ADMINISTERING MEDICATION TO OLDER MENTAL HEALTH PATIENTS

AUTHORS Geoff Dickens, BSc, RMN, DipN, is research nurse/research coordinator; Jean Stubbs, MSc, MRPharmS, is head pharmacist; Camilla Haw, MA, MB, BChir, MRCP, MRCPsych, is consultant psychiatrist at Isham House; all at St Andrew’s Hospital, Northampton.

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This article reports on a survey that was undertaken to investigate the difficulties nurses face in administering medication in mental health wards for older people and to identify their training needs. The survey demonstrated that nurses need regular training with clear guidelines about medication administration, as well as professional guidance on covert administration. This is a summary: the full paper and reference list can be accessed at nursingtimes.net.

A number of literature reviews (for example, McBride and Foureur, 2006; Armitage and Knapman, 2003; O’Shea, 1999) have summarised the many studies of medication administration conducted in general medical hospitals. However, little is known about the problems and difficulties faced by nurses administering medication in mental health settings or about their training needs.

AIM
We wanted to identify the difficulties nurses face when administering medications in an elderly mentally ill (EMI) setting, what current training they receive related to this role and whether there are further training needs.

METHOD
Nurses in one hospital were surveyed regarding their views and training needs in relation to medication administration for older people with mental illness and observed nursing practice on two inpatient wards during medication rounds.

We collected quantitative data on nursing practice and made qualitative, descriptive accounts of our observations. This study formed part of a larger inquiry into medication administration errors in psychiatry.

The observation took place on two wards (A and B). Ward A is a 13-bed mixed-sex, locked ward for older people with dementia and challenging behaviour. Ward B is a 20-bed mixed-sex ward for older people who are physically frail with enduring mental illness, including dementia, and offers nursing-home type care.

Participants and procedure
All nurses in the hospital (n=49) were invited to participate in the survey. All nurses from wards A and B (n=12) were asked to participate in the observational research. The study was approved by an NHS Research Ethics Committee and written, informed consent was sought from nurses for participation in the observational study.

One observer recorded the activity of the administering nurse (such as medication given, whether tablets were crushed) while the other made notes about environmental distractions and patient activity. Our observation was largely non-participatory but participants frequently volunteered information and we occasionally asked questions to clarify our observations.

RESULTS
Survey of nurses
Completed questionnaires were returned by 27/49 (55%) nurses. Twelve (44%) had been qualified for more than five years, and two (7%) for less than a year.

Twenty (74%) respondents were D and E grade equivalent nurses and the remaining seven (26%) were F grade equivalent and above. Twenty-three (85%) respondents had received training in medication administration in the past 12 months. Four (15%) had received formal training, 10 (37%) had received ‘on-the-job’ training, for instance with a colleague, and 19 (70%) had undertaken self-directed learning such as reading articles. Fifteen (56%) said the training they had received was adequate and relevant.

Respondents were asked whether, in their experience, each of a 19-item list related to medication administration occurred frequently, occasionally or never. We asked respondents under which circumstances they would covertly administer medication. Twenty-four (89%) said they would if a multidisciplinary team decision had been taken to do so. Thirteen (48%) said they would if the patient lacked capacity to make an informed decision – of these, six (22%)
said this would be contingent on a multidisciplinary decision – while five (18%) would do so ‘to a patient who has capacity to make an informed decision but refuses’.

Observational study
Twelve nurses were approached and of these, nine (75%) agreed to participate. We observed 1,423 medication events (1,313 administrations of medicines and 110 omissions) to 32 patients over 36 medication rounds. Thematic analysis of our field notes suggested that multiple issues contributed to make medication administration in this setting difficult.

Thematic analysis
Medication administration
With the exception of night-time (10pm) drugs, medication rounds were scheduled to coincide with mealtimes. Medication administration was therefore frequently undertaken in an already-busy environment. When it was conducted away from mealtimes or in a separate area the atmosphere seemed calmer and more conducive to accurate preparation.

Noise and environmental distraction
We noted numerous cases of noise and other obvious distractions. Specific examples included one patient repeatedly shouting sexual remarks and another frequently screeching.

There were several instances of patients using verbal and physical aggression in the vicinity of the nurse who was undertaking medication administration. Distractions were not solely caused by patients. We also noticed noise from workmen, other staff making unrelated enquiries during the administration of medication, telephone calls and pagers.

Medication issues
Nurses frequently voiced doubt about the correct procedures regarding the crushing of tablets. We noted that one-quarter of all solid oral medication doses were crushed before administration.

Medicines were sometimes served in food but portions containing medication were frequently left partially uneaten. Crushed or liquid medications placed in patients’ food did not appear to be done so covertly. Some patients received multiple medications at one time.

Single or dual-nurse administration
In single-nurse administration the administering nurse prepared and then administered medications. In some dual administrations the second nurse checked the actions of the first and usually acted as a ‘runner’ by taking and giving medicines to the patient. In other cases care workers gave medications to patients that had been prepared by a nurse.

Administration of multiple medications was the norm and the 1,322 doses offered during our observation comprised 404 interactions. Single-nurse administration accounted for 108 interactions and dual-nurse administration for 207. Care workers administered nurse-prepared medication on the remaining 89 occasions. On 49 (55%) of these 89 occasions the care worker was in direct sight of the administering nurse.

Discussion
The problems nurses most commonly cited in our survey were patient confusion, tablet crushing, swallowing difficulties, patient concordance and noise or other distractions. Just over half of respondents (56%) stated that the training they had received was adequate and relevant; most training was self-directed (70%).

About one in five (18%) respondents said they would administer disguised medicines to a patient who had the capacity to consent but refused to do so. Some respondents commented on the circumstances under which such administration might be justifiable, usually citing issues of physical emergency such as a diabetic collapse where administration against the patient’s explicit wishes might be life-saving or in their best interest.

Our survey demonstrated the need for regular training for nurses incorporating clear guidelines about medication administration as well as guidance on covert administration. Noise and distractions during medication administration were apparent throughout our observation and have previously been implicated in errors in non-mental health settings (Armitage and Knapman, 2003). An inpatient mental health ward with numerous patients who are confused may be more distracting.

It would be wise to consider separating mealtimes and medication administration rounds. Nurses conducting medication administration should also pay attention to the positioning of the trolley – we noted that placing it in the middle of the room meant that patients could approach unseen from behind. Before starting a medication round, checks should be made to ensure appropriate lighting and heating, and that the trolley is fully stocked. There should be sufficient staffing to ensure that interruptions are minimised.

Kruse et al (1992) found that double-checking by a second nurse significantly reduces the incidence of medication errors. We felt that, on balance, appropriate use of care workers was defensible. However, staffing levels on the wards studied were high and all care assistants were very familiar with the patient group.

Training should address the issues of double-checking and the appropriate role of care workers in the medication administration process. There is a need for clear guidelines on crushing tablets, including ensuring the prescriber has authorised crushing (and has in turn ascertained the safety of crushing), and training should address this.

References

