Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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Administration and checking of medicines by Assistant Practitioners

Lead executive	Medical Director
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Type of document	Policy
Target audience	All CWP registered nurses and Assistant Practitioners with a Foundation Degree in Health and Social Care
Document purpose	To promote safe and consistent practice in the checking and administration of medicines, including the intramuscular and subcutaneous routes, by Assistant Practitioners working in CWP

Approving meeting	Medicines Management Group	4-May-17
Implementation date	May 2017	

CWP documents to be read in conjunction with	
IC1	Trust wide infection prevention and control operational policy
CP24	Cardiopulmonary resuscitation policy
MP1	Medicines policy
HS1	Waste management policy
CP3	Health records policy
CP64	Anaphylaxis policy
GR33	Lone worker policy
GR1	Incident reporting and management policy

Document change history	
What is different?	The amendments to the policy will allow CWP Assistant practitioners to work to their full capabilities having completed their foundation degree and work place assessments
Appendices / electronic forms	New Document
What is the impact of change?	This will increase the duties of the Assistant Practitioner freeing up the band 5 and 6 nurses to visit patients who require more in depth treatment

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Learning and Development (L&D)

Document consultation	
East locality	N/A
Wirral locality	N/A
West locality	Linda Wain, Janet Durrans
Corporate services	Ian Winton
External agencies	N/A

Financial resource implications	None

External references
1. Nursing and Midwifery Council Standards 2006 2. Royal College of Nursing Standards 2008 3. Firefly report 2012

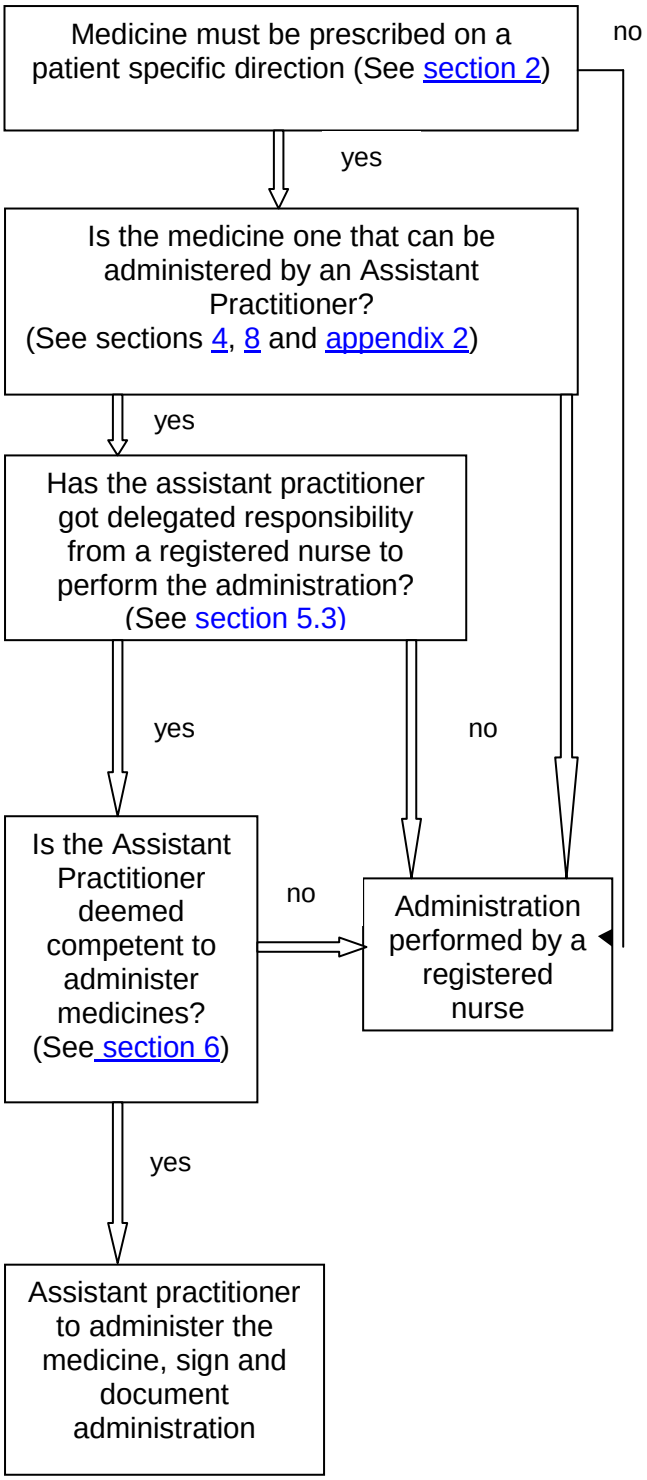
Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Content

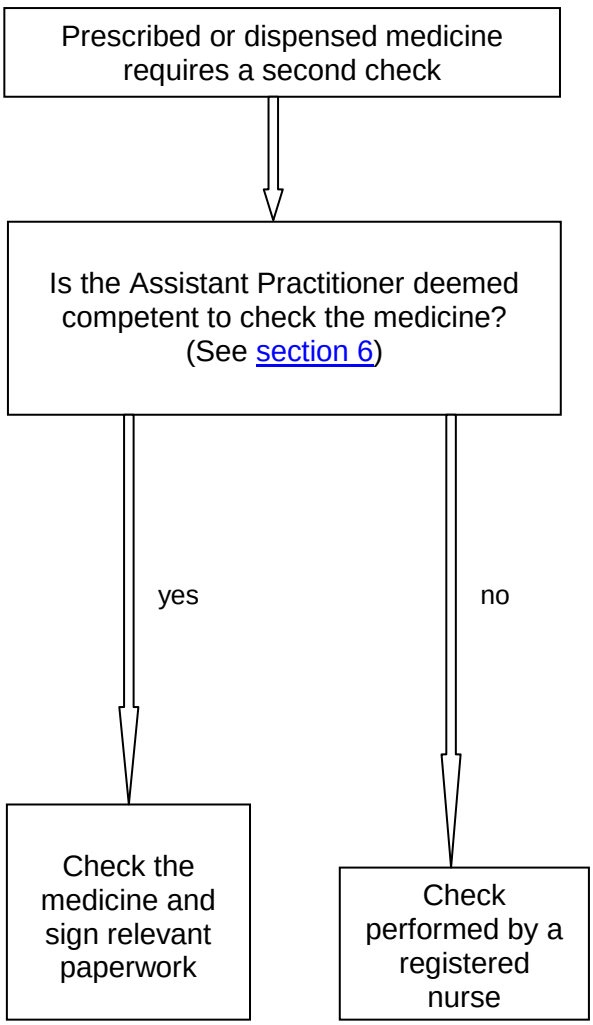
Quick reference flowchart

For quick reference the guide below is a summary of actions required for medicine related duties by Assistant Practitioners:

Administration of medicine



Second checking of medicine



1. Introduction

The increasing focus on utilising health care support workers more flexibly has provided opportunities for the development and expansion of roles; one such development has been that of the Assistant Practitioner's role, who complement the work of the registered nurse (Firefly report, 2012).

At the present time, the Assistant Practitioner (AP) role in CWP varies between services. In CWP West Physical Health Community Nursing, the AP role is limited to wound care, continence reassessments, catheterisations and other tasks traditionally delegated to Health Care Assistants.

In order to take advantage of the full potential of this role and to achieve the desired outcomes of improving the efficiency and effectiveness of services, the next step is to develop and expand the role of the Assistant Practitioner, and working within their achieved competencies, allow the administration and checking of certain medicines and vaccinations.

2. Definitions

Assistant Practitioners (AP) Assistant Practitioners (AP's) hold a Foundation Degree in Health & Social Care and the role is at Level 4 of the health sector Career Framework. An AP is defined as a worker who competently delivers high quality healthcare to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The AP is able to deliver elements of healthcare and undertake clinical work in domains that have previously only been within the remit of registered professionals. The AP may transcend professional boundaries. They are accountable to themselves, their employer and, more importantly, the people they serve (Skills for Health, 2014).

In 2009, Skills for Health published the Core Standards for AP's in England, in response to requests from healthcare employers for standardisation of the role. Module work-based competencies have been mapped to the Core Standards for AP's [APCS] (Skills for Health, 2009). These roles have been developed locally by employers to meet individual service need. The specific technical competencies required for the role will vary depending on the clinical area in which the AP is working (*Skills for Health Core Competence and Knowledge framework for a Higher Level Apprenticeship for Assistant Practitioners, 2012).*

The **Health Care Assistant (HCA)** role is defined by the Nursing and Midwifery Council (NMC, 2006) as: 'Those who provide a direct service – that is they have a direct influence / effect on care and treatment to patients and members of the public and are supervised by and/or undertake health care duties delegated to them by NMC registrants.'

A **Patient Specific Direction (PSD)** is a traditional written instruction, from any qualified prescriber (doctor, dentist, nurse or pharmacist independent prescriber) for medicines to be supplied or administered to a named patient. A PSD may take the form of an instruction in the patient's notes, written on an in-patient medicine chart, or written on an authorisation to administer form in the community setting. The majority of medicines are supplied or administered using this process.

A **Patient Group Direction (PGD)** is defined in the Health Service Circular (HSC 2000/026) as:
'A written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment' Supply and administration under a PGD may only be by certain registered health care professionals.

3. Purpose

This policy applies to Assistant Practitioner's within CWP, who have completed a Foundation Degree in Health and Social Care. This policy will be adopted in all areas across the Trust where it is deemed appropriate and should be read in conjunction with the Trust's MP1 Medicines Policy.

This policy does **NOT** apply to Health Care Assistants who have completed the NCFE level 2 and 3 certificate. The HCA role and duties in relation to medicines are covered within MP1 Medicines Policy (section 8.11)

The purpose of this policy is therefore to:

- Outline the legislation governing Assistant Practitioners
- Define the medicine related duties for Assistant Practitioners
- Set out an accountability framework for practice
- Define a minimum standard of training and competency for Assistant Practitioners to check and administer medication and vaccinations
- Set out the principles on which medicines administration by Assistant Practitioners are based
- Define a standard within CWP that provides an auditable process.
- Ensure that all Registered Nurses and Assistant Practitioners within CWP are aware of their roles, responsibilities and limitations with regard to Assistant Practitioner medicine checking and administration.

4. Legislation

A competent trained member of staff within their scope of professional practice in health and social care can administer medicines that have been prescribed by an authorised prescriber, for an individual patient. The medicines can only be given to that named patient**.** This principle applies to both registered and non-registered staff at all levels.
However, non-registered staff cannot administer medicines using a patient group direction and cannot train to prescribe medicines. (NHS Northwest, 2007)

4.1 Medicine related duties for Assistant Practitioners (non-registered nurses) in CWP

Medicine related duties that can be performed by Assistant Practitioners, who have successfully completed a Foundation Degree in Health and Social Care, and have been authorised by the Trust to **assist** a Designated Practitioner, include the following:

- Check the medicine label with the prescription sheet as a second check
- Administer oral and topical medicines (including inhaler, eye and ear drops) to a patient once prepared and checked by a Designated Practitioner
- Check and countersign controlled drugs with a Designated Practitioner
- Check and countersign intravenous medicines with a Designated Practitioner
- Check the patient's name and hospital number against a prescription with a Designated Practitioner
- Check discharge/leave medicines with a Designated Practitioner against a discharge/leave prescription
- Check outpatient medicines, including clozapine, with a Designated Practitioner against an outpatient prescription
- Supply of discharge/leave/outpatient medicines to patients following second check
- Witness the self-administration of medicines either in a ward or in a patient's home following patient specific assessment and training by a Designated Practitioner.

4.1.1 Scope of role for medicine administration by Assistant Practitioners in CWP

Assistant Practitioners can, where the need arises for their role and in accordance with their job description and KSF outline, administer medication, once trained and assessed as competent in their service field, under the following conditions:

- The Assistant Practitioner can independently administer medicines to patients (excluding IV's) following training from a Designated Practitioner **and** against **a patient specific direction**
- The Assistant Practitioner can only prepare and administer IM/SC injectable medications/ vaccinations that are included in the 'Authorised list of injectable medication for Assistant Practitioner administration**'** (appendix 2) **and** under the **direct delegation of the registered nurse**, **and** against **a patient specific direction**

- The Assistant Practitioner must prepare any medication in the presence of a registered nurse **unless** deemed competent, **has been delegated** the duty **and** working within the Lone Worker Policy.
- The Assistant Practitioner will **not** administer or countersign any medication under a Patient Group Direction
- The Assistant Practitioner will adhere to the trust MP1 Medicines Policy.

4.2 Medicine related duties that CANNOT be performed by Assistant Practitioners:

- Administration of Controlled Drugs

5. Liability and accountability

5.1 Liability of employer

Both employer and employee should ensure that the employee's job description and Knowledge and Skills Framework (KSF) includes a clear statement that checking and administration of medicines is required as part of the duties of that post or service.

The employer is accountable for the standard of care delivered and responsible for Assistant Practitioners working within their areas of competence appropriate to their abilities.

5.2 Accountability and the Assistant Practitioner

Assistant Practitioners are:

- Legally accountable to the patient for any errors they may make through civil or criminal law;
- Accountable to their employer through employment law, through their contract of employment;
- Expected to follow their own Code of Conduct: 'Code of Conduct for Assistant/Associate Practitioners and Healthcare Support Workers – Working to standards (2011).

Assistant Practitioners cannot be 'professionally accountable' as they are currently unregulated and therefore not part of a profession; but they are accountable for their own practice as stated in their contract of employment and their role specification.

Guidance from the NMC states that Assistant Practitioners become responsible for care delegated by Registered Nurses when it forms part of their individual employment contracts. This normally occurs when the AP has undergone training and has been assessed as competent within the employer's framework (NMC 2008a).

5.3 Accountability and the Registered Nurse (RN)

Being accountable for deciding to delegate work to another person, the Registered Nurse must be sure the person has the knowledge, skills and competence to undertake the delegated work. Continued supervision of Assistant Practitioner remains an integral part of the Registered Nurse role. While Assistant Practitioners are responsible for their actions, the Registered Nurse holds responsibility for the general standard of nursing in the workplace.

The NMC's Code of Professional Conduct advises on effective delegation (NMC 2008b):

- By establishing that anyone you delegate to is able to a carry out your instructions;
- By ensuring that everyone you are responsible for is supervised and supported;
- By confirming that the outcome of any delegated task meets required standards.

Royal College of Nursing (RCN) guidance on accountability and delegation (RCN 2010) notes that when registered staff delegate a task, they must ensure that the task has been appropriately delegated. This means:

- The task is necessary and delegation is in the patient's best interest;

- The Assistant Practitioner understands the task and how it is best performed;
- The Assistant Practitioner has the skills and abilities to perform the task competently;
- The Assistant Practitioner accepts the responsibility to perform the task competently.

Unless the task delegated clearly forms part of the Assistant Practitioner's individual job description (and hence his or her employment contract) and he or she has been signed off as competent to do it, the RN remains professionally accountable for any aspect of care he or she delegates to the Assistant Practitioner (NMC 2008b).

If a registered nurse is supervising an Assistant Practitioner who is carrying out a task that is part of his or her job description and competences, then although the registered nurse is not directly accountable for the Assistant Practitioner's actions, the registered nurse is still accountable for ensuring the overall care.

When the Assistant Practitioner is working within the scope of the Lone Worker Policy the registered nurse does not need to be present when carrying out the delegated task. See section 4.1.1 scope of role.

6. Competency based training

The Assistant Practitioner will have completed module competences during training: Principles of Care Practice incorporating individual service area legislation, policy and practice which will address the issues relating to:

- Legal accountability
- Anatomy and physiology
- Infection prevention and control
- Medicine calculations
- Basic pharmacology
- Medicine therapeutics
- Monitoring and side effects.

A framework has been developed by the Health Protection Agency which provides a tool to help organisations assess individuals' competence in practice (see appendix 1**)**; this tool can be utilised as part of the structured educational programme which all Assistant Practitioner's must attend to enable them to work towards completing their competencies in this area.

This educational programme must include the following prior to commencing their practical competencies:

- New immunisers course - once only
- Immunisation update training - annual
- Basic life support and anaphylaxis - annual

All training to be booked and recorded through electronic staff record (ESR) Education CWP.

6.1 Competency records

Evidence of acquired competencies and training should be held on the individual's ESR for inspection if necessary, and be discussed as part of the annual appraisal to identify areas for continual professional development.

It is the responsibility of the Assistant Practitioner's line manager to ensure the ESR is updated when each competency is achieved.

7. Principles of safe administration of medication by Assistant Practitioners

Assistant Practitioners administering medication or vaccinations must:

1. Know the general therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.

2. Be certain of the identity of the patient to whom the medicine is to be administered; have considered the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing therapies (the five rights).

3. Be familiar with the patient's care plan.

4. Check that the prescription, patient specific direction or authorisation to administer form, is clearly written and unambiguous.

5. Where medication has been dispensed for a named patient, ensure that the label on the medicine correlates to the instructions on the prescription or authorisation to administer form.

6. Check the expiry date of the medicine to be administered.

7. Check that the patient is not allergic to the medicine before administering it.

8. Contact the prescriber, other authorised prescriber or registered professional without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable.

9. Make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring that any written entries and the signature are clear and legible.

10. Report any adverse incidents to their line manager following the National Standards and local policies and procedures, and report adverse effects according to the yellow card scheme.

8. Authorised list of injectable medication for Assistant Practitioner administration in CWP

See appendix 2.

All patients MUST be 18 years or over to receive medicines from an AP

9. Consent

All patients should give their informed consent to treatment. Verbal consent to treatment should also be recorded in the patient's records. Patients who lack capacity to make an informed choice, a best interest discussion must be undertaken and documented in their care plan.

In order to give informed consent to treatment, the patient should be given appropriate information regarding the course of treatment, including particular risk and side effects of the medication.

10. Technical information (Standard operating procedures)

- Administration of medication by injection via the intramuscular route – see appendix 3
- Administration of medication by injection via the subcutaneous route – see appendix 4

11. Audit and monitoring

The following criteria will be measured to assess compliance with the policy:

1. Percentage EMIS documentation by each Assistant Practitioner of medicine administrations
2. Number of Assistant Practitioner medicine related datix reports and lessons learnt from such reports.

Appendix 1 - Competency toolkit

Assistant Practitioner competencies	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*
Demonstrates understanding of importance of maintaining the cold chain: - Can state correct temperature range for vaccine / drug storage; - Records current maximum / minimum fridge temperature range.										
Checks clients' records prior to vaccination / drug administration to ascertain previous medicine administration history.										
Knows who to contact for advice if unsure about the vaccination drug.										
Gives appropriate advice and information										
Ensures informed consent has been obtained and recorded prior to any medicine / vaccine administration										
Correctly reconstitutes drug / vaccine and is aware of which drugs / vaccines can be mixed and cannot be mixed together										
Ensures anaphylaxis equipment is readily available, knows what should be given and how and when to use it										
Checks correct vaccine / medicine dose has been prepared prior to administration										
Provides reassurance to client / carer and correctly positions patient prior to medicine/vaccine administration										
Demonstrates correct injection technique, using recommended needle size and site										
Disposes of sharps, vials and other vaccine equipment safely										
Documents type of medicine / vaccine, batch number, expiry date, date given and injection site in patients' clinical record system and prints name and signature.										

* Initial and date when each assessment completed
When all 10 assessments completed and passed:

Signature of assessor _____ Date_____

Signature of assessee _____ Date_____

Evidence sheet

Name		Signature		Date	

Assessors' name		Signature		Date	

Date	Evidence / activity	Reflection / mentors comments

Appendix 2 - Authorised list of injectable medication for Assistant Practitioner administration

Medicines name	Indication	Dose	Route of administration	Rationale/risk assessment for inclusion
Hydroxocobalamin injection (vitamin B12)	Pernicious anaemia and other macrocytic anaemias without neurological involvement	1mg every 12 weeks - maintenance dose only (Loading dose by Registered Nurse)	Intramuscular injection	1mg in 1mL injection ampoule Appendix 3
http://www.medicines.org.uk/emc/medicine/22177				

Appendix 3 - Administration of medication by injection via the intramuscular route

1 Equipment

- Needle - size (gauge) and length dependant on site of administration.
- Filter needle (if withdrawing medication from a glass vial)
- Syringe - size appropriate to the volume of medicine to be given
- Medication to be administered
- Essential technical information (SOP)
- Care plan
- Current CWP district nursing documentation
- Anaphylaxis pack
- Single use disposable apron
- Single use disposable non sterile gloves
- Sharps box
- 70% alcohol impregnated swab
- Sterile gauze

2 Choice of needle size

For intramuscular the needle needs to be sufficiently long to ensure that the medication is injected into the muscle. An individual assessment must be made to determine the correct size needle to be used. Immunisation against infectious disease 2006:
https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Careful attention must be paid to pre-filled syringes with fixed needles in respect of needle length as these may vary and therefore influence the angle of insertion. Always refer to the manufacturer's guidance on administration.

Colour	Length	Gauge
Blue (for patients with a low body mass index)	25mm	23
Green (for patients with high body mass index)	38mm	21

Note: Higher gauge number = Narrower lumen
(Immunisation against infectious disease 2006)

3 Choice of syringe size

The size of syringe must be appropriate to the volume of drug to be given.

4 Skin cleansing

For skin that is visibly soiled wash with soap and water and dry thoroughly.

Skin must be cleansed using a 70% isopropyl alcohol swab, allowing skin to dry, in the following instances:

- Deep intramuscular injections
- For patients who are immunosuppressed.

5 Intramuscular injection sites

The following sites are for intramuscular injections:

Site	Rationale
Anterolateral aspect of the thigh: Is the preferred site for intramuscular and deep subcutaneous injections in infants under one year of age (Immunisation against infectious disease (2006)	The anterolateral aspect of the thigh provides a large muscle mass, free from major blood vessels and nerves minimising risk of damage.

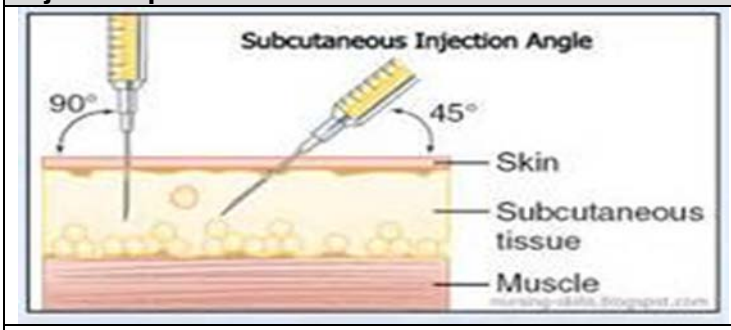
Site	Rationale
Deltoid muscle: Preferred site for intramuscular and deep subcutaneous injections in older children and adults. (Immunisation against infectious disease 2006) The maximum volume that should be administered at this site is 1ml (Rodger & King , 2000)	The site is easy to access; however in infants under one year of age, the muscle is not sufficiently developed. Owing to the small area of this site.
Dorsogluteal site: (upper outer quadrant of the buttock) Can be used for deep intramuscular injections	This site should only be used if recommended by the medicine's manufacturer (Rodger and King, 2000).

NB. The dorsogluteal site must not be used as first choice. There is a risk of injury to the sciatic nerve and the superior gluteal artery; a clinical risk assessment must be carried out by the registered nurse if this site is being considered for use.

6 Procedure for the administration of intramuscular injections

Injection procedure	Rationale
1. Confirm identity of patient, by asking for full name and date of birth. Clarify identity with carers if patient not able to do so	To confirm correct identity of patient
2. Explain procedure to the patient, obtain valid consent and document in the patients' health record	To enable patient to make an informed decision about their own health care
3. Discuss risks and benefits of the medication to be administered with the patient/carer if the medication is new to the patient or if the patient's health needs have changed	To enable patient to make informed decisions and reduce potential risks
4. Check the Patient Medicines Administration Chart specifies the following confirming they relate to the patient to be treated: • Patient's full name • Patient's date of birth (DOB) • Prescriber's signature • The approved medicines name • The dose and frequency of administration • The date and route of administration • The allergy status of the patient • NHS Number, if available **NB check when last injection administered (if appropriate)** Where relevant the prescription should also specify the following: • The date on which treatment should be reviewed	To ensure correct prescription and that all relevant information is recorded on the prescription The date on the community prescription chart must be checked to determine if it is legal and remains current for individual care plan To ensure patient is not allergic to the medication
5. Check no ambiguities in the medicine, dose, frequency, mode of administration and start and finish dates	To reduce potential risks

Injection procedure	Rationale
6. Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications In the case of unfamiliar medicines refer to the package insert for manufacturer's information or a current British National Formulary (BNF) If the dosage is not within usual ranges specified in the SOP contact the registered nurse for advice	To reduce the possibility of medication error
7. Check all details on the label issued by the supplying pharmacy correspond to the Patient Medicines Administration Chart and the manufacturer's packaging	To check the correct medication has been dispensed by the pharmacist
8. Check the expiry date of the medication to be administered	To ensure expired medication is not administered to the patient
9. Read the patient's care plan and know its current contents and check that the medicine is due for administration at that time and has not already been given.	To reduce medication errors To prevent patient client from receiving the medication twice
10. Ensure that the area in which the medicine is to be prepared is as clean, uncluttered and free from interruption and distraction as possible	To prevent errors when preparing medication for administration
11. Assemble and check all equipment and ensure that the packaging of the equipment is intact.	To prevent delays and enable full concentration on the procedure. To ensure that sterility is maintained and minimise risk of infection.
12. Prepare the medication for administration following manufacturer's instructions, take prepared injection directly to the patient	It is unacceptable to prepare substances for administration in advance of their immediate use except for advanced preparation of insulin
13. Close doors / curtains where appropriate	Maintain privacy and dignity
14. Having selected the appropriate site (follow manufacturer's instructions), assist patient / client into a comfortable position and expose the site to be injected (may involve removal of tight sleeved shirt etc.)	Ease of access to relevant site - adequate exposure increases accuracy of procedure and prevents bleeding at site from tight clothing (RCN 2001).
15. Decontaminate hands prior to procedure	To reduce the risk of transfer of transient micro-organisms on the health care workers hands
16. Apply single use disposable apron when there is a risk of contamination with blood or body fluids	To protect clothing or uniform from contamination and potential transfer of micro-organisms
17. Apply single use disposable non-sterile gloves when there is a risk of contamination with blood or body fluids	To protect hands from contamination with organic matter
18. If skin at injection site is visibly soiled wash with soap and water and dry completely or clean with alcohol swab, allowing skin to dry as appropriate	Reduce the risk of transfer of skin contaminants into the puncture site
19. Hold the skin firmly. Introduce the needle at a 90 degree angle to the skin. The skin should be stretched not bunched, leaving ¼ of needle length exposed	To ensure needle penetrates target muscle Minimise patient / client discomfort and reduce the risk of needle stick injury / accidental breakage of needle.

Injection procedure	Rationale
	
20. Aspirate needle, if no blood present proceed to give the injection slowly and withdraw smoothly. If blood is present, stop the procedure and re start the procedure with new equipment.	Reduce patient / client discomfort and enhance even distribution of medication To allow diffusion into muscle and prevent haematoma formation
21. If bleeding occurs at site following removal of needle, apply gentle pressure with a sterile gauze swab for a few seconds – do not massage the area	Stop bleeding and prevent irritation of local tissue
22. Do not re-sheath needles – dispose of needle and syringe directly into sharps container	This helps to prevent needle stick injury and ensures safe disposal of sharps.
23. Ensure patient / client is comfortable following procedure	Maintain privacy and dignity
24. On completion of procedure remove and dispose of Personal Protective Equipment if worn (PPE) to comply with waste management policy.	To prevent cross infection and environmental contamination
25. Decontaminate hands following procedure and removal of PPE if worn	To remove any accumulation of transient and resident skin flora that may have built up under gloves and possible contamination following removal of gloves and apron
26. Document actions in nursing records including the following: • Consent • Date • Time • Dose • Name of medicine • Administration site • Expiry date • Batch number • Patient / client perceptions • Complete medicines administration sheet In the case of vaccines also specify the following: • Specific name of vaccine • Manufacturer Print, sign and note designation of staff member for all entries made If medication NOT given – document and explain reasoning.	Ensure compliance with NMC and CWP record keeping guidelines

7 After care and advice for intramuscular injections

Procedure	Rationale
Recipients of any vaccine should be observed for	Rapid access to treatment in case of

immediate adverse drug reactions. Consult individual summary of product characteristics for recommendation of post injection observation.	hypersensitivity / anaphylaxis. There is no evidence to support the practice of keeping patients under longer observation in the surgery.
Give a clear explanation of potential effects of injection, for example, site tenderness, mild fever etc. Advise on appropriate treatment for any effects. If verbal advice is given, check understanding and document in patients records advice given	Allay patient / client anxiety – promote self-care

8. Clinical incidents

Any related incidents arising from carrying out this procedure which may involve a clinical error or near miss must be reported via Datix following the GR1 Incident reporting and management policy and advise the team leader as soon as is practicable.

Appendix 4 - Administration of medication by injections via the subcutaneous route

1 Equipment

- Needle – 25 gauge, 16mm length
- Filter needle (if withdrawing medication from a glass vial)
- Syringe - size appropriate to the volume of drug to be given
- Medication to be administered
- Essential technical information (SOP)
- Care plan
- Current CWP district nursing documentation
- Anaphylaxis pack
- Single use disposable apron
- Single use disposable non sterile gloves
- Sharps box
- 70% alcohol impregnated swab
- Sterile gauze

2 Choice of needle size

For subcutaneous injections, the needle needs to be sufficiently long to ensure that the medication is injected into the subcutaneous tissue. An individual assessment must be made to determine the correct size needle to be used.
Immunisation against infectious disease 2006:
https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Careful attention must be paid to pre-filled syringes with fixed needles in respect of needle length as these may vary and therefore influence the angle of insertion. Always refer to the manufacturer's guidance on administration.

Colour	Length	Gauge
Orange (sub cut injections)	16mm	25

Note: Higher gauge number = Narrower lumen
(Immunisation against infectious disease 2006)

3 Choice of syringe size

The size of syringe must be appropriate to the volume of drug to be given.

4 Skin cleansing

For skin that is visibly soiled wash with soap and water and dry thoroughly.
Skin must be cleansed using a 70% isopropyl alcohol swab, allowing skin to dry, in the following instances:

- Prior to inserting a butterfly (e.g. subcutaneous fluids);
- For patients who are immunosuppressed.

5 Injections via the subcutaneous route

These are given beneath the epidermis into the fat and connective tissue underlying the dermis.
Subcutaneous injections can be given straight in at a 90 degree angle or at a 45 degree angle. Give the injection at a 90 degree angle if you can grasp 2 inches of skin between your thumb and first finger. If you can grasp only 1 inch of skin, give the injection at a 45 degree angle.

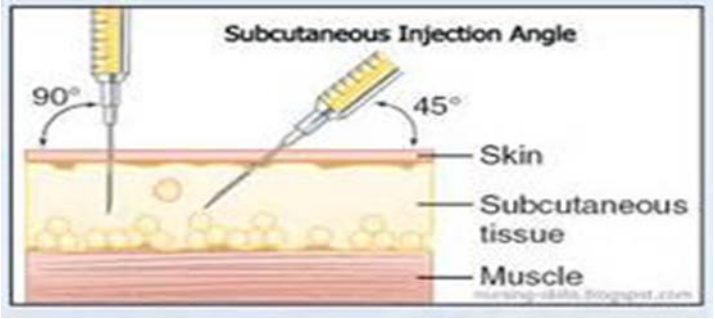
Injection sites for subcutaneous injections	Rationale
- Umbilical region (abdomen) - Lateral or posterior aspect of the lower part of the upper arm	Absorption from these sites through the capillary network is slower than that of the intramuscular route.

Injection sites for subcutaneous injections	Rationale
- Anterior aspects of thighs	It is recommended that the sites are rotated to prevent irritation and ensure improved absorption

6 Procedure for the administration of subcutaneous injections

Injection procedure	Rationale
1. Confirm identity of patient, by asking for full name and date of birth. Clarify identity with carers if patient not able to do so	To confirm correct identity of patient
2. Explain procedure to the patient, obtain valid consent and document in the patients' health record	To enable patient to make an informed decision about their own health care
3. Discuss risks and benefits of the medication to be administered with the patient/carer if the medication is new to the patient or if the patient's health needs have changed	To enable patient to make informed decisions and reduce potential risks
4. Check the Patient Medicines Administration Chart specifies the following confirming they relate to the patient to be treated: • Patient's full name • Patient's date of birth (DOB) • Prescriber's signature • The approved medicines name • The dose and frequency of administration • The date and route of administration • The allergy status of the patient • NHS Number, if available NB check when last injection administered (if appropriate) Where relevant the prescription should also specify the following: • The date on which treatment should be reviewed	To ensure correct prescription and that all relevant information is recorded on the prescription The date on the community prescription chart must be checked to determine if it is legal and remains current for individual care plan To ensure patient is not allergic to the medication
5. Check no ambiguities in the medicine, dose, frequency, mode of administration and start and finish dates	To reduce potential risks
6. Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications. In the case of unfamiliar medicines refer to the package insert for manufacturer's information or a current British National Formulary (BNF). If the dosage is not within usual ranges specified in the SOP contact the registered nurse for advice	To reduce the possibility of medication error
7. Check all details on the label issued by the supplying pharmacy correspond to the Patient Medicines Administration Chart and the manufacturer's packaging	To check the correct medication has been dispensed by the pharmacist
8. Check the expiry date of the medication to be administered	To ensure expired medication is not administered to the patient
9. Read the patient's care plan and know its current	To reduce medication errors

Injection procedure	Rationale
contents and check that the medicine is due for administration at that time and has not already been given.	To prevent patient client from receiving the medication twice
10. Ensure that the area in which the medicine is to be prepared is as clean, uncluttered and free from interruption and distraction as possible	To prevent errors when preparing medication for administration
11. Assemble and check all equipment and ensure that the packaging of the equipment is intact.	To prevent delays and enable full concentration on the procedure. To ensure that sterility is maintained and minimise risk of infection.
12. Prepare the medication for administration following manufacturer's instructions, take prepared injection directly to the patient	It is unacceptable to prepare substances for administration in advance of their immediate use except for advanced preparation of insulin
13. Close doors / curtains where appropriate	Maintain privacy and dignity
14. Having selected the appropriate site (follow manufacturer's instructions), assist patient / client into a comfortable position and expose the site to be injected (may involve removal of tight sleeved shirt etc.)	Ease of access to relevant site - adequate exposure increases accuracy of procedure and prevents bleeding at site from tight clothing (RCN 2001).
15. Decontaminate hands prior to procedure	To reduce the risk of transfer of transient micro-organisms on the health care workers hands
16. Apply single use disposable apron when there is a risk of contamination with blood or body fluids	To protect clothing or uniform from contamination and potential transfer of micro-organisms
17. Apply single use disposable non-sterile gloves when there is a risk of contamination with blood or body fluids	To protect hands from contamination with organic matter
18. If skin at injection site is visibly soiled wash with soap and water and dry completely or clean with alcohol swab, allowing skin to dry as appropriate	Reduce the risk of transfer of skin contaminants into the puncture site
20. Select an appropriate site -follow manufacturer's guidelines. If patient / client are receiving regular subcutaneous injections, rotate sites used. Check documentation to ensure site last used is not re-used at next injection.	Rotation of sites decreases the likelihood of irritation and ensures improved absorption
21. Expose site and gently pinch the skin into a fold to elevate the subcutaneous tissue. Give the injection at a 90 degree angle if you can grasp 2 inches of skin between your thumb and first finger. If you can grasp only 1 inch of skin, give the injection at a 45 degree angle. If using a diabetic pen, insert the pen needle at a 90 degree angle. It is not necessary to aspirate after the needle has been inserted.	Lifts adipose tissue away from underlying muscle (especially in thin patients / clients) Piercing a blood vessel during a subcutaneous injection is rare. (Peragallo and Dittko 1997;Workman 1999; cited in Dougherty and Lister 2008)

Injection procedure	Rationale
	
22. After the needle is completely inserted into the skin, release the skin that you are grasping. Press down on the plunger to release medication into the subcutaneous layer in a slow, steady pace. **If using a pen**, press the injection button completely (or until it clicks). Count 10 seconds before removing the needle from the skin.	Allow diffusion into tissue minimise local irritation
21. If bleeding occurs at site following removal of needle, apply gentle pressure with a sterile gauze swab for a few seconds – do not massage the area	Stop bleeding and prevent irritation of local tissue
25. On completion of procedure remove and dispose of Personal Protective Equipment (PPE) if worn to comply with waste management policy	To prevent cross infection and environmental contamination
26. Decontaminate hands following procedure and removal of PPE if worn	To remove any accumulation of transient and resident skin flora that may have built up under gloves and possible contamination following removal of gloves and apron
27. Ensure patient / client is comfortable following procedure	Maintain privacy and dignity
28. Document actions in the nursing records as per procedure for intramuscular injections	Ensure compliance with NMC and CWP Procedure for Record keeping

7 After care and advice for subcutaneous injections

Procedure	Rationale
Recipients of any vaccine should be observed for immediate adverse drug reactions. Consult individual summary of product characteristics for recommendation of post injection observation.	Rapid access to treatment in case of hypersensitivity / anaphylaxis There is no evidence to support the practice of keeping patients under longer observation in the surgery.
Give a clear explanation of potential effects of injection, for example, site tenderness, mild fever etc. Advise on appropriate treatment for any effects. If verbal advice is given, check understanding and document in patients records advice given	Allay patient / client anxiety – promote self-care

8. Clinical incidents

Any related incidents arising from carrying out this procedure which may involve a clinical error or near miss must be reported via Datix following GR1 Incident reporting and management policy and advise the team leader as soon as is practicable.