MEDICATION ADMINISTRATION

1. Before any medications are administered, the patient's identification will be verified by checking the patient identification bracelet and checking that against the information on the MAR. Refer to Administrative Policy No. 40-68: "Patient Identification."

2. All medications should be checked for the following:
   A. Correct patient name, drug, dosage, route and expiration date.
   B. The MAR corresponds with the medication dispensed by the Pharmacy or from floor stock.
   C. The MAR clearly identifies the date and time for administration.
   D. Any parameters or instructions that should be followed related to the medication administration (hold for BP, on call, QOD, etc.).

3. Standard precautions should be followed during any medication administration:
   A. Safety devices such as needleless or blunt cannula components of an IV system will be used. The use of traditional needle/syringe systems is not acceptable when a safe system alternative is available.
   B. Do not remove a needle/cannula from the syringe, bend, break or otherwise manipulate by hand.
   C. Never recap a used needle/cannula using both hands. Use either a one-handed "scoop" technique or a recapping device to hold the sheath.
   D. Any ampule, vial, needle, blunt cannula, and syringe with a needle/cannula should be placed directly into the nearest sharps disposal container after use. Any syringe without a needle/cannula, if not contaminated with blood or body fluids, may be discarded into regular (non-biomedical) trash.

4. All medications and IV infusions are documented on the MAR or special flowsheets with the nurse's initials. If a medication is held or refused, the nurse should put an asterisk (*) by the medication and time on the MAR. Medications that are held, refused or any PRNs given should also be accompanied by a nursing note explaining the reason for giving or not giving, dosage (if a range is given), any complications and the patient's response to the medication. If there are parameters with the order, the reason for not giving a medication should be noted on the MAR.

5. If a patient has been placed on NPO or HOLD for a procedure, check with the physician which medications, if any, should be given. It is especially important to clarify insulin orders.

6. All IV fluids and medications will be labeled with the date and time of **expiration** by the Pharmacy, the nurse preparing them or the manufacturer.

7. Medication Orders:
   A. The pink carbon of the original order will be forwarded to the Pharmacy. The white carbon is given to the nurse administering medications for that patient. Any new PRN medications that need to be filled immediately will be circled on the pharmacy carbon.
   B. When physician order sets are used, 3 copies are needed. The first copy is for the permanent patient record, the second copy is to be sent to Pharmacy and the third copy is for the nurse.
   C. The time and "C.P." for carbon pulled will be noted on the left hand margin of the original order before the carbon is pulled. The Pharmacy copy of the orders will be sent to the Pharmacy via the tube system. The nursing copy is given to the nurse.
   D. STAT and NOW orders will be called to the attention of the nurse responsible for the patient's medications by the staff member transcribing the orders. These orders are to be circled and the order sheet checked for legibility and complete patient information before being placed in a red envelope and tubed to the main Pharmacy unless there is a unit dose satellite or stock medication available.
   E. All new medication orders are written on a blank MAR or on the existing MAR using standard dosing times except for the first dose of antibiotics which will be given within two hours of being ordered. The RN verifies the handwritten order with the physician's order and initials it in the initial box.

8. Allergies to foods or medications identified on admission will be entered under the Allergy section of Powerchart, written on the MAR and placed on "allergy" tape along with the patient's name and attached to the front of the chart. Any new allergies identified during the hospital stay should be added to the Allergy section of Powerchart, the MAR and the chart.

9. The patient's height and weight will be entered into the Weights and Measurements section of Powerchart on admission and updated any time there is a weight change of 10 pounds or more.

10. Standard Dosing Times:
   A.

QD	-	0800
BID	-	0800, 2000
TID	-	0800, 1400, 2000
QID	-	0800, 1200, 1600, 2000
qPM	-	1800
qHS	-	2200
AC	-	varies according to unit; should be 30 minute before meals.
PC	-	varies according to unit; should be 30 minute after meals.

B. COUMADIN: Given at 1600 to allow for the return of lab values and reporting to the physician as indicated. At the time Coumadin is administered, the nurse will enter the current PT/INR value on to the MAR or make an entry that no PT/INR was ordered. This must be addressed with each dose.

C. DIGOXIN: Given at 1200 to allow for the return of lab values and reporting to the physician as indicated. The patient's heart rate will be measured before administration and recorded on the MAR.

D. LASIX: Given at 0800 if ordered daily and at 0800 and 1600 if ordered BID.

11. Administration of HEPARIN:

Prior to administering heparin, the medication and dosage MUST be verified by a second nurse. Both the nurse who is giving the heparin and the nurse who is double checking to be certain that the correct medication and dosage have been drawn up will initial the appropriate medication administration document. At all times, the physician's order, the MAR or the appropriate nomogram will be used by both nurses to verify that medication and dosage are correct.

A. When administering a heparin infusion or bolus as directed by a weight based order set, documentation will occur on the Heparin Flow Sheet and Nomogram. The RN administering the medication or changing pump settings will initial in the "RN" column. The nurse double checking the drug calculations, pump settings and medication will initial in the "Co-sign" column.

B. When administering subcutaneous, intravenous bolus or a continuous non-weight based infusion of heparin, documentation will occur on the MAR. The nurse administering the medication will initial next to the administration time. The nurse double checking the medication and dosage (as well as pump settings with an infusion) will initial and indicate that it is a double check on the line below.

C. When administering dilute heparin flushes into an intravenous line, documentation will occur on the MAR. The nurse flushing the line will initial next to the administration time. The nurse double checking the heparin strength and dosage will initial and indicate that it is a double check on the line below.

12. Administration of INSULIN:

Prior to administering insulin, the medication and dosage MUST be verified by a second nurse. Both the nurse who is giving the insulin and the nurse who is double checking to be certain that the correct medication and dosage have been drawn up will initial the appropriate medication administration document. At all times, the physician's order or the MAR will be used by both nurses to verify that medication and dosage are correct.

A. When administering an insulin infusion, documentation will occur on the Diabetic Flow Sheet Record. The nurse administering the medication or changing pump settings will initial in the "Given Initials" column. The nurse double checking the pump settings and medication will initial in the "Checked Initials" column.

B. When administering subcutaneous or intravenous insulin (not associated with a continuous infusion), documentation will occur on the Diabetic Flow Sheet Record. The nurse administering the medication will initial in the "Given Initials" column. The nurse double checking the medication and dosage will initial in the "Checked Initials" column.

C. If the patient is self-administering insulin, two nurses are to double check the medication prior to it being taken into the patient's room. After the patient draws the insulin dose up, the nurse will double check the dosage. The nurse double checking both the medication and dosage will initial in the "Given Initials" column and the nurse double checking only the medication will initial in the "Checked Initials" column.

13. I.V. POTASSIUM:

A. Peripheral Infusion: IV potassium administration will not exceed a dilution of 10 mEq/100 ml. and will not be given over less than one hour.

B. Central Line Infusion: Non-monitored areas - IV potassium administration can not exceed a rate greater than 10 mEq per hour and a dilution of greater than 10 mEq/100 ml. Monitored areas - IV potassium administration can not exceed a rate greater than 20 mEq per hour. If there is a specific physician's order to exceed 20 mEq per hour, the patient should be in an intensive care unit (ICU) or intermediate care unit (IMCU).

14. If an adverse or allergic drug reaction is suspected, the drug is to be stopped or held until reported to the physician. If an adverse or allergic drug reaction is confirmed, document the patient's symptoms with any interventions taken in the nursing notes and complete an incident report. Refer to Administrative Policy No. 10-8: "Incidents: Definitions/Reporting Requirements/Duties of the Risk Manager".

15. Courtesy Medication: A dose of courtesy medication for family members in deaths and other traumatic occasions will be dispensed to the nursing unit from Pharmacy following the receipt of a prescription. If additional doses are needed, a prescription must be written for outpatient use, to be filled at a later date at a commercial pharmacy.

16. Routine medications should be administered within one hour of the scheduled time (i.e., if the medication is scheduled for 0800, it should be given between 0700 and 0900). The exact time a medication is given is to be noted on the MAR.

17. If a patient vomits shortly after receiving oral medications or if the IV infiltrates while receiving medication, the nurse will observe the emesis or amount of medication absorbed and call the physician for further instructions as needed. A focus nursing note should be made in the chart about redosing.

18. The nurse must verify that medication can be opened or crushed for oral or gastric tube administration before giving.

19. A patient may self-administer medications or use medications brought from home while hospitalized only under special circumstances. Refer to Administrative Policy No. 40-2: "Medications Brought into the Hospital by Patients".

20. An order to "list meds patient is on" or "continue home meds" does not constitute an order to give the medications. Obtain a list of the medications and confer with the physician for specific orders to administer the medications.

21. A new order for a medication will cancel the previous orders for that medication unless otherwise stated.

22. All orders to hold a medication must specify a time period or the medication will be discontinued.

23. Patients receiving medications for the conversion of an **unstable** cardiac arrhythmia (Verapamil, Lidocaine, Inderal, Cardizem, etc.) must have continuous ECG monitoring during administration.

24. Medication carts will be attended or locked at all times.

25. A multidose vial **without** preservatives will be labeled with the date, time and initials of the person opening it and discarded within 24 hours.

26. A multidose vial **with** preservatives is to be discarded by the manufacturer's expiration date. Do not date, time or initial these vials when opened.

27. A multidose vial **containing a lyophilized powder** requiring reconstitution will be labeled with date, time of preparation, discard/expiration date (stated in hours or days according to manufacturer), initials of person preparing as well as diluent and final concentration. Storage conditions (room temperature or refrigeration) will be stated on the vial by the manufacturer.

28. Standard dilutions for all medications have been established. A list is maintained in the Pharmacy for reference. If the diluent or final concentration needs to be altered, the nurse and pharmacist should discuss alternatives.

29. For patients on continuous infusions of vasoactive/antiarrhythmic drugs:
    A. Infusion pumps will be used for all vasoactive/antiarrhythmic drugs.
    B. The infusion rate will be calculated and documented in the patient record every shift.
    C. Patients on vasoactive/antiarrhythmic infusions may be placed on general nursing units according to the following chart:

MEDICATION	IMCU or DIALYSIS	CPCU (3N)	GENERAL UNITS
Activase	Only low dose when used by IV Therapy to declot lines.		
Amiodarone	Yes	Yes	No
Cardizem	Yes	Yes	No
Dobutamine	Yes	Yes	*Yes
Dopamine	Yes	#Yes	#Yes
Lidocaine	Yes	Yes	No
Nipride	Yes	No	No
Nitroglycerine	Yes	No	No
Pitressin	Yes	No	No
Primacor	Yes	Yes	*Yes
Pronestyl	Yes	Yes	No

* = Only if patient is a No CRT

= Only if renal dose; may go to general unit after drug initiation in ICU, IMCU or CPCU.

Approved: 8/93
Revised: 10/93; 1/95; 1/96; 2/97; 7/97; 10/97; 11/98; 11/99
Revised: 4/00 (Combined GENMED1 & GENMED2); 5/00; 12/00; 3/01
(m-medadm.wpd)