Policy Name:	Policy Number:
MEDICATION ORDERING & ADMINISTRATION	**0216**
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Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** Reviewed and updated.	Next Date for Review: October 18, 2024
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Policy

OBJECTIVES

- To ensure consistency and awareness of safe medication administration practices for health care professionals.

PRINCIPLES

- Medication administration is a resident-centred, shared inter-professional responsibility to facilitate optimal medication therapy for all residents in a manner that promotes safe patient care.

- Health care professionals must have the knowledge, competence and authorization to provide medication administration as determined by applicable regulatory bodies.

APPLICABILITY

Compliance with this document is required by all Agape Hospice RN's (including nursing students from an approved institution under the direct supervision of an RN) employees, students, volunteers, and other persons acting on behalf of Agape Hospice (including contracted service providers as necessary). Medications will be administered by:

Physician's orders will be taken by grad nurses who hold a temporary license, or registered nurses. Student nurses will not take physician's orders.

POLICY ELEMENTS

1. Patient Consent and Identity

- Informed consent from the resident shall be obtained prior to administration of the medication unless there is an emergency situation and informed consent cannot be immediately obtained.

- A resident identity shall be verified immediately prior to administering medications using two resident identifiers which are full name and date of birth. This can be verified by checking the resident's ID band or asking the resident to state their name and date of birth.

2. Medication Orders

2.1 Health care professionals shall adhere to their regulatory practice standards when prescribing, processing and enacting medication orders/prescriptions.

2.2 All orders will be recorded on one of the following forms by the attending physician or the RN in the case of a telephone order.
- Admission Medication Reconciliation Best Possible Medication History (BPMH)
- Hospice Palliative Care Order Set
- Doctor's Orders Form
- Epidural Order Set for Epidural/Intrathecal Infusion
- Epidural/Intrathecal Doctor's Orders

2.3 The RN is responsible for ensuring the orders have been transcribed accurately onto the Medication Administration Record (MAR). (See policy 0230 Transcribing and Checking Physician's Orders).

2.4 In case of doubt, unclear, inappropriate, or incomplete medication orders shall be clarified. The RN will contact the ordering physician for clarification before the order is processed.

2.5 Pro re nata (as-needed or as required; PRN) medication orders will indicate the specific time interval between doses (e.g. every 3 hours) as well as the indication.

2.6 A health care professional who administers a medication or natural health product as ordered by an authorized prescriber requires a copy of the medication order or prescription to be accessible in the health record.

2.7 Verbal (in-person) medication orders shall only be accepted by a health care professional in an emergent or urgent situation where delay in treatment would place a resident at risk of serious harm, and it is not feasible for the authorized prescriber to document the medication order (e.g., during a catastrophic event).

2.8 Telephone medication orders shall only be accepted by a health care professional where the authorized prescriber is not physically present to document the medication order and a delay in ordering, administering, or discontinuing the medication would compromise resident safety and care.

2.9 Pharmacy meetings will be held at minimum annually and as needed when determined by the CQI committee.

3. Hospice Palliative Care Order Set

- The Hospice Palliative Care Order Set is used as a guideline for common practices of care for residents at the time of admission. This format allows the RN to respond quickly to resident's needs. The attending physician will review the Hospice Palliative Care Order Set and Medication Reconciliation BPMH and make any changes as necessary.

4. Patient Education

- Health care professionals shall provide the resident with:
  a) Education on their medication, where appropriate, using an interdisciplinary approach; and
  b) Information to engage in activities that support safe medication management processes.

5. Withholding/Refusal of Medication

- When a health care professional identifies the need to delay or withhold a resident's medication, this shall be based on resident assessment and clinical judgement.
  a) The health care professional is responsible to discuss the delay or withholding of a medication with the resident and physician, when indicated, based on clinical judgement and as soon as practical.

- Where a resident refuses a medication, the health care professional shall:
  a) Determine the reason for refusal;
  b) Assess the resident's level of understanding about medication effects; and
  c) Follow-up with the physician as appropriate.

- When medication is delayed, withheld or refused, the health care professional shall document in the residents' health record:
  a) The reason for the medication delay, withholding or refusal;
  b) Resident assessment performed;
  c) Ongoing resident monitoring or follow-up performed;
  d) Notification and/or follow-up completed with the physician; and
  e) Resident discussion.

6. Medication Administration

- Health care professionals shall adhere to Infection Prevention and Control routine practices and best practice guidelines, found in the IP&C binder in the nursing station:
  a) Effective hand hygiene;
  b) Safe injection practices;
  c) The use of aseptic technique; and
  d) Waste and sharps handling.

- Health care professionals shall confirm the following 8 rights prior to administering medication to a resident:
  a) Right resident
  b) Right medication;
  c) Right dose (amount)
  d) Right time;
  e) Right route;
  f) Right reason;
  g) Right documentation; and
  h) Right of refusal.

- Any identified allergies and potential drug interactions will be considered before the administration of medications.

- When administering PRN medications, the health care professional shall:
  a) Assess the resident prior to administering the PRN medication;
  b) Document the time the PRN medication was administered;
  c) Re-assess the resident for effect of medication administered; and
  d) Document the effectiveness of the medication in the multidisciplinary progress notes.

  NOTE: PRN medication may only be administered for the indication identified in the order or prescription.

- The initiation/change in narcotics and/or route should be assessed and documented during the first 24-hour period as to the efficacy of the outcome.

- An independent double-check shall be performed prior to the administration of continuous subcutaneous infusions or when a health care provider is uncertain or unclear about an order. Resolve all questions before proceeding with medication administration.

- The same health care professional shall prepare and administer the residents medication, with the exception of the following situations:
  a) Pre-dosed medication from the drug manufacturer;

b) Ready-to-administer medication prepared by a pharmacy (e.g. infusion medication):
c) An emergency/urgent situation where one health care professional prepares and labels the medication for another health care professional to administer.

DEFINITIONS

Adverse reaction: means a unintended reaction to a medication, food, environmental or blood/biologic substance not related to an immunologic response. [Provisional definition from Provincial Allergy Working Group]

Emergency Situation: Means a circumstance which requires health care that is necessary to preserve life, to prevent serious physical or mental harm, or to alleviate severe pain.

Health care professional: means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practises within scope and role.

Health record: means the Agape Hospice legal record of the resident's treatment and care information.

Independent double-check: means a verification process whereby a second health care professional conducts a verification of another health care professional's completed task. The most critical aspect is to maximize the independence of the double-check by ensuring the first health care professional does not communicate what he or she expects the second health care professional to see, which would create bias and reduce the visibility of an error.

Informed consent**:** means the agreement of a resident undergoing a treatment/procedure after being provided with the relevant information about the treatment/procedure(s), its risks and alternatives and the consequences of refusal.

Medication**:** means any substance or mixture of substances manufactured, sold or represented for use in the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state, or its symptoms, in human beings, and restoring, correcting or modifying organic functions in human beings.

Medication administration**:** means the activity of supplying to a resident a dose of a medication for the purpose of immediate ingestion, application, inhalation, insertion, instillation, or injection. The administration of medications is more than just a psychomotor task of giving a medication to a resident. It is a cognitive and interactive aspect of care and involves assessing the resident, making clinical decisions, and planning care based on this assessment. Medication administration requires the knowledge and skills of a competent health care professional.

Natural health product**:** means medicinal products containing herbs, vitamins, minerals, and nutritional supplements (also known as traditional, natural, holistic or homeopathic medicines).

Resident**:** means all persons who receive or have requested health care or services from Agape Hospice and its health care providers and also means, where applicable: a) a co-decision-maker with the person; or b) an alternate decision-maker on behalf of the person.

CROSS REFERENCES

Policy 0217 - Resident's Self Administration of Medications
Policy 0224 - Management of Febrile States
Policy 0248 - Controlled Drug Management
Policy 0259 - Received/Returned Drugs
Policy 0916 – Recognizing and Responding to Clinical Adverse Events

REFERENCES

Alberta Health Services Governance Documents:

- Medication Administration Policy HCS-219

Institute for Safe Management Practices: ismp-canada.org

Procedure

1. Medication Orders:

1.1 When accepting physician's orders for medications over the telephone, the order will be documented and read back to the physician, including the medication dose, frequency, route, indication, and resident's name for whom the order is intended.

1.2 It is the responsibility of the registered nurse taking the telephone order to ensure the chart is flagged and (with the yellow tab for physician orders) placed on the "new orders" chart rack to alert the physician to sign the order(s). The attending physician will co-sign telephone orders within 72 hours of giving the order.

1.3 Any medication order that is unclear or inconsistent with therapeutic resident outcomes should be questioned by the RN and communicated to the prescribing physician for rationale before administration.

1.4 The RN is responsible for ensuring the orders have been transcribed accurately onto the Medication Administration Record (MAR) and asked for an independent double check. (See policy 0230 - Transcribing and Checking Physician's' orders).

2. Administration

2.1 The following medication administration procedure must be followed in addition to point 6 of the above policy:

a) It is critical that the following 3 checks are performed along with the 8 rights of administration noted in the policy above:

- Check 1 - Before preparing or removing the medication from its container or packaging.
- Check 2 - While preparing, and once the dose of medication ordered is removed from its container or packaging.
- Check 3 - After the preparation process has been completed and before administering to the resident.

2.2 RNs will record the medications they have administered.

2.3 Medications prepared by one RN should not be administered by another RN.

2.4 If medications are not administered at their scheduled time (this is 30 minutes before or after the scheduled time), the RN will indicate the exact time medications were administered on the MAR, and document reason for the time discrepancy.

2.5 In a circumstances that residents request to self-administer medications please refer to Policy 0217 – Resident Self-Administration of Medication.

2.6 The RN will provide education to the resident during administration as the resident is able and/or is requested.

2.7 See appendix 1 and 2 for information on subcutaneous administration and intramuscular injection.

3. Documentation

3.1 Documentation on Medication Administration Record (MAR) by the RN for medications given will include:

- Specific dosage, if a range is provided
- Specific route if more than one route is ordered (i.e.: Oral/Subcutaneous)
- RN’s initial in date/time column and initials and signature in designated box on MAR

3.2 Incident Reports are to be completed in all cases of medication administration error. Serious, life threatening errors (Level 3 or 4) are to be reported immediately to the attending or on call physician. These incidents also must be immediately reported to the Nursing Lead or designate.

3.3 When documenting in the patient health record, health care professionals shall adhere to ISMP *Do Not Use List of Abbreviations,* list found at the front of each chart.

3.4 The health care professional performing medication administration shall document all related activities in the resident health record.

3.5 Documentation shall align with legislative or other required best practices, and Agape Hospice Policy 0105 – Clinical Documentation.

4. Administration of Breakthrough (BT) Doses

4.1 Complete the assessment of the residents' symptoms.

4.2 Document the assessment in the residents' progress notes and the type of medication given.

4.3 On the MAR, record the time and dosage of medication given along with the route used.

4.4 Record the information on the residents Controlled Drug Record as per Policy 0248 – Controlled Drug Management.

4.5 Assess the effectiveness of the BT medication and document in the progress notes. This is to be done after each BT is given.

4.6 If more than three (3) doses of breakthrough medication are required in a twelve (12) hour shift, the physician should be contacted as soon as possible.

4.7 If new orders are received from the physician the RN is to complete the order as per Policy 0230 – Transcribing and Checking Doctor's Orders

5. Monitoring Medication Response

5.1 In addition to monitoring for therapeutic effectiveness, health care professionals administering medications are responsible to monitor, and respond to, signs and symptoms of side effects or an adverse reaction.

5.2 The initiation\change in narcotics and/or route should be assessed and documented during the first 24-hour period as to the efficacy of the outcome.

5.3 Agape Hospice will report any adverse reactions as per Policy 0227 – Management of Adverse Effects of Medication.

APPENDIX 1

Administration of Intermittent Subcutaneous Medication

1.1 For Intermittent Subcutaneous Medication Administration

- **a.** Locate site specific for that medication. If there is none, then initiate a site as described above.
- **b.** Obtain medication as ordered and required supplies, (alcohol swabs, medication, syringe, blunt tip cannula (for drawing up medication)).
- **c.** Following the physician's orders, draw up the medication in a syringe. For the first time a medication is administered through a site, add an extra 0.25 mL of medication (to account for the prime required in the winged infusion set). This ensures the full dose of medication is received.
- **d.** Review the medication and wound care plan prior to administration and ensure site is healthy and labelled correctly.
- **e.** Cleanse the injection cap for 30 seconds and allow to dry. Administer the medication
- **f.** Insert the medication syringe into the injection cap and gently administer medication. If blood return is noted: waste medication, remove the winged injection set and establish a new site. The maximum amount of medication to be administered at one time (excluding flush) which is 2 mls per site.
- **g.** Assess the insertion site pre-and post-medication administration for signs and symptoms of possible complications including dislodgement, edema, redness, irritation, or heat.
- **h.** Complete required documentation, including any adverse effects or difficulties encountered.

1.2 Subcutaneous sites may be left in place indefinitely unless symptomatic at the insertion site. Assess the insertion site at least every 4 hours (Q4H) for signs of irritation, edema, inflammation or dislodgement of the cannula.

1.3 Document in the medication and wound care plan:

- Date and time of insertion
- Medication name and concentration
- Any important considerations that are applicable

1.4 Manage complications in the following manner:

Dislodgement:	If cannula becomes displaced, remove the cannula completely, dress if required, and restart at a new site.
Edema:	It is normal for the site to feel slightly boggy. If there is a large amount of edema and hardness can be felt; restart at a new site.
Redness/Irritation/ Heat:	If redness persists for more than an hour after insertion or heat can be felt at site, restart at a new site.

APPENDIX 2

Intramuscular Injections (IM)

Required Equipment:

- Appropriate size needle/syringe
- Blunt-Fill Needle
- Needle – 22 or 25G, 1-1.5 inch
- Sharps container
- Alcohol swabs

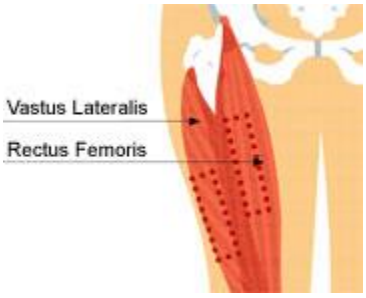
1. To establish a standard and safe practice for Intra-Muscular (IM) injections. Vaccine injection requires additional training.
2. The IM route should be avoided in the palliative population as it causes discomfort with long term use and absorption is erratic.
3. Assess the resident for any factors that may contraindicate an IM injection, and conduct any other required pre-administration assessment.
4. Pick at site for that is best suited for the resident. Choose a site that is free from pain, infection, abrasions, or necrosis.
5. The following are guidelines for site and needle consideration, however the RN will choose the site and needle gauge and length bases on their assessment.
    a. Vastus Lateralis. Use 25G, 1-1.5 inch needle. Administer up to 5.0 mL
    b. Deltoid. Use 25G, 1-1.5 inch needle. Administer 0.5-2.0 mL
    c. Ventrogluteal, Use 22G, 1.5 inch needle. Administer 2.0-5.0 mL
6. Perform hand hygiene
7. Identify resident using 2 resident-specific identifiers.
8. Conduct 8 Rights of medication administration
9. Assemble supplies and prepare medication from an ampule or a vial.
10. Attach red blunt fill needle to syringe.
11. Cleanse top of medication vial with alcohol swab for 20-30 sec.
12. Puncture the stopper of the medication vial in the centre of the stopper, and at a 90° angle. Turn vial with syringe upside down. Keeping the tip of the needle in the medication, withdraw the ordered dose of medication. Remove any air as needed.
13. Remove the blunt fill needle and replace with appropriate size gauge and length needle.
14. Cleanse the injection site with a new alcohol swab by circling from the centre of the site outward for 1-2 inches. Let dry.
15. After land marking, place your thumb and forefinger on either side of the site of injection.

16. Insert the needle in at 90° angle to the skin to the desired depth.
17. Aspiration is not necessary, however if blood is noticed in the hub of the syringe, the needle and syringe should be discarded. Start again with a new syringe, needle and medication.
18. Slowly inject the medication, especially if it is more viscous.
19. Remove the needle quickly. Activate the safety mechanism and discard into the sharps container.
20. Use a cotton ball and apply pressure to the injection site. Use adhesive bandage if necessary.
21. Perform hand hygiene.
22. Document on Medication Administration, document in progress notes in resident's clinical record how the resident tolerates procedure and any issues or concerns.

Landmarking Sites for Injection:

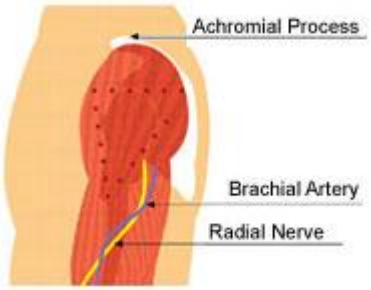
Vastus Lateralis Site

- To find the thigh injection site, make an imaginary box on the upper leg. Find the groin. One hand's width below the groin becomes the upper border of the box
- Find the top of knee. One hand's width above the top of the knee becomes the lower border of the box
- Stretch the skin to make it tight
- Insert the needle at a right angle to the skin (90°) straight in



Deltoid Site

- Find the knobbly top of the arm (acromion process)
- The top border of an inverted triangle is two finger widths down from the acromion process
- Stretch the skin and then bunch up the muscle
- Insert the needle at a right angle to the skin in the centre of the inverted triangle



Ventrogluteal Site

- Find the trochanter. It is the knobbly top portion of the long bone in the upper leg (femur). It is about the size of a golf ball
- Find the anterior iliac crest
- Place the palm of your hand over the trochanter. Point the first or index finger toward the anterior iliac crest. Spread the second or middle finger toward the back, making a 'V'. The thumb should always be pointed toward the front of the leg. Always use the index finger and middle finger to make the 'V'
- Give the injection between the knuckles on your index and middle fingers
- Stretch the skin tight
- Hold the syringe like a pencil or dart. Insert the needle at a right angle to the skin (90°)