ Patients feel confident in nurses' ability to administer medication and their knowledge of it.

It is clear to see how patients can perceive these factors to interfere with concentration, information retention and therapeutic relationships.

### Recommendations

- ▶ Nurses are accountable for their own practice in this area and need to be familiar with the four areas of accountability.
- ▶ There are professional, national and local policies and protocols to follow that are helpful and indicative of templates of good practice. These may need to be more accessible.
- ▶ Training, support and supervision are required post basic registration. This may be in-house or through dedicated courses. Content needs to incorporate as a minimum, pharmacology, factors pertaining to safety and efficacy, side effect monitoring, legal and ethical frameworks, therapeutic communication and assessment.
- ▶ Distractions should be avoided or managed with the availability of sufficient staff. The administration of medications is a therapeutic role that requires dedicated time and energy.
- ▶ Medications should not be left outside of the trolley. For example on shelves or the lower external part of a medication trolley.
- ▶ The trolley should be locked at all times when left unattended. (Requirement)
- ▶ Suitable locations to discuss patients' mental health status and experience of side effects needs some consideration. This may involve an examination of where and how medications are administered locally.
- ▶ Trust forums should be established with representatives from each ward to meet on a regular basis and with representation from pharmacists. Dedicated 'champions' on each ward might be a suitable approach.
- ▶ LUNSERs or similar tools are an effective way of determining and addressing side effects. Computer programmes are available and licences can be purchased. Wards may want to consider them as an investment and useful tool as part of individual care packages.
- ▶ Information sheets should be available to all patients about their medication and distributed accordingly. This is a valuable opportunity to discuss issues with patients.
- ▶ There is a need to improve communication between the multi-disciplinary team and the patient regarding medication and any proposed changes. Whilst patients in some instances feel informed there is a lack of uniformity to this and they would like to be more involved in decisions made.

### With thanks

This project has been funded by the Burdett Charitable Trust for Nursing.

It has been scrutinised by Tameside & Glossop Local Research Ethics Committee, the research governance committee of Manchester Mental Health and Social Care NHS Trust and the ethics committee at the University of Central Lancashire.

All groups have favourably reviewed this study.

We would like to thank the dedicated research team of Pamela Barnes, Karen Wright and Diane Bradley for their work on and contributions to this project.

Finally and not least of which we would like to thank the staff and patients who participated in this study and the Trust for granting access to one of their mental health units.

If you have any questions or would like to discuss this manual further please contact Dr Joy Duxbury.

### Additional reading

Healy D. (2005) *Psychiatric drugs explained*. 4th Ed. London: Elsevier Churchill Livingstone.

Taylor D, Paton C, Kerwin R. (2005) *The Maudsley prescribing guidelines 2005-2006*. 8th. ed. London: Taylor and Francis group.

### References

1. Usher K, Lindsay D, Sellen J. Mental health nurses' PRN psychotropic medication administration practices. *Journal of Psychiatric & Mental Health Nursing*. 2001; 8(5):383-390.
2. Whitaker R. The case against antipsychotic drugs: a 50-year record of doing more harm than good. *Medical Hypotheses* 2004; 62:5-13.
3. Bowers L, Simpson A, Alexander J, Hackney D, Nijman H, Grange A, et al. The nature and purpose of acute psychiatric wards: The Tompkins Acute Ward Study. *Journal of Mental Health* 2005; 14(6):625 - 635.
4. Standing Nursing and Midwifery Advisory Committee. *Mental Health Nursing: Addressing Acute Concerns*. London: Department of Health 1999.
5. Clarke S. *Acute Inpatient Mental Health Care: Education, Training & Continuing Professional Development for All*. London: National Institute for Mental Health in England and Sainbury Centre for Mental Health, 2004.
6. Gray R, Wykes T, Gourney K. The effect of medication management training on community mental health nurses' clinical skills. *International Journal of Nursing Studies* 2003; 40:163-169.
7. Jordan S, Hardy B, Coleman M. Medication management: an exploration study into the role of community mental health nurses. *Journal of Advanced Nursing* 1999; 29(5):1068-1081.
8. Richards DA, Bee P, Loftus SJ, Baker JA, Lovell K, Bailey L, et al. Core competencies for Modern Mental Health Care. The effect of an innovative training programme on the quality of care for acute in-patient mental health services. Manchester: The University of Manchester, 2003.
9. Royal College of Psychiatrists. *Good psychiatric practice (CR125)*. 2nd ed. London, 2004.
10. Nursing Midwifery Council. *Guidelines for the administration of medicines*. London.: NMC, 2004.
11. Nursing Midwifery Council. *The NMC code of professional conduct: standards for conduct, performance and ethics: Nursing Midwifery Council.*, 2004.
12. O'Shea E. Factors contributing to medication error: a literature review. *Journal of Clinical Nursing* 1999; 8:496-504.
13. Whittington D, McLaughlin C. Finding time for patients: an exploration of nurses' time allocation in an acute psychiatric setting. *Journal of Psychiatric and Mental Health Nursing* 2000; 7:259-268.
14. Stubbs J, Haw C, Taylor D. Prescription errors in psychiatry - a multi-centre study. *Journal of Psychopharmacology* 2006; 20(4):553-561.
15. Armitage G, Knapman H. Adverse events in drug administration: a literature review. *Journal of Nursing Management* 2003; 11:130-140.
16. Joint Formulary Committee. *British National Formulary*. London: British Medical Association and Royal Pharmaceutical Society of Great Britain, 2006.
17. Royal College of Psychiatrists. *Consensus statement on high-dose antipsychotic medication*. London: Royal College of Psychiatrists, 2006.
18. Nirodi AJ, Mitchell. The quality of psychotropic drug prescribing in patients in psychiatric units for the elderly. *Aging & Mental Health*. 2002; 6(2):191-196.
19. General Medical Council. *Good Medical Practice*. London: GMC, 2001.
20. Taylor D, Paton C, Kerwin R. *The Maudsley prescribing guidelines 2005-2006*. 8th. ed. London.: Taylor and Francis group., 2005.
21. Anderson D, Webster C. A systems approach to the reduction of medication error on the hospital ward. *Journal of Advanced Nursing* 2001; 35(1):34-41.
22. Department of Health. *Building a safer NHS for patients: Improving medication safety*. London: DH, 2004.
23. Healthcare Commission. *Talking about medicines. The management of medicines in Trusts providing mental health services*. London: Commission for Healthcare Audit and Inspection, 2007.
24. Duxbury J, Baker J The use and nursing management of benzodiazepines in acute, mental health inpatient care: a discussion, *Journal of Psychiatric and Mental Health Nursing*, 2004, 11: 662-667
25. Waraich PS, Adams CE, Roque M, Hamill KM, Marti J. Haloperidol dose for the acute phase of schizophrenia (review). *Cochrane Database of Systematic Reviews* (3) Art No.: CD001951, 2002.
26. Harrington M, Lelliott P, Paton C, Okocha C, Duffett R, Sensky T. The results of a multi-centre audit of the prescribing of antipsychotic drugs for in-patients in the UK. *Psychiatric Bulletin* 2002; 26:414-418.
27. Joukamma M, Heliövaara M, Knekt P, Aromaa A, Raitasalo R, Lehtinen V. Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry* 2006; 188:122-127.
28. Humble F, Berk M. Pharmacological management of aggression and violence. *Human Psychopharmacology* 2003; 18:432-436.
29. Richards D, Bee P, Loftus SJ, Baker JA, Bailey L, Lovell K. Specialist educational intervention for acute inpatient mental health nursing staff: service user views and effects on nursing quality. *Journal of Advanced Nursing*. 2005; 51(6):634-644.
30. Harrison B. Nursing considerations in psychotropic medication-induced weight gain. *Clinical Nurse Specialist*. 2004; 2(18):80-87.
31. Day J, Wood G, Dewey M, Benetall R. A self rating scale for measuring neuroleptic side-effects; validation in a group of schizophrenic patients. *British Journal of Psychiatry* 1995; 166:650-3.
32. Haglund K, Knorring L, Sidenvall B. Medication administration in inpatient psychiatric care - get control and leave. *Journal of Psychiatric and Mental Health Nursing* 2004 11: 229-234
33. Glover D. *Accountability NT Monographs*, 1999 London, NT
34. Usher K, Arthur D. Process consent: a model for enhancing informed consent in mental health nursing. *Journal of Advanced Nursing*. 1998 27, 692-697.
35. Department of Health. *Good Practice in Consent Implementation Guide*. London DH, 2001
36. Department of Health The Caldicott Committee: *Report on the Review of Patient - Identifiable Information*. London: HMSO 1997
37. Department of Health *The NHS Confidentiality Code of Practice: Guidelines on the use and protection of patient information* London, DH 2003
38. Marinker M, Shaw J. Not to be taken as directed; putting concordance for taking medicine into practice, *British Medical Journal* 2003, 362; 348.
39. Jones A, Harborne G. Supplementary prescribing in hospital settings. *Mental Health Practice* 2005; 9: 38-40.
40. Baker J, Lovell K, Easton K, Harris N. Service users' experiences of 'as needed' psychotropic medications in acute mental health settings. *Journal Compilation*, 354-362.
41. Day J, Bentall R, Roberts C, Randall F, Rogers A, Cattell D, et al. Attitude toward antipsychotic medication: the impact of clinical variables and relationships with health professionals. *Archives of General Psychiatry* 2005; 62:717-724
42. Ogden J 2007 *Health Psychology: A Textbook*, Milton Keynes, Open University
43. Janseen B, Gaebel W, Haerter M, Komaharadi F, Lindel B, Weinmann S. Evaluation of the factors influencing medication compliance in inpatient treatment of psychotic disorders. *Psychopharmacology* 2006 187; 229-236.
44. Pollock K, Grime J, Baker E, Mantala K. Meeting information needs of psychiatric inpatients: Staff and patient perspectives, *Journal of Mental Health* 2004 13; 389-401
45. National Institute of Clinical Excellence *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. NICE, London 2002.



Department of Nursing  
Preston PR1 2HE  
Tel: 01772 201201