Guidelines for the handling of palliative care medicines in community services

Version 3, May 2026

caring@home is a National Palliative Care Project, funded by the Australian Government and led by the Brisbane South Palliative Care Collaborative.

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These Guidelines were developed by caring@home, a National Palliative Care Project, funded by the Australian Government and led by Brisbane South Palliative Care Collaborative, and are endorsed by Palliative Care Australia. They represent a consensus-based approach to the handling of palliative care medicines by community service providers for home-based patients who wish to be cared for and die at home, if possible, and consider jurisdictional legislative requirements, policies and guidelines across all Australian states and territories.

ACKNOWLEDGEMENT

caring@home and QUM Connect would like to acknowledge the many people and organisations who have contributed their time and expertise in the development and review of this document.

ACT: Pharmaceutical Services, Health Protection Services

NSW: Pharmaceutical Services, NSW Ministry of Health

NT: Medicines and Poisons Control, NT Department of Health

QLD: Medicines Approvals and Regulation Unit, Department of Health, Queensland

SA: Office of the Chief Pharmacist, Department of Health and Wellbeing, SA Health

TAS: Pharmaceutical Services Branch, Tasmanian Department of Health

VIC: Health Regulator, Department of Health

WA: Medicines and Poisons Regulation Branch, WA Department of Health

National: Palliative Care Australia

caring@home acknowledges the Traditional Custodians of Country throughout Australia and their connections to sky, land, sea, culture and community. We pay our respect to Elders past, present and future and extend that respect to all Aboriginal and Torres Strait Islander people.

Version History

V1	2018	Brisbane South Palliative Care Collaborative & NPS MedicineWise	
V2	2020	Brisbane South Palliative Care Collaborative & NPS MedicineWise	Minor editorial updates made to definitions, email and contact details. Content updates made to reflect legislative changes, adjusted medicines to align with ANZSPM list.
V3	2026	Brisbane South Palliative Care Collaborative & QUM Connect	Full review and content update.

Contents

1. Introduction

Many patients receiving palliative care wish to remain at home for as long as possible. To help achieve this aim, they may need rapid access to medicines to provide symptom relief. Without adequate symptom relief, patients may need to seek care in their local emergency department or face unwanted admissions to acute care facilities. Community service providers recognise the need for patients receiving home-based palliative care to:

1. maximise their independence and quality of life – this includes optimal pharmacological management of symptoms related to their disease processes
2. remain at home for as long as is desired and/or possible
3. be provided with suitable support, including support for their carers, to enable their wishes to be fulfilled.

Who is this document for?

This document presents consensus-based best practices for the handling of medicines for symptom relief in patients receiving home-based palliative care, by individuals, and staff of community service providers.

Community service providers may use these guidelines to develop detailed protocols and procedures tailored to the requirements of their individual services or facilities. Such protocols and procedures support health professionals in the practice of handling and administration of palliative care medicines to palliative care patients living at home.

Staff employed in medication management roles in these services may include healthcare professionals such as doctors, nurse practitioners, pharmacists, registered nurses and enrolled nurses (EN). In some jurisdictions, assistants in nursing or other categories of care workers (however titled), may perform medicines-related tasks under supervision.

At all times, approved providers and their delegated managers and staff must comply with relevant legislation, such as state and territory drugs and poisons Acts (however titled). Community service providers also affiliated with healthcare facilities such as hospitals and community health centres have additional responsibilities relating to the supply, administration and storage of medicines, in line with these legislative requirements.

Provision of palliative care services to patients in residential aged care homes (RACH) is not covered in this document.

These guidelines have been developed as part of the caring@home project, a National Palliative Care Project that aims to increase access to quality and timely end-of-life care for home-based patients by developing practical and evidence-based resources and providing associated education for health professionals.

2. Key Terms and Definitions

A list of key terms and their definitions, as used throughout these guidelines, is provided in Appendix A. These include:

- authorised person
- authorised prescriber
- carer
- community service provider
- drug register
- healthcare professional
- health practitioner
- imprest stock
- medical practitioner
- nurse practitioner
- patients' own medicine
- person responsible
- prescriber
- standing order
- stock medicine

3. State and Territory Variations

As part of the development of these guidelines, state and territory medicines, drugs and poisons legislation were reviewed, and expert policy advice was sought from relevant government departments. Similarities and differences between the states and territories were noted, and variations are listed within each section of the guidelines.

The guidelines will be subject to periodic review to ensure the information remains current and aligned with legislative and policy changes.

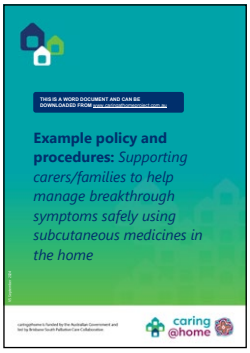
We would like to acknowledge all the government departments involved in the initial development and ongoing updates.

Users of these guidelines are reminded that legislation for each state and territory varies in the extent to which it regulates the administration of medicines once prescribed, dispensed and supplied for or to an individual.[1] Additionally, legislation regulating professional groups – for instance, the *Health Practitioner Regulation National Law Act 2009*, and guidelines for government-funded programs – may set out rules controlling the circumstances in which different groups of healthcare professionals and other care workers (however titled) may administer medicines.[1]

Community service providers should refer to the relevant medicines, drugs and poisons legislation listed in Appendix B *State and territory medicines regulations* and Appendix C *Contact details for state and territory regulators* for further guidance on the safe handling of medicines in their state.

4. Community Service Providers

Community service providers may use these guidelines to develop detailed protocols and procedures tailored to their individual services or facilities.



An example policy and procedure document is available through the caring@home project.

4.1. Medicine management

A multidisciplinary approach to the development of policies, procedures and medicine management processes within an organisation is advisable. This approach may be applied to:

- the development and approval of written medicine policies and procedures
- the rationalisation of medicine use in relation to efficacy, safety and cost
- the analysis of medicine incident reports
- any recommendations concerning the ongoing education of staff
- any recommendations concerning quality activities relating to medicine use.

4.2. Medicine storage

PART A: SERVICES THAT ADMINISTER PATIENTS' OWN MEDICINE IN THE HOME

4.2.1. Storage: All medicines

Advise patients and their carers that, to ensure medicine safety and effectiveness, appropriate storage in the home is important. Medicines should be stored according to the instructions on the packaging.

Ideally, medicines should be stored in their original container in a cool, dry place. The stability and effectiveness of some medicines depend on correct storage temperature – for example, those medicines requiring refrigeration.

Patients and carers who require assistance with medicine management may also need help to securely store medicines in a safe manner – for example, out of reach of children.

Some patients and their carers may be unable to read or understand medicine labels and instructions because of minimal reading skills, low health literacy or limited English proficiency. These people may need more help with medicine management and safe storage.

4.2.2. When a patient needs to take medicine away from home

Patients should be advised on appropriate storage and transport. For example, medicines normally stored in the fridge can be put in a portable icebox or insulated box with a cooler block to keep the temperature between 2°C and 8°C during transport.

4.2.3. *Individual responsibility for medicine storage and security*

Inform patients and carers that they are responsible for safe storage of all medicines in their home.

4.2.4. *Individual disposal of medicine*

Medicines should be disposed of safely and in a way that is not harmful to the environment and in accordance with the relevant state or territory legislation.[1] Unwanted and expired medicines should be returned to community pharmacies; most will be disposed of via the Return Unwanted Medicines (RUM) project, which provides a free and safe method for disposal.

Individual services should develop guidelines for the disposal of any unwanted, unused or expired medicines owned by the patient, after obtaining consent from the patient. These guidelines can be adopted from Guiding Principles for Medication Management in the Community[1] and Guiding Principles to Achieve Continuity in Medication Management.[2]

See section 4.2.10. *Service disposal of medicine* for more information on the disposal of medicines.

PART B: HEALTH SERVICES AUTHORISED TO HOLD IMPREST MEDICINES

4.2.5. *Service responsibility*

Healthcare settings authorised to hold imprest medicines have additional responsibilities relating to the storage of medicines.[1]

The service manager or other designated person has overall responsibility for the storage of all medicines at the service. If the manager is not a registered nurse, this responsibility may be delegated to a specified senior nurse or nursing position depending on state or territory law. This authorised person should ensure that correct storage conditions are met, in relation both to the legislation and manufacturer recommendations.

State and territory variations: Service responsibility

Queensland

Refer to Chapter 8, Part 2 of Medicines and Poisons (Medicines) Regulation 2021 for the terms used and requirements for storing medicines in Queensland.[3]

South Australia

Facilities which hold an imprest or emergency stock of medicines require a licence if they will be possessing and/or administering and/or supplying a Prescription Drug and/or a Controlled Drug.

Tasmania

The authorised officer of a medical institution is authorised under the Poisons Regulations 2018 to possess and supply scheduled substances in accordance with the Regulations.

Authorised officer, in relation to a medical institution, means:

(a) a pharmacist employed as such in that institution or, where more than one pharmacist is employed, the chief pharmacist; or

(b) where no pharmacist is employed in that institution, the medical practitioner in charge of that institution; or

(c) where no pharmacist is employed in that institution and there is no medical practitioner in charge thereof, the registered nurse in charge of that institution.

Victoria

If scheduled medicines are obtained and stored as imprest stock by the entity providing the service a Health Services Permit is required.

Western Australia

If scheduled medicines are stored as imprest stock, a permit is required.

4.2.6. *Ownership of medicine*

Using a patient's own medicine as stock medicine for other patients is illegal, even if the medicine has been returned or donated to the organisation.

4.2.7. *Security: Storage of Schedule 8 medicines within the confines of the service*

Storage of Schedule 8 medicines held within the service facility should comply with state and territory legislated requirements. Schedule 8 medicines are stored in a separate secure enclosure that is not accessible to members of the public and is locked when not in use. At all times, the key or combination to the enclosure is kept in the possession of the authorised person.

The enclosure should comply with the requirements of the relevant state or territory legislation, as outlined below:

Australian Capital Territory

Storage requirements for controlled medicines are outlined in the Medicines, Poisons and Therapeutic Goods Regulation 2008.[4]

New South Wales

Storage requirements for controlled medicines are outlined in the Poisons and Therapeutic Goods Regulation 2008.[5]

Northern Territory

Storage requirements for Schedule 8 medicines are outlined in Schedule 8 Substances, Volume 2 – Storage & Transportation.[6]

Queensland

Storage requirements for Schedule 8 medicines are outlined in Queensland Health Departmental Standard Secure storage of S8 medicines.[7]

South Australia

Storage requirements for Schedule 8 medicines are outlined in the Code of Practice for the Storage and Transport of Drugs of Dependence 2025.[8]

Tasmania

Narcotic substances must be stored apart from other goods in an enclosure that is constructed and secured in a manner approved by the Secretary of the Department of Health. A medical practitioner, authorised health professional or authorised nurse practitioner may, for emergency purposes, keep narcotic substances in a bag in a vehicle or room that is kept securely locked when not occupied.

Storage requirements for narcotic substances in a medical facility must comply with Regulation 33(I) of the Poisons Regulations 2018.[9]

Victoria

There are exceptions in aged care services when controlled poisons are supplied in certain dose administration containers. See the Drugs, Poisons and Controlled Substances Regulations 2017 for more information.[10]

Western Australia

Imprest Schedule 8 medicines must

be stored in a compliant safe. See Regulation 95 of the Medicines and Poisons Regulations 2016 for further guidance.[11]

4.2.8. Storage: Temperature-dependent medicines

Store all medicines at the temperature specified by the manufacturer and stated on the original packaging. Most medicines should be stored below 30°C, although some should be stored below 25°C and others must be stored in refrigerated conditions – taking care not to freeze them.

Examine stock regularly for any visible discolouration, irregularities, precipitates and impurities.

When possible, medicine that is in use or in the possession of the authorised person should be transported in a thermally appropriate container such as an icebox or insulated box.

Individual pre-prepared medicines (e.g. injectables) should be stored in accordance with the manufacturer's recommendations.

Temperature may affect the stability of subcutaneous infusions. See section 4.9.1. *Storage of subcutaneous infusions for more information*.

4.2.9. Stock rotation

It is recommended that services have in place a routine procedure of stock rotation and monitoring of medicine expiry dates to prevent the accumulation of old stock.

4.2.10. Service disposal of medicine

Medicines no longer required should be disposed of safely so there is no risk of reuse or diversion, and in a way that is not harmful to the environment. Services should develop their own guidelines for the appropriate disposal of pre-prepared, excess and unused medicines.

This excludes cytotoxic medicines which are subject to other disposal restrictions. Refer to individual state and territory regulations for guidance on the disposal of cytotoxic medicines.

Unwanted and expired medicines should be returned to the community pharmacy to be disposed of via the Return Unwanted Medicines (RUM) project, which provides a free and safe method for disposal.

Schedule 8 medicines that have first been rendered unusable can be disposed of in RUM bins. Refer to the RUM project website for individual state and territory collection protocols.

4.2.11. Emergency medicine for home visits

A service may hold a small range of medicines in a secure bag that can be taken on home visits for use in an emergency. The service should determine a set list of the medicines and quantities held in the bag. The medicines from this list may be obtained by requisition as stock medicine, as described in section 4.3. *Acquisition of stock medicine*. While held at the service, the emergency medicines bag should be securely stored, or the medicines held in the bag returned to their correct storage locations within the service. Although Schedule 8 medicines should not be routinely included in an emergency medicines bag, in some situations or locations a service may consider this to be necessary. In these cases, it is recommended that only a minimal quantity be held in the emergency bag supply. Keep a register of Schedule 8 stock and its use, as per state and territory legislative requirements.

Schedule 8 medicines being transported between the service's place of practice and a patient's home should be kept in a lockable metal enclosure– refer to section 4.2.7. *Security: Storage of Schedule 8 medicines within the confines of the service*.

Only personnel who are authorised to possess, supply and administer emergency stock medicine to patients may access and carry the emergency medicines bag – refer to section 4.5.1. *Who can administer?* Administration should also be authorised – refer to section 4.4.1. *Medicine authorisation*.

State and territory variations: Emergency medicine for home visits

South Australia

Services which hold an emergency stock of medicines require a license to possess a prescription drug and/or controlled drug. These licenses do not require the services of a pharmacist.

Tasmania

A registered nurse must be granted an authorisation under Section 25A of the Poisons Act 1971 to be in possession of restricted or narcotic substances. See the Tasmania Poisons Act 1971 for more information.[12]

Victoria

The service needs to hold a Health Services Permit to lawfully possess Schedule 4 or Schedule 8 poisons that have not been supplied for the treatment of a specific patient. See the Drugs, Poisons and Controlled Substances Regulations 2017: Part 1 – Possession for more information.[10]

4.2.12. Transport

Keep medicine that is transported between the service facility and a patient's home in a lockable metal container that has:

- either a combination lock or a tamper-proof lock
- sturdy tamper-proof hinges with continuous welding to the lid and body – they should also be concealed on the inside of the container, if possible.

While on home visits to patients, avoid storing medicine in a vehicle wherever possible. However, if required medicine may be temporarily secured in the boot of a locked vehicle in some states and territories, provided:

- the authorised person is in possession of the key to the vehicle, and
- the scheduled medicines are not visible from the outside of the vehicle (for example, stored under a luggage cover in the back of a station wagon).

Additional requirements may apply to the transport of Schedule 8 medicines. Refer to individual state and territory legislation and health policy.

Following the visit, ensure that the metal container is locked and safely stored in the vehicle and return it to the service at the earliest convenience.

Note: Be mindful of the vehicle temperature if medicine is stored inside and ensure that any specified storage requirements are followed.

State and territory variations: Transport

Australian Capital Territory

Under the Medicines, Poisons and Therapeutic Goods Regulation 2008, only a dentist, doctor, medical radiation practitioner, endorsed health practitioner or veterinary practitioner may store controlled medicines in a locked vehicle. If controlled medicines are included in the emergency bag, they should never be left in the vehicle unless the authorised person is listed above.

Queensland

Refer to the Queensland Health Departmental Standard Secure storage of S8 medicines.[7]

South Australia

S8 drugs must not be left in vehicles overnight or when the vehicle is unattended unless secured in a premises fitted with an alarm system monitored by a security company or patrolled by a security guard, per SA Health Code of Practice for the Storage and Transport of Drugs of Dependence, 2025.[8]

Western Australia

See Regulations 90(3) and 95(3) of the Medicines and Poisons Regulations 2016[11] for further information on the necessary steps to be taken to protect medicine from being lost or stolen when attending a patient at a place other than the health professional's usual place of practice. The medicine must be in the possession of the health professional at all times.

4.3. Acquisition of stock medicine

A service may hold a small range of stock medicine for use on home visits in an emergency, subject to state and territory regulations. The service should determine the list of medicines held and the quantities.

A record should be kept of any medicines administered. This record should show the patient's name, the medicine name, strength and quantity; the healthcare professional's name and signature; and the date administered. This should be linked to the patient's medical record.

See section 4.13. *Drug register* regarding record keeping for Schedule 8 medicines.

State and territory variations: Stock medicine

Northern Territory

In order to possess and use stock medicines, a written purchase order must be signed by an authorised staff member. The medicine supplier has the right to request evidence that the facility can hold the particular medicine ordered and ask for the credentials of the person ordering. The stock medicine list must have been approved in content and quantity through the governance process for the service. Regular review of this list and any incidents is required.

South Australia

Services that hold imprest or emergency stock of medicines and are required to supply medicines not dispensed by a pharmacist require a license to possess and supply medicines.

Victoria

Palliative care services need to hold a Health Services Permit to lawfully possess Schedule 4 and Schedule 8 poisons that have not been supplied for the treatment of a specific patient. See the Drugs, Poisons and Controlled Substances Regulations 2017 for further information.

Western Australia

A health service permit is required to obtain and use the scheduled medicines listed on the permit in providing health services at or from the premises listed on the permit.

4.4. Prescribing

4.4.1. Medicine authorisation

Schedule 4 medicines must not be supplied or administered to a patient unless an authorised prescriber has provided a prescription or medication order. The instruction should preferably be issued on the prescription, or on the written or electronic medication order, but emergency telephone orders may also be given (see section 4.4.2. *Emergency telephone orders and prescriptions*).

The prescriber should enter the following information on the medication order:

- the patient's identifying particulars
- any drug allergies
- the name, strength and form of the medicine
- full directions for medicine use, including the dose, route and frequency of administration
- the maximum dose allowable over a 24-hour period
- the minimum time periods between dosing
- the nominated review period, as per state and territory regulations
- the date of the medication order
- the prescriber's name (printed), signature and date (each medication order must be signed – it is not sufficient to sign across several orders).

The medication order should bear the name of the community service provider.

The prescriber should regularly review medication orders. Services should implement their own procedures for the review of medication orders.

The details on the medication order should also be included in the patient's medicine record so that a complete and up-to-date reference record is available. Any changes in dosage, route and/or frequency are included in this record.

State and territory variations: Medicine authorisation

Australian Capital Territory

See Section 41 of the Medicines, Poisons and Therapeutic Goods Regulation 2008 for requirements for prescriptions in the ACT.[4]

Queensland

The Medicines and Poisons (Medicines) Regulation 2021 has different requirements for lawful prescriptions for supply (Sections 86 and 87) and prescriptions for administration (Section 95).[3] A prescription may not be required under an extended practice authority (EPA). Refer to Queensland Health Extended practice authority - Registered nurses.

Victoria

Administration of prescription-only medicine should be done in accordance with instructions on the label of the lawfully supplied medicine.

4.4.2. Emergency telephone orders and prescriptions

Where a patient is in urgent need of a medicine and the treating prescriber is not in attendance, the prescriber, or another prescriber, may give a telephone order or prescription.

Telephone medication orders

The person receiving a medication order should be a registered nurse or a pharmacist. The prescriber must verify with the person receiving the order that the patient does not have an allergy or has not experienced

a significant Adverse Drug Reaction (ADR) before giving the order. The person reads back the medication order to the prescriber to confirm that it is correct.

The order should be recorded in the patient's medical record (or in the notes if no record currently exists). The dose given is also recorded in the patient's medicine record.

The prescriber confirms this record of administration within 24 hours and either countersigns the order or sends a written prescription that confirms the order to the community service provider. Receipt of the written authorisation should be recorded in the patient's records.

If the medicine is to be ongoing, the prescriber should either:

- issue a prescription for dispensing at a community or hospital pharmacy, or
- complete the regular or PRN (as required) section of the medication order to authorise that the medicine can continue to be administered.

Note: Services should have in place a procedure to ensure that emergency telephone orders are followed up if confirmation is not forthcoming within the designated period.

Telephone prescriptions

A prescriber can issue a prescription (including for Schedule 8 medicines) to a pharmacist via phone, fax or email (where permitted). The prescriber is then responsible for immediately dispatching the original hard-copy or electronic prescription to the supplying pharmacist. Requirements vary depending on state or territory law so refer to relevant state or territory legislation for more information.[13]

State and territory variations: Emergency telephone orders

Queensland

Requirements for oral prescriptions for supply (dispensing) appear under section 92 and for administration under section 100 of the Medicines and Poisons (Medicines) Regulation 2021.[3]

South Australia

For Schedule 8 medicines for administration in a health service facility, prescribers are required to confirm the order to a second person. The prescriber must also sign the entries in the medical record within 48 hours. If a prescription is given to a pharmacist by telephone, they must forward the written prescription for a Schedule 8 medicine within 24 hours. Requirements for telephone orders are specified in Part 4 of the Controlled Substances (Poisons) Regulation 2011.[14]

Western Australia

The prescriber must sign the medication chart or clinical record for Schedule 4 or Schedule 8 medicines within 24 hours of giving the direction. See Regulation 15(3) in the Medicines and Poisons Regulations 2016 for further information.[11]

4.5. Medicine administration

Administration practices must be in accordance with legislation, professional and regulatory requirements, and the community service provider's medicines administration policies, procedures and guidelines.[1]

4.5.1. Who can administer?

In considering who may administer medicine to a patient, a distinction is made between:

- stock medicine, as described in section 4.5.1.1. *Stock medicine* and
- *patients' own medicine* (section 4.5.1.2.), dispensed and labelled by a pharmacist on prescription or other lawful mechanism.

4.5.1.1. Stock medicine

In facilities that keep stock medicines only registered nurses and enrolled nurses without notation may administer them. Administration should be on the prior direction of an authorised prescriber in accordance with their directions or an approved standing order. See section 4.4.1. *Medicine authorisation*.

4.5.1.2. Patients' own medicine

On request from a community-based palliative care patient, their carer or substitute decision-maker, registered nurses and authorised enrolled nurses can:

- prepare an injection using prescribed medicine directly from the patient's own labelled medicine container[a]
- administer an injection using prescribed medicine directly from the patient's own labelled medicine container[a]
- fill a dose administration aid with prescribed medicine directly from the patient's own labelled medicine container
- assist a patient to take or administer their own prescribed medicine, and/or
- assist a carer to administer a patient's own prescribed medicine.

Note: If a dose administration aid is considered appropriate, it is recommended that this be filled by a community pharmacist, although the patient's family may also assume this responsibility.

In general, people other than registered nurses or enrolled nurses, such as enrolled nurses not authorised to administer medicines, or assistants in nursing/ personal care workers (however titled) may only assist or support a person to self-administer their own medicines. However, exceptions apply.[1]

[a] ENs can only administer intravenous (IV) medicines if they have completed intravenous medicines administration education.

State and territory variations: Patients' own medicine

Queensland

A person may support a patient to administer their own dispensed medicine in accordance with its approved label to lawfully help the patient.

Tasmania

An aged care worker who is not a nurse may administer, or make available for self-administration, to another person who is being provided with community care service, a medicinal poison, potent substance, restricted substance or narcotic substance under conditions specified in Regulation 134 of the Poisons Regulations 2018.[15]

Victoria

Except in the course of actual use of a poison or controlled substance, a person must not remove that poison or controlled substance from the container in which it was dispensed, sold or supplied. For more information, see Regulation 151(b) of the Drugs, Poisons and Controlled Substances Regulations 2017.[10]

Western Australia

Under Section 14 of the Medicines and Poisons Act 2014,[11] a carer is

authorised to be in possession of an S4 or S8 medicine for the purpose of administering the medicine to the person for whom it was prescribed, in accordance with the instructions of the prescriber. A carer is defined as a person who assists in the health care of the patient on a full-time or part-time basis, regardless of whether the carer is paid or unpaid.

4.5.1.3. Role of the carer

Carers need appropriate training to safely assist with medicine administration. Prescribers, pharmacists and registered nurses have a role in educating carers about the safe and appropriate administration of medicines. caring@home has a range of resources to support families and carers, including guidance on how to administer subcutaneous medicines at home.

If a patient is unconscious or unable to consent to receiving medicine, their carer can be appointed as the person responsible. There is no requirement to complete forms or formally appoint the person responsible.

4.5.2. Transcribing

Only an authorised prescriber can issue and sign medication orders in a patient's medication record. The practice known as 'transcribing' (whereby someone other than the authorised prescriber writes on a medication order to direct subsequent administration of a medicine to a palliative care patient) should not occur. Similarly, attachments should not be added to the original medicine authorisation to extend therapy.

4.5.3. Procedure for administering stock medicines

See also section 4.4.1. *Medicine authorisation*.

A nurse administering a stock medicine refers directly to the prescriber's written instructions except in the case of emergency telephone orders (see section 4.4.2. *Emergency telephone orders and prescriptions*) or nurse-initiated stock medicine (see section 4.5.5. *Nurse-initiated stock medicine (single-dose only)*).

The same person should select and prepare the medicine. Each time a stock medicine is administered to a patient, it should be recorded on the patient's medication record or in the patient's notes.

The following should also be considered:

- contact the prescriber for clarification if the medication order is unclear or ambiguous
- carefully read the label on the container and check the name and strength against the medication order to avoid selecting the wrong medicine
- use a new syringe and needle for each administration of an injected medicine
- discard any unused portion of a single-use ampoule according to facility policies and document the dose administered in the medication order. Schedule 8 medicines should also be documented in the drug register.

4.5.4. Pre-preparing injectable medicines

Medicine should remain in the original container supplied by the community or hospital pharmacy and administered to the patient directly from that container, except when indicated below:

- A registered nurse or pharmacist may need to pre-prepare up to a 24-hour supply of injectable 'as required' medicine if the patient's carer is unable to do so. This medicine must be stored in an appropriately labelled syringe and stored according to the manufacturer's recommendations (temperature and light). Medicines must be stored safely, including keeping them out

of reach of children. Each syringe should be individually labelled with the following:

- medicine name and dose
- date
- signature of the registered nurse who prepared the medicine.

Manufacturer and research-based recommendations are available for the length of time some medicines can be stored in a pre-filled syringe. However, there are no recommendations for all the medicines used for symptom management in the last weeks of life.

Consensus-based practice is that pre-filled syringes, drawn up under aseptic conditions and secured with a bung, can be stored for 24 hours. For terminal palliative patients who may be geographically or otherwise isolated, clinical judgement needs to be exercised when determining the risk-benefit balance between unlikely microbiological contamination and patient comfort. For these patients, the storage times may need to be extended to 48 or 72 hours to ensure symptom control and quality of life. Refer to Appendix E for stability data and compatibility information for some injectable medicines.

See section 4.13.1. *Witness to administration and discarding of a Schedule 8 medicine (including patients' own medicine) in the home*.

See also section 4.5.1.2. *Patients' own medicine*.

Injectable medicines are a high-risk therapy for patients and health professionals. All injectable medicines drawn up in a syringe that will leave the hand of the person filling it should be labelled immediately, including those medicines intended for bolus use. If colour-coded labels are used when labelling syringes, the colour coding should be consistent with Australian and New Zealand Standards (see Appendix D *User-applied labels for use on syringes containing drugs used during anaesthesia*).

4.5.5. Nurse-initiated stock medicine (single-dose only)

Australian, state and territory legislation, together with local organisational policies, define some medicines as potential nurse-initiated medicines.[1]

Facilities that keep stock medicines may approve a list of unscheduled and Schedule 2 and Schedule 3 medicines that may be administered by a registered nurse without a prescription from an authorised prescriber, provided appropriate detailed written protocols for use are also developed.

Before administering a nurse-initiated medicine, it is the registered nurse's responsibility to ensure that the patient is not allergic to that medication, there are no other contraindications, and no interactions with the patient's existing medicines. Check for all other medicines (including over-the-counter and complementary medicines) that might interact with prescription and non-prescription medicines. Contact the local pharmacy or poisons information centre for further guidance on medicine interactions.

- If there are no documented allergies or interactions, the medicine can be administered.
- If there are documented allergies or interactions, contact the prescriber to obtain appropriate instructions. A medicines review may be required to determine best management. Pharmacists and prescribers also have a responsibility to check for allergies and ensure there are no drug interactions.

After administering a dose of medicine from the approved list to a patient, the nurse should make an indelible record on the medication order including, as a minimum, the following details:

- the date and time given
- the name, strength, route and dose of the medicine
- the reason for administration of the medicine
- the signature of the administering person, printed name and designation.

If a nurse is needing to initiate the same medicine for a patient on a frequent basis, then a clinical assessment should be performed to determine if a regular order should be prescribed.

State and territory variations: Nurse-initiated medicine

Queensland

Nurse-initiated medicines can be administered by a registered nurse in Queensland without a prescription for Schedule 2 and Schedule 3 medicines.

4.6. After-hours emergency situations

Services should develop procedures to deal with after-hours emergency situations. This includes provision for access to appropriately qualified healthcare professionals.

See section 4.4.2. *Emergency telephone orders and prescriptions*.

4.7. Dose administration aids

A variety of dose administration aids (DAAs) are available. If a DAA is considered appropriate for a palliative care patient, a community pharmacist should be approached to provide and fill the aid. In some states and territories, in exceptional circumstances and where a pharmacist is not available, another healthcare professional, e.g. medical practitioner, registered nurse or Aboriginal Health Worker, may be authorised to prepare a DAA.[1] Family may also assume responsibility for filling the aid.

Pharmacy-prepared DAAs must comply with state and territory labelling requirements and include:[16]

- Patient's name
- Name, address and telephone number of the dispensing pharmacy or pharmacy department
- Brand and active ingredient name, strength and dose form of each of the medicines in the DAA
- Directions for use for each of the medicines (including frequency and dose) in plain English (if space permits, other languages that are accurate translations of English may be used on the DAA label if beneficial for optimising the medication management of the patient)
- Directions for use of each medicine
- Date the DAA was packed and the expiry date of the DAA
- Any applicable storage instructions
- Any cautionary advisory labels required or recommended for individual medicines
- Date and day of the week when the DAA is to be used [1,3]
- The words **Keep out of reach of children**
- If more than one DAA is being used, clear directions that there are more medicines in another DAA (e.g. DAA 1 of 2)

If registered and enrolled nurses are administering medicines from a DAA, it must be packaged and fully labelled by a pharmacist. Registered and enrolled nurses must not administer from DAAs where individual medicines cannot be clearly identified.[1]

4.8. National Core Community Palliative Care Medicines List for managing end-of-life symptoms

The National Core Community Palliative Care Medicines List identifies four medicines to manage common symptoms in the terminal phase for home-based patients requiring urgent symptom relief (Table 1).[17]

This List supports palliative care patients to remain in the home for end-of-life care and assists community-based prescribers and pharmacists to provide timely and optimal care to these patients and their families.

Common symptoms in the last days of life include anxiety, dyspnoea/distressing breathlessness, nausea/vomiting, noisy breathing, pain and terminal restlessness. People frequently cannot swallow in the terminal phase, making it essential to use non-oral formulations, such as buccal or subcutaneous.[11]

Criteria used to select the four medicines on the List were:

- cost and ease of access (including Pharmaceutical Benefits Scheme subsidies)
- availability in a community-friendly dose form, and
- where applicable, being able to address more than one frequently encountered symptom.[17]

Table 1. The National Core Community Palliative Care Medicines List[17]

Medicine		Clinical uses for the terminal phase
Clonazepam	2.5 mg/mL drops* AND/OR 1 mg/mL injection	Seizure, anxiety, dyspnoea/distressing breathlessness, terminal restlessness/agitation
Haloperidol	5 mg/mL injection	Delirium, nausea/vomiting, terminal restlessness/agitation, refractory distress
Hyoscine butylbromide	20 mg/mL injection	Respiratory tract secretions/noisy breathing (prophylactic)
Morphine	10 mg/mL injection	Pain, dyspnoea/distressing breathlessness

* *Strategies to support the safe use of CLONazepam oral liquid*

It is recommended that prescribers caring for home-based palliative patients consider using the medicines in the List where clinically appropriate and community pharmacists stock the medicines in the List to allow timely and easy access for patients.

For more information, refer to the *National Core Community Palliative Care Medicines List factsheet*. Prescribing information about the medicines on the List is available via the palliMEDS app.

Pharmacies can inform their community that they keep the National Core Community Palliative Care Medicines by listing on *Healthdirect*.

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4.9. Subcutaneous infusions

While the preferred route of medicine administration in palliative care is oral, subcutaneous infusions are commonly used for symptom management where oral administration is impractical, no longer clinically viable or undesirable. Many medicines used in subcutaneous infusions have narrow margins of error. Adverse drug reactions can result due to prescription, preparation and administration errors.

To prevent these errors, services should consider adopting the following principles:

- To avoid confusion, use only one type of infusion device in each setting.
- Use the same brand of syringe each time to minimise errors in setting up the device and calculating the rate.
- Use an aseptic technique when preparing and setting up an infusion.
- Set up a minimum volume extension to minimise dead space in the line.
- Prime the line after drawing up the prescribed medicine and when changing the extension set and/or cannula.
- Ensure that medicines being delivered are compatible. Check compatibility tables and references for all prescribed medicines before commencing.
- Ensure that medicine calculations are checked according to best practice, legislative requirements and organisational policy when the infusion device is set up.
- Carefully inspect tubing for patency and syringe volume remaining, recommended to be at least every 4 hours, and document findings.

The insertion site of a subcutaneous line should be inspected as part of routine care. This includes checking for tenderness, the presence of swelling and leaking at the insertion site. It is important to educate patients and carers to inspect insertion sites, and they should be given instructions on what to do if there is a problem.

Local protocols may specify a maximum number of medicines to use simultaneously in a single device, to minimise the likelihood of incompatibility occurring. Regular monitoring of the syringe contents and tubing is required to check for incompatibility (for example, clouding and colour change) when medicines are combined. However, lack of visible evidence does not necessarily mean that medicines are compatible.

caring@home also has guidance for carers and families on how to administer subcutaneous medicines at home.

4.9.1. Storage of subcutaneous infusions

Temperature may affect the stability of medicines. Ensure infusion devices are placed on top of bedclothes and outside of clothing, rather than beneath.

Prepare infusions immediately before infusion.

Protect infusions from light where possible.

For more information about the stability of commonly used medicines in palliative care, refer to Appendix E *Injectable medicine information to prevent degradation*.

4.10. Complementary and alternative medicines

Complementary and alternative medicines (CAMs) are seldom 'prescribed' by authorised prescribers and are generally not listed on the Pharmaceutical Benefits Scheme. CAM can potentially interact with other medicines, and it is recommended that services develop local policies on their approach to the administration of CAM.

4.11. Adverse drug reactions

Adverse drug reactions (ADRs) include allergic reactions and dose-related side effects. Reactions can vary in severity from being minimally inconvenient to life-threatening. All information on any ADRs needs to be shared within the extended healthcare team to support administration and intention-to-treat decisions.

A patient having an ADR record is not, in itself, a contraindication to administering the involved medicine (unless the reaction is life-threatening) but provides guidance on future therapy for the patient.

To minimise the risk of ADRs:

- Ask patients whether they have experienced any ADRs (patients may be more familiar with the terms 'allergy' and 'side effects' rather than ADR, so these may be a better prompt).
- If a patient is unaware of any previous ADR, record 'Nil known' in the documentation. If ADR status is unknown, record 'Unknown'. If a health professional adds information to the documentation after the initial interview, they should sign next to the addition, print their name and date the entry (or use the appropriate procedure for electronic medication management systems).
- Record ADR details (the medicine and the nature of the reaction) in a manner that shares this information within the extended healthcare team.
- If requested to administer a medicine to which the patient has previously experienced an ADR, consult with the patient's prescriber for clarification of the safety of the order.

Any suspected ADR should be reported in accordance with local reporting protocols and sent to the TGA using their online portal or Blue Card adverse reaction reporting form 'Report of suspected adverse reaction to medicine or vaccines' by post (pre-paid), facsimile or email.[18]

4.12. Medication errors

Patients receiving palliative care are at risk of medication errors due to their declining physical condition combined with the use of high-risk medicines such as opioid analgesics. Medication errors include errors causing harm to the patient, errors due to the administration of the wrong therapy with or without harm, and errors in documentation.[18] It is important that community service providers are clear on these definitions and develop procedures for documenting and managing medication errors, including emergency procedures in cases of overdose from opioids.

State and territory variations: Medication errors

Northern Territory

In the event of a medication error, an incident report should be generated and the incident reviewed by the medication governance committee according to the organisation's process.

4.13. Drug register

A drug (medicine) register should be kept in accordance with state and territory legislative requirements and the policies and procedures of the facility.

The authorised person at the service keeps the drug register to record the receipt, administration and any other transaction of all Schedule 8 medicines that are stored at the service. The record in the drug register should be accurate and contemporaneous,

made as soon as practicable after the transaction occurs, and definitely on the same day. However, state and territory legislative requirements vary. Refer to the requirements in the relevant state legislation.

Each medicine and its strength is recorded on a separate page in the drug register. Patients' own medicines stored by the service are recorded on a separate page for each patient and each medicine. Details required in the register should comply with state, territory and local policy regulations but generally include the following (in ink if a written register), as a minimum:

- the date of the 'transaction'
- the time of day (note: this is not a mandated regulatory requirement in Australian Capital Territory, Queensland or Victoria)
- the name and address of each person involved (i.e. the person it is being received from and the person it is being supplied to)
- the medicine name, strength and form
- the amount received, for medicine from the pharmacist
- the amount used, for administration of medicine to a patient
- the amount discarded, if only part of an ampoule or tablet is administered to the patient
- the balance of stock remaining after the transaction has been made
- the signature of the authorised person making the entry
- the signature of the person who witnessed receipt of the medicine, its administration to the patient or the discarding of the remainder; see also section 4.13.1 *Witness to administration and discarding of a patient's own medicine*. (note: a witness is not a mandatory requirement in Victoria)
- the prescription reference number if the medicine is supplied in accordance with a prescription.

The authorised person making an entry in the drug register should not make any:

(i) false or misleading entries

(ii) in a written register, alterations, obliterations or cancellations (including crossing out or drawing a line through an entry). If a mistake is made, it must be left as it is, marked with an asterisk and the entry rewritten as appropriate. A note explaining the error must be made in the margin or at the foot of the page, initialled and dated.

Note that the mandatory requirements for recording in S8 registers do not apply to patients' own dispensed medicines administered in the home.

State and territory variations: Drug register

Australian Capital Territory

An electronic controlled drug register may be used, ensuring that a separate record is kept for each form and strength of controlled medicine.[4]

A controlled medicine contained in a dose administration aid does not need to be recorded in the drug register if the medicine is held at a residential aged care facility or residential disability care facility.[4]

The requirements for entering information into the drug register are detailed in Section 543 of the Medicines, Poisons and Therapeutic Goods Regulation 2008.[4]

Signing of register entries is mandated under the Medicines, Poisons and Therapeutic Goods Act, Section 52.[19]

New South Wales

An electronic Schedule 8 drug register may be used, provided it complies with specified NSW Health standards.[20]

Queensland

For Queensland requirements for S8 medicines registers, refer to Chapter 8, Part 2, Division 3 of the Medicines and Poisons (Medicines) Regulation 2021.[3]

South Australia

A person making an entry in a drug register can cross out or draw a line through an entry as long as the entry is clearly legible. All records must be kept for a minimum of 2 years from the date of the last entry in the register. An approved electronic register may be used.

Tasmania

A narcotic substances register is to be:

(a) in a form approved by the Secretary; and

(b) kept in such manner as the Secretary may direct.

An electronic narcotic substances register may be used provided it has been approved by the Secretary of the Tasmanian Department of Health.

Records relating to narcotic substances must be kept for at least 2 years from the date on which the medicine is administered or supplied.

Victoria

Computerised records that cannot be altered or deleted are also lawful.

Western Australia

Drug registers need to be in a format approved by the Western Australia Department of Health: see Schedule 8 drug registers.[21]

4.13.1 Witness to administration and discarding of a Schedule 8 medicine (including patients' own medicine) in the home

Where a registered nurse visits a patient at home to administer a Schedule 8 medicine that has been brought from the service, the nurse records the amount administered to the patient in the S8 drug register.

Often, it is not possible for a second staff member to be present at a patient's home to witness medicine administration. Refer to state legislation and local policy for the requirements for second checks of the administration and destruction of Schedule 8 medicines.

The actual amount administered and any amount discarded is also recorded in the patient's medication record by the administering nurse.

Where a patient's own Schedule 8 medicine is administered in their home, no service S8 register record is required when the medicine is administered by service staff.

State and territory variations: Witness to administration and discarding of a Schedule 8 medicine

Australian Capital Territory

Those who witness the administration and discarding of a controlled substance must be listed under Section 544 and 545 respectively of the Medicines, Poisons and Therapeutic Goods Regulation 2008.[4]

Victoria

Having a witness to the administration and discarding of a patient's own medicine is not a mandatory requirement.

4.13.2. Balance checks

The balance of Schedule 8 medicines held by the service should be checked regularly depending on state or territory requirements and local service policy. In patient care areas, this check can be carried out by a registered nurse and a second person and confirmed by a signed entry in the drug register on the relevant page for each medicine.

State and territory variations: Balance checks

Australian Capital Territory

There is no requirement for additional balance checks of controlled medicines. Individual institutions develop their own policies on the frequency of balance checks.

New South Wales

Balance checks of all Schedule 8 medicines in patient care areas of NSW Health facilities must be conducted at least once every 24 hours. Under the NSW Poisons and Therapeutic Regulation 2008 balance checks by pharmacy services must be made during March and September each year as a minimum, and at other times under facility procedures.[5]

Northern Territory

The balance in the register must be correct at all times. It is up to the service to risk-manage this requirement and institute a balance check interval that suits its service.

Queensland

For a manager of an S8 safe or approved store a stock check should be carried out at intervals of not more than one month.

Regulated places such as community pharmacies, hospitals, and RACFs need to have a substance management plan. If a substance management plan applies to a place at which the S8 safe or approved store is located, the reconciliation must be done at the times stated in the substance management plan (which may be more than once a month). Refer to Medicines and Poisons (Medicines) Regulation 2021.[3]

South Australia

In a health service facility, all drugs of dependence must be counted at the end of the shift. For the definition of a health service facility refer to the Controlled Substances (Poisons) Regulations 2011.[14]

Tasmania

A person must not make any entry in a narcotic substances register if the person knows the entry to be false or misleading. There is no requirement for balance checks of narcotic substances as the person making the entry in the register is declaring the balance to be true and correct at the time of the entry. A business unit may have their own standard operating procedures in respect to regular balance checks.

Victoria

The balance in the register true and accurate at all times. It is up to the service to risk-manage this requirement and institute a balance check interval that suits its service.

Western Australia

As a regulatory requirement, an inventory of Schedule 8 medicines must be completed at intervals of not more than one month for 'stock' medicines. Under Western Australian legislation,

a second check is not mandatory when a Schedule 8 inventory is being undertaken.

4.13.3. *Loss or theft of a Schedule 8 medicine*

Procedures following the loss or theft of a Schedule 8 medicine differ between the states and territories, as follows.

Australian Capital Territory

- For loss or suspected loss of a controlled medicine – notify the Chief Health Officer of the nature of the loss and how it occurred no later than 7 days after becoming aware of the loss.[19]
- For theft or suspected theft – notify a police officer and the Chief Health Officer in writing no later than 24 hours after becoming aware of the theft or suspected theft.[19]

New South Wales

- A person who is authorised to be in possession of drugs of addiction or prescribed restricted substance must immediately notify the Secretary if the person loses a drug of addiction or if a drug of addiction is stolen from the person.
- Notify the NSW Ministry of Health Pharmaceutical Service immediately using the on-line notification form.
- There are additional requirements for incidents in the NSW public health system. Each incident of the loss or theft of accountable medicines must be notified by the Director of Pharmacy, or the Director of Nursing where no pharmacist is employed.

Northern Territory

- For loss or suspected loss of a controlled medicine – notify the Chief Health Officer of the nature of the loss and how it occurred no later than 7 days after becoming aware of the loss.

Queensland

- Refer to Queensland Health Position statement s226MPMR - Reporting lost or stolen medicine.[22]

South Australia

- In the case of a suspected theft, a report should be made to the South Australian Police and Controlled Substances Licensing, Department for Health and Wellbeing.
- In the case of unaccounted loss, a report should be made to Controlled Substances Licensing. A report to the South Australian police may also be required. Refer to Theft and loss of medications from health facilities and licence or permit holders.

Tasmania

- The health professional who discovers the loss must inform another health professional as soon as practicable.
- Both health professionals must enter the details of the loss in the narcotic substances register and sign that entry, as soon as practicable.
- The health professional who discovered the loss must report the loss to the authorised officer as soon as practicable.
- In the event of theft of a narcotic substance, a local police officer and the Pharmaceutical Services Branch should also be informed.

Victoria

- Immediately inform the Department of Health, Health Regulator.
- Notify the local police.

Western Australia

- If at any time a health practitioner, or licence and permit holder, identifies that S4 or S8 medicines have been stolen from their practice or business, then the Department of Health must be notified as soon as practicable.

4.13.4. *Destruction of unusable Schedule 8 medicines*

Schedule 8 medicines that are stored at the service and have become unusable (for example, expired, damaged or no longer in use) should be destroyed in accordance with state and territory regulations.

More information for patients can be obtained through Storing and disposing of your palliative care medicine safely.

State and territory variations: Destruction of unusable Schedule 8 medicines

Queensland

Refer to Queensland Health Disposal and destruction of diversion-risk medicine waste Medicines and Poisons Act 2019 – Factsheet July 2022.[23]

Tasmania

A person who is licensed or authorised to be in possession of a narcotic substance must not wilfully destroy that narcotic substance or cause or permit the narcotic substance to be destroyed unless certain requirements are met under the regulations. A person who is authorised to be in possession of a narcotic substance who destroys, or works jointly with another authorised person to destroy a narcotic substance, must record the destruction in the drug register in accordance with regulation.[15]

Western Australia

Schedule 8 medicines can be destroyed only when they are no longer suitable for patient use because they are expired, contaminated, damaged or otherwise unfit for human or animal use.

Destruction of Schedule 8 medicines must be independently witnessed by another authorised person.

Each time a Schedule 8 medicine is destroyed, this action must be recorded in the approved transaction register, including the date, item and quantity destroyed and the reason for destruction.

4.13.5. *Loss of a drug register*

If the service's drug register is lost or destroyed:

- immediately report the fact and the circumstances of the loss in writing to the service director
- notify the relevant government authority of the loss along with any other interested parties, as per state or territory requirements
- make an inventory of all Schedule 8 medicines held in stock at the service and enter the particulars in a new drug register
- retain the new drug register at the service for a minimum of 2 years from the date of the last entry made in it, or as specified in state or territory legislation.

State and territory variations: Loss of a drug register

New South Wales

Immediately after a drug register is lost or destroyed, the person responsible for keeping the register:

(a) must give written notice to the Secretary of that fact and of the circumstances of the loss or destruction, and

(b) must make an accurate inventory of all drugs of addiction held at the premises concerned and enter, in a new drug register, the particulars of the drugs so held.

Northern Territory

Notify the Chief Health Officer no later than 7 days after becoming aware of the loss.

Tasmania

Records relating to Schedule 8 substances must be kept for not less than 2 years from the latest date.

Victoria

Report the circumstances surrounding lost or stolen records to the secretary of the service without delay.

Western Australia

Information on a register must be kept for at least 5 years from the date on which the information is recorded.

Appendix A: Key Terms and Definitions

Anticipatory prescribing – when medicines are prescribed and dispensed in preparation for a time when a person needs them. They are used to manage symptoms in the home with the goals of rapid relief and avoiding unplanned or unwarranted admission to a healthcare facility.

Authorised person – an individual who is approved or permitted through their employment conditions to carry out specific work-related activities or duties.

Authorised prescriber – a healthcare professional approved through their employment conditions to prescribe medicines.

Carer – a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation or caring as part of a training or education program.

Community service provider – a provider of a health and community care service in the community.

Complementary and alternative medicines (CAMs) – CAMs include herbal, vitamin and mineral products, nutritional supplements, homeopathic medicines, traditional Chinese medicines, Ayurvedic medicines, Australian Indigenous medicines, and some aromatherapy products regulated under the Therapeutic Goods Act 1989.

Cytotoxic medicine – a medicine that is toxic to cells.

Drug register – a register or administration book to record the receipt, administration and any other transaction of all Schedule 8 (S8) medicines, as required by state legislation/ local policy, that are stored at the service. Can be paper-based or electronic. Some states and facilities may require registers for restricted medicines other than S8s.

Dose administration aid (DAA) – a device where medicines are stored and divided into containers according to an administration period.

Electronic prescribing (e-prescribing) – prescriptions that are issued and dispensed in an electronic system, without the use of a paper-based document at any point.

Enrolled nurse (EN) – a person who provides nursing care under the direct or indirect supervision of a registered nurse. They have completed the prescribed education preparation and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. ENs are able to administer medicines if they have completed

medication administration education at some stage in their career. An EN can administer medicines unless they have a notation on their registration which advises that they have not completed medicines administration education.

Healthcare professional – a healthcare provider, trained as a health professional. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and others.

Health practitioner – a health professional who is registered with the Australian Health Practitioner Regulation Agency (ahpra).

Imprest stock – a store of stock medicines maintained at a pre-determined level for use in the facility or service, according to state or territory legislation and licensing arrangements. See also stock medicines.

Medical practitioner – a person who is registered under the Health Practitioner Regulation National Law Act to practise in the medical profession.

Medication order – direction to administer a medication as a written or electronic order by an authorised prescriber.

Medication record – a written history of orders for the administration of medicines to a patient.

Nurse practitioner – a registered nurse endorsed as a nurse practitioner by the Nursing and Midwifery Board of Australia (NMBA) under the Health Practitioner Regulation National Law Act.

Nurse practitioners practice at an advanced level, including the prescribing of medicines.

Palliative care – a person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life.

Patients' own medicine – medicines prescribed for and dispensed to a specific person. This includes Schedule 8 and Schedule 4 medicines.

Person responsible – can consent for treatment on behalf of the patient.

Poisons Standard – a legislative instrument that consists of decisions regarding the classification of medicines and poisons into schedules and controls such as packaging and labelling in Australia.

Prescriber – a health professional authorised to write prescriptions and medication orders and give directions (verbal or written) about the administration and supply of prescription-only medicines.

Schedule 4 medicines – also known as prescription-only medicines are 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 8 medicines – also referred to as drugs of dependence, are prescription-only medicines that have a recognised therapeutic need but also a higher potential for misuse, abuse and dependence. According to the Poisons Standard they require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

Scheduled medicine – a medicine that is scheduled under the national classification system (Poisons Standard) according to the level of regulatory control over the availability of the medicine required to protect public health and safety.

Standing order – treatment protocols, allowed by some states and territories, where a nurse or Aboriginal Health Practitioner may initiate treatment with a prescription-only medicine under the protocol, usually only for urgent or emergency care.

Stock medicine – a medicine used by a facility or service that has not been individually supplied for a specific patient. See also imprest stock.

Substitute decision-maker – people appointed or identified by law to make substitute decisions on behalf of a person whose decision-making capacity is impaired. Substitute decision-maker(s) have legal authority to make decisions about health, medical, residential and other personal matters (but not financial or legal decisions); the relevant legislation varies between jurisdictions (states and territories). More than one substitute decision-maker may be appointed.

Appendix B: State and Territory Medicines Regulations

For further information on the safe handling of medicines in each state or territory, see the regulations listed below:

Australian Capital Territory

Medicines, Poisons and Therapeutic Goods Act 2008

Medicines, Poisons and Therapeutic Goods Regulation 2008

New South Wales

Poisons and Therapeutic Goods Act 1966

Poisons and Therapeutic Goods Regulation 2008

Northern Territory

Medicines, Poisons and Therapeutic Goods Regulations 2014

Queensland

Medicines and Poisons Act 2019

Medicines and Poisons (Medicines) Regulation 2021

South Australia

Controlled Substances Act 1984

Controlled Substances (Poisons) Regulations 2011

Tasmania

Poisons Regulations 2018

Victoria

Drugs, Poisons and Controlled Substances Regulations 2017

Western Australia

Medicines and Poisons Act 2014

Medicines and Poisons Regulations 2016

Appendix C: Contact Details for State and Territory Regulators

Australian Capital Territory

Pharmaceutical Services

Health Protection Services

Tel: 02 5124 9208

Email: hps@act.gov.au

Website: ACT Health and Community Services Directorate - Pharmaceutical Services

New South Wales

Pharmaceutical Services

NSW Ministry of Health

Email: MOH-PharmaceuticalServices@health.nsw.gov.au

Website: NSW Ministry of Health - Pharmaceutical Services

Enquiry form: Pharmaceutical services - Pharmaceutical services enquiry form

Northern Territory

Medicines and Poisons Control

Department of Health

Tel: 08 8922 7341

Email: poisonscontrol@nt.gov.au

Website: Environmental health - Medicines and poisons control

Queensland

Medicines Approvals and Regulation Unit

Office of the Chief Medical Officer, Queensland Health

Email: MARU@health.qld.gov.au

Website: Legislation, standards and extended practice authorities

South Australia

Office of the Chief Pharmacist

Department for Health and Wellbeing

Tel: 08 8204 1944

Email: HealthOfficeoftheChiefPharmacist@sa.gov.au

Website: Controlled Substances Legislation

Controlled Substances Licensing, Public Health Services

Department for Health and Wellbeing

Tel: 08 8226 7100

Email: HealthControlledSubstances@sa.gov.au

Website: Controlled substances legislation

Drugs of Dependence

Drugs of Dependence Unit

Tel: 1300 652 584

Email: HealthDrugsofDependenceUnit@sa.gov.au

Website: Drugs of Dependence

Tasmania

Pharmaceutical Services Branch

Department of Health

Tel: 03 6166 0400

Website: Medicines and poisons regulation

Victoria

Department of Health

Health Regulator

Website: Victorian Government Health Information – Drugs and poisons regulation in Victoria

Enquiry form: MPR Enquiry Tab

Western Australia

Medicines and Poisons Regulation Branch

Public and Aboriginal Health Division

Department of Health, Western Australia

Tel: 08 9222 6883

Email: mprb@health.wa.gov.au

Website: Medicines and poisons regulation

Appendix D: Australian/New Zealand Standard 'User-Applied Labels' For Use On Syringes Containing Drugs Used During Anaesthesia[24]

Standard background colours for user-applied labels, for use on syringes containing the most common 'as required' medicines.

Drug classification	Examples	Colour
Antiemetics	Metoclopramide	**Salmon**
Anticholinergic agents	Atropine, hyoscine butylbromide	**Green**
Induction agents	Ketamine	**Yellow**
Major tranquillisers	Haloperidol, chlorpromazine	**Salmon**
Opioids	Morphine, fentanyl	**Blue**
Benzodiazepines	Midazolam, diazepam	**Orange**

Adapted from: Australian Commission on Safety and Quality in Health Care. National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines. Sydney: ACSQHC, 2015.[24]

Appendix E: Injectable Medicine Information to Prevent Product Degradation (per Australian Product Information)[25–37]

Drug	Storage	After preparation in syringe*
Clonazepam	Protect from light and store below 25 °C.	Stable for 24 hours after preparation.
Cyclizine	Protect from light and store below 25 °C.	Not available
Dexamethasone	Protect from light and store below 25 °C.	Stable for 24 hours after preparation when stored between 2–8°C
Fentanyl	Protect from light and store below 25 °C.	Not available
Glycopyrronium	Store below 25 degrees.	Not available
Haloperidol	Protect from light and store below 30 °C.	Not available
Hydromorphone	Protect from light and store below 30 °C.	Not available
Hyoscine butylbromide	Protect from light and store below 25 °C.	Not available
Ketamine	Protect from light and store below 25 °C.	Stable for 24 hours after preparation when stored between 2–8°C.
Metoclopramide	Protect from light and store below 25 °C.	Not available
Midazolam	Protect from light and store below 25 °C.	Stable for 24 hours after preparation when stored between 2–8°C
Morphine sulfate	Protect from light and store below 25 °C.	Not available
Octreotide	Stable for two weeks when stored at room temperature (30°C). Otherwise, protect from light and store between 2–8°C. Refrigerate; do not freeze.	Not available

*see section 4.5.4. *Pre-preparing injectable medicines* for additional information.

For subcutaneous infusion compatibility, refer to your organisation's policies and procedures.

Other available resources on this topic include:

- SA Pharmacy Medicines Information Service – Parenteral Compatibility/Stability
- Safer Care Victoria – Syringe Driver Compatibility Guidance document, February 2021

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