VAN RENSSELAER MANOR
UPDATE

I have reviewed Van Rensselaer Manor's Medication/Treatment Policy & Procedure that was recently updated 4/2014.

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Employee Signature and Title Date

_____

Print Name

Via
Nurse Connection Staffing
11 Computer Drive West
Albany, NY 12205
518-459-6612
518-459-6614-fax

VAN RENSSELAER MANOR
Policy and Procedure

Medication/Treatment

Policy: It is the policy of Van Rensselaer Manor that medications and treatments are provided by an RN or LPN by order of a physician according to recognized standards of practice.

Purpose: To ensure appropriate administration and documentation of medications and treatments while maintaining residents' dignity and respect.

Administration:

Rule 1- Medications will be administered to resident by RN or LPN or under the direct supervision of an RN according to physician's order.

Rule 2- Counting controlled substances:

a) The Nurse coming on duty and the Nurse going off duty are to count controlled substances together per Controlled Substance Handling Policy. This must be done in the Medication Room.
b) Both Nurses indicate they have counted by signing the bottom of the Nurses Daily Report Sheet and the Controlled Substance Count Sheet.
c) Both Nurses are responsible to check medication container, pharmacy label and Controlled Substance Record for accuracy.
d) Both Nurses will check Narcotic Box on medication cart.

Rule 3- The Emergency Drug Box lock is also checked at Controlled Substance Count to be sure lock is intact. Sign on the Nurses Daily Report Sheet to indicate this. (Plastic lock may be green or red.)

Rule 4- Syringes/Needles – Do Not Recap – Dispose in Sharps Container
The Sharps Container on the Medication Cart is checked by the nurse going off duty for fullness. The Sharps Checklist is signed. The sharps should be discarded when reaches "fill line" and/or every 30 days. New sharps container must be dated when put on the med cart. **For safety measure: Do not place hand in the Sharps Container.**

Rule 5- SAFE-T-LOK Syringes – immediately employ safety lock after injection, then place in Sharps container. Notify Nursing Supervisor immediately if needles do not have safety feature.

Rule 6- The Medication/Treatment Nurse is to carry the keys on his/her person at all times, except when leaving grounds for lunch and/or punching out on time clock. You should count off and give the keys to the nurse that you counted with. ***If keys are taken home, they are to be returned immediately.***

Administration continued:

Rule 7- The Nurse will keep the medication/treatment cart within view at all times and assure that the cart is not left unlocked while unattended. When unattended, all medications should be removed from the top of the cart and any resident information must be covered or turned over.

Rule 8- Medication Carts and Treatment Carts are to be locked when not in use.

Rule 9- The cart should be stocked with needed supplies and cleaned before starting and when finished. Do not stack cups over 12 inches high.

Rule 10- External meds are to be placed in a separate compartment from internal medications. Eye drops and ear drops are to be stored in individual plastic bags or boxes to prevent cross contamination; may use plastic dividers, available from Royal Care, in top drawer of med cart.

Rule 11- Keep medications that require refrigeration in a locked refrigerator (medication refrigerator) in the medication room. Must check and record temperature twice daily. Report abnormal temperature to maintenance.

Rule 12- Do not carry personal items on the medication cart or treatment cart. This includes food, drink, cell phones and/or any other electronic devices.

Rule 13- The Nurse must check for resident medication allergies prior to administering meds.

Rule 14- The Nurse must possess current pertinent drug knowledge.

a) Do not administer medication you are not familiar with.
b) Check the drug indication, dosage range, and adverse effects in an up-to-date reference.
c) Be aware of resident's response to medication. A reaction, especially those that are adverse, must be reported immediately to the Charge Nurse / Nursing Supervisor.

Rule 15- If an order is not absolutely clear- **Do <u>not</u> give the medication or treatment until the order is clarified.** When the order varies from the usual dosage, verify it with the physician's order or with the pharmacist. Question without fail any dosage order that seems incorrect.

Rule 16- At the beginning of shift the Medication Nurse should check for residents who are N.P.O., diabetic (on insulin), on Coumadin, or fasting. Nurse should check on residents for renewals, appointments, and those leaving the building. Flagging system must be used to organize and identify medication delivery times. Do not remove flag until you have signed the MAR/TAR.

Administration continued:

Rule 17- The Medication and Treatment Nurses for all (3) shifts are responsible for checking the cart for medications and treatments that need to be reordered. Pull off reorder label and place on pharmacy "Medication Orders and Misc. Merchandise" form. Fax to Royal Care Pharmacy. Note "faxed", date, time and initials in red ink on top and file in pharmacy fax binder.

Rule 18- If a medication / treatment is not available, notify Head Nurse/Charge Nurse/Nursing Supervisor immediately.

Rule 19- Borrowing medication from another resident is contraindicated unless directed by a Nursing Supervisor.

Rule 20- Wash hands before starting and when visibly soiled. Hand sanitizer should be used when contact has been made.

Rule 21- Medications should be given in an appropriate time frame. Medications may be administered one hour before or up to one hour after time ordered.

Rule 22- Any time a scheduled med is not given in the appropriate time frame; it has to be reported to the Head Nurse/Supervisor. The Head Nurse/Supervisor will be responsible for deciding how, or if, this med can be administered at another time. Check with MD if necessary.

Rule 23- Medications are to be poured immediately prior to administration.

Rule 24- The nurse that prepares the medication is the one responsible for administering it.

Rule 25- Check medication/treatment with Medication/Treatment Administration Record (M/TAR) for and administer according to:

a) date
b) drug
c) dosage
d) route
e) time
f) expiration date-if expired, notify Charge Nurse/Nursing Supervisor
g) allergies

Rule 26- Verify it is the right medication. Remove medication, without contaminating, from individual container according to the **three-step-method**.

a) **Read** label on medication carefully
b) **Read** Medication/Treatment Administration Record (M/TAR) carefully
c) **Read** label again – carefully

This procedure is done before med is poured and after medication is poured.

Administration continued:

Rule 27- If a medication administration is dependent on vital signs or lab work, take vital signs first and check lab value. Then, if criteria for administration are met, give the medication and document vital signs in designated area.

a) VRM has a **flow sheet for vital signs, Procrit/Aranesp, Coumadin, Heparin/Lovenox, Insulin and Finger Sticks, Exelon Patches, etc.**
b) If medications are poured before vital signs are taken, place the medication in a separate soufflé cup.

Rule 28- Medications are not to be given in any form other than ordered. If contraindication arises, refer to Rule #35.

Rule 29- Verify it is the right resident:

a) identify the resident by wrist band or;
b) by photo
c) ask resident "What is your name?"
****Please consult Head Nurse/Charge Nurse/supervisor if either photo or name band needs replacement.****

Rule 30- After administering the medication, check to see that all medications are swallowed. Residents should be encouraged to take a full glass of water with pills, if appropriate.

Rule 31- Never leave medications at the bedside, unless ordered by a physician.

Rule 32- Medications and treatments are not to be done while resident is eating a meal unless specifically ordered by the physician and care planned for individual resident needs.

Rule 33- Medications and treatments are not to be done while resident is sitting on toilet and/or commode.

Rule 34- Privacy is to be provided for injections, patches, G-tube access, and finger sticks unless resident declines privacy.

Rule 35- Enteric-coated effervescent tablets, sublingual or buccal tablets, and time-release tablets cannot be crushed. If a medication cannot be given unless "crushed" – and it states "DO NOT CRUSH" – notify the physician/pharmacist to investigate an appropriate substitute.

Rule 36- When crushing medications, use two soufflé cups in the pill crusher – one to hold the medication and another to cover the medication. There are 2 types:
1) Manual 2) Automatic

Administration continued:

Rule 37- Liquid medications are measured at eye level. Be sure to shake/rotate liquid medications prior to pouring, unless otherwise specified. Do not pour liquids over kardex.

Rule 38- Liquid iron preparations are to be given through a straw if at all possible and within dietary guidelines.

Rule 39- Do not touch the medication with your hands – a glove can be used.

Rule 40- Gloves are to be worn when administering eye drops, applying patches, performing fingersticks, administering G-tube medications and injections, and for treatment applications.

Rule 41- Eye medications – wait 2 minutes between drops of the same medication. Different eye medications are to be given 5 minutes apart.

Rule 42- When applying a patch, make sure all previous patches of same medication have been removed. Sites are rotated and documented on the M/TAR. Date and initial patch.

Rule 43- Inhalers – wait 2 minutes between puffs of same inhaler. For different inhalers wait 5 minutes between the different types. (Bronchodilators must be administered first, then steroids, then anticholinergics.)

Rule 44- For odd-dose liquid medication a syringe of appropriate size will be used to measure liquid meds. This will be changed weekly and dated by the 7-3 Medication Nurse and rinsed out after each use. Syringe is to be attached to medication bottle with a rubber band.

Rule 45- Resident's pulse must be taken apically for prescribed medications that effect heart rate as per ordered by physician.

Rule 46- Blood pressures are not to be taken over clothing.

Rule 47- Injection sites should be rotated.

G-Tubes:
Medication Administration:

Rule 1- Check Medication Administration Record (MAR) for medications to be given.

Rule 2- Medication should be poured so that each medication will be administered one at a time.

Rule 3- Use liquid medications, if possible.

Rule 4- If tablets are crushed, dilute in warm water.

*If tablet states "DO NOT CRUSH", Physician/Pharmacy should be notified to advise of possible substitute.

Rule 5- Procedure should be done providing the resident with privacy and in correct position with head of bed raised to at least a 30° - 45° angle.

G-Tubes With Feeding Running:

Rule 1- Place enteral nutritional pump on HOLD.

Rule 2- Disconnect tubing from g-tube, preventing contamination of tubing.

Rule 3- Flush tubing with 30cc of water prior to administering meds.

Rule 4- Instill medications in liquid form thru tube, one at a time.

Rule 5- Flush with 30cc of water after administering each medication.

Rule 6- Reconnect tubing, preventing contamination of tubing.

Rule 7- Place pump on RUN.

G-Tube Meds Without a Feeding:

Rule 1- Disconnect plug or protective cover, preventing contamination.

Rule 2- Check tube placement by aspiration of stomach contents or auscultation method per tube feeding policy and procedure. Must return stomach contents to prevent electrolyte imbalance.
If there is a doubt of placement, the nurse should report this to their supervisor.

G-Tube Meds Without a Feeding: (continued)

Rule 3- Flush with 30cc of water prior to starting.

Rule 4- Flush with 30cc of water after each med.

Rule 5- Reconnect plug or protective cover to tubing when meds are completed and avoid any contamination.

Transcription:

Rule 1- Transcribe all orders in chart room. Limit interruptions

Rule 2- Clarify unclear or incomplete orders with physician before transcribing the order.

Rule 3- Check that you have the correct resident's MAR before transcribing.

Rule 4- Use black ink. Write out full drug name – do not abbreviate.

Rule 5- Transcribe the order exactly as it appears on the Physician's Order Sheet on to the Medication Treatment Administration Record. (See below.) Do not alter physician order.

a) As a cue only, times for each shift are: red area for 11-7 shift, black area for 7-3 shift, and green area for 3-11 shift. Use corresponding color ink to identify hour of administration.

b) Check off each medication order on Physician's Order Sheet after it has been transcribed.

Rule 6- a) After order is transcribed, note date, time, signature, and title below orders on right-hand side, thereby showing order was transcribed and by whom.

b) Before signing the order sheet, carefully review all parts of the order.

c) Re-check the accuracy of each transcription and check for omissions.

Rule 7- Stat Meds – are transcribed on the M/TAR. Initial after administration, write D/C'd, date and initials and then use yellow highlighter indicating it has been d/c'd.

Transcription (Continued):

Rule 8- New Orders:

a) Note the drug (full name), dose, route, frequency, and any special instructions.
b) Note time of administration in appropriate column.
c) Spaces prior to medication start date and time blocked out by line with arrow in ink.
d) Place order date on left of order
e) Place your initials at end of order.
f) Space is provided for documentation of vital signs and/or for site locations. If flow sheet is used, it is stated to use flow sheet on M/TAR.
g) Write note in Progress Note.
h) Note new order on 24 Hour Report
i) Notify family/resident of new order.

Rule 9- Limited Number of Days:

a) A straight line is drawn to the day prior to the first dose – in ink.
b) The squares are numbered and blocked out to the correct number of doses.
c) A straight line is drawn through the remaining days – in ink.

Rule 10- If awaiting medication from pharmacy, communicate with Medication Nurse, flag Kardex and place on 24 Hour Report.

Rule 11- Once a Week / Month:

a) A straight line is drawn to the day – in ink.
b) The square is traced around when medication is to be given.
c) A straight line is drawn through the remaining days.

Rule 12- Alternating Days or Several Times a Week:

a) An "X" is used to block out dates not given.
b) If ordered several times per week, days are written under order (ex: Mon-Wed-Fri)

Rule 13- Changed Order:

Old Order – Write D/C date, and initials after last day initialed on Medication/ Treatment Administration Record. Transcribe new order on Medication Treatment Administration Record. Place green "Direction Change Refer to Chart" sticker on top left of blister pack.

Rule 14- Held Meds and Treatments:

Hold is penciled in and date placed under order, then held is written under each day medication is held – in ink (on M/TAR).
Place blue "Hold Medication" sticker on top left corner of blister pack with date and initial. *If medication is being held for pre-op, indicate "pre-op" on MAR*

Transcription (Continued):

Rule 15- See #8 on other policy. Pull old blister pack from med cart and place in med room return basket.

Documentation:

Rule 1- Documentation must be legible. You may need to print and must use black ink.

Rule 2- Sign Master Signature Sheet legibly in front of Medex for your shift and date.

Rule 3- Initial Medication/Treatment Administration Record (M/TAR) immediately after administering medications, treatments, and nursing measures. Document sites as appropriate (ex:Duragesic patches, Exelon, injections, heparin, lovenox, etc.). Document pulse, BP and fingerstick as indicated on flowsheet.

Rule 4- PRN Medications and Treatment:
All PRN medications must be assessed by an RN

a) PRN Meds: All PRN medications administered must be documented on the back of M/TAR with reason PRN was given, what amount was given, effect of drug, and resident response to PRN medications. RN must cosign LPN note.

b) Medications used on a frequent basis should be reviewed with physician to determine if they need to be added to routine orders.

** All shifts are responsible for follow-up**

If a PRN is given before shift ends (up to 30 minutes before), that shift has to document a response in medical record and/or on back of MAR. If 30 minutes before and no response, it must go on report and follow-up in the medical records.

Rule 5- Wrong Space Initialed: Star in red ink on Medication/Treatment Administration Record (M/TAR) and document in medical record.

Rule 6- If a medication or treatment is not given, place a circle in the space on the MAR and document on back of MAR why the medication was not given. (Ex. LOA, refused, held)

Rule 7- Hospitalized Residents: Hospitalized is written and highlighted across the days on both Medication and Treatment Administration Records when resident is readmitted. M/TARS are turned over in binder until resident is readmitted.

Rule 8- Nurses are not to re-label any container of medication.

Rule 9- When medication is given to treat a "behavior", document the behavior, interventions used, and effect of medication on that behavior.

Controlled Substance Guidelines:

Rule 1- Controlled substances are to be kept under a double lock system at all times.

Rule 2- The Nurse coming on duty will count with the Nurse going off duty to verify the count is correct, the medication is correct, the dosage is correct, the amount is correct and the Rx numbers match on the control sheet and medication. See Administration Rule #2 for details.

Rule 3- When counting controlled substances, all pills and vials/patches will be counted individually within view of both nurses. **You must remove any container so it is visible to count.** (Duragesic patches are to be individually checked for tampering.)

Rule 4- Do not sign Controlled Substance Record unless you have counted, observed count sheet quantity, and pharmacy label verifying count is correct.

Rule 5- Med Nurse must complete controlled substance count if keys are to change hands – See Administration Rule #6.

Rule 6- The order for a controlled substance must be rewritten every 30 days. A controlled substance prescription is filled out as needed with daily dose and number to be dispensed. A copy is placed in the Medex and chart. Order cautiously to avoid wasting medication. Place renewal date on MAR.

Rule 7- Nursing Supervisor must be immediately notified if there is any discrepancy with the count. Nursing Supervisor must then verify the count for all controlled substances on that unit. Nursing Supervisor must sign each balance.

a) This may include, but is not limited to: an error, extra pill, vial opened, original package has been tampered with.
DO NOT TAPE OR ALTER THE PACKAGE – WHEN IN DOUBT CALL A SUPERVISOR.

Rule 8- When wasting any unused narcotic medication, it must be done at the time the medication is to be given. Only an RN Supervisor or Head Nurse can witness and sign for wasting of a controlled substance.

Rule 9- Hand deliver completed Controlled Substance Disposition Sheet directly to the DON, ADON or QA Nurse during drug return.

Rule 10- Hand deliver controlled substances for destruction to DON, ADON, QA or designee on during drug return.

a) Complete heading of disposition sheet
- Quantity remaining
- Reason
- Signature and date

Controlled Substance Guidelines - continued

Rule 11- Pharmacy will deliver controlled substances to a Nursing Supervisor.

Rule 12- Nursing Supervisor will deliver controlled substances to Medication Nurse on unit. Both will count and sign Controlled Substance Record verifying that the prescription number on the medication matches the prescription number on the Controlled Substance Sheet.

Rule 13- Then file Controlled Substance Sheet into Narcotic Binder and place controlled substance under double lock. Nurse must sign out on Controlled Substance Sheet according to MD order, administer medication, then sign MAR.

Rule 14- Controlled substances are to be kept under double lock in Medication Room. If part of an active medication pass, then will be locked in narcotic box in the med cart.

Rule 15- Controlled Substances that require refrigeration must be double locked in plastic box in Medication Refrigerator which is also kept locked.

Rule 16- All PRN controlled substances must be approved by the Nursing Supervisor or Head Nurse. The medical record/back of MAR must reflect the reason given, time given, name of medication, and resident's response to medication.
- RN must co-sign this note.

Rule 17- The one hour rule for passing of routine medications – one hour before or after the time ordered, does not apply to the dispensing of a PRN controlled substance. Strict adherence to the time frame the medication is ordered for must be maintained.

Rule 18- Follow current policy for Duragesic Patch –Removal and Destruction. Record on log, fold onto itself, and flush down hopper with another nurse.

Medication Error Discovery:

Rule 1- The Nurse discovering the error is responsible to report the error to the Charge Nurse or Supervisor and complete Med Error Form.

Rule 2- If Medication/Treatment error is an omission completely fill in box with Red ink to denote the error as discovered and the Med Error form has been completed.

Rule 3- The nurse is responsible for checking previous entries & previous doses when they are signing for their medications/treatments. Report omissions to Nursing Supervisor and follow Rule #2 above.

Medication Error Discovery (continued)

Rule 4- Once an omission is identified, the nurse cannot go back and fill in initials.

Rule 5- Nursing Supervisor is responsible to log med error on daily log kept in Nursing Office.

Rule 6- Nursing Supervisor is responsible to leave voice mail on QA Nurse's phone describing the med error.

Rule 7- Nursing Supervisor/Charge Nurse is responsible to have physician review the error as soon as possible, prior to submission. For critical med errors physician must be notified immediately. Examples, but not limited to: wrong dose, meds to wrong resident, insulin error, resident allergy

Rule 8- Nurse receiving medication error must receive education and nurse must write a statement with details of errors and preventative measures.

Self-Administration of Medications:

Rule 1- The nurse will check weekly on supply of medications that are kept locked in resident's night stand.

Rule 2- Monitor Self Administration Record daily to evaluate compliance.

Rule 3- Verify the resident has administered the drug(s) at the correct time(s) and initial on Medication Administration Record (MAR).

Rule 4- Document weekly in medical record: medication, dose, route and frequency, use and effectiveness of PRN medications, that inspection was made, any medications removed and reason for removal, any change in ability to self-medicate.

Insulin Administration:

Rule 1- Blood glucose will be checked per MD orders and documented on Finger Stick Flow Sheet.

Rule 2- Notify MD of blood glucose 50 or below OR 400 or above unless otherwise indicated by MD order.

Rule 3- Insulin is administered with meals and at bedtime unless otherwise specified by MD order. If resident refuses meal, MD is notified for recommendations.

Rule 4- Do not hold insulin without notification of Nursing Supervisor.

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Revised: 4/98, 12/98, 2/99, 8/99, 9/99, 1/03, 2/05, 10/05, 9/10, 4/14

Reviewed by DON: M Gonzales, RN
Date: 4/24/14

Reviewed by Medical Director:
Date: 4/29/14