## Contents

Preface xii  
Reviewers xiii  
Table of Abbreviations xiv  

### CHAPTER 1 Introduction to the law  
Understanding what the law is  
Influence of the different philosophies on the development of our laws  
Where does our law come from?  
Development of the common law  
Parliamentary or statute law  
The application of English legal principles to Australia  
How the law operates  
Criminal law  
Civil law  
Civil and criminal consequences from one action  
Administrative machinery of the law  
State and territory courts  
Local courts or Magistrates’ Courts  
District or County Courts  
State and territory Supreme Courts  
Federal courts  
Federal Magistrates Court  
Family Court of Australia  
Federal Court of Australia  
High Court of Australia  
Other court systems and tribunals  
The appeal process  
The doctrine of precedent  
Who pays the bill?  
Criminal law  
Development of the criminal law  
The elements of a crime  
Criminal negligence and the significance of the element of intent in healthcare settings  

### CHAPTER 2 The relationship between law and ethics  
Ethics: what it is  
Ethics: what it is not  
An example of an ethical problem  
How might the nurse respond?  
What resources are available to assist nurses and midwives to address such dilemmas?  

#### Major ethical theories  
Deontological or intrinsicalist theories  
Teleological or consequentialist theories  
Modern feminist ethics  
The four major ethical principles  
Autonomy  
Beneficence  
Non-maleficence  
Justice  
Models for ethical decision-making in healthcare  
Clearly state the problem  
Get the facts  
Consider the fundamental ethical principles  
Consider how the problem would look from another perspective or using another theory  
Identify ethical conflicts  
Consider the law  
Make the ethical decision  
Evaluate the decision  

### CHAPTER 3 Professional negligence and vicarious liability  
Negligence as part of the law of civil wrongs  
Legislative changes affecting the law in relation to civil negligence and professional negligence in particular  
Professional negligence in a healthcare context  
Negligence: Principle 1 — that the defendant owed the plaintiff a duty of care  
Duty of care as a nurse or midwife  
What is the position outside of work?  
Determining the standard of care for healthcare professionals generally  
Standard of care in treatment cases  
Legislative provisions relevant to determining the standard of care  

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### Preface  
This section provides an introduction to the legal principles relevant to various aspects of healthcare practice, including understanding the law, its sources, and how it operates. It also discusses the application of English legal principles to Australia and the various types of courts involved in the legal system.

### Reviewers  
The reviewers are acknowledged for their contributions to the development of the book.

### Table of Abbreviations  
The abbreviations used throughout the book are listed in this section.

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### CHAPTER 1 Introduction to the law  
This chapter delves into the understanding of what the law is and its influence on the development of our laws. It also explores where our law comes from, focusing on the development of the common law, parliamentary or statute law, and the application of English legal principles to Australia. The chapter concludes with an overview of how the law operates, distinguishing between criminal and civil law. It discusses civil and criminal consequences from one action and the administrative machinery of the law.

### CHAPTER 2 The relationship between law and ethics  
This chapter examines the relationship between law and ethics, discussing what ethics is and what it is not. It includes an example of an ethical problem and explores major ethical theories such as deontological or intrinsicalist theories, teleological or consequentialist theories, and modern feminist ethics. The chapter also outlines the four major ethical principles: autonomy, beneficence, non-maleficence, and justice. It provides models for ethical decision-making in healthcare and discusses how to clearly state the problem, get the facts, and consider the fundamental ethical principles.

### CHAPTER 3 Professional negligence and vicarious liability  
This chapter focuses on professional negligence and vicarious liability, exploring negligence as part of the law of civil wrongs and legislative changes affecting the law in relation to civil negligence and professional negligence in particular. It also examines professional negligence in a healthcare context. The chapter outlines negligence principles, with a focus on determining the standard of care and the legal implications for healthcare professionals.
The determination of the standard of care in treatment cases following the introduction of the civil liability legislation in the states and territories 58
The standard of care in information cases 59
The standard of care expected of nurses and midwives acting in a professional capacity 63
Expert evidence from professional peers 63
Professional practice standards 64
Statutory obligations 65
Departmental guidelines and/or employer policy and procedure directives 66
Academic texts and publications 67
The patient’s medical records 67
Understanding the approach to be taken in determining the professional standard of care 67
Example 1: Coroner’s Inquest into the death of Tracey Baxter 68
Example 2: Sha Cheng Wang (by his tutor Ru Bo Wang) v Central Sydney Area Health Service 73
Example 3: McCabe v Auburn District Hospital 77
Example 4: Norton v Argonaut Insurance Company 80
Example 5: Ison v Northern Rivers Area Health Service 81
Example 6: Langley v Glandore Pty Ltd (in liquidation) 84
Example 7: Elliott v Bickerstaff 86
Example 8: Coroner’s Inquest into the death of Samara Lea Hoy 87
Questioning a medical practitioner’s orders 91
Example: Coroner’s Inquest into the death of Timothy John Bice 91
Other examples 93
Negligence: Principle 2 — that the defendant’s conduct on the occasion in question fell below the standard of care expected 94
Negligence: Principle 3 — that, as a consequence of the defendant’s breach of his or her duty of care to the plaintiff, the plaintiff suffered damage 94
Damage suffered by the plaintiff 95
The causal relationship between the damage and the negligent act 98
Barnett v Chelsea and Kensington Hospital 99
Hotson v Fitzgerald 101
Finch v Rogers 103
Tabet v Gett 104
Negligence: Principle 4 — the damage that the plaintiff is complaining about is a reasonably foreseeable consequence of the defendant’s negligent act 105
Damages 107
Provision for an apology within the context of potential civil liability for negligence 109
Time limits or limitation periods 111
Defences to an action in negligence 112
A general denial and rebuttal of the allegation 112
Contributory negligence 113
Voluntary assumption of risk 114
Vicarious liability 114
Who is an employee for the purposes of the doctrine of vicarious liability? 115
Example: Albrighton v Royal Prince Alfred Hospital 118
Example: Ellis v Wallsend District Hospital 119
What constitutes the course and scope of employment? 123
Problems arising from the use of motor vehicles provided by the employer 125
Contribution and indemnity 127
The employer’s personal liability 128
The nurse or midwife as an independent contractor 129
Professional indemnity arrangements for healthcare professionals 129
The nurse or midwife as a good Samaritan 131
CHAPTER 4 Consent to treatment 137
Why is consent important? 137
Assault and battery 137
Relevance of consent generally 138
Negligence must be distinguished 138
What information is available to help professionals and patients? 141

How may consent be given? 142

What are the elements of a valid consent? 144

Any consent given is freely and voluntarily given 144

The patient is informed ‘in broad terms of the nature of the procedure which is intended’ 145

How much information does the patient require to make a decision to consent to treatment? 146

Who is responsible for giving sufficient information to a patient? 148

Therapeutic privilege 152

The person giving consent has the legal capacity to give such consent 153

Adults and consent 154

Statutory provisions 161

Temporary factors which might impair capacity 162

Minors and consent 162

The right to refuse medical treatment 169

Start a new report 170

Advance directives, advance care planning and proxy decision-making 170

The right to restrain or detain patients without their consent 171

What is false imprisonment? 173

How is false imprisonment committed? 173

Restraint must be intentional and complete 174

Defences to an action alleging false imprisonment 175

Reasonable condition 175

Lawful arrest in relation to criminal offences 175

Specific defences in relation to hospitals and healthcare generally 175

CHAPTER 5 The contract of employment, including occupational health and safety and workers compensation 181

The contract of employment 181

Terms and conditions of the contract of employment 182

The employee’s obligations 183

The employer’s obligations 184

The creation of an industrial award or workplace agreement 186

How the contract of employment is terminated 189

A contract for a fixed period or a specific undertaking 189

Death 189

Transfer of business 189

Frustration or impossibility of performance 189

Consent 190

Redundancy 190

Termination by notice 190

What constitutes an ‘unfair’ dismissal warranting reinstatement? 191

Workplace health and safety 192

Occupational health and safety legislation 193

Duty of care owed by an ‘employer’ under the model Work Health and Safety Act 194

What is meant by ‘reasonably practicable’ 195

Definition and duties of a ‘worker’ and ‘others’ under the Act 196

Obligation on a PCBU to consult with workers 196

Requirement for workplace health and safety representative(s), work groups and health and safety committees 197

Compliance provisions under workplace health and safety legislation 198

Entry by an authorised union officer 199

Penalties for non-compliance 199

A comprehensive workplace health and safety system 199

Workers compensation 200

Workers compensation versus other types of compensation for injury at work 200

How does an employee qualify for workers compensation payments? 200

The person must be an employee 201

Injury or disease 201
Arising out of or in the course of employment 202
Defences to a claim for workers compensation 204
Making a workers compensation claim 205
Some practical considerations and advice concerning workers compensation 206
Safe system of work 207

CHAPTER 6 The administration of drugs 211
Examining the relevant Regulations 214
Schedule 4: restricted substances 214
Schedule 8: controlled substances 215
Ward registers or drugs books 216
Problem areas with drugs 218
Administrative considerations 218
Clinical considerations 219
Endorsements for medication administration under the new national registration scheme 222
Criminal and professional issues relating to the administration of drugs 223
Appendix A: List of statutes and regulations governing medications in Australia 224

CHAPTER 7 Report writing 227
Report writing 227
Relevant considerations in writing reports 228
Integrated recordkeeping 231
Reading the patients’ records 231
The value of good nursing records when used as evidence in court 232
The difficulties for nurses when records produced in court are poor 233
Principles in relation to documentation 233
Advice available to nurses on documentation and confidentiality 236
Documentation in nursing homes 237
The national e-health transition authority (NEHTA) 238
Reporting and documenting adverse events and clinical incidents 240
Confidentiality of healthcare records 243

Patients’ right of access to their healthcare records 245
At common law 245
Legislative provisions in relation to right of access to healthcare records and privacy considerations 246
Open disclosure 247

CHAPTER 8 Professional regulation of nurses and midwives 253
Introduction 253
Relevant legislation and structure of the scheme 253
The National Boards 255
Principles of the new National Registration and Accreditation Scheme 256
The national registers 259
Student registration 260
The nursing and midwifery board of Australia (NMBA) 261
Codes of conduct and ethics and competency standards 261
Standards for initial registration 262
The continuing professional development registration standard 263
The professional indemnity insurance registration standard 265
The recency of practice (RoP) registration standard 266
Endorsements under section 94 of the National Law 268
Endorsement as a nurse practitioner under section 95 269
Nurse practitioners’ access to the Australian Government Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) 271
The regulation of midwifery 272
Background 272
Eligible Midwives Registration Standard under section 38(2) 273
Registration Standard for Endorsement for Scheduled Medicines for Midwives under section 94 275
Professional indemnity insurance requirements for privately practising midwives 277
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The composition of the tribunal</td>
<td>343</td>
</tr>
<tr>
<td>The role of the tribunal</td>
<td>344</td>
</tr>
<tr>
<td>The procedure of the tribunal</td>
<td>344</td>
</tr>
<tr>
<td>Appeals from decisions of the tribunal</td>
<td>345</td>
</tr>
<tr>
<td>Forms and types of treatment under the Act</td>
<td>345</td>
</tr>
<tr>
<td>Community treatment orders</td>
<td>345</td>
</tr>
<tr>
<td>Electroconvulsive therapy (ECT)</td>
<td>347</td>
</tr>
<tr>
<td>Surgery or special medical treatment</td>
<td>349</td>
</tr>
<tr>
<td>Patient rights, review of care and appeal mechanisms under the Act</td>
<td>350</td>
</tr>
<tr>
<td>Review of care</td>
<td>351</td>
</tr>
<tr>
<td>Northern Territory: <em>Mental Health and Related Services Act 1998</em></td>
<td>352</td>
</tr>
<tr>
<td>Objectives and definitions</td>
<td>352</td>
</tr>
<tr>
<td>Admission to and detention in an approved treatment facility</td>
<td>354</td>
</tr>
<tr>
<td>Forms and types of treatment under the Act</td>
<td>358</td>
</tr>
<tr>
<td>The regulation and prohibition of certain forms of treatment under the Act</td>
<td>359</td>
</tr>
<tr>
<td>Patient rights, community visitors and appeal mechanisms under the Act</td>
<td>362</td>
</tr>
<tr>
<td>Mental Health Review Tribunal</td>
<td>363</td>
</tr>
<tr>
<td>Appeals to the Supreme Court of the Northern Territory</td>
<td>363</td>
</tr>
<tr>
<td>Queensland: <em>Mental Health Act 2000</em></td>
<td>363</td>
</tr>
<tr>
<td>Definitions</td>
<td>364</td>
</tr>
<tr>
<td>Admission to and detention in an authorised mental health service</td>
<td>365</td>
</tr>
<tr>
<td>Justices examination order</td>
<td>366</td>
</tr>
<tr>
<td>Emergency involuntary assessment</td>
<td>367</td>
</tr>
<tr>
<td>Involuntary treatment order</td>
<td>368</td>
</tr>
<tr>
<td>Treatment plans</td>
<td>369</td>
</tr>
<tr>
<td>The role of the Mental Health Review Tribunal and Mental Health Court</td>
<td>370</td>
</tr>
<tr>
<td>Forms and types of treatment under the Act</td>
<td>371</td>
</tr>
<tr>
<td>Treatment prohibited by the Act</td>
<td>372</td>
</tr>
<tr>
<td>Restraint and seclusion</td>
<td>372</td>
</tr>
<tr>
<td>Patient rights, review of care and appeal mechanisms under the Act</td>
<td>374</td>
</tr>
<tr>
<td>South Australia: <em>Mental Health Act 2009</em></td>
<td>375</td>
</tr>
<tr>
<td>Definitions</td>
<td>375</td>
</tr>
<tr>
<td>Admission to and detention in an approved treatment centre</td>
<td>376</td>
</tr>
<tr>
<td>Guardianship Board</td>
<td>380</td>
</tr>
<tr>
<td>Patient rights, review of care and appeal mechanisms under the Act</td>
<td>381</td>
</tr>
<tr>
<td>Community visitors</td>
<td>382</td>
</tr>
<tr>
<td>Appeal rights</td>
<td>382</td>
</tr>
<tr>
<td>Tasmania: <em>Mental Health Act 1996</em></td>
<td>383</td>
</tr>
<tr>
<td>Definitions</td>
<td>383</td>
</tr>
<tr>
<td>Admission to and detention in an approved hospital</td>
<td>384</td>
</tr>
<tr>
<td>The role of the Mental Health Tribunal Forensic Tribunal</td>
<td>388</td>
</tr>
<tr>
<td>Forms and types of treatment under the Act</td>
<td>389</td>
</tr>
<tr>
<td>Patient rights and the role of official visitors under the Act</td>
<td>390</td>
</tr>
<tr>
<td>Official visitors</td>
<td>391</td>
</tr>
<tr>
<td>Victoria: <em>Mental Health Act 1986</em></td>
<td>392</td>
</tr>
<tr>
<td>Proposed new Mental Health Act for Victoria</td>
<td>392</td>
</tr>
<tr>
<td><em>Mental Health Act 1986</em></td>
<td>392</td>
</tr>
<tr>
<td>Definitions</td>
<td>392</td>
</tr>
<tr>
<td>Admission to and detention in an approved mental health service</td>
<td>394</td>
</tr>
<tr>
<td>Voluntary admissions or treatment</td>
<td>394</td>
</tr>
<tr>
<td>Involuntary admission or treatment</td>
<td>394</td>
</tr>
<tr>
<td>Mental Health Review Board</td>
<td>396</td>
</tr>
<tr>
<td>Forms and types of treatment under the Act</td>
<td>398</td>
</tr>
<tr>
<td>Application of bodily restraint and seclusion</td>
<td>403</td>
</tr>
<tr>
<td>Patient rights, review of care and appeal mechanisms under the Act</td>
<td>406</td>
</tr>
<tr>
<td>Community visitors</td>
<td>408</td>
</tr>
<tr>
<td>Western Australia: <em>Mental Health Act 1996</em></td>
<td>409</td>
</tr>
<tr>
<td>Definitions</td>
<td>409</td>
</tr>
<tr>
<td>Admission to and detention in an authorised hospital</td>
<td>410</td>
</tr>
<tr>
<td>Emergency psychiatric treatment, seclusion and restraint of patients</td>
<td>412</td>
</tr>
<tr>
<td>Forms and types of treatment under the Act</td>
<td>414</td>
</tr>
<tr>
<td>Patient rights, review of care and appeal mechanisms under the Act</td>
<td>415</td>
</tr>
<tr>
<td>Mental Health Review Board</td>
<td>415</td>
</tr>
<tr>
<td>Index</td>
<td>417</td>
</tr>
</tbody>
</table>
Dedication

To my parents with love and affection. Patricia Staunton

For Laurie. Mary Chiarella
It has always been our goal to provide nursing students and practising nurses with an introduction to the legal issues relevant to the provision of health care in Australia, and do so in a practical and readily understandable text with a clear, concise and readable exposition of the law.

With the recent changes to regulations for nurses and midwives under National Registration, we have updated the seventh edition of *Law for Nurses and Midwives* with the aim of reflecting these standards, and as the new title indicates, incorporated legislation relevant to midwifery practice.

All chapters have been revised and updated to reflect recent changes in legislation and regulations relating to nursing and midwifery practice, as have references to relevant court decisions. Special attention has been given to areas where legislative provisions apply, such as professional standard of care, occupational health and safety, coroners’ jurisdiction and mental health, to ensure that a nationwide perspective is provided.

Chapter 8 *Professional regulation of nurses and midwives* has undergone a complete rewrite to incorporate the new standards and regulations established by the Nursing and Midwifery Board of Australia (NMBA) for National Registration, and includes a specific section on maternity services law to address the new standards and guidelines for eligible midwives.

As always, we are extremely grateful for the comments and feedback we have received from readers and professional critics of our text to ensure it remains relevant to those who use it.

Again, we thank our own staff who have provided us with assistance in undertaking our task as well as our publishers for their support and patience during the writing of the seventh edition.

We trust this most recent edition of our text continues to provide assistance to all who use it and we thank them for their encouragement and interest in the ongoing editions of this text.
Reviewers

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Table of abbreviations

<table>
<thead>
<tr>
<th>A</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS</td>
<td>IIMS</td>
</tr>
<tr>
<td>Appeal Cases</td>
<td>Incident Information Management System</td>
</tr>
<tr>
<td>ACORN</td>
<td>IIS</td>
</tr>
<tr>
<td>Australian Council of Operating Room Nurses</td>
<td>Incident Information System</td>
</tr>
<tr>
<td>AC</td>
<td>J</td>
</tr>
<tr>
<td>Appeal Cases</td>
<td>Judge</td>
</tr>
<tr>
<td>AHEC</td>
<td>L</td>
</tr>
<tr>
<td>Australian Health Ethics Committee</td>
<td>LQR</td>
</tr>
<tr>
<td>AHWAC</td>
<td>Law Quarterly Review</td>
</tr>
<tr>
<td>Australian Health Workforce Advisory Committee</td>
<td>LRC</td>
</tr>
<tr>
<td>AIRC</td>
<td>Law Reform Commission</td>
</tr>
<tr>
<td>Australian Industrial Relations Commission</td>
<td></td>
</tr>
<tr>
<td>ALJ</td>
<td>N</td>
</tr>
<tr>
<td>Australian Law Journal</td>
<td>NEHTA</td>
</tr>
<tr>
<td>All ER</td>
<td>National e-Health Transition Authority</td>
</tr>
<tr>
<td>All England Reports</td>
<td></td>
</tr>
<tr>
<td>ALR</td>
<td>NHMRC</td>
</tr>
<tr>
<td>Australian Law Reports</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>ANMC</td>
<td>NMBA</td>
</tr>
<tr>
<td>Australian Nursing and Midwifery Council</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>APAC</td>
<td>NSWLRC</td>
</tr>
<tr>
<td>Australian Pharmaceutical Advisory Council</td>
<td>NSW Law Reform Commission</td>
</tr>
<tr>
<td>ART</td>
<td>NSWWR</td>
</tr>
<tr>
<td>assisted reproductive technology</td>
<td>New South Wales Reports</td>
</tr>
<tr>
<td>C</td>
<td>P</td>
</tr>
<tr>
<td>CCO</td>
<td>President</td>
</tr>
<tr>
<td>continuing care order</td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td>QC</td>
</tr>
<tr>
<td>Consumer Health Forum</td>
<td>Queens Counsel</td>
</tr>
<tr>
<td>CLR</td>
<td>QPD</td>
</tr>
<tr>
<td>Commonwealth Law Reports</td>
<td>Queensland Parliamentary Debates</td>
</tr>
<tr>
<td>COAG</td>
<td>R</td>
</tr>
<tr>
<td>Council of Australian Governments</td>
<td>RCA</td>
</tr>
<tr>
<td>CTO</td>
<td>root cause analysis</td>
</tr>
<tr>
<td>community treatment order</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>S</td>
</tr>
<tr>
<td>DEST</td>
<td>SAC</td>
</tr>
<tr>
<td>Department of Education, Science and Training</td>
<td>Severity Assessment Code</td>
</tr>
<tr>
<td>E</td>
<td>SASR</td>
</tr>
<tr>
<td>ECT</td>
<td>South Australian State Reports</td>
</tr>
<tr>
<td>electroconvulsive therapy</td>
<td></td>
</tr>
<tr>
<td>EHR</td>
<td>W</td>
</tr>
<tr>
<td>electronic health record</td>
<td>WLR</td>
</tr>
<tr>
<td></td>
<td>Weekly Law Reports</td>
</tr>
</tbody>
</table>
Chapter 6

The administration of drugs

In 2009 the Australian Pharmaceutical Benefits Scheme (PBS), the means by which the Australian Government subsidises prescription medication in Australia, was costing the tax payer over $8 billion per year. However, this equates to just over 14 percent of total government expenditure on healthcare, and less than 8 percent of the cost of the total health system.\(^1\) In addition, many medicines are purchased over the counter without a prescription and these include analgesics (pain-killers), cough medicine, vitamins and complementary medications. In Australia hospital admissions associated with adverse drug events range from 5.6 percent in the general population to 30.4 percent in the elderly, and 3.3 percent of the time admissions are paediatric emergency department attendances reported to be associated with adverse drug events.\(^2\)

The great majority of medications that nurses and midwives administer on a day-to-day basis are considered to be, and are defined by legislation as, poisons. That is, generally speaking, they are substances that, by their very nature, are inherently dangerous to one’s health if not used appropriately. Accordingly, it is considered necessary to identify them and lay down clear provisions as to how such substances may be obtained, the basis on which a person may have possession of them, who may prescribe them, how they must be stored, and so on.

The Commonwealth, as well as each state and territory of Australia, has specific legislation which covers the control and supply of poisons and therapeutic goods in that state or territory.\(^3\) This is set out in Appendix A to this chapter.\(^4\) Amongst other things, that legislation sets out the specific responsibilities of nurses and midwives in relation to the various types of drugs that they have to deal with and administer in their work. The possibility of making drug-related errors, and the legal consequences that can flow from this, are such that nurses and midwives need to be aware not only of specific legislative requirements that apply to them, but also how to minimise the possibility of errors occurring.

The information contained in this chapter will be of value to registered nurses and midwives and also enrolled nurses. In the past, only registered nurses and midwives were allowed to administer medications against a prescription. However, over the past 10 years new programs have been developed for enrolled nurses across
Australia to enable them to administer medications. At the time of writing all enrolled nurses are presumed to be medication-endorsed under the new national registration scheme. Enrolled nurses who are not medication-endorsed are expected to advise the Nursing and Midwifery Board of Australia (NMBA) so that a notation can be put against their registration to advise employers and the general public that they are not able to administer medications. This notation provides protection not only for the public, but also for the enrolled nurse, as it ensures they are not expected to deliver care outside of their scope of practice. If an enrolled nurse who is not medication-endorsed completes a required program of study they are able to apply to the NMBA to have the notation lifted from their registration.  

The legislation that governs the management of medication has different titles in the different jurisdictions and these are set out in Appendix A of this chapter. Not only are there statutes that govern the control of drugs, there are very specific regulations and orders that set out exactly how medications must be managed and the degree of control to which specific medications and drugs are subject. The legislation embraces all conceivable types of poisons available, ranging from agricultural poisons and domestic pesticides to drugs of addiction. The relevant legislation in each state and territory is relatively similar in the way in which it classifies and identifies poisons and therapeutic goods but there are differences in the detailed provisions that apply in some areas. In addition, as part of these various statutes, certain criminal offences are indicated where a person deals with certain poisons in a manner contrary to the provisions, particularly the drugs of addiction. Criminal charges in relation to well-publicised drug offences, such as possession or supply of heroin or cocaine, arise under other legislation.

For the sake of clarity and because of varying legal requirements, the types of poisons or drugs available are divided into various sections, or schedules, which are determined by the Poisons Standard (currently Poisons Standard 2011) established under paragraph 52D(2)(b) of the Therapeutic Goods Act 1989 (Cth). Such provisions are then incorporated into the various statutes in each jurisdiction. For legal definitions, it is still necessary to check with each relevant state or territory authority but the Standard for the Uniform Scheduling of Medicines and Poisons No 1 (the SUSMP 1) provides the template for each jurisdiction.  

The schedules of poisons are set out in the SUSMP 1 and a comprehensive list of the poisons that are identified within each schedule follows. The information in the SUSMP 1 points out that poisons are not scheduled on the basis of a universal scale of toxicity. Although toxicity is one of the factors considered, and itself incorporates a complex set of factors, the decision to include a substance in a particular schedule also takes into account many other criteria such as the purpose of use, potential for abuse, safety in use and the need for the substance. The SUSMP 1 now lists poisons in nine schedules according to the degree of control recommended to be exercised over their availability to the public. The types of poisons in each schedule are set out in Table 6.1.

The specific schedules that are most relevant to nursing staff are those generally identified as Schedule 4 substances and Schedule 8 substances. Schedule 4 substances are commonly referred to as ‘prescription only’ or restricted substances and cover all drugs that are able and required to be provided on the prescription of
The administration of drugs

Schedule 2. Pharmacy Medicine — Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.

Schedule 3. Pharmacist Only Medicine — Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.

Schedule 4. Prescription Only Medicine, or Prescription Animal Remedy — Substances, the use or supply of which should be by or on the order of persons permitted by state or territory legislation to prescribe and should be available from a pharmacist on prescription.

Schedule 5. Caution — Substances with a low potential for causing harm, the extent of which can be reduced through the use of appropriate packaging with simple warnings and safety directions on the label.

Schedule 6. Poison — Substances with a moderate potential for causing harm, the extent of which can be reduced through the use of distinctive packaging with strong warnings and safety directions on the label.

Schedule 7. Dangerous Poison — Substances with a high potential for causing harm at low exposure and which require special precautions during manufacture, handling or use. These poisons should be available only to specialised or authorised users who have the skills necessary to handle them safely. Special regulations restricting their availability, possession, storage or use may apply.

Schedule 8. Controlled Drug — Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

Schedule 9. Prohibited Substance — Substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or training purposes with approval of Commonwealth and/or state or territory health authorities.

Table 6.1 Schedules of poisons under SUSMP 1

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Schedule 1.</td>
<td>This Schedule is intentionally blank.</td>
</tr>
<tr>
<td>Schedule 2.</td>
<td>Pharmacy Medicine — Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.</td>
</tr>
<tr>
<td>Schedule 3.</td>
<td>Pharmacist Only Medicine — Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.</td>
</tr>
<tr>
<td>Schedule 4.</td>
<td>Prescription Only Medicine, or Prescription Animal Remedy — Substances, the use or supply of which should be by or on the order of persons permitted by state or territory legislation to prescribe and should be available from a pharmacist on prescription.</td>
</tr>
<tr>
<td>Schedule 5.</td>
<td>Caution — Substances with a low potential for causing harm, the extent of which can be reduced through the use of appropriate packaging with simple warnings and safety directions on the label.</td>
</tr>
<tr>
<td>Schedule 6.</td>
<td>Poison — Substances with a moderate potential for causing harm, the extent of which can be reduced through the use of distinctive packaging with strong warnings and safety directions on the label.</td>
</tr>
<tr>
<td>Schedule 7.</td>
<td>Dangerous Poison — Substances with a high potential for causing harm at low exposure and which require special precautions during manufacture, handling or use. These poisons should be available only to specialised or authorised users who have the skills necessary to handle them safely. Special regulations restricting their availability, possession, storage or use may apply.</td>
</tr>
<tr>
<td>Schedule 8.</td>
<td>Controlled Drug — Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.</td>
</tr>
<tr>
<td>Schedule 9.</td>
<td>Prohibited Substance — Substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or training purposes with approval of Commonwealth and/or state or territory health authorities.</td>
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</tbody>
</table>

a medical practitioner, nurse practitioner, eligible midwife, dentist or veterinary surgeon. Schedule 8 substances are called ‘controlled drugs’ and sometimes ‘drugs of addiction’. Apart from the Schedule 8 drugs, there are few drugs that nurses or midwives administer on a day-to-day basis that do not come within Schedule 4. For example, such drugs as antibiotics, antihypertensives and anticoagulants clearly fall into Schedule 4, as they can be obtained only on prescription.

In some jurisdictions certain drugs are declared to be Schedule 4 substances but in terms of storage and security are required to be dealt with in the same manner as Schedule 8 substances. As an example, the substances set out in Appendix D of the Poisons and Therapeutic Goods Regulation 2008 (NSW) include barbiturates, benzodiazepines and pseudoephedrine. While Schedule 8 substances are commonly referred to as controlled drugs, in New South Wales they are known as drugs of addiction, (sometimes) in Tasmania as narcotic substances, and in Western Australia, drugs of dependence. Whatever the minor variation in titles, the type of drugs that come within this Schedule are usually the narcotic analgesics.
such as opium, opium derivatives (morphine) and synthetic opium derivatives (pethidine).

Some substances that nurses and midwives administer from time to time are not required to be provided on prescription. They are often referred to as ‘nurse- or midwife-initiated medications’ and can be administered by nursing or midwifery staff without a medical officer’s authority or prescription. These medications usually include substances such as antacids, aperients and paracetamol. Nurses and midwives should not automatically assume their right to administer such substances without reference, and should do so only in accordance with clearly written guidelines drawn up by the hospital or health authority.7

The specific list of drugs under the various schedules changes fairly frequently as new drugs are developed and introduced. It is therefore essential that nurses and midwives be aware of this aspect and that any relevant addition or change to the list of drugs in Schedule 4 or Schedule 8 be communicated to them. Hospitals are automatically notified of relevant changes to the poisons legislation by the state or territory health departments, generally by way of departmental circulars. To the extent that they are relevant, such circulars should be acted upon where necessary and distributed to all staff concerned.

**Examining the relevant Regulations**

As we have already indicated, the various state and territory Acts and the division of the schedules are essentially similar in fundamental layout and content and it is not intended to incorporate the precise details of each state or territory’s legislative provisions in this text. The Regulations that accompany each of the Acts, and which are extremely important to nurses and midwives, vary in the precise words used concerning requirements as to the authority to prescribe, possess, control, supply, store and so on, but not to any significant degree. Some Regulations are more precise and detailed than others, and nurses in each state and territory should read their relevant Regulations carefully. When doing so, it is important to note the distinction between the words ‘prescribe’, ‘dispense’ and ‘administer’ — that is, in general terms, medical and nurse practitioners and eligible midwives (and others) prescribe, pharmacists dispense and nurses and midwives (and others) administer. The degree of commonality in the various state and territory Regulations can best be summarised as follows.

**Schedule 4: restricted substances**

As a general rule, only medical and nurse practitioners, eligible midwives, dentists and veterinary surgeons can issue a prescription for a restricted substance. Prescriptions are required to contain specific details, such as the name and address of the patient, date, drug and dosage. Some states and territories require that the prescriber shall write ‘legibly’ although this may be overcome with electronic prescribing. In an emergency, a medical practitioner can direct the dispensing of a restricted substance orally, including by telephone, subject to certain requirements.

Except in hospitals, no person other than a pharmacist or a pharmacist’s assistant can dispense a prescription for a restricted substance. In hospitals where
a pharmacist is employed, he or she is responsible for the storage and recording of restricted substances. In hospitals where no pharmacist is employed, the director of nursing or, in his or her absence, the person acting in the position, or the medical superintendent, has the responsibility for such storage and recording. More often than not, in remote areas, such a task falls to the registered nurse in charge because there is no medical practitioner on the premises. Whoever is responsible for the storage and supply of restricted substances must not issue such a substance from hospital stocks unless he or she has a proper prescription or the appropriate ward requisition slip from the nurse in charge of the ward.

Restricted substances can be administered in hospitals only on the written authority of a medical or nurse practitioner or an eligible midwife, except in the case of an ‘emergency’, when the medical or nurse practitioner or eligible midwife may verbally authorise the administration of a restricted substance. If the medical or nurse practitioner or eligible midwife verbally authorises the administration of such a substance he or she must confirm that verbal authority generally within 24 to 48 hours by writing in the patient’s notes.

**Schedule 8: controlled substances**

Certain persons are authorised to be in possession of and supply certain drugs of addiction for the purposes of their profession or employment. Such persons include:

- a pharmacist;
- a medical practitioner;
- the director of nursing of a public hospital where no pharmacist is employed, or, in the pharmacist’s absence, the person acting in the position;
- the nurse or midwife in charge of a ward in a public hospital;
- a nurse or midwife employed in a community health centre;
- a nurse employed in air ambulance duties; or
- a director of nursing and/or midwifery of a private hospital or nursing home.

It is important to remember that where a nurse or midwife, or any other person for that matter, is given authority to be ‘in possession and supply’ of drugs of addiction, provision is also made for such authority to be withdrawn if it is breached or exceeded.

Only a medical or nurse practitioner, eligible midwife, dentist or veterinary surgeon can issue a prescription for a drug of addiction. The requirements for such prescriptions are similar to those for restricted substances. In an emergency a medical or nurse practitioner or eligible midwife can direct the dispensing of a drug of addiction orally, including by telephone, subject to certain requirements. Except in hospitals, no person other than a pharmacist or a pharmacist’s assistant can dispense a prescription for a Schedule 8 drug.

The nurse or midwife in charge of a ward is required to keep all drugs of addiction stored separately from other goods, with the exception of certain restricted
substances. The storage area should be a separate receptacle or cupboard securely fixed to the premises and it should be kept securely locked when not in use. Any person, including a nurse or midwife, authorised to be in possession of and supply drugs of addiction is to keep the safe or cupboard in which they are stored securely locked and is to keep the key on his or her person. If the authorised person is absent from the premises the key to the cupboard or safe should not be left lying around.

Approval can be given by state or territory health authorities for drugs of addiction to be kept in approved first-aid kits for use in an emergency in isolated localities, in an occupational health centre, in search and rescue operations or in other approved situations. In such approved situations a register must be kept.

The requirements for the storage of drugs in hospitals and health services are all similar to those set out in the South Australian Department of Health’s *Code of Practice for the Storage and Transport of Drugs of Dependence*, the relevant sections of which are set out below in Box 6.1.

### Ward registers or drugs books

There is also a requirement with controlled substances that the nurse in charge of a hospital ward will keep a register of controlled drugs (a ‘ward register’) in that ward. For example, under section 101(1) of the *Health (Drugs and Poisons) Regulation 1996* (Qld), the ward drugs book is required to record information about obtaining controlled drugs into the unit from the central storage point and administering controlled drugs to persons in the unit. The person in charge is expected to ensure that the ward drugs book is bound and sequentially numbered, relates only to one class of controlled drug, has a heading describing the class of controlled drug and records in the measurement unit the quantities of the drug involved in a transaction.

If any drug of addiction is lost, destroyed or rendered unusable, a person authorised to possess such drugs must be notified. In the case of a drug of addiction that is unusable and has to be destroyed, the destruction of the drug must be undertaken by the pharmacist, director of nursing or medical superintendent in the presence of another person and a record made in the register of such loss or destruction. Where an ampoule of a drug of addiction is only ‘part used’ and the remainder discarded, the entry in the register should record that fact. For example, if a patient is ordered 75 mg of pethidine and the only ampoules available are 100 mg ampoules, the register should record that the patient received 75 mg and the remaining 25 mg was destroyed on the basis that it had been rendered unusable.

In some jurisdictions there are specific requirements concerning the responsibilities of the nurse in charge of a private hospital or nursing home. These do not differ in any significant degree from the requirements already mentioned, except to the extent of limiting the quantities of drugs of addiction that person is authorised to possess.

The relevant Regulations usually specify what a nurse should do if there is a discrepancy or there are missing drugs. This usually requires notification to a relevant person or body. The process for such notification should also be spelled out in the employer’s policy and procedure manual.
Health service and surgery

4) All drugs of dependence stored in a health service, ward, day surgery unit, or medical, dental or veterinary surgery, must be placed in a securely locked storage cabinet that meets or exceeds the following requirements:

4.1) Where the quantity of drugs stored is not more than 15 doses—
   4.1.1) made of 15mm thick hardwood; and
   4.1.2) fitted with a 5 lever key lock or equivalent locking mechanism; and
   4.1.3) securely fixed to the wall or floor; or

4.2) where the quantity of drugs stored is more than 15 doses and the immediate area in which the cabinet is situated is supervised at all times, the requirements specified in sub-paragraphs 4.1.1 to 4.1.3 above; or

4.3) where the quantity of drugs stored is more than 15 doses and the immediate area in which the cabinet is situated is not supervised at all times (eg nights) the requirements of Australia/New Zealand Standard for Safes and Strongrooms (AS/NZS 3809:1998) Resistance Grade 1; or

4.4) as approved by the Director, Pharmaceutical Services.

Restricted access

5) No person other than an authorised person shall have a key to the cabinet.

5.1) At all times, while on duty, the authorised person for the time being in charge of a ward, medical, dental or veterinary surgery, day surgery unit or nursing home must keep the key to the cabinet in his or her control and possession.

5.2) Where the key is a combination, PIN or password it must not be divulged to any unauthorised person. Combinations and passwords must be changed at regular intervals and de-activated when a person having knowledge of the combination or password ceases employment at the hospital, surgery or nursing home.

5.3) No person other than an authorised person shall lock or unlock the cabinet or remove or add to or in any way interfere with drugs in the cabinet.

5.4) The cabinet must only be unlocked for the purposes of:
   5.4.1) the storage of drugs;
   5.4.2) supply, administration or destruction of a drug; or
   5.4.3) the examination and counting of drugs for audit purposes.

5.5) The cabinet must be re-locked immediately after use.
Problem areas with drugs
Although a sound knowledge of the relevant legislation relating to drugs and poisons is essential for nurses and midwives, what is equally as important is an awareness of the problem areas in relation to drugs and how to avoid and/or deal with them. Mistakes can and do occur and it is unlikely that any system devised will ever entirely eliminate the probability of drug-related errors occurring in the future. Hospital administrators, medical practitioners, nurses and midwives should recognise their respective responsibilities in this area and take steps to minimise the risk of errors occurring and, when it does, minimise the damage that flows from it — the law would expect such a standard to be reasonable, having regard to the clear duty of care that is owed to the patient.

The Australian Commission on Safety and Quality in Health Care has identified medication safety as one of its priorities. Reducing error and harm from medicines through safe and quality use of medicines is identified as an important element of the work to achieve the objective of leading and coordinating national safety and quality improvements in healthcare.

The aim of the Medication Safety Program is to improve the safety of medication usage in Australia. The environment in which medicines are regulated, prescribed, supplied, administered and monitored in Australia is complex but the Commission has chosen to focus its efforts in five areas:
1) standardising and improving systems (see medication charts and other standardisations, and tools for systems improvement);
2) reducing practice gaps;
3) employing continuity in managing medicines (see medication reconciliation);
4) using technology (see Safety in E-health);
5) advocating medication safety and quality by working with the National Medicines Policy Executive and other organisations.

One of the major changes has been the introduction of a National Inpatient Medication Chart. Since 2006 a number of charts have been developed for national usage, including charts for acute care, long stay in acute care and paediatric charts; the most recent project relates to charts for Residential Aged Care Facilities. Importantly there is also a list of national terminology, abbreviations and symbols. All healthcare professionals need to be familiar with these standardised terms as their use will reduce the risk of error significantly.

Administrative considerations
Most hospitals and some other health organisations have a permanent drug committee made up of relevant personnel to formulate specific policy in relation to drug control and administration. Some hospitals and health centres are too small to warrant such a committee. Nevertheless, whatever situation prevails, hospital and health administrators should lay down firm and clear policies for employees concerning drug administration. The policies should:
1) Ensure that the relevant legislative provisions are implemented and adhered to.
2) Ensure that all staff concerned are advised of any relevant changes to the legislation which may occur from time to time. This can be easily achieved by bringing such changes to the attention of the staff through standard communication strategies.
3) Ensure that staff are informed and instructed about the use, requirements for handling, storage, contraindications and so on, of new drugs.
4) Ensure that policies exist for contentious issues that arise; for example:
   a) legibility of medication orders;
   b) procedures to be followed by staff in the making and taking of verbal medication orders, especially in an emergency.
5) Specify checking procedures for drugs of addiction and certain restricted substances, such as the frequency of checking by visually counting each substance, and which staff do the checking.
6) Identify procedures that should be followed if medication orders are to be transcribed.
7) Clarify what medications, if any, outside Schedule 4 and Schedule 8 substances, can be given by nursing and midwifery staff without a medical officer’s authority or prescription; for example, such substances as paracetamol on the basis of what is commonly referred to as ‘nurse- or midwife-initiated medications’.
8) Where appropriate, determine standard medication protocols, commonly referred to as Standing Orders, able to be followed by nursing and midwifery staff in emergency situations or in areas such as obstetric delivery wards, where many organisations have a standard medication protocol for routine admissions.

Clinical considerations
In the day-to-day task of administering medications, nurses and midwives should bear the following 12 considerations carefully in mind to help reduce the possibility of errors occurring.

1) The guiding principle behind the administration of medication is — if in any doubt, question and clarify with the prescribing practitioner concerned. A useful maxim is often described as ‘The Five Rights’ of medication safety: the right patient should receive the right dose of the right drug via the right route at the right time.
2) Read medication sheets carefully. If the handwriting is illegible, steps should be taken to have it clarified and, if need be, rewritten before the drug is administered. This very real problem can to some extent be overcome if the hospital administration rigidly adheres to the policy of legibility in the writing up of prescriptions and medication sheets. Also, if a nurse or midwife is present at the time the medication sheet is written up, they should ensure that the entry is legible and, if not, have it clarified immediately.
3) Check the labelling of the drug carefully. If it is an ampoule or tablet in a blister pack, check the labelling on the ampoule or blister, not the box or container it is in.
4) Leave medications in the packaging they arrive in from the pharmacy — don’t transfer them to another container. Most of the Regulations make provision for such a situation.

5) Do not transcribe a patient’s medication orders from his or her medication sheet into any other part of the patient’s notes or other documents unless absolutely unavoidable. This eliminates the risk of transcription errors and the possibility that some other person may give a drug to a patient based on the transcribed error. Transcribing medication orders is not against the law as such, but it has become such an important issue for healthcare staff because of the great danger of errors arising in such a practice. Therefore it is essential that, in whatever system is devised in relation to medication, the necessity to transcribe such orders is eliminated or reduced to an absolute minimum.

6) If it is necessary, in an emergency situation, to take a drug order over the telephone, the following six steps should be observed:
   a) Obtain the patient’s notes if possible.
   b) Ask the prescribing practitioner to repeat the order at least once — more if it is unclear.
   c) Repeat the order back to the prescribing practitioner.
   d) If a second nurse or midwife is present and available, have them listen to the order as a second check.
   e) Make an immediate entry in the patient’s notes (not on a scrap of paper) recording the date, time, drug, amount, number of dosages and so on, and sign the entry. Have the second nurse or midwife, if available, countersign the entry. A problem that sometimes arises here is where to make the entry in the patient’s notes; that is, in the medication sheet or in the body of the patient’s notes. Unless contraindicated by hospital policy, there is no legal reason why the entry cannot be made on the medication sheet. It would certainly seem the most sensible thing to do, particularly as the prescribing practitioner has to countersign and confirm the order generally within 24 to 48 hours. Some hospitals take the view that the patient’s medication sheet constitutes a hospital prescription form and as nurses and midwives in general (unless endorsed to prescribe as nurse practitioners or eligible midwives) cannot prescribe drugs they cannot write on the medication sheet. Whichever view is taken, it is more important to make the entry directly into the patient’s notes and that the hospital administration make a clear policy on such a matter, which it then communicates to the staff concerned.
   f) Appropriate steps should be taken to ensure that the prescriber confirms the verbal order in writing in the patient’s notes within a specified time. In most states and territories the Regulations specify the time, which usually ranges from 24 to 48 hours.

7) Registered nurses and midwives are presumed to have specific knowledge and expertise in relation to drugs, which they acquire as part of their training and education. That knowledge and expertise should cause them to question
medication orders carefully in certain situations rather than blindly follow instructions; for example:

a) if a dosage seems excessive in all the circumstances;
b) if the drug seems inappropriate having regard to known contraindications, drug interactions, side effects or allergies;
c) if the drug is one they have not encountered before.

8) If, after carefully checking the drug and dosage with the patient’s medical practitioner, the nurse or midwife is still concerned, he or she should be able to communicate that concern to a person in authority for further checking. That may not be possible in isolated situations, but in most hospitals a system to deal with such concerns should be devised.

9) Whatever procedure for further checking does or does not exist, any query raised by a nurse or midwife with the prescribing practitioner concerning the suitability or dosage of a particular drug ordered for a patient should be documented immediately by the nurse or midwife in the patient’s record. In making such an entry, care should be taken that it is factual and objective. For example, assume that the prescribing practitioner has prescribed an intravenous dose of 0.5 mg of digoxin for a patient. The registered nurse on duty feels that such a dose administered intravenously is excessive in the circumstances and wishes to check it with the prescribing doctor. In doing so, it is suggested that the following entry may appear in the patient’s notes:

15.5.10: 14.00 Contacted Dr Brown concerning his order of 0.5 mg of digoxin IV. Dr Brown directed that the order be amended to 0.05 mg of digoxin IV. Medication sheet amended accordingly. P Smith RN.

OR

15.5.10: 14.00 Contacted Dr Brown concerning his order of 0.5 mg of digoxin IV. Dr Brown confirmed order. P Smith RN.

If the second example is the outcome and the nurse is still concerned, contact should be made with a person in authority, if such a system has been devised. If it has, the following entries may then appear:

15.5.10: 14.15 Contacted Dr Jones concerning Dr Brown’s order of 0.5 mg of digoxin IV.

14.30 Received a telephone order from Dr Jones to change the order to read 0.05 mg of digoxin IV. Medication sheet amended accordingly. P Smith RN.

In the event that Dr Jones confirms Dr Brown’s order, the following entry may appear instead of the last entry above:

14.30 Dr Jones telephoned and stated that he had discussed the order of 0.5 mg of digoxin IV with Dr Brown and he confirmed Dr Brown’s order. P Smith RN.
10) Registered nurses and midwives should not be required to administer complicated drug regimes in specialised or high-dependency areas, unless they are assessed as competent to do so. This is particularly so with children where drug dosages are required to be fractionally precise and the margin for error is extremely small.

11) Where certain drugs are required to be checked prior to administration, they should be checked by two people. In situations where nurses or midwives work alone or in isolation this is often not possible. This problem frequently occurs with community nurses and midwives who are required to administer medications in the home. The drawing up of insulin for diabetic patients is a good example. In such situations the nurse or midwife concerned has no alternative but to administer the drug after carefully checking it alone. However, the patient is often highly knowledgeable about their own illness and regime, and if they are able to check and assist, it is always useful and instructive to involve them.

12) There are also instances where a community nurse is required to visit a patient in the home on a weekly basis. At that visit the nurse leaves prescribed medications in a ‘dosette’ box for the patient to self-administer at set times during the week. When that situation arises, the nurse should take all reasonable steps to ensure the medications are correctly administered — such as careful explanations and, if need be, written instructions to the patient and/or relatives as to the time and method such medications are to be taken, as well as any other relevant instructions. Where there is a language barrier between the nurse and patient, it may be necessary to arrange for an interpreter to be present. If that is not possible, perhaps the nurse can arrange to have the instructions translated in writing for the patient.

**Endorsements for medication administration under the new national registration scheme**

Under the new national registration scheme, there is provision under section 94(1) of the *Health Practitioner Regulation National Law Act 2009* (Qld) for a National Board (in this case the NMBA), to endorse the registration of a registered healthcare practitioner (in this case either a nurse or midwife) as being qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines if the registered nurse or midwife:

a) holds either of the following qualifications relevant to the endorsement —
   i) an approved qualification;
   ii) another qualification that, in the Board’s opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification; and

b) complies with any approved registration standard relevant to the endorsement.  

These endorsements will be discussed in detail in Chapter 8, but suffice it to say here that nurse practitioners are specifically endorsed under section 95; remote and
isolated practice registered nurses in Queensland have limited endorsement under section 94(1) (although this limited and specific endorsement will be reviewed to be more representative of the work of registered nurses at the earliest opportunity); and eligible midwives (once they are notated as such under s 38(2)) will also be endorsed for their scope of practice under section 94(1).

Criminal and professional issues relating to the administration of drugs

It is not unknown for a nurse or midwife to have a personal drug addiction problem. Nurses and midwives are often able to maintain such a habit because of their relatively easy access to drugs generally and, as registered nurses and midwives, to drugs of addiction in particular. The provisions of the various Poisons Acts and Regulations authorise registered nurses and midwives to be ‘in possession of and supply certain drugs of addiction’. Such authority arises when they become registered and is generally symbolised by the possession of keys to the cupboard where the drugs are kept.

If this authority to possess and supply drugs is breached by self-administration, or by supplying or administering to another person other than a patient, the authority can clearly be withdrawn. Apart from anything else, such an action also constitutes a criminal offence under the provisions of the poisons or crimes legislation of each state and territory.

Should a registered nurse or midwife be found guilty (convicted) of such an offence, he or she will invariably be required to appear before the relevant panel or responsible tribunal described in Part 8 of the Health Practitioner Regulation National Law Act 2009 (Qld) in the appropriate state or territory. The powers under the Health Practitioner Regulation National Law Act 2009 (Qld) include the power to remove a nurse’s name from the register, subject to certain provisions, thereby effectively depriving the nurse from pursuing employment in his or her profession or placing conditions on the nurse’s right to practise. It is not uncommon for registered nurses to have their registration cancelled or suspended for varying periods of time as a result of convictions arising from drug offences related to their employment.17

CONCLUSION

The rules governing medication administration and management are changing rapidly at present, particularly with the changes to national registration and the advent of electronic prescribing. Nurses and midwives need to follow local policy and national developments closely.

Endnotes

Note: All links given below were last accessed on 20 January 2012.


2) Easton K, Morgan T and Williamson M, Medication Safety in the Community: A Review


4) See Appendix A below.


6) Poisons Standard 2011 (please note that amendments are made to the Standard throughout the year, therefore the website needs checking regularly for currency if you require accurate information about a schedule), http://www.comlaw.gov.au/Details/F2011L01612.


17) Although the legislation on which this textbook is based has now been superseded, the Professional Conduct Casebook (2010) commissioned by the (then) NSW Nurses and Midwives Board, and co-authored by Adrian A and Chiarella M, provides a range of case law relating to drug misuse that is still relevant for nurses today. Order forms can be downloaded from http://www.nmb.nsw.gov.au/professional-conduct-books/default.aspx.

Appendix A: List of statutes and regulations governing medications in Australia

Narcotic Drugs Act 1967 (Cth)
Therapeutic Goods Act 1989 (Cth)
Therapeutic Goods Amendment Act (No 1) 2006 (Cth)
Therapeutic Goods (Charges) Act 1989 (Cth)
The administration of drugs

Therapeutic Goods Regulations 1990 (Cth)
Dangerous Substances Act 2004 (ACT)
Drugs of Dependence Act 1989 (ACT)
Medicines, Poisons and Therapeutic Goods Act 2008 (ACT)
Medicines, Poisons and Therapeutic Goods Regulation 2008 (ACT)
Drug and Alcohol Treatment Act 2007 (NSW)
Drug Court Act 1998 (NSW)
Drug Misuse and Trafficking Act 1985 (NSW)
Poisons and Therapeutic Goods Act 1966 (NSW)
Poisons and Therapeutic Goods Regulation 2008 (NSW)
Misuse of Drugs Act 1990 (NT)
Misuse of Drugs Regulations 1990 (NT)
Poisons and Dangerous Drugs Act 1983 (NT)
Poisons and Dangerous Drugs Regulations 2004 (NT)
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