I. PURPOSE

To ensure safe administration of medications to patients.

II. POLICY

It is the policy of University Healthcare Alliance ("UHA") to establish a process which contributes to the competent and safe administration of medications by clinical and support staff.

Who May Perform (all licensed/certified/and registered professionals including;)

1. Medical Doctor ("MD") /Doctor of Osteopathic Medicine ("DO")/Podiatrists
2. Nurse Practitioner ("NP") /Physician Assistant ("PA") or Advanced Practice Provider ("APP")
3. Registered Nurse ("RN")
4. License Vocational Nurse ("LVN")
5. Medical Assistant ("MA")
6. Radiation Technologist/Imaging Specialist
7. Respiratory Therapist ("RT")
8. Nuclear Medicine Technologist/Imaging Specialist
9. Physical Therapist ("PT")
10. Audiologist

III. DEFINITIONS

A. Seven Rights (7) of Medication Administration: Includes the following medication rights
   1. right patient
   2. right drug
   3. right route
   4. right time
   5. right dose
   6. right reason
   7. right documentation

B. Three Checks of Preparing a Medication: Involves assuring the appropriate drug is selected:
   1. Check the medication label for the correct name.
   2. Check for the correct concentration and expiration date.

3. Check the medication color and clarity prior to withdrawing the medication, after reconstituting, before administering, or returning it to the shelf/discarding.

C. Medication Error: A medication error is any preventable event that may cause or lead to inappropriate medication uses or patient harm while the medication is in the control of the health care professional, patient, or consumer (National Coordinating Council for Medication Error Reporting and Prevention).

D. Near Miss: A near miss is an error that did not happen or did not reach the patient. These errors are captured and corrected before reaching the patient either through chance or purposely defined system controls that have been put in place. (As defined by the Institute for Safe Medication Practices ("ISMP"), March 27, 2009)

E. Adverse Drug Event: An adverse drug event is an injury (noxious or harmful effect) resulting from medical intervention related to a drug (Bates et a; JAMA 1995 274:29-34)

IV. PROCEDURE

A. Medication Management Profile

1. To facilitate continuity of care, treatment, and services; patient-specific information is readily available to those involved in any aspect of the medication management profile, including:
    a. Creating an accurate medication history and a current list of medications to assist in medication reconciliation.
    b. Ordering, preparing, dispensing, administering and monitoring medications, as appropriate.
2. The information includes the following:
    a. Age
    b. Sex
    c. Current medications
    d. Diagnoses, co-morbidities and concurrently occurring conditions
    e. Relevant laboratory values
    f. Allergies and past sensitivities
3. As appropriate, the information also includes:
    a. Weight and height
    b. Pregnancy and lactation status

B. Medication Orders
   1. All medications require an order from a person lawfully authorized to prescribe. Medication orders may be given by the following persons:
   2. To be acceptable, the order must include the patient name, name of the drug, dosage, and frequency of administration, route of administration, date, time, and wet signature or e-signature of the prescriber.
      a. The order must clearly state the administration time or time intervals between doses.
      b. The metric system must be used in prescription and administration of medications except for dosages commonly expressed in drops, "puffs" or inches.
      c. Unapproved symbols and abbreviations may not be used.
   3. For Specialty Clinics and Practice (Oncology, Rheumatology and other specialty areas) and Clinics using Bar Code Medication
      a. Specific procedures & protocols related to PRN (as needed), Range Order, and Patient's Own Medications will be followed.
      b. If applicable, barcode medication administration ("BCMA") will be used whenever available for positive patient identification and validation of medication orders prior to administration. It should be noted and reinforced that the bar-coding process does not, in any way, relieve the responsibility for reading the medication label and verifying the "seven rights" of medication
   4. Verbal/telephone orders:
      a. The use of verbal orders is not allowed and should be used only in situations when the provider is unable to write or enter the order in the event of an emergency.
      b. Verbal/telephone orders must be countersigned within 48 hours.
      c. Verbal orders must be read back to the prescriber at the time the order is written or entered to ensure that it is correct and any alerts have been addressed. The read-back must be documented.

C. Medication Preparation
   1. Medications must be prepared and administered by a certified, licensed or lawfully authorized personnel including but not limited to; MD/DO/Podiatrist, NP/PA or APP, RN, LVN, MA, Radiation Technologist/Imaging Specialist, RT, Nuclear Medicine Technologist/Imaging Specialist, PT).
   2. Staff preparing and administering medications must comply with all applicable medication policies/procedures.

3. The person preparing and administering the medication must be knowledgeable about the dosage, action, and side effects of that medication.
4. ***When the person administering, the dose is a medical assistant or technician, this responsibility rests with the licensed person verifying the dose.***
5. Medical assistants and technicians must verify the medication and the dose with a licensed person prior to administration for each medication administered. Ophthalmic technicians in the Eye Clinic are exempt from this requirement and may administer medications without prior verification to prepare patients for examination as consistent with current protocols and state statute.
6. The Medication Administration Record ("MAR") and/or original provider order should be used at all times to guide preparation and administration of medications, including infusions.
7. Clarification of orders
    a. The person administering the medication (RN, LVN/LPT, MA or technician) has the right and the obligation to question the administration of a medication:
        i. When there is a lack of knowledge or skill to give the medication.
        ii. When there are, any concerns regarding administration, e.g., the drug, dosage, route, etc.
    b. If the above occurs, discuss it with the RN, Manager, and/or provider, as appropriate, to safely resolve the problem.
8. Medications should be prepared and given as close to the specified time as possible (no more than 60 minutes before or after designated time).
9. Single-dose vials and syringes must be used immediately if reconstituted.
10. Multi-dose vials may be used for 28 days after opening unless there are signs of contamination (e.g. precipitate, cloudiness, or discoloration) or the manufacturer recommends a shorter beyond-use date. All multi-dose vials must be dated with the expiration date (aka "Toss Date") and open date.
11. When preparing multiple medications in advance, syringes must be labeled as follows:
    a. Name and strength of the medication
    b. Time syringe is filled
    c. Initials of licensed person filling
12. When medication is prepared into a syringe and not administered immediately by the person preparing, follow the following guidelines.

a. If a single-dose or single-use vial has been opened or accessed (e.g., needle- punctured) the vial should be discarded according to the time the manufacturer specifies for the opened vial or at the end of the case/procedure for which it is being used, whichever comes first. It should not be stored for future use.
b. If a single-dose or single-use vial has not been opened or accessed (e.g., needle punctured), it should be discarded according to the manufacturer's expiration date.

13. Each pre-filled syringe may be used for one patient only and then appropriately discarded.
14. A filtering device (e.g., filter straw, filter needle) must be used when drawing up the contents of an ampule, to ensure that all glass particles are removed from the medication before administration to the patient.
15. When medications are mixed in the same syringe or container, observe the mixed solutions to ensure that no precipitate or other evidence of incompatibility has occurred.
16. Drugs may never be used beyond the expiration date on the manufacturer's unit dose label, or if prepared by the pharmacy, the expiration date listed on the patient's label or on the pre-pack label.
17. Medication Pens can be used with only one person "one pen one patient".

D. Medication Administration – Before administration of any medication by any route:

1. Evaluate product integrity (inappropriately stored, expired, decomposed, or adulterated) and properly dispose of any medication that is deemed unusable.
2. Verify the '3 Checks' and '7 Rights' during the process of medication preparation and administration.
3. Label each syringe and or basin containing medication or solution with the name of the medication or solution and if applicable include dose, concentration, and date/time prepared.
4. In every instance, prior to administration of medication by the medical assistant, a licensed physician or podiatrist, or another person authorized by law to do so shall verify the correct medication and dosage (LVN, RN, NP, PA, DO or MD) prior to administration (California Code Regulation 1366Additional Technical Supportive Services (b)).
5. Inquire as to patient allergies/sensitivities prior to administration.
6. Verify two patient identifiers prior to medication administration.
7. Check patient identification

8. Medication must be kept in or with the original packaging up to the point of actual drug administration. Check expiration date on label for each medication. If oral medications require cutting or crushing, the original packaging needs to be retained to bring to the tableside.
9. Change in the route of administration and/or dosage must be ordered by the licensed provider.
10. RNs, LVNs, and MAs will only administer medications they have prepared (Position of the California Board of Registered Nursing), except for medications that are prepared by a pharmacy technician, Registered Nurse or staff member responsible for preparing the medication (pharmacy, oncology unit) and delivered to the person administering the medication under protocol and properly labeled with the name, strength, date of compounding, and date of expiration.

E. Medication Documentation in the Electronic Health Record ("HER"/patient chart is to include:
1. Patient name
2. Date and time of administration
3. Medication name, dose and route/site of administration (includes Over-The-Counter ("OTC") medications)
4. Medication manufacturer
5. Medication expiration date, lot number, Vaccine Information Statements ("VIS") date (requirement for ALL vaccines)
6. Document drug National Drug Code ("NDC") number (from the medication vial/syringe)
7. Name of person administering medication

F. When an adverse reaction or medication error occurs:
1. Notify the physician
2. Observe the patient for adverse reaction
3. Record event in EHR/patient chart
4. Provide support/therapeutic intervention as necessary
5. Refer to QP-01 Incident Reporting and Management Policy to complete an online incident report (Click here to view)

V. COMPLIANCE

A. All workforce members, including employees, affiliated providers, and contracted staff are responsible for complying with this policy.

B. Violations of this policy must be reported to the author of this policy. Violations will be investigated to assess the nature, extent and potential risk to UHA.

C. Employees and contracted staff who violate this policy will be subject to the appropriate disciplinary action up to and including termination.

D. Affiliated providers who violate this policy will be subject to the appropriate disciplinary action through Medical Group governance or UHA Quality and Credentialing Committee ("QCC") as appropriate.

VI. DOCUMENT INFORMATION

A. Legal Authority Reference
1. California Code of Regulations, Title 22, Chapter 1, § 70263. § 70749 (a)(6)(C)
2. United States Pharmacopeia ("USP") General Chapter 797 [16]
3. Centers for Disease Control and Prevention: Injection Safety, Information for Providers and Safe Practices for Medical Injections

B. Review and Revision History
1. Initial policy – 05/09/2019
2. Author – UHA Quality Department