Subject: Medication Verification and Administration

Purpose: To ensure accuracy and safety of medication provisions to patients by use of systemic processes and techniques.

Policy: All medication administration will utilize the “medication verification” process.

- Patient identification accuracy as defined by Administrative Policy #145 “Patient Identification.”
- Licensed staff will administer medications to hospital patients follow demonstration of competency in the knowledge and process of medication administration.
- Medication Administration will utilize the Medication Verification System (Bedside Barcode Scanning). If bedside medication verification is not available for any reason, two patient identifiers in conjunction with the patient identification band will be used.
- Medications must be ordered by a physician or as an approved nursing judgment order and per pharmacy protocol.
- Staff will consistently use the ‘5 Rights’ of medication administration using two methods of patient identification.
- High risk medications will only be administered with special considerations: ie: 2 licensed coworkers will verify accuracy of high risk medications.
- Medications will be administered per prescribed timeframes unless there is a valid clinical reason for the deviation supported with clinical documentation. Medications are determined to fall into one of 3 categories: time-critical medications, non-time-critical medications, or medications not eligible.
  - **Time-Critical medications** must be administered within 30 minutes before or after the scheduled dosing time.
    - Antibiotics
    - Anticoagulants
    - Insulin
    - Anticonvulsants
    - Immunosuppressive Agents
    - Pain Medication (Non-IV)
    - Medications prescribed for administration within a specified period of time of the medication order
- Medications that must be administered apart from other medications for optimal therapeutic effect
- Medications prescribed more frequently than every 4 hours

  o **Non-Time-Critical medications:**
    - Scheduled meds which are included in this category have a frequency of BID up to every 4 hours. These medications must be administered within 60 minutes before or after the scheduled dosing time.
    - Scheduled meds which are included in this category have frequency of every 24 hours or greater. These medications must be administered within 120 minutes before or after the scheduled dosing time.

  o Medications deemed **not eligible**, meaning they require exact or precise timing of administration are:
    - STAT doses (immediate)
    - First time or loading doses
    - One-time doses, doses time for procedures (ie: antibiotic on-call to surgery),
    - Time-sequenced doses: Doses timed for serum drug levels, i.e. Vancomycin and Gentamycin when Peak and Trough levels are ordered.
    - Investigational drugs
    - PRN doses.
    - STAT orders are used only for life threatening/critical situations. STAT generally means within 5 minutes or, if not possible in that timeframe, in the shortest amount of time possible.
    - Now orders= not an emergency, but typically 30-60 minutes.

- Adverse drug reactions will be treated, monitored, and appropriate documentation completed.
- Failure to comply with this policy shall be considered a “Type A Offense”, dependent upon the circumstances leading to the breach of policy, and may result in a suspension or termination on the first occurrence, as determined by the executive.
- **Exceptions to Medication Verification**
  - STAT drugs not yet entered onto the MAR
  - Crisis Code situations
  - Contact and Airborne Isolation (only if it is not possible to leave a mobile cart in the room).

**Additional Information:**

1. Responsibilities Regarding Administration of Medication:
a. Before administration, clinicians must be familiar with commonly accepted doses, routes of administration, indications and actions, adverse reactions and contraindications of each medication given.
b. The nurse organizing and preparing the medication is responsible for administration.
c. Medication orders must be verified prior to administration.
d. Medications should never be administered from memory or verbal communication without checking the patient’s MAR or the Physicians’ Orders in the electronic medical record.
e. Patient safety is always the first consideration of medication administration.
f. Particular attention should be given to prevent administration of any medication for which the patient has a documented sensitivity or allergy.
g. If bedside medication verification is not available for any reason, two (2) patient identifiers in conjunction with the patient ID band will be used.

2. Activities Prior to Administration of a Medication:
   a. Read the patient’s MAR carefully, noting the name of the patient, two identifiers of the patient (the room number will not be used), the medication, dosage, and route of administration, or any comments added by the ordering physician or pharmacist.
   b. READ THE MEDICATION LABEL THREE DIFFERENT TIMES during the administration process (for example: 1-when first obtaining the medication, 2-when comparing the medication to the MAR, 3-just before administration of the medication). Always use the following criteria for medication administration:
      i. Right medication
      ii. Right dosage
      iii. Right patient
      iv. Right time
      v. Right route
   c. Check for non-recurring medication, ie: pre-operative, one-time, now, STAT, or other special scheduled doses.
   d. Recheck the MAR for previously delayed or omitted doses.

3. Medications Scheduled but not Administered
   a. To document these occasions, use “Not Given” drop down and select reason.
   b. Occasions may include:
      i. Patient refuses medication
      ii. Dose Omitted
      iii. Withholding medication
      iv. Adverse medication reaction suspected- withhold medication until the physician can be contacted for instructions.
   c. “Nothing by mouth” (NPO) orders (e.g. for surgery, test, etc.)- do not administer oral medication unless there is a physician order to do so. Seek
clarification from the provider as to whether they want certain medication to be continued, even though a general NPO order has been written, due to the nature of the specific medication therapy (e.g. digoxin, anticonvulsants, steroids, hypoglycemic, antibiotics and Beta Blockers) or given by a different route.

d. Patient vomits after medication is administered- attempt to identify the medication. Contact the physician to determine if the dose is to be repeated. Make proper notations in the patient’s records.

e. Medication therapy delayed- due to test, etc. and is later resumed- rearrange the hours of administration only if clinical judgment determines it necessary, (see Half-Time Guidelines, Policy 3.07 Pharmacy), or contact the Pharmacist for help for this circumstance.

4. Electronic Medication Record (MAR)

a. Verification of Medication Orders- all orders entered on a designated shift should be verified on that shift.

b. During Pharmacy hours, Pharmacy personnel are responsible for processing medication orders on the electronic MAR.

c. After Pharmacy hours, remote pharmacy is responsible for processing medication orders on the electronic MAR.

d. Any orders entered through Pharmacy during regular Pharmacy hours shall require a license nurse to verify.

e. Correction of medication orders- if an error is discovered, nurse should notify Pharmacy, or remote pharmacy, to make the appropriate correction.

5. Administration Process

a. Medication Administration Technique

   i. Check the MAR for medications that are to be administered to the patient.

   ii. Obtain the medications (i.e. from the Pyxis, nurse server, etc.)

   iii. Take the mobile computer and the unopened medications into the patient’s room.

   1. Isolation

      a. If the patient is in droplet, the mobile can be taken in the room.

      b. If the patient is in Contact or Airborne Isolation, med verify can be used. The mobile cart is taken in and left in the room, and is removed during terminal cleaning.

   iv. Scan the patient’s name bracelet. Check the screen to make sure it is the correct patient. If not, scan the patient’s bracelet again.

   v. Ask the patient for the 2 patient identifiers, name and date of birth are on the screen.

   vi. Scan each medication. Confirm.

      1. If the medication is being given before or after the appropriate allowed timeframe of when the medication was due, a screen
will appear giving you the option to clarify the reason for time discrepancy.

2. Choose a reason for being late or early or create a note.
3. Give the dose shown on the screen, or change the number to make it the correct dose as ordered by the physician.
4. READ and follow the screen prompts for each medication. You can put a comment in a note.
   a. PRN medications will require a reason to be filled in and the dosage. Fill in the reason and continue with medication administration.
5. When you are done scanning all the medications for the patient, administer the medication.
6. To document administration, click chart.

b. High Alert/High Risk Medications
   i. These are medications that are considered high alert because of the increased risk of a medication error, or the significant impact on patient safety.
   ii. These medications may have restricted access to prevent errors (Potassium Chloride vials and NaCl concentrations of greater than 0.9% are stored only in the pharmacy). Other concentrated electrolytes have restricted access to prevent errors by limiting over-ride access to Directors, Supervisors and the ER.
   iii. These medications, by policy, require a double check by another practitioner (another nurse) prior to administration
      1. Insulin (double check-nursing)
      2. Warfarin (extra caution and/or check labs)
      3. Heparin IV injections and infusions (concentrations of 1,000 units/ml or greater) (double check-nursing)
      4. PCA-opiates double check-nursing
      5. Fibrinolytics
      6. Kcentra
   iv. If the double check is not required by policy, extra caution to verify accuracy in all steps of administration of the medication should be done.
      1. Potassium (any salt form) concentrated vials for injection (Restricted Access)
      2. Digoxin (extra caution and/or check labs)
      3. Calcium (any salt form) vials for injection (extra caution & monitor labs)
      4. Neuromuscular blocking agents (restricted access & usage)

c. Insulin Administration
i. 5 Rights are followed and verified with a Nurse as a “double check.” (Subcutaneous route: LPN or RN; IV route: RN Only)
   1. Documentation of double check is in the computerized MAR in the insulin comment line with verified blood glucose and initials of verifying nurse.

ii. Scheduled Insulin Administration steps:
   1. MAR is reviewed in computer for order noting “last time administered”
   2. Correct insulin is selected from the patient’s medication drawer. If not present, remove from Pyxis. Correct insulin and dose is drawn into syringe or primed into pen.
   3. Insulin dose is verified by another nurse prior to administration
      a. Correct patient reviewed (check name on the pen.
      b. MAR is reviewed for order
      c. Accucheck is reviewed.
      d. Insulin selection is reviewed.
      e. Insulin outdate is reviewed.
      f. Dose is reviewed
      g. Administration time is reviewed.
      h. Administration route is reviewed.
   4. Double identification is completed prior to administration to include the patient’s name on the insulin pen.
   5. Medication is documented following administration. This includes Accucheck.

iii. Insulin administration per “Correction Factor” or sliding scale.
   1. Accucheck is obtained.
   2. Chart is reviewed for most current physician order.
      a. Correction factor scale orders can change frequently.
   3. Review MAR for “last time” insulin administration on the screen. Select appropriate amount from scale.
   4. Follow above steps for insulin administration.

d. PRN Medications
   i. Remove the medication from Pyxis and note the time and date the med was removed last.
   ii. Scan the barcode on the PRN medications, with the patient, using the method previously discussed. Complete the pop-up screen. Click confirm.
   iii. Reason is a required field for a PRN medication.
      1. Click the drop down by reason. Select one of the predefined reasons or see note.
   iv. Once all the medications have been scanned, administer the medication.
   v. To document administration, click chart.

e. Omitting or Discontinuing a Medication:
i. After the medication has been scanned, if the patient refuses the medication or you were unable to administer it:
   1. Click on the “Rx” symbol
   2. Select the “Not Given Reason Code”
   3. Select an option from the drop down menu.

f. Medication with unrecognized NDC number:
   i. Notify pharmacy regarding the unrecognized NDC number.
   ii. When unable to scan, nurse re-verifies 5 Rights before administration.
   iii. Nurse selects in EMR the reason option scan was not possible.

6. Adverse drug reaction

   a. Following administration of a medication, should signs and symptoms of an adverse drug reaction occur:
      i. Stop medication immediately.
      ii. Evaluate patient for extent of response.
      iii. Notify physician.
      iv. Complete electronic event reporting for adverse drug event.