OHSU Health Care System

Medication Administration Safety

Effective Date: October 06, 2011
No: HC-CLN-MPI-P048

POLICY:

Purpose:
The purpose of this policy is to describe the process used in safe administration of medications.

Persons Affected:
Any qualified provider responsible for the safe and accurate administration of medications within their scope of practice.

Policy:
All medications received by OHSU patients will be administered according to the safe medication administration practices described in this policy.

Definitions:

MAR Action Definitions for single administration medications:

Due: used to reschedule an administration time.

Given: indicates that a dose has been administered. Given should not be documented until the administering caregiver is assured that the dose has been administered. Given should only be documented by the caregiver who actually administered the medication.

Given by Other: to be used when the clinician documenting the administration has actually witnessed or otherwise verified the administration has actually been completed. Documentation of who actually administered medication and how administration was verified should be completed in the notes section of the MAR.

Note: It is important NOT to use this action to document a med for RT. If you mark RT’s meds as given, and they have not been given, RT cannot document when they do give the medication.

Pt. Administered: indicates that the patient instead of the caregiver administered the dose of medication. Will only be used for approved medications. Refer to “Self Administration of Patient’s Own Medications” policy for a list of approved medications and appropriate process.

Patch Removed: indicates that a transdermal patch has been removed. All transdermal patches that have been documented as given on the MAR should eventually be documented as removed except if the patient is going home with a patch that has already been administered.

Returned to Pyxis: indicates that a medication was not given and returned to the pyxis machine.

See OB Tracevue: indicates that the actual documentation of a medication in Labor and Delivery occurred on the OB Tracevue system.

Not Given: indicates that the medication was not administered.

Held: indicates that a medication was not administered due to a procedure or test. Should only be used if a medication needs to be held for a short period of time.

MAR Hold: indicates that a medication has a due time during a MAR hold i.e. when pt transfers to pre-op, was not given due to the fact that the MAR was on hold and will prevent the medication from being overdue.

MAR Unhold: this action must be used when a medication needs to be administered during a MAR hold.

Bolus from same bag: used when a bolus is given from a bag which is already hanging (with two separate orders for bolus and continuous). Because the bag has already been scanned it will not have to be scanned again for a bolus.

IV Pause: used only by ambulatory infusion units, indicates that an infusing medication has been temporarily stopped.
**IV Resume:** used only by ambulatory infusion units, indicates that an infusing medication has been restarted.

**Stopped:** indicates that a medication has been paused or stopped.

**MAR Action Definitions for continuously infusing medications:**

**Due:** used to reschedule an administration time.

**New Bag:** indicates that a new bag, syringe, or other container containing an intravenous (IV) medication has been administered.

**See OB Tracevue:** indicates that the actual documentation of a medication in Labor and Delivery occurred on the OB Tracevue system.

**Given by Other:** to be used when the clinician documenting the administration has actually witnessed or otherwise verified the administration has actually been completed. Documentation of who actually administered medication and how administration was verified should be completed in the notes section of the MAR.

*Note:* It is important NOT to use this action to document a med for RT. If you mark RT’s meds as given, and they have not been given, RT cannot document when they do give the medication.

**Given:** indicates that a dose has been administered. Given should not be documented until the administering caregiver is assured that the dose has been administered. Given should only be documented by the caregiver who actually administered the medication.

**Restarted:** to be used when patient remains connected to medication to be administered. Because the patient has not been disconnected from the tubing, the medication will not need to be rescanned.

**Reconnected:** is to be used when the patient’s infusion has been stopped and the tubing disconnected. The medication will need to be scanned since there has been a disconnection of tubing from the patient.

**Stopped:** indicates that a medication has been paused or stopped.

**Completed:** indicates that a blood transfusion is complete. Is not used for medication administration.

**Rate:** indicates that a new rate has been administered for a particular IV medication.

**Rate Unchanged:** indicates that the rate of an IV medication is unchanged from the previous documentation.

**Rate Verify:** indicates that verification by a second nurse during shift change or after transfer/transport has occurred for any previously programmed unchanged intravenous rate and/or bolus in the Medex pumps and Alaris pumps. “Rate Verify” is typically used in Pediatric ICU and Adult ICU to ensure that previously programmed rates and boluses that are still being administered to the patient are programmed correctly and match the corresponding order.

**Not Given:** indicates that the medication was not administered.

**Held:** indicates that a medication was not administered due to a procedure or test. Should only be used if a medication needs to be held for a short period of time.

**MAR Hold:** indicates that a medication has a due time during a MAR hold i.e. when pt transfers to pre-op, was not given due to the fact that the MAR was on hold and will prevent the medication from being overdue.

**MAR Unhold:** this action must be used when a medication needs to be administered during a MAR hold.

**Bolus from same bag:** used when a bolus is given from a bag which is already hanging (with two separate orders for bolus and continuous). Because the bag has already been scanned it will not have to be scanned again for a bolus.

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**PROCEDURE:**

<table>
<thead>
<tr>
<th>RESPONSIBILITY</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Admission</td>
<td></td>
</tr>
</tbody>
</table>
Nurse, RT, MA, DX
Radiation Tech

1. Review home medication list with patient/family. Review admission orders for chronic home medications that should be continued while the patient is hospitalized, but have not been ordered. Call LIP for questions, clarifications or changes.
2. Go to "Allergies" tab in Epic:
   a. Review patient's current list of allergies with patient/family.
   b. Document new allergies or changes on the Epic allergy list.
   c. When changes have been documented click "Reviewed" button to document that review of allergy list has been completed on admission.

### At Time of Medication Administration

<table>
<thead>
<tr>
<th>Nurse, RT, MA, DX Radiation Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proceed to Medication Room and open patient's integrated health record to identify medications to be administered.</td>
</tr>
<tr>
<td>3. Compare any written orders against what is transcribed on the MAR for accuracy (this is necessary only for medications that are hand-written, e.g. chemotherapy).</td>
</tr>
<tr>
<td>4. Remove medications from Pyxis MedStation, patient drawer, refrigerator or other storage site assuring that the right medications are being removed for the right patient.</td>
</tr>
</tbody>
</table>
   a. Check dose label against order on the MAR for congruence of drug name, dose/strength, and form appropriate for route. If present check manufacturer's label with pharmacy's label. |
   b. Verify that the medication has not expired. |
   c. Visually inspects the medication for particulates, discoloration, or other losses of integrity. |
     i. Contact pharmacy for discrepancies if necessary. |
     ii. If medication is not dispensed in the exact patient-specific unit, independently verify calculations. |
   d. If it is absolutely necessary to remove medications from original packaging, label product with drug name, strength and quantity. Medication label may be used for this purpose. |
| 5. Proceed to patient's room and open patient's chart in the room. |
   a. Obtain two-patient identifiers from the patient verbally or by obtaining information from their ID band and compare to the chart that is currently opened:Medication Labels |
     i. Patient name |
     ii. Patient date of birth |
     iii. Patient medical record number (only if 1 of first 2 identifiers not available) |
   b. Compare medications to be administered to allergy list at the top of the MAR. |
   c. Conduct the 7 Rights: |
     i. Right patient |
     ii. Right medication |
     iii. Right dose |
     iv. Right route |
     v. Right time |
     vi. Right documentation |
     vii. Right indication |
   d. Inform the patient or family about any potential clinically significant adverse drug reactions or other concerns regarding administration of the new medication. |
   e. Administer medications to patient while assessing patient's perception of the medication's effectiveness, dosing and side-effects. |
   f. Observe patient taking oral medication; check to assure infusion flowing; check other delivery systems for proper functioning. |
   g. Obtain second RN check at time of administration for the following medications: |
     i. Chemotherapy infusion |
     ii. Insulin drip |
     iii. Heparin drip |
     iv. Hypertonic saline |
     v. Pressor drip |
     vi. PCA |
     vii. Epidural |
viii. Magnesium Sulfate
ix. See Medication Safety Precautions-Peds (HC-PCS-PAC-P030) for list of pediatric double-check medications.

h. Transdermal patches:
   i. Date, time and initial at time of patch application.
   ii. Document location of patch placement.
   iii. Verify adherence of the patch at the beginning of each shift. If necessary, apply a transparent occlusive dressing over the transdermal patch to assure adherence.
   iv. Upon removal of the patch, document date, time and authentic (initials) removal.

i. If patient has difficulty swallowing multiple oral drugs due at same hour, do not leave medications at the bedside. Return labeled medications to patient's drawer. Continue to assist patient's intake of remaining medications within the hour of the scheduled dose.

6. Document administration of medication and relevant assessments in MAR and appropriate flow sheet. Documentation of medication administration should only be done after medication has been administered.

1. Safe Medication Administration Practices:
   a. Medications can be prepared and administered for only one patient at a time.
   b. Removal of more than one patient's medications from the storage areas is prohibited. Medications are only to be removed from the storage areas right before administration, and should never be documented as given before they are administered.
   c. Medications are to be left in the original packaging until immediately prior to administration whenever possible. If the medication must be removed from its original packaging because it must be crushed, diluted, etc., it must be placed in a cup or syringe labeled with the patient's name, drug name, strength, and quantity.
   d. Crushed or liquid medications should not be mixed together due to potential drug interactions and safety.
   e. Medications cannot be left in the patient's room for later administration by a hospital employee or by the patient themselves; patients must be observed taking oral medication.
   f. Two qualified providers should independently verify the calculations for any medications not dispensed in exact patient-specific doses.
   g. Any liquid medication which is to be administered by the oral route (including NG, JT, and other oral tube systems) must be drawn up for administration in a syringe labeled "ORAL USE ONLY" or poured into a graduated medication cup and labeled with medication name, strength, and quantity (use medication label).

2. Medication Administration Responsibilities for all Patients:
   a. Coordinate the plan of patient care with medication administration to optimize safety.
   b. Conduct all processes to assure safe medication administration, including the 7 rights, 2-patient identifiers, allergy review.
   c. Clarify with the Licensed Independent Practitioner any questions or concerns about the medication order.
   d. Review references or call pharmacy if unfamiliar with the medication.

3. Medication Administration Responsibilities for all Patients on Admission:
   a. Review home medication list and reconcile with patient/family.
   b. Review patient allergies with patient/family and update allergies in Epic.
   c. Assure that patient's ID band is accurate and is present, if needed.

4. Second Qualified Provider Independent Verification
   Some medications require a second qualified provider to independently verify dose preparations and IV pump settings. Medications requiring a second nurse to check dose preparations and IV pump settings are:
   a. Insulin
   b. Antineoplastic agents
   c. Heparin bolus and infusions
   d. Hypertonic saline
   e. Pressor infusions
   f. PCAs
   g. Epidurals
   h. Narcotic infusions
Magnesium Sulfate continuous infusions See Pediatric/DCH Cluster Medication Safety Precautions (HC-PCS-PAC-P030) for list of pediatric double-check medications

5. Second Qualified Provider Independent Verification: IV Pump Settings
   a. At the beginning of the shift
   b. After transfer or transport
   c. When starting an epidural or PCA
   d. With any tubing or syringe change

6. High Alert Medications: Required Double Signatures (Clin 05.09) (link here)
   a. Antineoplastic agents
   b. Heparin bolus and infusions
   c. Insulin
   d. Narcotics: PCA, epidural, IV infusions
   e. Sodium chloride, hypertonic (> 0.9%)

7. Patient Self Administration of Medications
   a. Self-administration of inpatient medications by patients is permitted as part of patient/family education and learning (action, side effects, self administration techniques and home regimen) during preparation for discharge and only under the direct supervision of an RN.
   b. Inpatient medications will be stored securely on the unit.
   c. Patient's self-administration will be documented as such on the "Medication Administration Record" and "Diabetic Record", as applicable. Additional documentation as needed on: "Multidisciplinary Health Education Record: Self-Administration of Medications, PE-2462", "Diabetes Survival Skills Sheet, NU4715" or Diabetes Survival Skills - Pediatrics, NU4716, or "Diabetes Basic Skills Documentation for Adult Inpatients (Pilot), NU4743"
   d. NOTE: for high-risk medications that require an RN double-check, two RNs are required to check the medication and document this check as described in "High Risk Medications and Look-alike, Sound-alike Medication Pairs" and "Pediatric/DCH Cluster: Medication Safety Precautions, dch-p-m-01". The learner (patient/family) will check the medication as part of their learning to self-administer safely at home.
   e. Administration of a patient’s own prescription discharge medication is not permitted. Non-opioid discharge medication prescriptions may be filled by Outpatient Pharmacy within 48 hours of patient discharge (Use "Discharge Medications and Prescriptions, DC-1811" form to write prescription for discharge medications). These medications may be used for demonstration and return-demonstration purposes only as part of patient/family education and learning. Patients’ own supply of discharge medications is not to be used in lieu of inpatient medications provided by the Inpatient Pharmacy. The patient’s discharge prescription medications will be clearly identified and stored on the unit.

Bibliography:


The Joint Commission Comprehensive Accreditation Manual for Hospitals

Related Forms:

- Medication & Parenteral Infusion Orders For Hospitalized Patients
- Pediatric DCH Cluster: Medication Safety Precautions (HC-PCS-PAC-P030)
- Continuous Epidural or Intrathecal Medication Administration
- Medication Labels
- Multidisciplinary Health Education Record: Self-Administration of Medications, PE-2462
- Diabetes Survival Skills Sheet, NU4715
- Diabetes Survival Skills - Pediatrics, NU4716
- Diabetes Basic Skills Documentation for Adult Inpatients (Pilot), NU4743
- Discharge Medications and Prescriptions, DC-1811 [order from WorkflowOne - Item #131811]
• **High Risk Medications and Look-alike, Sound-alike Medication Pairs**
• **Patient's Personal Medication, Use of**
• Discharge Medications and Prescriptions, DC-1811 [order from WorkflowOne - Item #131811]

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