Table 2. Consensus-based standards for best practice in medication management

A. Routines for stock requisitions and receipt of medication

Round#	Statement	Median	IQR¤
R1	Only nurses/social educators should order and receive medications from pharmacies or prescriptions from medical centres	1	1
R1	It is important for the service to have a written agreement with pharmacies covering the labelling of products (e.g.: 'in the fridge', 'in the toxic substances cabinet')	1	0
R1	Agreements with pharmacies should also cover the pharmacy's responsibility for updating substitution lists and labelling generic products with the name of the original medication (e.g.: Metoprolol = Selo-Zok)	1	0
R1	Emergency supplies loaned from another department or another patient (in the community nursing service) should be reported as a deviation	1	1
R2	It is important to document and record reasons for urgent orders or orders without the signature of a doctor	1	0
R2	Emergency supplies loaned from another department or another patient (in the community nursing service) should be documented in the 'Loan of emergency supplies register'	1	0
R2	Urgent orders must be verified by a doctor within one week	1	1
R2	When ordering seldom-used and expensive medications, consideration should be given to package size and a pharmacist should be contacted*	Konstant*	
R3	Nursing homes should order medications based on a specific list of medications (financial and evidence-based selection of medications) for use in the service	2	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

B. Routines for storing medications

Round#	Statement	Median	IQR¤
R1	Packages containing medications with a short expiry date should be marked and used first	Constant*	
R1	All medications in the service (including those stored outside medical supply rooms) should be stored in line with the same standards (e.g.: temperature monitoring, restricted access)	1	1
R1	The private supply of medications in a patient's possession upon admission/when they first start using the service should not be placed in shared medical supply storerooms	1	1
R1	Quarterly routines for medical supply rooms should include checking medication expiry dates, cleaning shelves and discarding ceased medications	1	0
R1	Weekly routines for medical supply rooms should include temperature checks and cleaning of dosette boxes	1	1
R2	Medications should be stored separately when identical products have a different expiry date and batch number	1	1
R2	When storing medication in non-original packaging, the name and strength of the medication, the number of tablets/capsules, expiry date and batch number must be marked on the temporary packaging (zip-lock bag, plastic cup)	Constant*	
R2	Patient-bound medications in non-original packaging should be identifiable by the patient's name, dosage, doctor's name and date they were prescribed	Constant*	
R2	When sharing medical supply rooms with other services, each service should have an agreement that covers responsibility for adhering to routines for the rooms	Constant*	
R2	All medications in non-original packaging or whose primary packaging has been opened, should be visually inspected prior to being dispensed	1	0
R2	The private supply of medications in a patient's possession upon admission/when they first start using the service should be checked regularly for changes and ceased/expired medications should be forwarded for discarding	1	0
R3	Packaging for creams, ointments and liquid medications etc. must be marked with the opening date	1	0
R3	When using medications whose primary packaging was opened more than two months ago (creams, liquid medications etc.), the pharmacist should be contacted	2	1
R3	Ceased and/or unused patient-bound medications (e.g.: antibiotics, popular painkillers etc.) cannot be used as an 'emergency supply' in the community nursing service	1	1
R3	Each service must appoint at least two people to take responsibility for medical supply rooms and ordering medications	1	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

C. Routines for assembling, preparing and dispensing medications

Round#	Statement	Median	IQR¤
R1	IsThe assembling of dosette boxes should be documented on the relevant form	Constant*	
R1	Only nurses/social educators should assemble dosette boxes	1	1
R1	Where medications are transferred to a beaker, this should take place immediately prior to being dispensed	1	1
R2	Dosette boxes that have been checked should be physically separated in the medical supply room from those that have not been checked	1	0
R2	All dispensed medication should be documented (daily dose, weekly dosette box, multi-dose) with a signature on the relevant form	1	0
R2	Incompletely prepared dosette boxes (with some medications missing) should not be dispensed in the community nursing service	1	1
R3	Healthcare workers can dispense medications without conferring with a nurse/social educator if the process is specified and documented clearly and accurately in a personal procedure (e.g.: where a patient's temperature is over 39oC, give Paracetemol 1g)	1	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

D. Routines for cross-checks

Round#	Statement	Median	IQR¤
R1	All medications in dosette boxes must be cross-checked	Constant*	
R2	When transferring medications from the original packaging to a zip-lock bag or plastic cup, a cross-check should be made	1	1
R2	Incompletely prepared dosette boxes (with some medications missing) should not be cross-checked until all medications have been added	1	1
R3	It is important that personnel who administer medications other than those prepared in dosette boxes receive thorough training in cross-checks/self-cross-checks so that they can act appropriately and are aware of their responsibility	1	1
R3	Only nurses/social educators are permitted to check assembled dosette boxes	1	0
R3	When substituting medications, a cross-check should be made to ensure that the original medication has been substituted with the correct generic product	1	0

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

E. Routines for narcotics and Class B drugs

Round#	Statement	Median	IQR¤
R1	Quarterly accounts should be kept for the purchase and consumption of Class B drugs	1	1
R2	Routines for narcotics should include information about handling open vials/ampoules, discarding unused liquid narcotics etc.	1	0
R2	If only one nurse/social educator is on duty, narcotics being dispensed should be cross-checked at the earliest opportunity, e.g. the next day	1	0
R2	Private narcotics that, for example, the patient has in their possession upon admission (respite patients, short-term patients) should be entered on the dedicated narcotics form and stored in line with the routines for medicine supply rooms	1	1
R3	If only one nurse/social educator is on duty when narcotics are dispensed, a technical check (reading) can be carried out by healthcare workers who have been authorised to dispense medications	2	1
R3	When the dispensing of narcotics entails calculating doses/quantities, a cross-check must always be carried out by a nurse/social educator	1	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

F. Routines for handling sterile medications

Round#	Statement	Median	IQR¤
R3	Opened receptacles containing sterile medications should be marked with the date, time and signature	Constant*	
R3	The service should have accessible data showing the shelf life of sterile medications	1	0
R3	The service should adopt the use of an observation form for infusions	1	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

G. Documentation routines

Round#	Statement	Median	IQR¤
R1	If unused medications are returned in a dosette box (in the community nursing service or for temporary discharges from an institution), this should be documented in the relevant records, and the doctor informed of this	1	1
R1	Medication-related data should only be transferred to and from the patient's medical records and cross-checked by a nurse/nurses	1	1
R2	Only a nurse/social educator should be given verbal information about prescriptions/cessation/changes in relation to the patient's medication	1	0
R2	Verbal prescriptions/cessation/changes should be documented by a nurse/social educator in the patient's medical records and cross-checked by another nurse/social educator	1	1
R2	Verbal prescriptions/cessation/changes should be signed by the doctor in the patient's medical records within three days	1	0
R2	Services that use agency workers/temporary staff or students to work on record-keeping and/or medication management should establish signature lists showing which signatures or initials they use	1	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

H. Routines for transfers between service levels

Round#	Statement	Median	IQR¤
R2	Services and medical centres should communicate with each other and agree fixed meeting points for updating medication records	1	1
R3	Failure to cooperate and/or interact with the specialist health service and/or other service levels within the municipal health service should be reported as a deviation	Constant*	
R3	During arrival and transfer, it is the nurse's duty to check the case history against the patient's medication list	1	1

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

I. Auditing and monitoring medication-related routines

Round#	Statement	Median	IQR¤
R1	All medication-related procedures should be evaluated by a doctor, pharmacist or interdisciplinary team	2	1
R1	A doctor, pharmacist or interdisciplinary team should be the first choice for obtaining information on medication management	1	1
R1	Internal audits of medication-relation routines should conclude with an action plan	1	1
R2	The action plan should include a list of identified deviations and the necessary measures, responsibilities and deadlines for rectifying these	1	0
R2	Healthcare service managers should indicate who is responsible for introducing the measures proposed in the action plan	Constant*	
R2	The pharmaceutical advisor or interdisciplinary team should be sent a copy of the approved action plan	1	1
R3	The regulatory pharmacist submits an audit report no later than one month after conducting an audit	1	1
R3	The service must establish routines for medication reviews that meet the requirements of the Norwegian Directorate of Health	Constant*	

*Constant means that almost 100 per cent of the respondents agreed about a statement – a consensus was reached.
¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

J. Competence, training and training plans

Round#	Statement	Median	IQR¤
R1	The service should devise a training plan that enables permanent employees to maintain and develop competence in medication-related tasks	1	1
R1	The service should devise written routines for training and documenting the training of personnel who only work extra shifts	1	0
R2	The training of personnel with limited authority in medication management should include a foundation theory course followed by a written test	1	0
R2	Refresher courses for personnel with limited authority in medication management should be held every two years	1	0
R2	Medication management authorisation for personnel with limited authority in this area is renewed every two years	1	0
R3	The training of personnel with limited authority in medication management should also include practical training in medication management	1	0
R3	The service should offer both theory classes and practical training for employees with a need for special competence within, for example, cancer, diabetes, analgesia pumps, intravenous fluids etc.	Constant*	
R3	The training of personnel with limited authority in medication management should also include training in documenting patient responses, side effects and other observations when dispensing medication	1	1

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¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.

Table 2. Consensus-based standards for best practice in medication management, cont.

K. Transferring responsibility between service and service user in the community nursing service

Round#	Statement	Median	IQR¤
R2	Personnel should not assemble dosette boxes and/or dispense medication in the patient's home if this is not covered by an agreement	Constant*	
R2	The agreement with the patient/service user should specify that they or their family must report all medications and prescriptions they have received outside the institution/service	1	1
R2	The patient's ability to use medications appropriately should be evaluated on an annual basis	2	1
R3	At the start of the service provision (community nursing service), a nurse/social educator should assess the patient's cognitive and physical capacity for appropriate use of their medication	1	1
R3	The patient's ability to use their medication appropriately is evaluated and documented on an ongoing basis by a nurse/social educator	1	0
R3	Changes in the patient's ability to use their medication appropriately must be reported to their GP immediately	1	1

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¤ Interquartile range
#R1–R3 show the rounds in which a consensus was reached for the standard.