I. PURPOSE

To define the control and administration of medications for the safety of patients.

II. POLICY

A. General

1. Medications are administered only under a prescriber’s order or protocol as described in Administrative Policy 8.16.
2. The person administering the medication is responsible for documenting its administration in the patient's medical record.

B. Personnel Authorized to Administer Medications (See procedure section A for additional detail)

1. Administration of medications is the responsibility of the medical staff, but may be performed by specified, qualified personnel.
2. A clinical service may restrict the administration of selected medications to physicians or to specified, qualified personnel with approval of the P&T committee.

C. Ensuring Safe Medication Administration (See procedure section D for additional detail)

1. Those administering medications are responsible for assuring appropriateness and accuracy of medications and treatments they administer under prescribers’ orders.
2. Emergency medications and resuscitative equipment are stored on all units where medications are administered.

D. Medication Disposal or Waste (See procedure section E for additional detail)

1. Medications will be wasted appropriately, and the waste will be documented according to state and federal regulations.

E. Sample Drugs (See Administrative Policy 8.36 for information on the use of sample drugs). Sample drugs are not to be dispensed to inpatients in the hospital. In the event that sample drugs are found in the patient care area, they should immediately be given to the unit pharmacist for disposition.

F. Investigational Drugs (See Administrative Policy 4.11 for information on administration of investigational drugs). Investigational drugs and devices must receive approval of the UW Health Sciences Institutional Review Board prior to their use.

G. Administration of IV Medications (See Administrative Policy 8.31 for guidelines on hospital location-specific administration of IV medications).

H. Administration of High Alert Medications (See Administrative Policy 8.33 for information on...
administration of high alert medications).

I. Administration of Chemotherapy (See Administrative Policy 8.59 for information on administration of chemotherapy).

J. Range Orders. A range order is a medication order where the dosage is expressed as a range rather than a specific amount. Use of range orders is a clinical practice designed to provide flexibility in dosing to meet an individual’s unique needs. A range order requires nursing staff to exercise judgment in determining the most appropriate dose for a given clinical situation. Clarification from the prescriber should always be sought if the intent of an order is not clear.

III. PROCEDURES

A. Personnel Authorized to Administer Medications

1. Registered nurses (e.g.; CRNAs, Nurse Practitioners, Clinical Nurse Specialists, etc) may administer all medications.
2. Nursing Assistants may administer medicated treatments as described in their respective position descriptions.
3. LPNs may administer medications and treatments as described in their position descriptions.
4. Pharmacists, pharmacy interns and residents may administer medications based on their training and position.
5. Respiratory Therapists and Respiratory Therapy Technicians may administer medications delivered through the respiratory tract.
6. Students in disciplines normally authorized to administer medication may do so, but only under the supervision of a fully qualified individual in the field.
7. Physicians may administer any medications.
8. Physician assistants may administer medications consistent with Administrative Policy & Procedure #9.30, Review & Supervision of Physician Assistants.
9. Medical assistants may administer medications under the supervision of a physician, nurse or pharmacist as described in their position description and after successful completion of a standard instructional program administered by the Department of Nursing.
10. Radiologic technologists may administer contrast media per modality protocol.

B. Self-administration by Inpatients and Medications Stored at Bedside

1. The decision that an inpatient should be responsible for self-administration of medications or treatment "at bedside" is made jointly by the physician, nurse, and pharmacist (or respiratory therapist for aerosolized medications) in consultation with the patient. The physician or designee must write this directive on the Physician's Order Sheet.
2. An assessment of the patient’s ability to safely and accurately self-administer their medications, along with patient instruction on the safe self-administration of each drug,
will be completed prior to initiating patient self-administration of medications.

2. Prescription medications for self-administration (excluding patients’ own medications where procedures are outlined below) are issued from the Pharmacy labeled with the name of the patient and physician, the instructions for administration as stated in the physician's order, and the name, strength of the drug, and quantity issued.

3. Self-administered medications must be documented by the caregiver in the patient's medical record.

4. Self-administration requires medications to be stored at the bedside.

5. Respiratory therapists may determine the need to store multi-dose aerosolized medications at the bedside regardless of self-administration status. Such orders must be documented in patient care orders and do not require a counter signature.

C. Patients’ Own Medication

1. Patients’ own medication should be given to the unit pharmacist for identification and storage.

2. Use of personal medication supplies is discouraged and should be ordered only when an equivalent formulary product is not available and the medication cannot be reasonably obtained by the pharmacy department.

3. Use of a patient's own medication is permitted based on a physician order if the following standards are followed:
   a. The patient, guardian or the patient’s legal representative must give verbal consent allowing personal medications to be administered by hospital personnel.
   b. The unit pharmacist must positively identify the patient’s medication for content and integrity, and store the medications appropriately.
   c. For an inpatient, the medication should be stored in the patient's medication drawer or in an automated dispensing cabinet if the medication is a schedule II or III controlled substance. The medication will remain in the patient’s medication drawer unless there is a written order for the patient to self-administer their medication or to store the medication at bedside. Schedule II and III controlled substances may not be stored at the patient’s bedside.
   d. Within 24 hours of receipt of the medications, the pharmacist will assess the number of days’ supply of each non-formulary medication ordered, based on the current dosage regimen. The pharmacist will document the days’ supply of the medication in the Pharmacy computer system using the notation “enough through (date)”. This notation will appear on the patient’s medication profile. The supply of the non-formulary medications will be monitored by the pharmacist on a daily basis via a report generated from the Pharmacy computer room. The report includes all current orders with the “patient’s own” attribute.
   e. The supplies will concurrently be monitored during daily distribution of the medication to the patient by the nurse or designee, who will re-assess the current supply of medication and communicate any apparent discrepancies to the unit pharmacist immediately.
   f. The medications should be profiled, administered, and charted by the same
D. Ensuring Safe Medication Administration:

1. To ensure safe and accurate administration of medications to patients, a pharmacist reviews all non-emergency inpatient medication orders against the medication profile prior to medication dispensing and administration, unless the absolute necessity of patient clinical needs or safety does not permit such a review. Nurses and physicians are responsible for judging whether the patient’s clinical condition warrants bypassing the pharmacist review.

2. Pharmacist order review prior to administration is not required in settings where a physician controls the ordering, preparation and administration of the medication.

3. Each person administering medications or treatment is required to check the medication against the medication administration record (MAR) or original written order, verify patient allergy status, and verify identification of the patient using two patient identifiers (excluding patient location) prior to medication administration. If urgency necessitates administration of a scheduled medication to an inpatient prior to it reaching the profile, a nurse will check the medication label against the original order to verify accuracy prior to administration.

4. On patient care areas using the point of care bar code medication administration scanning system (AcuScan), the patient’s wrist band bar code (and medication bar code when applicable) must be scanned to confirm accurate patient (and medication) identity prior to administering non-emergency doses of medications.

5. Access to patient-specific medication in non-patient–specific storage areas (pharmacy delivery bins) is limited to pharmacists, and medications should not be removed prior to a pharmacist’s check, unless patient safety dictates otherwise.

6. In emergency situations, all drug therapy should be announced to another health-care provider immediately before administration - saying for example “I am now giving heparin 2,000 units IV”.

7. Whenever possible an explanation of purpose of each medication is to be provided to the patient or patient’s family prior to administration.

8. Nurses or others administering medications shall remain with the patient until medications are taken.
9. Medications should be administered within sixty minutes of their scheduled time of administration. Acceptable reasons do exist and should be documented in circumstances where medications are not administered within this timeframe (e.g., nursing clinical judgment, scheduled procedure, etc).

10. Errors and other significant incidents related to ordering, dispensing, or administration of medications are to be reported verbally to the employee’s immediate supervisor and via the Patient Safety Net on-line occurrence reporting system.

11. Medications that are not being drawn up for immediate administration must be labeled with drug name and dose at the point of preparation. Any time one or more medications are drawn up or prepared for later use, the container (syringe, bottle) must be appropriately labeled. In addition, every drug must be labeled during any intermediate step of the preparation process, if the medication could possibly be confused or mistaken for another. Any time the medication leaves the hand of the clinician who has prepared it, it must be labeled, even if that clinician intends to administer or use it immediately.

12. If a question arises about the intent of a medication order or whether a medication should be held, the prescriber should be consulted.

E. Medication Disposal or Waste:

1. Intact medications.
   a. Medications removed from AcuDose that are intact and in their original tamper-proof package and suitable for use for another patient must be returned to AcuDose. This ensures that the patient receives credit for drugs not administered to them. If the medication is a controlled substance, two licensed nurses must witness the return and document this in the cabinet.
   b. All medications returned to the cabinet must be placed in the return bin located in the bottom drawer of the cabinet. The central pharmacy will manage all returns and process them according to their subsequent usability.
   c. No uncapped or manipulated needles should be placed in the Return Bin, instead place them in a needle disposal box, and then waste the medication solution and syringe in the Hazardous Substance Waste Container.
   d. Defective dosage forms should be returned to pharmacy via the Return Bin in a zip-locked bag with a note attached describing the problem.
   e. Medications dispensed from patient medication cassette drawers that are intact and not used (or refused) by the patient should be returned to the patient’s cassette drawer and the MAR should properly indicate that the dose was omitted.

2. Medications that must be wasted:
   a. Any product that has come in contact with a patient should be wasted in a Hazardous Substance Waste Container, not in a needle box and not in the Pharmacy Return Bin.
   b. All controlled substances removed from their original tamper-proof package or protective plastic over-wrap, and/or not suitable for use with another patient must be wasted and documented as wasted by two licensed nurses/practitioners.
Such doses should not be returned to the AcuDose cabinet or to Pharmacy. The dose actually administered to the patient must be documented on the MAR, but waste should only be documented in AcuDose or on the appropriate controlled substance proof-of-use record in areas without AcuDose.

IV. RELATED POLICIES

There are a number of related procedures which are developed, coordinated and maintained by the utilizing services and which are available in the appropriate manuals. See especially Nursing Procedure 10.15 and the Pharmacy Policy & Procedure Manual.

V. COORDINATION

Sr Management Sponsor: Sr. VP Professional & Support Services
Author: Inpatient Pharmacy Manager
Review/approval Committees:
  Nursing Administrative Council
  Pharmacy and Therapeutics Committee
  Patient Care & Procedures Committee

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