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 per Electronic Health Record EMAR / ETAR guidelines while maintaining residents' dignity and respect.

Administration:

Rule 1- Medications will be administered to resident by RN or LPN according to physician's order.
All PRN medications must be assessed by an RN
Medications used on a frequent basis should be reviewed with physician to determine if they need to be added to routine orders.

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. (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 computer must be in locked mode to maintain resident privacy.

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 finishing. 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. Plastic dividers may be used 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 personal items.

Rule 13- The Nurse must check resident's Electronic Health Record for 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. or fasting. Nurse should check on residents for appointments and those leaving the building.

Administration continued:

Rule 17- If a medication / treatment is not available, notify Head Nurse/Charge Nurse/Nursing Supervisor immediately.

Rule 18- Borrowing medication from another resident is contraindicated unless directed by a Nursing Supervisor.

Rule 19- Wash hands before starting and when visibly soiled. Hand sanitizer should be used when contact has been made.

Rule 20- 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 21- 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 22- Medications are to be poured immediately prior to administration.

Rule 23- The nurse that prepares the medication is the one responsible for administering it.

Rule 24- Check medication/treatment with Electronic Medication/Treatment Administration Record (EMAR / ETAR) 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 25- 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 (EMAR/ETAR) carefully
c) **Read** label again – carefully

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

Rule 26- 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) There will be a diagram in the front of the Team Binder identifying sites on a body that will be used to document in the EMAR where the medication will be administered.

Administration continued:

Rule 27- Medications are not to be given in any form other than ordered.

Rule 28- 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 29- 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 30- Never leave medications at the bedside, unless ordered by a physician.

Rule 31- Medications and treatments are not to be done while resident is eating a meal in the dining room unless specifically ordered by the physician and care planned for individual resident needs.

Rule 32- Medications and treatments are not to be done while resident is sitting on toilet and/or commode.

Rule 33- Privacy is to be provided for injections, patches, G-tube access, and finger sticks unless resident declines privacy.

Rule 34- 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 35- Liquid medications are measured at eye level. Be sure to shake/rotate liquid medications prior to pouring, unless otherwise specified.

Rule 36- Liquid iron preparations are to be given through a straw if at all possible and within dietary guidelines.

Rule 37- Do not touch the medication with your hands – a glove can be used.

Rule 38- Gloves are to be worn when administering eye drops, applying patches, performing fingersticks, administering G-tube medications and injections, and for treatment applications.

Rule 39- Eye medications – wait 2 minutes between drops of the same medication. Different eye medications are to be given 5 minutes apart.

Administration continued:

Rule 40- When applying a patch, make sure all previous patches of same medication have been removed. Sites are rotated and documented on the EMAR. Date and initial patch.

Rule 41- 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 42- 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 43- Resident's pulse must be taken apically for prescribed medications that effect heart rate as ordered by physician.

Rule 44- Blood pressures are not to be taken over clothing.

Rule 45- Injection sites should be rotated and documented in EMAR.

G-Tubes:
Medication Administration:

Rule 1- Check Electronic Medication Administration Record (EMAR) 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.

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.

Order Reconciliation:

Rule 1- All orders will be reviewed for accuracy and schedule using the Reconciliation Log.
a) First check will be done on shift ordered.
b) Second and third check by next scheduled shift.

Documentation:

Rule 1- At the change of shift the Dashboard is to be checked for accuracy and completeness of medication/treatment pass.

Rule 2- Document EMAR / ETAR 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 per Electronic Health Record Directives.

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

Rule 3- Nurses are not to re-label any container of medication.

Rule 4- When medication is given to treat a "behavior", document the behavior, interventions used, and effect of medication on that behavior per Electronic Health Record directives.

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 renewed 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 Team Binder.

Controlled Substance Guidelines: (continued)

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, or ADON during drug return.

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

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

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 Team Binder and place controlled substance under double lock. Nurse must sign out on Controlled Substance Sheet according to MD order, administer medication, then sign per Electronic Health Record Directives.

Rule 14- Controlled substances are to be kept under double lock in Medication Room. If part of an active medication pass, then med 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/RN. The electronic medical record must reflect the reason given, time given, name of medication, and resident's response to medication.
- Nursing Supervisor or Head Nurse/RN must complete PRN med approval progress note template.

Controlled Substance Guidelines: (continued)

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. Fold onto itself and flush down hopper with another nurse to witness.

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

Rule 3- 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 4- 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 Electronic Medication Administration Record (EMAR).

Rule 4- Document weekly in electronic 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 per Electronic Health Record directives.

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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