

HIGH DESERT HEALTH SYSTEM AMBULATORY SURGICAL CENTER

SUBJECT: V-135 MEDICATION ADMINISTRATION	POLICY #: 1249
	VERSION: 1
APPROVED BY: ASC Approvers	
DATE APPROVED: 06/28/2016	

PURPOSE: To provide guidelines for licensed nursing staff involved in medication administration.

POLICY: Authorized nursing staff will administer medications safely by observing the six Rights of Medication Administration: Right Patient, Right Medication, Right Dose, Right Route, Right Time, and Right Documentation.

PROCEDURE:

A. MEDICATION ORDERS

1. A provider (physician/CRNA) order is required prior to administering any medication to a patient and must contain the following:
 - a. patient name
 - b. patient's medical record number
 - c. date and time of order
 - d. signature of ordering provider
 - e. name of pharmaceutical/medication
 - f. dosage
 - g. route of administration
 - h. time to be administered and/or frequency of administration
 - i. PRN orders must include specific parameters or conditions that trigger the administration of the medication.
2. All orders that are incomplete, unclear or contain unapproved abbreviations must be returned to the provider for clarification.

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3. Nursing staff will note/sign orders in appropriate space on order form.
4. The licensed nurse shall perform the following verification procedures prior to administration, to ensure medication orders are correct, appropriate and have been accurately transcribed.
 - a. Verify medication name, dose, route of administration, and administration time.
 - b. Check the label on unit dose medication(s) or medication container. Medication integrity and expiration date must also be reviewed.
 - c. Medication labels are check three (3) times during medication preparation.
 - When comparing medication with the provider's orders
 - Before opening container
 - After medication is removed from container
 - d. Verify that there are no contraindications or allergies before administering the medication.
 - e. The nurse administering medications is aware of the following information:
 - Therapeutic action of the medication
 - Side effects and adverse reactions
 - Route and frequency of administration
 - Normal dosage and maximum safe dosage
 - Precautions and contraindications
5. If unfamiliar with the medication, dosage range, action, indication, contraindications adverse reactions, or precautionary measures, refer to the drug reference manual, "Micromedex" or call High Desert Regional Health System pharmacy.

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6. Remove the correct amount of medication for the individual dose to be given at this time.
7. Do not recap if needle is used to administer medication, safety needles are to be used.
8. All syringes and needles are single use only.
9. Discard syringes and needles into sharps containers, located in all work areas.
10. The rubber septum on a single or multi-dose vial is disinfected with alcohol prior to each entry.
11. Multi-dose vial once opened should have the date opened and expiration date of **28** days or the manufacturer's expiration date, whichever comes first, from the date of opening. (Manufacturers' expiration date expressed as "month/year" will be interpreted as the product will expire on the last day of the month).

B. ADMINISTRATION

1. The patient's identity is verified using two identifiers (patient name and date of birth).
2. Hand hygiene or use of alcohol gel is required prior to administering medication.
3. The nurse administering the medication remains with the patient until the medication is taken or administration is complete. If the medication has been opened and refused by the patient, it is disposed of in the pharmaceutical waste container. If a medication is refused, this is noted on the medical record and the physician is notified.
4. Heparin and Insulin (High Alert Medication): dosages are verified with a second nurse prior to administration. After the first nurse documents the name of the drug, the dose, the route, and the time administered, the second nurse documents "dose verified by" and signs his/her name and title.
5. Ointments, gels or lubricants are to be used for a single patient, whenever possible.

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6. No intramuscular or subcutaneous injection of narcotics is permitted in the ASC.

C. DOCUMENTATION

1. All medication administered by a nurse are documented in the medical record following administration.
2. The site of injection is documented on the progress note, using approved anatomical landmarks, after the administration of any injectable medication.
3. The nurse advises the patient or, if appropriate, the patient's family about any potential clinically significant adverse reaction or other concerns when administering a new medication.
4. The nurse documents date, time, medication, dose, route/site and the effects or patient's response of the medication in the medical record.
5. Adverse drug reactions are reported immediately to the physician. An SI Report is completed and supervisor is notified. The actual medication administered is documented on the progress notes.
6. Errors in medication administration are reported immediately to the physician. An SI Report is completed and supervisor is notified. The actual medication administered is documented on the progress notes.

REFERENCE:

Kowalak, J., (Ed.) (2009). Lippincott's nursing procedures (5th ed.) Philadelphia: Lippincott Williams & Wilkins.

Department of Health Services Core Competency, 2012

The Joint Commission, Standards on Medication Practice – National Patient Safety Goals

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