

Draft for consultation

Guidance to [draft] Regulation 149Q of the Drugs, Poisons and Controlled Substances Regulations 2017

Exemptions to legislative requirement for nurses to administer medication in Victoria's residential aged care

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Purpose

The purpose of this document is to provide guidance in relation to the [incoming] requirement that only nurses and registered health practitioners administer medication in Victorian residential aged care. This document is intended to be read in conjunction with:

- [Drugs, Poisons and Controlled Substances Amendment \(Medication Administration in Residential Aged Care\) Act 2025 \(Vic\)](https://www.legislation.vic.gov.au/bills/drugs-poisons-and-controlled-substances-amendment-medication-administration-residential-aged-care) <<https://www.legislation.vic.gov.au/bills/drugs-poisons-and-controlled-substances-amendment-medication-administration-residential-aged-care>> and
- [Exposure draft of the Drugs, Poisons and Controlled Substances Amendment \(Medication Administration in Residential Aged Care\) Regulations 2026](https://www.health.vic.gov.au/drugs-and-poisons/medication-administration-in-residential-aged-care#consultation-on-the-exposure-draft-of-the-regulations) <<https://www.health.vic.gov.au/drugs-and-poisons/medication-administration-in-residential-aged-care#consultation-on-the-exposure-draft-of-the-regulations>>.

Background

People living in residential aged care often have complex health needs and medications that require clinical skills when administering.

Medication administration is a core nursing responsibility and a critical aspect of safe, person-centred care. As the final checkpoint before medication is given, nurses are responsible for ensuring it is correctly prescribed and dispensed. This requires medical literacy, and physiological understanding and knowledge of how medications affect older people - skills nurses develop through their education.

From 1 July 2026, registered aged care providers in Victoria will be required to ensure only nurses¹ (or other registered health practitioners²) administer prescribed and dispensed drugs of dependence and Schedules 4, 8 and 9 medications to residents of their homes. The requirement is through amendments to the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)* (DPCSA).³

This new obligation builds on existing Victorian legislative requirements that a registered nurse manages the medication administration process and aims to reduce the risk of medicine-related problems in residential aged care.

The new requirement does not:

- Apply when the resident administers their own medication. Consistent with [national guiding principles for medication management in residential aged care](https://www.health.gov.au/resources/publications/guiding-principles-for-medication-management-in-residential-aged-care-facilities) <<https://www.health.gov.au/resources/publications/guiding-principles-for-medication-management-in-residential-aged-care-facilities>>, personal care workers and others can continue to assist or support a person to administer their own medication (for example, by taking the screw-cap lid off a container).
- Apply when a resident is not on site at a residential aged care home. This covers situations such as when a resident may be in the community such as on an outing, a medical appointment, or with family or friends. In these circumstances, the registered nurse responsible for managing medication

¹ Includes registered nurses, nurse practitioners, designated registered nurse prescribers, and enrolled nurses (ENs) without notation. ENs with notation are identified by having a notation on their registration that states “Does not hold a Board-approved qualification in administration of medicines” and therefore cannot administer medication via any route.

² Registered health practitioner is defined as a person registered under the Health Practitioner Regulation National Law to practice in a health profession within the meaning of that Law (other than as a student). This refers to Australian Health Practitioner Regulation Agency registered professionals (such as medical practitioners, pharmacists, and dentists)

³ On 9 September 2025 the Victorian Parliament passed the *Drugs, Poisons and Controlled Substances Amendment (Medication Administration in Residential Aged Care) Act 2025*. The Act amends Division 10A of Part II of the *Drugs, Poisons and Controlled Substances Act 1981*.

administration continues to delegate medication administration in line with relevant codes, standards and guidelines issued by the Nursing and Midwifery Board of Australia.

- Change registered health practitioners' existing authorisation under the DPCSA or the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations), to administer medication within their scope of practice (for example general practitioners, dentists, pharmacists, paramedic practitioners, and Aboriginal and/or Torres Strait Islander Health Practitioners)
- Apply to unscheduled and Schedules 2 and 3 medications
- Change requirements of the voluntary assisted dying legislation
- Direct how providers implement changes to models of care or utilise [Commonwealth Government mandated direct care minutes](https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/care-minutes) <<https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/care-minutes>>.

A registered provider does not contravene the new requirement if:

- a) the registered provider has a reasonable excuse;⁴ or
- b) a person other than a registered or enrolled nurse or registered health practitioner administers the drug or poison in **prescribed circumstances**.

Regulations

Regulations, to take effect 1 July 2026, [will] **prescribe circumstances** where the requirement that a nurse or other registered health practitioner administers prescribed and dispensed drugs of dependence and Schedules 4, 8 and 9 medications does not apply. These may also be referred to as **exemptions** from the requirement.

The [draft] Regulations ([proposed] in Chapter 3C - Administration in residential aged care homes, Regulation 149Q) prescribe that a person other than a nurse or registered health practitioner may administer a person's prescribed and dispensed medication if —

- a) there is an **unforeseen event** that **unexpectedly affects** the availability of nurses (or other available registered health practitioners⁵);

AND

- b) the registered nurse managing the medication administration **determines** that medication for an individual resident cannot wait and delegates to someone other than a nurse (or registered health practitioner) to administer the medication.

A. Unforeseen event

An unforeseen event considers the environment of delivering care in residential aged care and that there may be, from time to time, unplanned situations that unexpectedly impacts nursing availability. The definition is given in [draft] Regulation 149.

⁴ 'Reasonable excuse' is a common defence featured in legislation which allows the accused to provide evidence of the reasonableness of their actions in the circumstances, to an objective standard. The prosecution must then prove to a criminal standard that their excuse is not reasonable.

⁵ Whilst the Drugs, Poisons and Controlled Substances Act 1981 enable an authorised registered health practitioner to administer medication, in practice, nursing staff are likely to be the only appropriate specified persons available to administer the drug or poison to a resident.

Illustrative examples of circumstances that could impact nursing availability to administer medication could include:

- A resident emergency that involves multiple nurses (such as stroke, cardiac event or other event such as an episode of acute psychosis)
- Emergencies such as flood, fire, or evacuation
- A critical scenario that requires senior staff including nurses' attention that cannot be delegated (such as serious concerns/complaints that require immediate action)
- Situations where there are unplanned, significant and temporary staff shortages – such as sudden staff illness or environmental factors that prevent nurses attending work (such as flood) and where there may be a short period within a shift before additional nurses can arrive.

These illustrative examples are not exemptions in their own right – exemptions need to consider the context and the reasonable availability of nurses.

Unforeseen events do not include routine or foreseeable rostering gaps, ongoing vacancies or foreseeable shortages that a provider can reasonably plan to ensure for sufficient workforce availability. Reasonable steps could include:

- Staff rosters that have some flexibility to respond to minor or foreseeable events
- Arranging replacement staff when a provider becomes aware of a staff leave (for example nurses on sick leave)

Exemptions are not intended to cover:

- Routine rostering gaps or 'known' nurse vacancies
- Avoidable inadequate rostering
- Ongoing workforce shortages or business-as-usual operating models
- Circumstances the provider could have reasonably planned for or mitigated.

The intention is that the exemptions is to be used only in limited, time-bound situations to prevent harm to a resident and to encourage homes to comply with the obligation as standard practice.

B. Determining medication is to be administered without delay by someone other than a nurse

Section 36E of Division 10A of Part II of the DPCSA requires a registered provider to ensure that a registered nurse *manages* the administration of drugs of dependence and Schedules 4, 8 and 9 medications.

Determining when medication is to be administered without delay

Should an unforeseen event occur that unexpectedly affects the availability of nurses, the registered nurse managing the medication administration must **determine** if there is risk of harm to a resident if that resident waits for a nurse (or other available registered health practitioner) to be available to administer their medication. This could be because the medication is time sensitive (i.e. parkinsonian medication) or other circumstances that may negatively impact a resident's health and wellbeing.

This is a clinical decision that considers the individual care needs of a resident. For example, if there is risk of harm to one resident from delayed medication, the registered nurse may delegate administration to someone who is not a nurse (for example a personal care worker). The exemption does not apply if there is not a risk to the individual resident if medication is administered later than scheduled.

Delegating the medication administration

The registered nurse delegating medication administration to someone other than a nurse (or registered health practitioner) in prescribed circumstances must consider codes, standards and guidelines issued by the Nursing and Midwifery Board of Australia, including the [decision-making framework](https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx) <<https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx>>.

The decision-making framework considers the complexity of the patient (or resident) and their medication needs, and the competency and skills of the individual to whom the responsibility of administering the medication is being delegated.

In these prescribed circumstances, the managing registered nurse can delegate the medication administration to a personal care worker (or equivalent) or an informal carer such as a family member.

The decision to delegate remains a clinical judgement of the registered nurse. There are protections in the Health Practitioner Regulation National Law to prevent a provider directing a nurse to act against their professional judgement.

Recording exemptions

[It is proposed that] following an unforeseen event that resulted in medication being administered by someone who is not a nurse (or registered health practitioner), the registered nurse managing the medication administration is to document:

- The date of the unforeseen event
- A brief description of the unforeseen event
- The period of time during which medication needed to be administered to a resident(s) by someone other than a nurse or registered health practitioner.

The records do not need to be exhaustive, rather factual of the situation.

Illustrative example of documentation:

On the morning of [date] there was a cardiac event that required all available nurses on shift at [location] to attend. Between [start time and end time], medication needed to be administered to resident A and B without delay.

On [date], floods affected staff attending work resulted in no available nurses from [start time] to [end time] at the [location]. During this time medication needed to be administered without delay to identified residents where delay would pose a risk of harm, and I delegated person A to administer medication to all residents on X ward.

Providers may wish to ensure additional information is included for internal purposes (such as who administered the medication). While this information is not essential in the context of documenting the unforeseen event/exemption, as a separate requirement under existing Regulations 107(d) and 108(1)(l), the name of the person that administered any Schedule 4, 8 or 9 medication must be recorded.

The [proposed] Regulations do not specify the method or form of the documentation or record keeping – providers can leverage existing processes should these be suitable. For example, the RN may record the event which may be filed through an existing administrative process. Or documentation could be centralised electronically through medication management system or spreadsheet, or physical record for example in a workbook.

The records must be provided upon request to the Health Regulator.

Documentation must be kept for a minimum of three years after the unplanned event occurs.

Other considerations

Aboriginal and/or Torres Strait Islander Health Practitioners

Regulations enable registered Aboriginal and/or Torres Strait Islander Health Practitioners (ATSIHPs) to administer Schedules 2, 3, 4 and 8 medications. This authorisation is not impacted and ATSIHPs, as registered health practitioners, can continue to administer medication within their scope of their practice.

Drugs of dependence and Schedules 4, 8 and 9 medications

Schedules 4, 8 and 9 medications are categorised in accordance with the Therapeutic Goods Administration's [Standard for the Uniform Scheduling of Medicines and Poisons \(SUSMP\)](#)

<<https://www.tga.gov.au/products/regulations-all-products/legislation-and-legislative-instruments/poisons-standard-susmp>>

Schedule 4 medications are prescription-only, for example antibiotics, local anaesthetics, and strong analgesics (for example, Panadeine Forte®).

Schedule 8 medications are those that have a higher risk for abuse, misuse and physical or psychological dependence (for example oxycodone (OxyContin® or Endone®), morphine (for example, MS-Contin®) and some benzodiazepines (for example flunitrazepam or alprazolam).

Schedule 9 medications are prohibited substances and may include medication used in clinical trials.

Drugs of dependence are listed in the Drugs, Poisons and Controlled Substances Act 1981 and have a higher potential for dependence – they include all medicines in Schedules 8 and 9 and some from Schedules 4 (such as benzodiazepines). Drugs of dependence should be treated with a higher degree of caution.

To receive this document in another format, phone 1300 650 172, using the National Relay Service 13 36 77 if required, or email Vic_AgedCare@health.vic.gov.au.

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

Available at [Medication administration in residential aged care](https://www.health.vic.gov.au/drugs-and-poisons/medication-administration-in-residential-aged-care#consultation-on-the-exposure-draft-of-the-regulations) <<https://www.health.vic.gov.au/drugs-and-poisons/medication-administration-in-residential-aged-care#consultation-on-the-exposure-draft-of-the-regulations>>