SUBJECT: **MEDICATION MANAGEMENT GUIDELINES**

Policy No.: C152
Effective Date: 06/1986

Purpose of Procedure: To ensure the proper and safe storage, preparation, administration, documentation and monitoring of medications.

Performed By: RNs, LVNs, Certified Medical Assistants (CMAs), and Affiliating RN/LVN Students - under the supervision of an Affiliating Instructor or Staff Nurse.

Definitions:

A. **Licensed Independent Practitioner (LIP)** – Practitioner who is credentialed by the appropriate committee to perform certain functions under the authorization of a licensed and credentialed physician or dentist, such as Nurse Practitioners (NPs), Physician Assistants (PAs), or Clinical Pharmacists (CPs).
Key Point: A listing of credentialed NPs, PAs and CPs, is available through the Medical Director's office.

B. **Orders by Protocol** – A CP is permitted by law to prescribe medications, tests and other therapeutic agents/modalities under protocol approved by Pharmacy and Therapeutics and Medical Executive Committees.
Key Point: An order by the physician authorizing the CP to initiate orders by protocol must be entered before the CP may enter such orders, (e.g., "Clinical Pharmacists may write daily INR and Coumadin orders").

C. **Breakthrough pain** – pain that erupts while a patient is already medicated with a pain reliever.

Policy Statements:

A. Nurses may administer only those medications labeled and distributed by the hospital pharmacy. LVNs may not administer investigational drugs, chemotherapeutic drugs or Patient Controlled Analgesia (PCA).

B. LVNs may administer oral Coumadin, subcutaneous heparin, subcutaneous low molecular weight heparin and peripheral saline flush (IV Certified).

C. IV Certified LVNs may hang and monitor the following IV infusions:
    1. Isotonic fluids: NS, D5W
    2. Hypertonic fluids: D5½NS, D5¼NS
Key Point: IV certified LVNs are not to hang any IV medications or additives (except vitamins).

D. Affiliating RN Students may administer intravenous (IV) medications under the direct supervision of a qualified Affiliating Instructor or RN. Students may not administer IV Push medications, blood or blood products.

E. CMAs may administer medications after verification by RN/LVN in the Ambulatory Care Network (ACN) and hospital based clinics. These medications include immunizations, vaccinations, and over the counter oral medications. No IV medications are to be administered by CMAs.

F. If an LIP administers a medication, the nurse will record on the medication administration record (MAR): the medication, dose, time, route, and name of the practitioner who administered the drug.

G. At a minimum, a complete medication order must include the patient's name, medical record number, date, medication name, dose, time or frequency of administration and route. PRN medications must include indication and frequency.

H. Orders containing a "Do Not Use" abbreviation must be corrected prior to the order being carried out by the nurse.

I. Unclear or incomplete orders shall be corrected prior to implementing.

J. Medication orders shall be reviewed by Pharmacy prior to administration.

K. To avoid therapeutic duplication the Physician/LIP will select only one medication for each PRN indication. If multiple medications are needed for same indication, specific instructions or parameters will be provided by the Physician/LIP.

Medication Reconciliation:

A. Refer to department of Pharmacy Policy 1.22.0 – Medication Reconciliation for further details.

B. Admissions.
   1. The admitting nurse will obtain a list of home medications from patient and will enter the information in the medical record.
   2. The admitting Physician or LIP will reconcile the medications and enter the orders that will be continued in the patient's medical record.
   3. The admitting nurse will affix a label onto the patient's MAR if available (non-DHS admissions) that includes the patient's name and FIN, and will place it in the medical record.

   Key Point: Patients admitted from another facility (Non-DHS), Nursing need to send a copy of MAR to inpatient pharmacy, see Pharmacy policy 1.22.0

C. Intra-facility transfers.
   1. The admitting Physician/LIP will complete the medication by history documentation.

D. Transfers to another Facility (Non-DHS).
   1. The current MAR will be used as the list of current medications that the patient is on at RLANRC and will be sent with the patient along with other medical records to the receiving facility.

E. Discharges.
   1. Physician/LIP will utilize the information in the medical record for discharges and will reconcile current medications.

   Key Point: The discharging licensed nurse will ensure that the medication reconciliation has been completed prior to discharging the patient.

   2. The patient, family member or caregiver will be educated by nursing staff on the importance of managing their medication information; i.e. updating the list of medications and keeping it readily available for the next practitioner.

Medication Administration Schedule:

A. Administration times for each medication will be established based on the following:
   1. Physician's order
   2. The type of medication
   3. Its compatibility with other scheduled medications
   4. Medication side effects
   5. Manufacturer's guidelines

6. The routine of the patient
7. Patient preference
8. Consistency with patient's home medication schedule
9. The recommended administration schedule
10. For routine IVPB medications initiated at times other than the established routine times, the administration times will be adjusted by Pharmacy, according to the IVPB Timing Wheel. Refer to Policy C122- Intravenous Therapy: IV Solution and medication administration -for IVPB Timing Wheel.

B. The pharmacist may change the time of administration to more regular intervals or a more appropriate time of day (e.g. tid to q8h, one time warfarin to 1800, TPN to standard time, administration time change in response to drug availability) Refer to Pharmacy Policy 1.48.0 – Approved Order Changes by Pharmacists. No medication will be administered after the automatic stop time or physician order limits unless properly reordered, see Pharmacy Policy 3.08.0- Automatic Stop Order for specifics.

C. STAT orders require a 15 minute turn-around-time from the time the medication is ordered to the time it is administered.

D. Urgent, Now or ASAP orders are orders that require a 60 minute turn-around-time from the time the medication is ordered to the time it is administered.

E. Routine orders are all other medication orders that do not fall into the above two categories and the turn-around-time is 2 hours from the time the order is written to the time the medication is available in the unit. Refer to Pharmacy Policy 3.05.5 – Timely Administration of Scheduled Medications - for further details.

Verbal/Telephone Orders:

A. Verbal Orders are only to be entered in an emergent or urgent situation in which harm to the patient would be imminent if the order is not implemented immediately and for which the physician is not available to enter the order.

B. Telephone Orders are discouraged and only used:

1. In the event a patient problem requires immediate attention for which the physician cannot be on the unit in a timely manner to intervene.
2. When waiting until the physician is available to enter the order would cause harm to the patient or unnecessary delay in initiating treatment.

C. A Verbal/Telephone Order may only be accepted by an RN in direct communication with the physician. **Key Point:** Telephone and Verbal Orders may not be accepted from PAs, NPs or CPs.

D. Immediately after obtaining the order, the RN will read back the order to the physician exactly as entered and request confirmation of its accuracy.

E. Verbal/Telephone orders are to be co-signed by the Physician within 48 hours.

Medication Removal:

A. All medications must be removed from the storage area just prior to administration and only for one patient at a time.

B. Upon retrieval of any medication, the healthcare provider will immediately carry the medication to the patient’s room.

C. Once removed from the storage area. Medication should not be left unattended.

D. If the patient refuses any medication prior to removing from the sealed package, or if the medication is not administered for any reason, the medication must be returned to pharmacy. Document the return or wastage information into the automated dispensing system. Medications requiring preparation, such as drawing up insulin, will be carried out in an area designated as the medication preparation area using aseptic technique.

E. If the medication is not administered immediately, the medication must be appropriately labeled including medication name and dose.

Drug Administration Guidelines:

A. The "Eight Rights" of medication administration will be observed when administering medications:
   1. Medication
   2. Dose
   3. Patient – two patient identifiers are used to verify right patient
   4. Route
   5. Time
   6. Documentation
   7. Reason
   8. Response

B. Examine medications to ensure they are without any indication of tampering, contamination, deterioration, or expiration.

C. Prior to administration, the individual administering the medication will check for allergies.

D. Routine medications are administered within one hour of the scheduled time.

E. For medications requiring specific parameters to be met prior to administration, document the parameter results.

F. Medications are to remain in the manufacturer's packaging until the third check is complete at the bedside.

G. Oral syringes are to be used to prepare and administer enteral medications. Parenteral syringes are not to be used to administered enteral medications.

H. Insulin – When mixing two insulins in one syringe, draw up the short acting insulin first (Lispro, Regular) and the long-acting insulin (NPH) second.

I. Filtered needles are to be used when withdrawing medication from ampules.

J. Nurses may only cut tablets that are scored.

K. Verification of the patient's name, medication, dose, route and frequency will be done at least three times prior to administration to ensure accuracy.

   1. First: as each medication is withdrawn from the automated dispensing system/cassette/refrigerator, the medication label will be read completely, including expiration date.

   2. Second: once removed, the medication will be double checked against the MAR or the order.

   3. Third: just before administering the medication, scan the patients ID band and medication as outlined below.
      Key Point: Use two identifiers to ensure right patient prior administering the medication: Patient's name and Medical Record Number (MRN) or Birthdate, see Nursing Policy C130 – Patient Safety.

L. Immediately before administering a medication:

1. Sign into the electronic medical record (EHR), launch the medication administration wizard (MAW), scan the patient's armband barcode, scan the medication barcode, and verify the medication is correct for the correct patient.

2. When administering medications to a patient who is in isolation, the nurse will follow infection control guidelines.

Controlled Substances:

1. Narcotic counts will be completed weekly.

2. All controlled substances are removed immediately prior to administration via the automated dispensing system by the nurse administering the medication, (see Nursing Policy A460 Controlled Substance Security and Administration).

3. Once a controlled medication is dispensed but not administered or if only a partial dose is required, the remaining amount must be wasted via the automated dispensing system (Pyxis). It must be verified by the 2 licensed staff and discarded in the following methods:

1. Pill: Crush medication, place on 2x2 gauze and discard in pharmaceutical Incineration Bin.
2. Liquids: Open medication package, Place on 2x2 gauze and discard in pharmaceutical Incineration Bin.
3. Capsule: Open medication, place on 2x2 gauze and discard in pharmaceutical Incineration Bin.
4. IV medications: Aspirate from vial, place on 2x2 gauze and discard in pharmaceutical Incineration Bin.
5. Transdermal patch: Fold the adhesive side of the patch against itself and discard in the appropriate disposal bin.
   Key Point: Any controlled medications must not be returned in the pharmacy bin.

PRN Medications

A. When a PRN medication is administered, a reassessment will be done to determine medication efficacy. The timing of this reassessment will depend on the medication given and route of administration, for example, 15-30 minutes after a parenteral medication (IV/IM/SQ) or 1-2 hours after an oral dose.

High Alert Medications

A. Insulins are designated as High Alert medications by Pharmacy and Therapeutics Committee. Insulins are independently double checked and co-signed by a second licensed nurse prior to administration. Refer to Pharmacy Policy 1.25.0 – High Alert Medications for further details.

B. Other High Alert medications such as anticoagulants are verified for accuracy by the electronic system as the medications and patient arm band are scanned. In the event that the medication cannot be scanned or a partial dose is needed, the administering nurse will request another licensed nurse to perform an independent double check and co-sign at the bedside.

C. An independent double check is completed by:
1. Independently comparing the label and product contents in hand against the MAR
2. Independently verifying any calculations for dose that require preparation
3. Verifying that the dose is safe and appropriate for administration
4. All parameters monitoring are within the appropriate range for administration
5. Ensuring the accuracy of infusion pump programming for continuous infusions
6. If there is any discrepancy in any steps, the Physician/LIP or pharmacist will be consulted

D. In urgent or emergent situations, when the nurse or physician determines the patient's clinical condition warrants bypassing of the above independent double check procedure, the provider administering the medication should verbally verify all drug therapy immediately prior to administration.

Titratable Medications

A. Examples of titratable medications include:
   1. Vasopressor therapy
   2. Sedation
   3. Pain medication (e.g. comfort measures)

B. Order must include the following:
   1. Medication name
   2. Route
   3. Initial infusion rate
   4. Incremental units to which the rate/dose can be adjusted
   5. Frequency of adjustments
   6. Maximum rate/dose
   7. Objective measure to guide changes
   8. Physician notification instructions if applicable

C. Assessment
   1. Patient will be assessed at frequent intervals as ordered to determine need for medication dose adjustment.
   2. Medication concentration will be verified with IV bag changes and within one hour of assuming care of the patient.
   3. Pausing the titratable medication
      i. It is acceptable to pause the titratable medication if the patient no longer meets the criteria for administration per objective measures
      ii. If the medication needs to be restarted based on the physiologic parameters for infusion, it is recommended to start at the last infusion rate unless the patient's condition guides otherwise

D. Documentation
   1. Dosage adjustments will be reflected in the MAR and/or documented using block charting during emergent situations. The following minimum elements must be documented in each block charting episode
      - Time of initiation of the charting block
      - Name of medication
      - Starting rate and ending rate
      - Maximum rate reached
      - Time of completion of the charting block (no more than 4 hours)
      - Physiological parameters evaluated to determine the administration of titratable medications during the charting block.

Specialty Infusions

A. These include medications such as Tysabri, Actemra, Orencia, Reclast, Rituxan, Inflectra and Gilenya.

B. Indications for these medications include autoimmune disorders such as Guillan Barre Syndrome, Rheumatoid Arthritis and Multiple Sclerosis.

C. Orders will be entered by the Specialist who will be available during the infusion process

First Dose Medication

A. Medications administered for the first time at Rancho are considered first dose medications.

B. The patient's response to the first dose medication will be monitored based on the medication and route administered.

C. If an adverse drug reaction is suspected, the established reporting procedure will be followed. See Pharmacy Policy 1.15.0 – Adverse Drug Reaction Reporting.

Investigational Medications

A. An RN may administer investigational drugs **only after**:
   1. The drug has been cleared by the Institutional Review Board for use and then verified by the pharmacy **Key Point:** A copy of the approved study protocol and the informed consent must be placed in the medical record.

   2. The nurse has been given comprehensive pharmacologic information about the drug and its intended and adverse effects.

Hazardous Drugs

1. Hazardous drugs are medications that may pose a risk for patients and staff. Special precautions are required when handling these medications to minimize occupational exposure. Hazardous medications are categorized by groups depending on their level of toxicity.
2. Medications can be administered on any nursing unit by trained registered nurses.
Key Point: No Intravenous Group 1 – Antineoplastic agents will be dispensed or administered with the exception of the outpatient infusion clinic.
3. Pharmacy personnel will deliver medications in appropriately labelled containers
4. Spills Management
   - Spill of <5mLs will be cleaned by unit staff following the spill kit manufacturer's instructions
   - Spills of >5mLs unit staff will isolate the area and call a Code Orange
5. Handling Precautions (Groups 1, 2 and 3)
   - Personal Protective Equipment (PPE)
   - Double gloves will be worn when handling medications in tablet or capsule form
   - For liquid or topical medications, double gloves, gown, mask, and eye protection will be used
   - All PPE will be worn any time there is a risk of splashing.

B. Antineoplastic Medications (Group 1 Hazardous Medications)
1. Nursing staff will verify that an informed consent has been completed by the physician for patients being treated for cancer.
2. An independent double check by 2 RNs is required prior to the administration of group 1 medications if ordered for the treatment of cancer
3. Waste Management
   - Nursing/medical equipment room staff will provide a chemotherapy waste container
   - Contaminated laundry bags will be utilized for linen that is contaminated with patient's body fluids
   - Environmental services will be notified when containers need to be removed or replaced (3/4 full)
   - When flushing excreta (feces, urine) a waterproof pad will be placed over the toilet lid to reduce the risk of splashing. Toilet will be flushed twice

C. Group 2 and 3 Hazardous Medications
1. Waste Management
   - Blue Pharmaceutical Waste
     1. Empty medication syringes
     2. Empty medication vials
     3. Medication waste

- Black Hazardous waste bin - Resource Conservation Recovery Act (RCRA)
    1. Any RCRA hazardous medication waste
- Regular trash
    1. Empty medication packaging
    2. Used PPE

D. Group 4 Hazardous Medications

1. These medications will be labeled as hazardous but no special handling is required

Medication Labeling

A. Drugs must be dispensed only from properly labeled containers or packages. Containers or packages with indistinct or questionable labels must be returned to the pharmacy, (see Pharmacy Policy 3.09.0 - *Medication Returns from Units*).

B. Medications shall be labeled only by persons authorized to prescribe or dispense or under the supervision of a pharmacist. Relabeling or pouring from one bottle to another may only be done by a pharmacist.

C. Medications reconstituted or dissolved by an RN, must be administered immediately by the same RN. If a medication will not be administered immediately after preparation, it must be labeled with:
1. Date and time of reconstitution
2. Concentration of mixture, if applicable
3. Initials of the person who reconstituted

Medication Storage

A. The temperature of the medication refrigerator will be checked and recorded twice a day on the Refrigerator/Freezer Log in order to ensure proper storage of medications, (see Nursing Policy C154 – *Refrigerator and Freezer Safety and Maintenance* for specifics).

B. The nurse manager(or designee) and pharmacist (or designee) will routinely monitor the emergency stock medications for amount, type, and expiration date to ensure:
1. Only authorized medications in the correct amounts are being stored, (see Pharmacy Policies 3.06.0 *Medication Storage on Units* for inspection procedure and 3.09.0 *Medication Returns from Units* for medication return procedure).
2. No expired medications are maintained on the unit.
3. Single dose vials are discarded after each use
   Key Point: For expiration date on multi-dose medications, refer to Pharmacy Policy 1.45.0 (Expiration dates)

Medications Stored at the Patient's Bedside:

A. Medications may only be stored at the patient's bedside with a physician's order and if they are approved by pharmacy. Only topical medications and inhalants have been approved to be stored at the patient's bedside. **Key Point:** Those medications ordered to be stored at the bedside must adhere to pharmacy guidelines (see policy Pharmacy Policy 3.07.0 Bedside Medication).

B. Medications kept at the bedside must be properly labeled and kept in the patient's bedside cabinet.

Medications Brought into Hospital by Patients:

A. All medications brought into the hospital by the patient will be returned to the patient's family when at all possible at the time of admission. If unable to return, the nurse will follow Pharmacy Policy 3.15.0- Medication containers brought into facility by patient.

B. Personal patient medications may be used while in the hospital, only if:

1. The Physician/LIP has written an order and the medication is unavailable in the pharmacy (non-formulary) and cannot be substituted with a formulary drug and cannot be obtained until the following day(s)
2. The patient's own medication has been approved for administration by pharmacy

Security of Medications:

A. The designated drug preparation/storage area must be kept locked at all times.

B. Maintaining the security of drugs in the medication storage rooms is a shared responsibility between pharmacy and nursing.

C. The nurse will remain with the patient until the medication is swallowed, injected or applied.

D. Partial doses and medications that have been prepared and not administered must be discarded according to Pharmacy policy 7.17.0 – Medical (pharmaceutical) Bio-hazardous Waste Disposal.

Quality Control:

A. All Shift RNs, LVNs and Unit Clerks will check for Physician's orders at least every two (2) hours.

B. The RN will review all orders entered during the assigned shift and will initiate planned orders once confirmed with the physician as needed.

C. If discrepancies exist, the pharmacist and/or Physician/LIP will be consulted.

Drug Recalls:

A. Pharmacy manages the recall of pharmaceuticals by vendors, distributors, or the FDA. Drug recall notices will be sent to all nurse managers.

Documentation:

A. All medications administered must be documented on the MAR. In areas where the MAR is not used, medication administration will be documented in the medical record.

B. The following shall be documented on the MAR:
   1. Date and time, name of medication, dose, route and site if appropriate
   2. If a dose was deleted or omitted, enter the reason for the omission (e.g. patient refused, patient nauseated, etc.) in the medical record
   3. Reason for and response to prn medication

C. Notification of the Physician/LIP of deleted or omitted medication will be documented in the medical record.

D. Adverse drug reaction, follow Pharmacy Policy 1.15.0 – Adverse Drug Reaction Reporting.

E. For One-time and STAT medications administered, a narrative note including effectiveness, if applicable, is required.

F. Patient education provided will be documented in the medical record.

Attachment:

1. Hazardous medications workflow

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10/17 – Revised	08/18- Revised	
10/19 – Revised	04/20 – Revised	

Attachment: Hazardous Medications Workflow

Hazardous Medications Workflow

Policy C152 Attachment

Department	Group 1	Group 2 &3
Physician	• Order medication • Obtain informed consent (if used to treat Cancer)	• Order medication
Pharmacy	• Verify with nurse that informed consent has been completed (Do not delay treatment while waiting for consent) • Deliver medication appropriately labeled • Provide Spill Kit if needed	• Deliver medication appropriately labeled and in the appropriate bag • Provide Spill Kit if needed
Registered Nurse	• Verify that informed consent has been completed when for the treatment of Cancer (Do not delay treatment while waiting for consent) • Administer the medication following appropriate precautions	• Administer the medication following appropriate precautions

Nursing Staff
• **RN**
• **CNA**
• **Charge RN**
• **Clerk (as applicable)**
• ****Administrative Nursing Supervisor**
	• Place signs outside patient's room and inside the room by the chemo waste container
	• Notify EVS when chemotherapy container is ¾ full
	• Request/obtain new container with red metal frame from nursing medical equipment room (NMER)
	• Place contaminated linen in "Contaminated Laundry" hamper
	• Place "Contaminated Laundry" bag in the dirty linen cart when full
	• Clean up spill 5mLs or less using spill kit
	• Call for a "Code Orange" for spills more than 5mLs
	  ○ Dial 0
	  ▪ **Afterhours ANS and EVS supervisor use the SDS sheet to determine cleaning procedure
		• Place contaminated linen in regular linen hamper
		• Clean up spill 5mLs or less using the spill kit
		• Call for a "Code Orange" for spills more than 5mLs
		  ○ Dial 0
		  ▪ **Afterhours ANS and EVS supervisor use the SDS sheet to determine cleaning procedure

EVS	• Dispose of chemotherapy waste container appropriately when ¾ full • Return red metal frame to dirty utility room • Respond to Code Orange ○ Clean up spills more than 5mLs as instructed in the SDS sheet.	• Respond to Code Orange and clean up spills more than 5mLs as instructed in the SDS sheet.
NMER	• Deliver replacement chemotherapy waste container and red metal frame to unit as requested • Go to dirty utility room, disinfect the dirty red metal frame and return to NMER	
Laundry Room	• Maintain supply of "Contaminated Laundry" bags in units • Handle contaminated linen appropriately	
Central Supply	• Maintain supply of 8-gallon chemotherapy waste containers in NMER • Maintain supply of chemotherapy gowns in NMER	
Safety Officer	• Responds to Code Orange during working hours • Evaluates the spill • Determines the cleaning procedure per SDS sheet	

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