Team Name: Acute Care Team Lead: Director - Acute Community Hospitals Approved by: Regional Lead - Acute Care & Chief Nursing Officer	Reference Number: CLI.4110.PL.015 Program Area: Across Care Areas Policy Section: General
Issue Date: May 23, 2019 Review Date: Revision Date: August 10, 2023	Subject: Safe Medication Administration: Acute Care

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POLICY SUBJECT:
Safe Medication Administration: Acute Care

PURPOSE:
To safely administer parental and non-parental medications to all patients receiving services in Acute Care.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02) – Treatment of Clients
Executive Limitation (EL-01) – Global Executive Restraint and Risk Management

POLICY:

- Each Southern Health-Santé Sud care provider who administers medications to patients is responsible for safe medication administration. It is an individual's responsibility to confirm that it falls within one's scope of practice and assignment.
- Safe medication administration requires good judgment, critical thinking, and clinical decision-making skills. This includes thorough patient assessment, and an understanding of pharmaco-therapeutics, pharmacokinetics, growth and development, nutrition, and mathematics.
- The need for patient assessment, informed consent, right to refuse care, education, and the evaluation of care provided transcends all interventions, including medication preparation and administration.

DEFINITIONS:

Administering - provision of a medication directly to the client for immediate ingestion or introduction into the body (e.g. by injection or other route) according to a prescription.

IMPORTANT POINTS TO CONSIDER:

- Medication distribution is a three (3) step process, starting with the prescribing of the medication, dispensing of the medication by pharmacists, and the administration of the medication to the patient.
- To prevent medication adverse events, review the Rights of Medication Administration with each medication administration. Elsevier Clinical Skills identifies 6 Rights of Medication Administration:
  1. Right Patient,
  2. Right Medication and concentration,
  3. Right Dose,
  4. Right Route and Frequency,
  5. Right Time, and
  6. Right Documentation.
- Accreditation Canada also identifies two (2) additional Rights of Medication Administration to support patient safety:
  7. Right Reason, and
  8. Right Response.
- Medications dispensed from Southern Health-Santé Sud pharmacies follow the Regional Drug Formulary and include tall man lettering for Look-alike Sound-alike medications as per Look-alike Sound-alike (CLI.6010.PL.002).
- A quiet environment without interruptions is essential during medication administration times.

PROCEDURE:

1. Complete hand hygiene prior to all medication preparation and before and after patient contact as per Hand Hygiene (CLI.8011.PL.001).
2. Follow safe medication preparation and administration practices defined in the Elsevier Clinical Skills – Skills while verifying the 8 Rights of Medication Administration:
   - RIGHT Patient
     - Verify two (2) patient identifiers to identify "Right Patient" as per Client Identification (ORG.1410.PL.301).
   - RIGHT Medication and Concentration
     - As per Provincial Clinical Standard, Safety Controls for High Alerts Medications, ensure the medication is the correct concentration prior to preparation.
     - Medications administered must have a signed prescribers order. For Telephone or Verbal Orders, refer to Telephone or Verbal Orders (CLI.6010.PL.010).
     - Applicable non-formulary drugs will automatically be substituted in accordance with the Automatic Therapeutic Interchange policy (CLI.6010.PL.016). In the

event a patient/client is stabilized on a medication not interchangeable with a formulary drug, the prescriber may authorize the administration of the Patients Own Medication (POMs) as per policy (CLI.6010.PL.008).

- Medications are prepared, administered and documented by the same nurse unless:
  - The medication is prepared by Pharmacy,
  - The medication is administered during an emergency situation, and/or
  - The patient is self-administering.
- Complete patient assessment based on order/medication protocol (i.e., Blood Pressure/Pulse Check.).
- Medications from containers without labels or with illegible labels are not to be used and are returned to Pharmacy.
- For proper management of antimicrobials refer to Antibiotic Stewardship Program (CLI.6010.PL.004) and Antimicrobial Intravenous to Oral Therapeutic Conversion (CLI.6010.PL.006).
- For Cannabis for Medical Purposes refer to Cannabis for Medical Purposes (CLI.6010.PL.023).
- For Hazardous Medications (Cytotoxic and Non-Cytotoxic) refer to the Safe Handling of Hazardous Medications (Cytotoxic and Non-Cytotoxic) (CLI.6010.PL.021) for direction and safety measures for the receipt, storage, preparation, transport, administration, waste management and spill clean up.
- For Narcotics and Controlled Drugs, dispense, administer, waste and document as per Narcotics and Controlled Drugs (CLI.6010.PL.015).
- Multi-dose vials (MDV):
  - Verify date that MDV has been opened and discard 30 days from date opened as per Expiry of Multi-Dose Injectable Products (CLI.6010.PL.012).

- RIGHT Dose
  - Dose coincides with MAR and prescriber's order.
  - Appropriate dose: Use metric system and/or exact dosage strength or milligrams, micrograms etc.
  - Perform dosage calculations as required.
  - Use appropriate size medication cup and/or oral syringe with oral medications.
  - Obtain an independent double check for all high alert medications, as defined in High Alert Medication Management (CLI.6010.PL.001).
- RIGHT Route and Frequency
  - Route is specified on prescriber order and is safe and appropriate.
  - Oral medications are followed with adequate fluid intake unless contraindicated.

- Document the route used on the Medication Administration Record (MAR) when multiple routes are prescribed.
- Administer subcutaneous (Subcut), intramuscular (IM), intradermal medications using sterile technique. Document location of injection and rotate sites.
- Crushed Medication:
  - Refer to Canadian Do Not Crush List under Pharmacy Resources to verify if medication can be crushed.
- Topical Medication:
  - Examples - patches and applications, document location of application and rotate sites as deemed appropriate.
- Intravenous (IV) Medications:
  - Administer IV medication as per the specific IV medication drug monograph.
  - If an IV infusion is running outside the soft limits in the large volume pump library, clarify the order with the prescriber. If an IV infusion is running outside the soft dose limits of the large volume pump library and the order is clarified with the prescriber, document the medication rate in the Integrated Progress Notes (IPN) (CLI.4510.PR.002.FORM.01).

➢ RIGHT Time

- Prepare medications immediately before use and no more than one (1) hour before the start of administration, when not prepared under sterile conditions in a pharmacy compounding area.
- Sign for Medication on MAR immediately after being given.
- For All PRN Medications: Verify time of last dose given prior to administration and that the dose does not exceed parameters. Document reason for PRN on the MAR/Integrated Progress Notes (IPN) and effectiveness of the medication.

➢ RIGHT Documentation

- Document all medications administered on the appropriate Medication Reconciliation Forms (MAR).
- PRN Medications:
  - Indication for Use is identified for all PRN medications.
  - Document use and effectiveness on the MAR/IPN.
- Narcotics and Controlled Drugs:
  - Ensure a double signature on the MAR when applying and removing narcotic patches as per Narcotics and Controlled Drugs (CLI.6010.PL.015).
- Document patient education in the health record.
- When an IV medication is titrated based on patient responses to treatment, document the medication on the appropriate MAR as per prescriber order but

document dosage adjustments on the Frequent Monitoring Record (CLI.4510.PR.002.FORM.02) or an alternative documentation record that captures close and frequent patient monitoring (ie. norepinephrine).
    - Document Allergies on:
        - Front of chart
        - Admission history
        - Armband
        - Prescriber Order Sheet (CLI.4510.PR.002.FORM.13)
        - MAR(s)
        - Medication Reconciliation Forms (BPMH, Transfer, Discharge)
        - Care Maps/Standard Orders/Clinical Circumstance Sheet
- RIGHT Reason:
    - Understand the rationale for administering medication. Research the medication if unknown or unfamiliar.
    - Follow up with prescriber for verification of orders if contraindicated and/or ordered dose exceeds recommended limits.
- RIGHT Response:
    - Once a medication is given, carefully monitor for the effectiveness, side effects, signs of drug reactions or interactions.
    - Document in the IPN.

3. Patient Education
    - As part of the Medication Administration process, provide education to patient regarding the reason for the medication, possible side effects, precautions and any special considerations. Document education provided and any patient concerns.
4. Patient Self-Administration of Medications
    - Refer to Patients own Medications (CLI.6010.PL.008).
5. Preparation of medication for patient leaves from facility
    - Refer to Patient Resident Leave of Absence Medications (CLI.6010.PL.022).
6. Patient's Right to Refuse
    - A patient/client has a right to refuse any medication, refer to Consent for Procedures, Treatment and Investigations (CLI.4110.PL.001).
    - Ask patient the reason for refusal.
    - A patient needs to be fully informed about potential consequences of refusal of any medication.
    - Inform the prescriber of the refusal and the reason for the refusal.
    - Document on the MAR as "refused" or "not given".
    - Document on the IPN the reason for the refusal and the conversation with the patient regarding the refusal and the potential consequences.

7. Medication Storage
   - Store medication securely on the unit and available to authorized personnel only. Medication rooms and carts are locked when not in use.
   - Store Narcotics and Controlled Drugs under a double lock as per Narcotics and Controlled Drugs (CLI.6010.PL.015).
   - Store medications appropriately when medications are prepared for administration and not used immediately. Including the use of appropriate labels, syringe caps, secure storage location within appropriate temperature and/or appropriate protection from light when required.
   - Discarded Medications
     - Discard opened medication in an irretrievable container.
     - For narcotics and controlled drugs, discard as per Narcotics and Controlled Drugs (CLI.6010.PL.015).
8. Management of Medication errors
   - Ensure proper treatment of the patient. Look for any unintended outcomes, side effects that may occur as a result of the error and perform relevant assessments.
   - Report the situation to the responsible care provider/prescriber and supervisor.
   - Document on the applicable MAR and IPN the error, the outcomes and follow-up.
   - Complete the Safety Event Report (ORG.1810.PL.001.FORM.01) and submit to the Manager.
9. Management of a Serious Adverse Drug Reaction
   - Follow the Mandatory Reporting (ORG.1810.PL.010) for the Management of Serious Adverse Drug Reaction & Medical Device Incidents Checklist.

Education:

- As part of orientation and training, complete education on Safe Medication Administration at a minimum with initial unit orientation.
- Infusion Pump Training:
  - Provide initial and re-training on the safe use of infusion pumps to team members:
    - Who are new to the organization or temporary staff new to the service area,
    - Who are returning after an extended leave,
    - When a new type of infusion pump is introduced or when existing infusion pumps are upgraded,
    - When evaluation of competence indicates that re-training is needed, and/or
    - When infusion pumps are used very infrequently, just-in-time.
  - Evaluate and document the competence of team members to use infusion pumps safely at least every **two** (2) years.

Quality Improvement:

- Conduct quarterly prospective audits on each unit/site using the Safe Medication Audit: Acute Care (CLI.4110.PL.015.FORM.01).

  - For the Regional Sites - each unit conducts a minimum of 4, maximum of 6 audits.
  - For the Community Hospital sites - each site conducts a minimum of 2, maximum of 4 audits.
  - Specific to Obstetrics, conduct a minimum of 2, maximum of 4 audits.
- If unsafe practices are noted during the audit, immediately inform the care provider and stop the unsafe practice from occurring.
- Local interdisciplinary team reviews audit results, identifies opportunities for improvement and develops an action plan. The results and the action plan are submitted to the respective program.

SUPPORTING DOCUMENTS:

CLI.4110.PL.015.FORM.01	Safe Medication Administration Audit: Acute Care
CLI.4110.PL.015.FORM.02	Safe Medication Administration Audit Summary: Acute Care
CLI.4510.PR.002.FORM.01	Integrated Progress Notes (IPN)
CLI.4510.PR.002.FORM.02	Frequent Monitoring Record
CLI.4510.PR.002.FORM.08	Medication Administration Record (MAR): STAT and Non-Recurring
CLI.4510.PR.002.FORM.09	Medication Administration Record (MAR): Scheduled
CLI.4510.PR.002.FORM.10	Medication Administration Record (MAR): PRN
CLI.6010.PL.001	High Alert Medication Management
CLI.6010.PL.002	Look-alike Sound-alike
CLI.6010.PL.003	Regional Parenteral Drug Monograph Manual
CLI.6010.PL.004	Antibiotic Stewardship Program
CLI.6010.PL.006	Antimicrobial Intravenous to Oral Therapeutic Conversion
CLI.6010.PL.008	Patients own Medications
CLI.6010.PL.010	Telephone or Verbal Orders
CLI.6010.PL.012	Expiry of Multi-dose Injectable Products
CLI.6010.PL.015	Narcotics and Controlled Drugs
CLI.6010.PL.016	Automatic Therapeutic Interchange
CLI.6010.PL.021	Safe Handling of Hazardous Medications (Cytotoxic and Non-Cytotoxic)
CLI.6010.PL.022	Patient Resident Leave of Absence Medications
CLI.6010.PL.023	Cannabis for Medical Purposes
CLI.8011.PL.001	Hand Hygiene
ORG.1410.PL.301	Client Identification
ORG.1810.PL.001.FORM.01	Safety Event Report
ORG.1810.PL.010	Mandatory Reporting

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