I. Purpose
To establish a standardized process for the preparation, administration and documentation of medication to assure that “best practice” and appropriate safety measures are followed.

II. Scope
Nursing

III. Policy
1. Only certified/licensed persons will administer medications and treatments with medications.
2. Staff members are not to give medications for which information is not available or from containers that are not clearly or appropriately labeled.
3. QMAs practice under the supervision of a licensed nurse and have a copy of their QMA certificate on file in the Staff Development department.
4. The QMA is responsible to inform the nurse of Injectable Medications to be given that shift/day.
5. The QMA will notify the nurse of medication refusals and abnormal reactions to medications.
6. Only a licensed nurse may administer medications ordered as debriding agents, injectables, nebulizer treatments or medications via G-tube/J-tube and treatments for any burn greater than a first degree or ulcer higher than a stage I.
7. All medications administered are documented in the electronic medication administration record (eMAR).
8. Medications are NOT to be set up in advance of the med administration time, and should be given at the time of dispensing from the automatic dispensing cabinets. The only exception is for patients whose meds need to be crushed or put in applesauce or pudding; these meds can be set up in labeled cups at the beginning of the med pass time in order to have them dissolved and ready for administration during the med pass. Labeling should include the patients first and last name, the date and time the meds are ordered and the name and title of the person who prepared the medication(s).
9. Annual QMA Practicums will be done by a nurse to assess competency of QMAs.
10. Administer all medication on time. A deviation of 60 minutes before or 2 hours after designated time is permitted unless otherwise indicated. i.e. insulin, etc. Mealtime and HS medications are to be administered according to the mealtimes and bedtimes for each unit, regardless of the time listed by electronic medication record for the medication.
11. QMA’s are to be assigned to administer medications at least once every month by the unit RN.
12. QMA’s are not to administer a PRN medication without the consent of a nurse and must document the name of the nurse who gave them permission.
13. When a nurse gives permission to a QMA to administer a PRN, that nurse is the responsible person for performing any required assessments and documenting them.

Equipment:
1. Black ink pen
2. Automatic dispensing cabinet (ADT)
3. Computer providing the electronic medication administration record
4. Medication cups

Related Policies and Procedures
210.04 Nursing Protocol for Clozaril; 530.01 Care of the Diabetic Patient 220.03 Subcutaneous, Intradermal, Intramuscular Injections; 220.08 Inspirease Drug Delivery System; 230.07 Medication & Treatment Record; 120.04 Documentation; 220.02 Medication Brought Into Hospital from outside source; 220.11 Medications Error Reporting (see RSH Drug Formulary tab A-180; Policy for Medication Orders (RSH Drug Formulary Tab A-7); Policy for Controlled Substances (RSH Drug Formulary C-2); Self Administered Treatments, Tests, and/or Medication (RSH Drug Formulary A-7)
5. Water  
6. Oral dispensers  
7. Pill splitter/pill crusher  
8. Blunt tip scissors  
9. Checklist for annual QMA Practicum  
10. Hand Sanitizer

**MAJOR STEPS**

1. **Wash your hands!**
   - Use aseptic technique throughout preparation and administration of medications.  
   - Do not touch medication directly.  
   - Do not touch the inside of medicine cups.  
   - It is permitted to wear gloves during the preparation of medications.

2. **Check supplies needed in the medication administration area**
   - Make sure the medication administration area is stocked and organized with the items listed in the Equipment Section on the first page of this policy.  
   - Keep internal and external drugs separate in appropriately labeled bins in the patient-specific med cabinet.  
   - Ensure there are adequate med cups for the liquids being given.  
   - Check for drugs with special directions:  
     1. Check for meds that require patient monitoring (vital signs, glucose) prior to administration.  
     2. Sulfur Drugs: encourage fluids.  
     3. Beta-Blockers/Blood pressure meds; Check blood pressure as ordered by physician.  
     4. Concentrates; dilute with at least 2 ounces of water. Do not give medications with juice due to negative interaction. Do not mix concentrates.  
     5. Cough syrup: Do not dilute with water, or follow with drink of water.  
     6. Drugs delivered by oral inhalation methods should be followed by rinsing out the mouth water followed by spitting the water out.

3. **Med Room preparation**
   - Medications are generally to be administered from the med room, but can be taken to the patient if necessary. For those rooms with dutch doors, the bottom of the door is to be closed to prevent patient entry into the room.  
   - In order to keep the area as free from distraction and noise as possible, no one except the QMA/nurse passing medications is allowed in the med room during a med pass.  
   - One attendant who is familiar with the patients is to assist the QMA/nurse during the med pass. The assisting attendant will escort each patient to the med room for medication at the request of the QMA/Nurse passing medication. The assisting attendant should be familiar with the patients and will act as the second identifier of the patient when needed.

4. **Locate the patient’s chart in the eMAR**
   - Open the patient’s chart in the eMAR (Reliable system).  
   - Make sure that the eMAR is open to the correct date and shift.  
   - The Reliable system patient medication list is considered the “correct” medication list to use to determine what medications are to be administered at any given time.

5. **Locate the patient’s medication profile in the ADT and select meds to be dispensed.**
   - Open the patient’s medication profile on the ADT screen.  
   - Using the eMAR list of meds due to be given, start at the top of that list and look for that med on the ADT screen.  
   - If the medication shown on the ADT screen matches the EMR list, touch the medication listed in the ADT to “highlight” the drug to be given.  
   - Continue “highlighting” the medications on the ADT screen until all are selected that are to be administered to the patient during the current med administration.

6. **Dispense the medication from the ADT**
   - When all of the medications have been selected in the ADT computer, touch “Dispense” to begin the ADT dispensing function.  
   - As each drawer opens, remove the medication from the compartment indicated on the ADT screen. Doses of controlled or high risk medications will dispense
from the single dose dispensing unit and will drop into the tray. The ADT will unlock the refrigerator or the patient-specific med cabinet to dispense from those units. **DO NOT CLOSE THE DRAWER, CABINET OR REFRIGERATOR UNTIL AFTER THE MEDICATION IS SCANNED OR VERIFIED ON THE ADT COMPUTER SCREEN.**

6c. As each medication is dispensed from the ADT, the refrigerator, or the cabinet, the nurse/QMA will scan the bar code on that medication. If more than one unit of medication is dispensed for a prescribed dose, each item should be scanned separately to assure that the proper number of units was dispensed from the ADT to match the dose ordered by the physician. **Observe the six rights: Right Medication, Right Patient, Right Dose, Right Route, Right Time, Right Documentation.**

6d. If the medication does not have a bar code or will not scan, use the manual verification. Visually compare the package information on the medication dispensed with the medication listed on the eMAR screen and touch the verify button on the screen when the correct medication and number of units have been obtained from the cart.

6e. Once the medication has been scanned or verified, close the drawer, cabinet or refrigerator. The drawer will open for the next medication to be dispensed from patient’s highlighted list. Set the previous med aside, and obtain the next med from the cart. Follow this process until all medications selected on the screen have dispensed.

7. **If the med in eMAR does not display on the ADT screen or is not the same**

7a. Check to see in the eMAR system if the med has been verified by pharmacy.

7b. Check to see if the correct date and the current administration time is displayed in the eMAR.

7c. If the med has been verified by pharmacy and the correct date and time are displayed in the eMAR system, close the patient profile in the ADT computer and get back into the profile again.

7d. If the medication still does not display in the ADT computer, and pharmacy is currently open, notify pharmacy of the issue.

7e. If the pharmacy is closed, override the ADT system to obtain the needed med from the cart (see instructions in the med room).

8. **Administering Medications**

8a. Only the person preparing the medications may give them.

8b. **AFTER CHECKING MEDICATION 3 TIMES AGAINST MED INFORMATION IN THE eMAR, IDENTIFY THE PATIENT USING TWO (2) IDENTIFIERS. THEN ADMINISTER THE DOSE(S).**

   (1) Give medication only if you can positively identify the patient using at least two identifiers. Use the photo in the patient’s chart in the eMAR, and another identifier from the patient’s demographics (birth date), or another staff person who knows the patient can identify the patient.

   (2) Hand the medication directly to the patient or place in the patient’s mouth.

   (3) Pour water into the medicine cup. Offer as much water as is necessary. **Watch the patient take the medicine.**

   (4) Check to see if the patient actually swallows the medication. Talk with them, examine mouth if any doubt remains.

   (5) Never leave medications with the patient to be taken later.

8c. **Any error in giving medication MUST be reported immediately.** Report to unit nurse who initiates the Medication Error Report SF42296, and notifies the physician.

8d. QMA/Nurse who gave the medications, documents that the medication is given using **The Empty Medicine Packets.** The QMA/Nurse administering meds documents in the patient’s eMAR by clicking on the “Given” button for each medication given. The QMA/Nurse must complete any associated documentation with each medication ie. vital signs, glucose readings, etc. The QMA must notify the nurse of any documentation that is requested in the eMAR that only a nurse can complete.

8e. **The Nurse/QMA should become familiar with the action, average dose, and side effects of the drugs being administered.** Check the eMAR medication
9. Medications or treatments not given.

9a. When Medications/Treatments ordered are not given for any reason, notify your RN.

9b. For each medication not given, document in the eMAR by clicking on the “Not Given” button for that medication. Select the appropriate reason for the omission in the drop down menu.

9c. The attending or OD physician is notified of the omission, via the doctor’s book or phone call, depending on the nature of the omission or medication.

10. Destroying or wasting medication

10a. When a pre-filled syringe contains more than the prescribed dose, and no other option is available, you may destroy the excess in the following way:
   1) The excess medication is expelled into the biohazard container in the med room.
   2) If the medication is a controlled medication, disposal of the excess medication must be witnessed through the ADT computer.

10b. When a tablet must be split, and no other option is available, you may destroy the excess portion of the medication by:
   1) Placing the unused portion in the biohazard container in the med room and recording the waste in the ADT system.
   2) If the medication is a controlled medication, disposal of the excess medication must be witnessed and must be recorded in the ADT system.

11. ½ Tablets (Non-controlled substance)

11a. Pharmacy dispenses ½ tablets as such when possible.

11b. If patient requires ½ tablet & Pharmacy dispenses as a whole tablet, the QMA/nurse will split the tablet and destroy the unused portion by placing it in the biohazard container in the med room, and recording the waste in the ADT.

12. Recording Medications

12a. DOCUMENT ADMINISTRATION OF MEDICATIONS IN THE eMAR IMMEDIATELY AFTER EACH PATIENT’S MEDICINE HAS BEEN GIVEN.

12b. Before leaving the patient’s eMAR, check none of the patient’s meds listed for the current med pass time are still showing to be administered.

13. PRN Medications

13a. Only Licensed Nurses may administer the following PRN meds:
   (1) Injectables
   (2) Medications by G-Tube/J-tube

13b. Ordered laxatives may be given without prior approval of nurse.

13c. To administer a PRN medication, open the patient's eMAR in the Reliable system and click on the red “PRN” button. Click on the “Administer” or “->” button to move the PRN med to the eMAR.

13d. Document any monitoring required for the medication (ie. pain scale, temp, etc.).

13e. Follow the same administration process as for routine meds.

13g. All PRN’s are to be documented by a nurse in the progress notes with documentation of a follow-up within 2 hrs.

13h. PRN Medications given for pain must have value on the pain scale documented when given and in the follow-up.

14. Crushing Medications

14a. Determine if medication can be crushed. Consult Nurse, eMAR, or Pharmacy if there is any doubt. Do not crush if enteric coated, or if there is CR, SR, or ER after the name of the medicine. Crushing slow release medications alters the absorption.

14b. Use pill crusher.

14c. Place crushed medicine in cup. Do not add to food or liquid until ready to give to the patient. Only add food or liquid after approval of nurse or with Doctor’s order.

14d. Pill crushers should be cleaned with alcohol wipe and allowed to dry after each use. Plier type crushers used to crush meds inside their unit dose package prior to opening may be cleaned with alcohol wipe as needed.
15. Liquid Medications
15a. Shake all suspensions well.
15b. Use clear plastic medication cups for liquids.
15c. Pour liquids from the opposite side of the bottles label to avoid soiling it.
15d. Wipe the top and sides of container with damp cloth/paper towel.
15e. Do not mix liquids in same cup.
15f. Dispose of refused liquids by pouring into a biohazard container. IT IS REQUIRED THAT A WITNESS IS PRESENT WHEN LIQUID CONTROLLED SUBSTANCES ARE DISPOSED, AND THAT WITNESS DOCUMENTS APPROPRIATELY (see above).
15g. Dilute liquids with 2 ounces of water before giving to patient, unless contraindicated. (i.e. cough meds, etc.)

16. High Risk Medications
16a. High Risk medications require special precautions to insure patient safety:
   (1) Insulin order, dose and units in the syringe must be verified by a second nurse prior to administration.
   (2) Nurse must be alert when administering Warfarin that special assessments are completed according to nursing care plan and that labs are completed as ordered by physician. Dose of Warfarin is dependent on INR value (see policy #220.14).
   (3) When administering Clozaril, physician must be notified of any omitted or refused doses. Labs must be drawn according to protocol for Clozaril and physician notified of results per policy #210.04.

17. STAT Orders
17a. QMAs may give STAT medications that are allowed to be given by the QMA as PRNS.
17b. The RN must be notified before giving STAT meds.

18. Give First Dose When Available.
18. When medication is prescribed and is unavailable from the pharmacy for same day administration, the physician’s order should be entered in the eMAR for a specific start date and time as to when the medicine does become available. Pharmacy notifies unit when medication is available. If the medication will not be available for over 24 hrs. notify the physician.

19. Transdermal Patches
19a. Wear gloves to remove previous patch.
19b. Date, time and initial the front of the patch before applying. This will help insure proper dosing schedule.
19c. To reduce skin irritation, select a new location/site.
19d. Peel off the backing and carefully apply to clean, dry, non-hairy site on the patient’s skin.
19e. On removal of patch, fold it in half and place it in the biohazard container in the med room. For patches containing controlled substances, the disposal MUST be witnessed by a licensed nurse. For accidental exposure; rinse with copious amounts of water; Do Not use soap.

20. Water/Juice Pitchers
20. Each unit will have two sets of water/juice pitchers. Night shift will exchange pitcher sets on Sunday, leaving used set for day shift to return to dining room in am. Day Shift will bring new set of pitchers back to unit and place in designated area in med room.

Medication Monitoring

1. New Medication monitoring and documentation
1a. Patient’s response to first dose of new medications (routine and PRN) will be monitored and documented by a nurse in the progress notes each shift for 24 hrs. (See page 6 of 7 for definition/criteria for a “new medication” designation.)
1b. When a new medication is verified by the nurse, the nurse is responsible for noting the new order on the shift report form.
1c. Patient education about new medication should be completed and charted by a licensed nurse in the progress notes.
1d. The nurse who gives the first dose of a new medication will follow up with the patient in one hour to assess patient response and complete the first
entry in the progress notes. If a QMA administers the first dose of a new med, they are to report it to the nurse as soon as possible after the medication is administered so that the nurse will know to assess the patient in one hour and document on the patients response in the progress note.

1e. Monitoring and documentation for the new medication will continue for 24 hours.
1f. Compliance will be audited quarterly for new med response documentation.

2. Medication Errors

2a. All errors reaching the patient require immediate assessment by an RN & reporting to the physician and nursing supervisor. (See Policy 220.11)
2b. Monthly monitor of errors is done by Med Process Group.
2c. Quarterly med error reports are monitored by the Pharmacy and Therapeutics Committee and the Safety Committee.

3. PRN Meds to treat behavior

3. Audited Quarterly.

4. PRN Meds to treat pain


New Medication Criteria

Per Nursing Policy #220.01:
- Patient’s response to the first dose of a new medication (routine and PRN) should be assessed and charted within one hour of administration by a nurse.
- Patient’s response to a new medication should be monitored and documented every shift for the first 24 hours of administration by a nurse.

The purpose of the new medication monitoring and charting is to detect and document any adverse reactions or allergic reactions to the medication.

Criteria for New Medication designation that requires monitoring and documentation:
- A new order for a medication the patient is not currently taking (the new order is not just a dosing or route change).
- Every antibiotic must be considered as a new medication (no matter how many times in the past the patient has taken the medication) unless the patient has taken the antibiotic for at least 24 hours prior to being admitted or re-admitted to our hospital.
- A medication the patient has not taken previously in the past year.
- The new medication being ordered is not just a different formulation of a med the patient is already taking or has taken in the past year (ie. Clozaril vs. Fozaclo or Depakote vs. Depakote ER).

Special considerations:
- PPD tests are not considered a New Medication.
- The first dose of Hepatitis B vaccination is considered a new medication. The Second and Third doses in the Hep B series are not considered new medications.

Reminder: If an adverse reaction or allergic reaction does occur with the initial dose(s) of a new medication, the nurse must initiate an adverse reaction form.