Originated By	
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MARINHEALTH MEDICAL CENTER
HOUSE WIDE CLINICAL MANUAL
PATIENT'S OWN MEDICATION (POM)

I. POLICY:

Without a physician's order on the chart, the patient may not use his/her own medication(s).

A. Criteria for use of own medications include:
   1. Medication not readily available at MarinHealth Medical Center.
   2. Multidose items such as eye drops not available at MarinHealth Medical Center.
   3. Medications which would be discontinued once the supply has been used up, such as a course of antibiotics.

B. Medications brought into the hospital by patients that are not being administered should be sent home with the patient's family or caregiver as soon as possible. If this is not possible, the medications shall be kept in the pharmacy's custody for storage during the patient's stay. Unless there are compelling reasons not to do so, the patient's medications will be sent home with the patient at discharge or barcode administration.

C. Use of the patient's own medication including controlled substances for routinely available medications is not permitted, primarily due to concerns of safety and timeliness. Use of patient's own medication does not allow for computerized screening of potential drug interactions or therapeutic duplication.

D. Physicians' orders allowing for the use of patients' own medications must appear in the chart, and include "patient's own medication to be used," the drug name, strength, and complete directions for administration. The pharmacist will determine if this medication meets criteria for own medication use.

E. Inpatient use of herbal/homeopathic medication or dietary supplements will not be permitted due to potential safety issues (Refer to Housewide Clinical Manual Policy #424.7 on Herbal medications)

II. PROCEDURE:

Upon admission, patients own medications that are not needed for use in the hospital are sent home with the patient's family as soon as possible.

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Scenario A: Patient will not use own medication during the hospital stay, but must store the medication in the pharmacy.

1. POMs for storage should be brought to the pharmacy by the nurse. **Under no circumstances can POMs containing controlled substances be sent to pharmacy via the tube system.**
2. Nursing MUST complete all information in section A of the "Receipt for medications brought from home" form. The total number of bottles must be counted and recorded in section A by the nurse. For a scenario where some of the patient's medications are stored in the pharmacy and some are used in the hospital, see the section below (scenario B) for further information.
3. Pharmacy will double check the completed information in section A of the form, and ensure accuracy of drug name and quantity of bottles. If controlled substances are part of the medications, it is the responsibility of the pharmacist/pharmacy staff to ensure appropriate count for such medications.
4. The yellow and pink copies are returned to the nurse. The yellow copy is to be placed in the patient's chart. The pink copy is to be given to the patient as a receipt.
5. Upon receipt of the POM, the alphabetical login sheets located in "POM" binder located in the Main Pharmacy is filled out: today's date, patient name, number of containers, Nursing Unit, and their initials.
6. Inside the pharmacy, "POM" medications are stored alphabetically in a designated POM cart in drawers labeled A-Z. Narcotic "POM" medications are stored in a designated, locked POM cabinet. "POM" medications are stored such that any required special conditions to ensure stability are met (e.g., refrigeration).
7. When a discharge order is written, nursing will call pharmacy for return of the POM. Nursing can request delivery of medications by pharmacy. Pharmacy will deliver the medications to the unit within 30 minutes of a request. Alternatively, the nurse or patient representative may pick up the medications at the pharmacy, sign and date the white copy of receipt form. The Pharmacy office will keep the white copy as verification that the medications were returned. After delivering the medications to the patient, the nurse will have the patient sign the yellow chart copy to confirm receipt of the medications.
8. If there is a compelling, medically justifiable reason why the pharmacist should not return medications to a patient, the physician may request destruction of the medication. However, the medications are the patient's property and must be returned if the patient requests unless there is a direct risk to the patient in having the medications. If the patient does not have discharge orders but requests medications, the pharmacist will consult with the patient's nurse or physician.

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9. Medications left behind at discharge are destroyed after 30 days. Pharmacy staff will call the patient at the designated home number in an attempt to have the patient pick up medications left behind. If medications are not picked up after two phone call attempts, they will be destroyed with signature and date destroyed documented. Both controlled substances and non-controlled are destroyed according to appropriate disposal processes (pharmaceutical waste disposal) and in agreement with state laws. Controlled substances waste is documented in a separate binder with the pharmacist's initials and date of destruction. If the controlled substance is in a manufactured intact packaging, it will be held in a locked safe for destruction by an authorized pharmaceutical waste disposal company.

B. **Scenario B: Patient will be using own medication during the hospital stay.** This scenario is only permitted if: 1) the medication is not available at the hospital 2) there is no formulary alternative 3) patient refuses to use the supply at the hospital

1. Patient's own medications must be identified by pharmacy before they may be administered to the patient. Patient's medication to be used in the hospital must also have MD's orders for in-house use of medications.
2. Nurse must hand deliver the patient's medication to the pharmacy. The medication cannot be sent via the tube system.
3. Pharmacy will document receipt of the medications and initial section A of the "Receipt for medications brought from home" form, identifying which medications have been identified for use in the hospital.
4. Each medication vial/bottle will be inspected and the completed label. below) attached/flagged. The pharmacist will visually inspect a patient's own medication brought in to be used in the hospital to:
    a) Verify and identify the medication by utilizing available resources (e.g., Micromedex Identidex, PDR picture palettes),
    b) Evaluate the integrity of the drug by examining the medication itself and determining that the medication is not expired.
5. Each medication container will be inspected and the completed label below) will be attached:

> MGH Pharmacy
> Patient's Own Medication
> APPROVED FOR USE BY:
> Date:_____

6. Each medication order is documented into the EMR with the following: POM notation, date inspected and initial of pharmacist who entered the order.
7. Pharmacy will return the identified medication, with the appropriate label (see sample above) to the nursing unit (labels provided inside the white

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binder). The name of the nurse receiving the medications for hospital use will be documented in section A of the form “Receipt for medications brought from home”.

8. The pharmacy staff will document the POM is for use on the unit, in the white POM binder, and in addition leave the white copy of the “Receipt for medications brought from home” form in the appropriate storage bin under the patient’s last name.
9. Non-controlled substances will be placed in the patient’s medication box if available in their room, otherwise in another room where a medication box is available. It is the nurses’ responsibility to ensure the medication box is locked at all times and that the medication is returned to the patient upon discharge.
10. All controlled substances will be placed in the appropriate Pyxis machine for use with appropriate schedule entered in the EMR system to ensure access security.
11. In the event the medication cannot be verified, mislabeled, or expired, the medication cannot be used in the hospital. It will be held in the Pharmacy via the mechanism outlined above for medication storage. The prescribing physician is contacted by Pharmacy to inform him/her that the POM will not be used. An order is then written for medications to come from the Pharmacy or be obtained by the pharmacy for patient use. The patient and/or family is then informed by pharmacy, nursing or the physician that the POM will be kept in the Pharmacy and an alternative medication will be supplied.

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REVIEWED BY:	Pharmacy Diirector,	DATE: 4/2019
	Michael Sillman, Director,	DATE: 05/2013
REVISED BY:	Michael Sillman, Director,	DATE: 10/2004
	Z. Ansari-Jaberi, Lead	DATE: 11/2012
	Michael Sillman, Director,	DATE: 05/2013
APPROVED BY:	P&T Committee	DATE: 1/2008
	Policy and Procedure Committee	DATE: 1/2008
	Medical Executive Committee	DATE: 10/2004

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MARINHEALTH MEDICAL CENTER

Housewide Clinical Manual, Pharmacy Department Policy/Procedure

SELF-ADMINISTRATION OF MEDICATIONS AND MEDICATIONS AT BEDSIDE

I. POLICY

A. Patients may self-administer certain medications if ordered in the chart by their physician. Only inhalers, topical creams/ointments (excluding nitroglycerin ointment) or eye drops may be kept at bedside for self-administration.

B. Any medications other than inhalers, topical creams/ointments, or eye drops which are ordered for self-administration must be kept in the locked medication cabinet and accessed only by authorized hospital staff.

C. For a patient to provide his or her own medications for use in his or her own care at Marin General Hospital the conditions of Pharmacy Policy and Procedure 734.00 "Patients Own Medications" and 201.00 "Medication Order Requirements" must be met and executed.

II. PURPOSE

A. The purpose of this policy is to ensure safe and effective medication management for patients who are capable of self-administering certain medications while hospitalized. This includes establishing clear guidelines and procedures to minimize errors, protect patient rights, and maintain the highest standard of care. The policy aims to clarify the conditions under which patients can self-administer medications and the roles of healthcare providers in facilitating this process.

III. GENERAL INFORMATION

A. Background/Scope

1. This section outlines the context and regulatory framework guiding the policy. It defines the scope of the policy, detailing its applicability and the specific procedures for its implementation.

B. Definitions

1. NA

C. Application

1. The policy is applicable to all healthcare providers responsible for patient medication management, including nurses, pharmacists, and physicians.

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2. Specific caregiver roles such as RN, LVN, and LCSW are outlined for adherence to the policy procedures.
3. The section describes the training and education methods for staff on policy implementation and maintaining competency.

IV. PROCEDURE

A. For medications to be self-administered the following criteria must be met:

1. The medication to be kept at bedside shall be limited to inhalers, eye drops, or topical creams/ointments. Any other medications must be locked in the medication cabinet and accessed by only the Nursing and Pharmacy Staff.
2. The physician's order in the patient's chart must indicate that the "patient may self-administer <name of medication, dose, route, instructions for use should be included in the order>".
3. The patient, or patient's caregiver, must receive appropriate written drug information and education from the Micromedex CareNotes available on the hospital's Intranet. No self-administered drug will be dispensed from pharmacy until the pharmacy verifies that the information has been provided to the patient or the patient's caregiver.
4. The patient, or patient's care giver, must receive appropriate administration instruction and training, in addition to demonstrating competency in administration.
5. The patient's nurse, pharmacist, respiratory therapist or physician must determine and appropriately document completion of the patient's instruction, and/or competency to self-administer in the education section of the Inter-Disciplinary Plan of Care.
6. Each dose administration must be supervised and verified by the RN or LVN prior to patient self-administration. Administration will then be recorded by the patient's nurse on the patient's MAR.
7. Schedule II, III, and IV controlled substances belonging to the patient may not be kept in the bedside locker and must be handled similarly to other controlled substances. Such medications are placed under Patient's Own Medication (POM) in the Pyxis Medstation.

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8. Patients will not be allowed to determine their own insulin dosing except in situations in which the competency of the patient has been verified by the registered nurse in consultation with the attending physician and Clinical Nurse Specialist for Diabetes. Physicians must specify the insulin dosing regimen as clearly as possible in chart orders, as with other medications. Orders for "patient to regulate own insulin" are not allowable. Patients will be required to clear their dosing with their nurse prior to administration. Patients may self-administer the physician ordered dose in keeping with other sections of this policy.
9. Patients will not be allowed to receive insulin through their own insulin pump devices except in situations in which the patient's clinical and mental status allows the continuation of the pump as evaluated by the responsible registered nurse, attending physician, and Clinical Nurse Specialist for Diabetes. This group will also need to make the judgment as to whether the particular insulin pump can be supported by the patient and the nursing staff. Any bolus dose or changes in basal rate need to be cleared by the patient's nurse.
    a. In any case in which the patient's clinical status is unstable, the patient's pump will be turned off and the catheter removed. The patient will then be placed on an infusion delivered by hospital equipment. In either of these situations, physicians must clearly specify the insulin dosing in chart orders, as with other medications.
10. In the care of a patient, the patient's nurse, physician or pharmacist may determine that the patient's care is being adversely affected by self-administration or unrestricted access to medications and ask that the hospital provide the medication and administer the medication. The nurse would then return the supply to the pharmacy in the manner described in Pharmacy Policy and Procedure 734.00.

VI. APPENDICES AND ATTACHMENTS

N/A

VII. AUTHORITY, REFERENCES, APPROVAL

A. Legal and professional guidelines such as the California Code of Regulations, Title 22 § 70707

B. Originators and Authors

Department or Function	Name	Title	Date
Originating Departments Pharmacy	Peggy Dracker, RPh	Pharmacy Director	03/01/1992

Policy Author	Pharmacy
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Department or Function	Name	Title	Date
Latest Authors (name department/ function)	full name(s), credentials	Insert corresponding title	Insert mm/dd/yyyy

C. Reviewed or Revised By

Department, Committee or Function	Subject Matter Experts Name	Title	Date
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Pharmacy	Arlene Johnstone, Pharm D	Pharmacy Director	06/2024

D. Approved By

Department, Committee or Function	Name	Title	Date
Pharmacy and Therapeutics Committee		Chair, Pharmacy and Therapeutics Committee	
Nursing Directors		Chair, Nursing Directors	
Policy & Procedure Committee		Chair, Policy & Procedure Committee	
Medical Executive Committee		Chair, Medical Executive Committee	
Quality & Patient Safety Committee		Chair, Quality & Patient Safety Committee	
Hospital Board of Directors		Chair, Hospital Board of Directors	

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MARINHEALTH MEDICAL CENTER
HOUSEWIDE ADMINISTRATIVE MANUAL
MEDICATION ERROR AND ADVERSE DRUG EVENT REPORTING

I. POLICY

A. All staff and providers are empowered to participate in reporting medication errors and adverse drug events in order to prevent future errors, improve processes, and promote a culture of safety.

II. PURPOSE

A. To minimize future harm from medications by encouraging identification of a breadth of opportunities for improvement in medication processing and management.

B. In accordance with the Housewide Administrative policy and procedure, Disclosure of Unanticipated Medical outcomes and Non-Punitive Error Reporting policy, the focus of the adverse reaction reporting program is quality improvement, not punishment.

III. GENERAL INFORMATION

A. Background/ Scope

1. Identification of both medication error and adverse drug events can occur during any point in the patient care process, at any location, and by any personnel. All staff are encouraged to report these events for this reason.
2. Reporting events by any and all staff (at minimum pharmacy staff) fulfills regulatory requirements of maintaining minimum documentation regarding medication errors attributable by personnel (California Code B&PC § 4125).
3. Additionally, a policy setting standards on how to report a medication error is a major component in the establishment and participation in a quality assurance program that documents and assesses medication errors to determine cause and appropriate response as part of a mission to improve the quality of pharmacy and other medical services, and prevent errors (16 CCR § 1711).
4. This policy/procedure is an extension of the #1103.17 MERP Plan, providing detail to all staff on how to properly report a medication error. Other details related to safety incident reporting (SIR) may be referenced in the #1106.11.5 Safety Incident Reporting policy.
5. A dedicated team referred to as the Medication Safety Team (MST) evaluate SIRs reported based on this policy. These cases are evaluated on a case-by-case basis as well as wholistically to improve the practices and procedures of the medical center.

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B. Definitions

1. **Adverse Drug Event (ADE)**: as an unintended injury resulting from use of a drug. This includes harm caused by the drug, such as an adverse drug reaction (ADR) and overdoses, and harm from the use of a drug, including dose reductions and discontinuations of drug therapy.
2. **Adverse Drug Reaction (ADR)**: a detrimental response to medication, excluding therapeutic failure, that is undesired, unintended, or unexpected in doses recognized in accepted medical practice which predicts hazard from future administration and warrants prevention or specific treatment or change of the dose regimen or withdrawal of the product.
3. **Automated Dispensing Machine (ADM)**: locked, secured medication storage unit used inside and outside the pharmacy for dispensing of medications.
4. **Medication Error**: there are various definitions outlined within California Code:
   a. A medication-related error is any preventable medication-related event that adversely affects a patient in a facility, and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to the 11 processes (see HSC § 1339.63, refer to #1103.17 MERP Plan)
   b. The any variation from a prescription or drug order not authorized by the provider. It does not include any variation that is corrected prior to furnishing the drug to the patient (CCR §1711). Pharmacy staff will refer to this definition when evaluating medication errors.
5. **Near Miss**: An event or situation that didn't produce patient injury, but only because of chance. Also known as “good catch”
6. **Safety incident report (SIR)**: a confirmed report that needs to be filled out to detail events of a medication error, including an adverse drug event.

C. Application

1. Any staff member, including providers, nurses, pharmacists, other ancillary staff, administration and leadership, including contract staff, are responsible for submitted SIRs to ensure the safety of the medical center.
2. Education and training regarding the procedures of reporting errors will be provided upon starting employment at the medical center and regularly provided to any and all departments for quality assurance purposes.
3. Quarterly reports summarizing SIRs reports are evaluated by the MST and reported to the Pharmacy & Therapeutics (P&T) Committee.

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IV. PROCEDURE

A. Criteria to submit a SIR

1. SIR should be completed in the following situations:
   a. When any event or occurrence results in a temporary or permanent patient/visitor adverse outcome. An adverse outcome is an outcome that might result in liability, causes the patient's condition to deteriorate, results in further treatments, results in a return to the hospital or lengthens the patient's hospital stay.
   b. When a significant patient concern or complaint may result in liability.
   c. When an occurrence is a potential risk indicator such as falls, decubitus or skin breakdown, medication error, adverse drug reaction or unusual patient behavior.
   d. When there is a breakdown of communication and/or equipment, or failure to follow policy/procedure.
   e. Suspicion of a significant ADR which can be detected based on direct observation, evaluation of daily abnormal laboratory reports, subjective patient/family/visitor complaints or concerns, evaluation of reversal agent report from ADM, unexplained changes in mental status.
   f. Unsafe condition or situation where there is potential for medication error (near miss)
2. The report should be completed by the first individual who is aware of the incident, as soon as possible after the occurrence within 24 hours of event.
   a. Staff is to communicate the occurrence to the Charge Nurse, Department Supervisor or Administrative Nursing Supervisor. The employee should follow the Chain of Command.
   b. The SIR procedure will bring to the attention of the Patient Safety team, and the department involved any concern, event or occurrence, actual or potential that may expose the medical center to liability for malpractice, personal injury or property loss or damage.

B. Communication of medication error and/or ADR reporting

1. All Staff
   a. Any personnel made aware of a possible or actual medication error, or identified ADE, shall submit a SIR to the housewide reporting and tracking system.
   b. Upon identification of a medical error the patient care provider will:
      1) Perform necessary healthcare interventions to protect and support the patient's clinical condition.
      2) Perform necessary healthcare interventions to contain the risk to others.

3) Contact the patient's attending provider and other provider, as appropriate, to report the error and carry out subsequent orders immediately.
4) Preserve any physical evidence or information related to the error. The remainder of dose(s) must be retrieved and returned to pharmacy.
5) Report the medical error to the staff member's immediate supervisor.
6) Submit a Safety Incident report (SIR) as soon as possible.
7) Notify Risk Management, if appropriate.

2. Pharmacy Staff
   a. When a pharmacist determines that a medication error, attributable to the Pharmacy or its personnel has occurred, and that the medication was administered to or by the patient, or if the error resulted in a clinically significant delay in therapy, a pharmacist (or designee) shall as soon as possible:
      1) Communicate to the prescriber the fact that a medication error has occurred.
         a) If the prescriber is unavailable, the pharmacist must communicate the medication error with the covering provider.
         b) A discussion should occur to identify required medical intervention or course of action to resolve the medication error.
         c) Notifications and consultations with the prescriber and/or other health care providers concerning the incident must be documented in the SIR module.
         d) The investigating pharmacist shall engage the prescriber or covering provider in a discussion of how and when notification of the patient or the patient's agent regarding the occurrence of the med error should occur.
      2) In consult with the provider, communicate to the patient or the patient's agent the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error
         a) While the patient is within the hospital, the patient's agent will be considered to be the patient's nurse.
         b) Following a patient's discharge, attempts will be made to communicate directly with the patient; however, if the patient is unavailable, the patient's agent, to whom communication will be directed, will be considered to be a person who is legally authorized to be provided with the patient's medical information. Attempts to contact the patient, and all discussions with the patient's agent will be documented in the Safety Incident Report (SIR) module.

3) If the pharmacist was notified of the error by the patient, the patient's agent, or a prescriber, the pharmacist is not required to reinitiate communication with the individual.
4) If a medication error meets any of the following criteria, the Pharmacy Manager must be contacted:
    a) A level 4 or greater (resulting in increased treatment to patient).
    b) A single medication error affects more than one patient, i.e. an error in a batch preparation.
    c) Related to sterile compounding
5) The Pharmacy manager will contact the Risk Manager.

C. Quality Assurance Program coordination

1. SIRs are reviewed by Department Director/Manager
2. Director /Manager of that Unit will forward the SIR to Risk Management/ Patient Safety within 24 to 48 hours after; investigating, discussing care issues with involved employees and completing documentation.
3. Medication Safety Subcommittee reviews quarterly SIRs, ADE (Adverse Drug Event)/PADE (Potential Adverse Drug Reaction Event) /ADR's (Adverse Drug Reactions) reports and recommendations. A report will then be forwarded to the P&T quarterly for analysis and review.

D. Required Data Documentation

1. Confirmed errors are to be reported to the Risk Manager, usually by phone.
2. Reporter Data Documentation:
    a. SIRs should be completed legibly and succinctly using "SBAR" format (situation, background, assessment, and recommendation).
        1) Medication information to include: medication name and/or product formulation.
        2) Include patient's age, medical record number (MRN). Include an attachment of the patient label, if possible, or write patient's name, age, date of birth, medical record number and account number.
        3) For ADE, include details of the reaction, mitigating treatments/ interventions, and preliminary outcome
    b. Significant ADRs require completion of the Adverse Drug Reaction Report, an electronic report form within the housewide reporting and tracking system.
        1) The suspected drug, suspected adverse reaction, and notification of the provider should be noted in the nursing notes of progress notes.
        2) The completed report will be reviewed by the Medication Safety Team for further evaluation, and reviewed specifically by a pharmacist.

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3. Quality Assurance Program data documentation at minimum will follow information required to be reported by Title 16, section CCR § 1711.
4. Storage of Records: an electronic copy of medication errors (at minimum pharmacy-related) shall be immediately retrievable in the pharmacy for at least one year from the date the record was created. These records will be retrievable by the Pharmacy Manager and/or Quality Management Department representative.

E. Patient Education

1. Disclosure of an adverse event to patients is made to the affected patient of identified designee as soon as practically possible after the adverse event has occurred or been identified.
2. Follow #1107.16 Policy for the process to disclose to the patient or family.

V. AGE SPECIFIC CONSIDERATIONS NA

VI. EQUIPMENT

A. Software application used to collect SIR and document evaluations and outcomes.

VII. APPENDICES AND ATTACHMENTS

Appendices and Attachments	Title
Attachment A	#1103.17 Medication Error Reduction Plan
Attachment B	#1106.11.5 Safety Incident Reporting
Attachment C	#1107.16 Patient Rights under HIPAA to Receive an Accounting of Disclosures of Protected Health Information

VIII. AUTHORITY, REFERENCES, APPROVAL

A. Replaces: #770 and 771.00 Medication Error Reporting in Pharmacy Department Manual

New Title: #1106.83 Medication Error and Adverse Drug Event Reporting, Housewide Administrative Policies Manual

B. Authority/ References

1. California Code of Regulations, Business and Professional Code §4125.
2. California Code of Regulations, Title 16 §1711. Quality Assurance Programs.
3. California Health and Safety Code §1339.63. Minimization of Medication-related Errors.

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C. Originators and Authors

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Department, Committee or Function	Subject Matter Experts Name	Title	Date
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E. Approved By

Department, Committee or Function	Name	Title	Date
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Policy & Procedure Committee	Lillian Chan, FACHE	Chair, Policy & Procedure Committee	11/16/2023
Medical Executive Committee	K. Jennifer Voss, MD	Chair, Medical Executive Committee	12/18/2023
Quality & Patient Safety Committee	Adam Nevitt, MD	Chair, Quality & Patient Safety Committee	01/23/2024
Hospital Board of Directors	Andrea Schultz	Chair, Hospital Board of Directors	02/06/2024

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MARINHEALTH MEDICAL CENTER
HOUSEWIDE CLINICAL MANUAL
MEDICATION ADMINISTRATION

I. POLICY

A. At MarinHealth Medical Center patients receive safe care, treatment and services. It is the responsibility of all Clinical Staff to assure all medications are given safely and as ordered, and documented in the patient's medical record in a timely manner. This policy serves to guide clinicians in meeting this requirement.

II. PURPOSE

A. To provide general information and procedural steps in the safe and timely delivery of medications.

B. To identify the individuals authorized to access medications, and to administer medications within their scope of the practice.

III. GENERAL INFORMATION

A. Background/Scope

1. This policy serves to ensure medication administration at the Medical Center will follow evidence-based practice and meet the guidelines set by regulatory agencies such as the Joint Commission and the Centers for Medicare and Medicaid Services.

B. Definitions

1. For the purposes of this policy, the "EMR" will refer to the patient's Electronic Medical Record. The "MAR" will refer to the electronic Medication Administration Record. Any reference to a paper record of medication administration used during downtime will be called a "Paper MAR". While there are specific situations when medications are documented on paper during procedures, such as by the Anesthesiologist or the Code Blue Recorder, these paper documents are not considered the patient's MAR or a Paper MAR, but rather procedural forms that specify what medications were given in an urgent manner in the presence of the prescriber or by the prescriber.
2. The "Restricted Drug List" provides guidance on which parenteral medications can be safely administered on the patient care units, based on the level of care provided by the unit.
    a. See Attachment 1 for the Restricted Drug List.
3. The Medical Center has identified four categories of medication orders: "Stat", "ASAP/Now", "Routine", and "Time-Critical". Unless stated or

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implied within the text of the order, a medication order will be handled as routine. Providers may designate the timeliness of medication administration in one of the following ways:

a. **STAT:** This priority level is for a medically urgent situation, including new antibiotic orders which requires treatment without delay. These situations will take priority over other activities in the Pharmacy. The Pharmacy expects to deliver the requested medication to the patient care area as soon as possible, not to exceed 30 minutes from receipt of the order in the Pharmacy. The Nurse (RN) is expected to administer the medication to the patient in less than 1 hour after the order was written by the prescriber.

b. **ASAP/NOW (As Soon as Possible):** This priority is for situations when a dose is needed prior to the next standard administration time but the prescriber does not consider the clinical situation to be urgent. The Pharmacy is expected to deliver the requested medication to the patient care area in less than 1 hour after receipt of the order in the Pharmacy. The RN is expected to administer the medication to the patient in less than 2 hours after the order was generated by the prescriber. Unless the prescriber orders a new antibiotic STAT, the order will be considered as an ASAP/NOW order.

c. **ROUTINE:** This is the default condition if no priority is indicated. If an order is written without an indicated priority, the order will be processed as routine. The Pharmacy is expected to deliver the requested medication to the patient care area no later than 2 hours after receipt of the order in the Pharmacy. The RN is expected to administer the medication no later than 3 hours after the order was generated by the prescriber, unless the first dose is scheduled for a future specific time.

d. **TIME-CRITICAL MEDICATION:** these are medications that require exact or precise timing of administration.
    1) The timing of medication administration will take into account the nature of the prescribed medication, specific clinical applications, and patient needs.
    2) Time critical medications will be given at the exact time indicated when necessary, or within 30 minutes before or after the scheduled time.
    3) See Appendix 1 for the list of time-critical medications.

e. **RANGE ORDERS:** orders that contain a dosing range which allow for titration of a dose to achieve a desired response/outcome.

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C. **Application**

1. Personnel authorized to administer medications within scope of practice:

Registered Dietician	Physical Therapist (PT)
Speech Pathologist	Physician
Nurse Practitioner	Physician Assistant
Registered Nurse (RN)	Radiology Technologist (CT, MRI, IR)
Pharmacist	Respiratory Therapist (RT)
Student Pharmacist	

2. Personnel authorized to access medication areas within their scope of practice:

Anesthesia Technician	Environment and Patient Care Technician (EPCT)
Biomedical Engineer	Environmental Services staff (EVS)
Building Engineer	Materials Management Staff
Central Supply Technicians	Obstetrical Technician
Certified Nursing Assistant	Sterile Processing Technician
Emergency Department Technician	Unit Clerk

3. The Nurse will:
    a. Assess the patient to determine the need, document the patient's condition and rationale for "as needed" medications in the electronic medical record (EMR).
    b. Educate the patient regarding the purpose of the medication and any side effects, and document medication education in the EMR.
    c. Administer medications ordered by the provider with an awareness of patient's allergies and according to the nurse's respective nurse practice acts, job descriptions and the Restricted Drug List.
    d. Evaluate the effects of medication for therapeutic outcomes and intervene as needed.
    e. Report any adverse reactions (drug events) to the Pharmacy and appropriate provider and intervene as needed.
    f. Document information concerning medications accurately, completely and on the appropriate sections of the EMR. Documentation includes:
        1) Route of administration

2) Administration time
3) RN's electronic signature, and witness signature if needed.

g. Medications held or refused by the patient will be documented as such in the MAR.

IV. PROCEDURE

A. **Key Steps**

1. Assessment
   a. Verify physician order and time order was written.
   b. Identify patient by using 2 identifiers (see Housewide Administration Policy 1106.23)
   c. Verify presence or absence of known allergies.
   d. Verify the "Five Rights of Medication Administration" (Timby, 2017), that it is the right patient, right drug, right dose, right time, and right route.
2. Accessing Automated Dispensing Machine (ADM) Medications
   a. Medications are pulled for only one patient at a time. Do not remove medications for additional patients until after administration to your current patient is complete.
   b. Scheduled medications are to be removed by time of administration.
      1) PRN medications and one-time drugs are pulled individually by medication.
      2) Medications pulled from multi-pocket matrix drawers must be scanned on removal to verify removal of the correct medication.
   c. While ADM drawer is open, it is against policy and nursing practice to remove drugs that were not included in the removal request.
   d. The maximum total time period for the medication to be removed is 1 hour and 59 minutes. For example, for a 09:00am administration time, the medication may be removed from ADM between 08:00am and 09:59am. As a result, medications can be administered up to 1 hour before or 1 hour after the scheduled time.
   e. If the ADM pocket is empty, communicate the stock out to the pharmacy by sending an electronic note to the pharmacist via the Electronic Health Record (EMR) software.
      1) Call the pharmacy only if the medication issue is urgent. Frequent calls can result in delayed pharmacy response and medication errors.

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3. Non-ADM Medications
    a. Medications that are not stored in the ADM will appear unavailable, or “grayed-out”, in the ADM. These medications will be stored in the patient’s medication cabinet, the patient’s bin in the Medication Room, the medication refrigerator, the medication cart, or other secured medication storage area. Medications are not to be kept unsecured at the patient’s bedside.
    b. Non-ADM medications will be hand-delivered to Behavioral Health.
    c. In all other areas except Behavioral Health, non-ADM medications will be sent via the pneumatic tube system or hand-delivered to patient care unit. These medications must be placed into the appropriate secure medication storage area by the responsible nurse.
    d. Transfer Patients: The transferring nurse must gather up all non-ADM medications including any meds from home and transfer them with the patient to the new location. The receiving nurse will locate and secure all medications in the patient bin on arrival.
    e. Discharged Patients: The discharging nurse must discard medications with open packaging in the pharmaceutical waste container per hospital policy. Medications in unopened packaging may be returned to the Pharmacy by pneumatic tube or placed in the Pharmacy Out Box location for pick-up. A patient identifying label needs to be on all returned medications.
4. Handling of Vials
    a. Whenever possible and practical, single-dose vials of injectable medication (unit of use) should be used in patient care areas.
    b. Single-dose sterile vials must be used within 1 hour after a dose is removed.
    c. When multiple-dose sterile vials are used, the following steps will be taken to minimize the risk of contamination and infectious complications.
        1) Aseptic technique must be utilized. If there is any concern whatsoever that there has been a break in aseptic technique or possible contamination is suspected, immediately discard the multiple-dose sterile vial.
        2) Use of multiple-dose sterile vials should be limited to a single patient whenever possible to reduce the potential for transmission of infectious diseases in the event of inadvertent contamination. For example, insulin vials should be used for a single patient and not shared among patients.
        3) All multiple-dose sterile vials need to be clearly marked with an expiration date.

4) Pharmacy will place the following label on all multiple-dose sterile vials “Medication expires on ___”.
5) The multiple-dose sterile vial may only be used for a maximum of 28 days after opening or puncture, unless the manufacturer identifies an expiration date earlier than the required 28-day expiration, then the earlier date must be used.
6) At the time of opening or puncturing a multiple-dose vial, the 28-day expiration date must be noted on the label.
7) Each time a vial is used, it should be inspected for cloudiness, particulates, or any other sign of possible contamination. If there is any question of contamination, the vial should be immediately discarded.

d. Multiple-dose sterile vials do not require refrigeration after opening if the drug product in question may be stored at room temperature prior to opening. The vial should be stored per original labeling recommendations both before and after opening.
1) Multiple dose oral and topical medication containers can be used until the manufacturer’s expiration date as noted on the package.

5. Transdermal Drug Patches
a. A skin assessment will be performed upon admission. If a medication patch is present on a patient, the nurse will request an order to continue the patch during admission or to discontinue it. If the patch is ordered to continue, and is on formulary, it shall be removed and replaced with a patch from hospital inventory. If the patch is a non-formulary medication and is continued on admission, the provider will enter an order for the patch as Patient’s Own Medication.
b. Transdermal patch administration procedure:
1) Wear gloves when handling both new and old patches.
2) Select an application site that is appropriate for the size of the drug patch. The site should be clean, dry, hairless, free from cuts, scratches, or irritations. Avoid distal area of the body, such as the forearm, that the patient moves frequently.
3) Apply new patch at the same time each day. Rotate site. Remove old patch.
4) Write the date and time on the patch when applying it.
5) Do not apply heating pad directly over patch.
6) Discard old patch by folding it in half with the sticky sides touching.

7) Clean skin beneath old patch.
8) If the patch is a controlled substance (e.g. fentanyl patch), it will be disposed of via the automated dispensing machine (ADM). Waste will be documented by two nurses in the ADM. See House-wide Administrative Manual 424.31 Disposal of Transdermal Fentanyl Patches.

6. Range Order Dose Determination for "As Needed – PRN" Orders
    a. The RN shall start by giving the first line "as needed" (PRN) medication starting with the lowest dose in the range.
    b. If there is a clinical justification (e.g. medical emergency/clinical regression) to initiate analgesia at a higher dose range (2nd line, 3rd line), the RN must document the reason on the Medication Administration Record (MAR).
    c. Example: ***5-10mg PO oxycodone every 4 hours as 1st line for pain:***
        - ***0800 RN gives 5mg oxycodone for a pain score of 7/10***
        - ***0830 RN reassesses; patient is now complaining of 8/10 pain***
        - ***0835 RN gives the remaining 5mg oxycodone, maximizing the full dose in the 1st line tier iv.***
        - ***0905 Patient reports 6/10 pain.***
        - The maximum dose in the range has been given over the past 1 hour. If additional analgesia is required, the RN may advance to the 2nd line PRN medication.

7. Administering Oral Medication. See appropriate clinical nursing reference[1].
8. Administering Medication Through an External Tube and or suppository. See appropriate clinical nursing reference[1].
9. Administering Eye Medication. See appropriate clinical nursing reference[1].
10. Administering Nasal Medication. See appropriate clinical nursing reference[1].
11. Administering Subcutaneous Injection. See appropriate clinical nursing reference[1].
12. Administering IM Injection. See appropriate clinical nursing reference[1].
13. Administering IV Medication. See appropriate clinical nursing reference[1].
14. Documentation of Medication. See appropriate clinical nursing reference[1].
15. Medication Order Verification in the MAR

a. Before giving any new medication, the medication order must be verified on the MAR by comparing it to the CPOE or written order from the provider.
    1) If there is an error on the MAR, mark the medication as inactive/unverified and notate the reason in the MAR order
    2) Follow appropriate steps to resolve any issues related to inactive medications.
    3) Send a note to the Pharmacy via the MAR to correct order entry errors.
        - If the order was written on paper, scan the communication to pharmacy.

16. Patient Identification
    a. After assessing the patient (following the steps listed above under the assessment section of the policy), the patient's ID band will be scanned prior to administering any medication or intravenous fluid.
17. Scanning Medication in the EMR
    a. Scan the medication barcode for all medications being administered after scanning the patient's ID band.
    b. Complete the charting fields as necessary on the MAR.
    c. For administration of Heparin, Insulin, Chemotherapy, PCA or ISN infusions (or any other medications with unit specific charting); also document on the appropriate forms in the EMR.
    d. For barcode problems:
        1) Over-ride the medication scanning during administration.
        2) Have another RN confirm the Five Rights of Medication Administration and sign as witness on the MAR
        3) Complete an electronic communication to Pharmacy.
        4) Place the empty medication package with the barcode in the appropriate box provided by pharmacy.
    e. If a scheduled medication is not given, chart "Not Given" and the reason for not giving it on the MAR.

B. **Required Data Documentation** NA

C. **Patient Education**
1. Assist the patient in understanding the medication regimen, including expected actions, schedule, side effects, proper handling and discarding of medication. All teaching and the patient's response should be charted in the EMR.

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2. Medication information is available in English and Spanish from within the MAR. Additionally, there are electronic clinical resources available in the EMR and on the Intranet that provide medication information in patient-appropriate language. Any paper education the patient receives will be documented in the EMR and placed in the Patient Passport or at the bedside for patient to review.
3. Every effort will be made to provide medication education in the patient's preferred language, and these efforts will be documented in the EMR.

V. AGE SPECIFIC CONSIDERATIONS

A. The route of administration and the dosage form of a medication (liquid versus solid) will be determined by patient's age, developmental level and ability to cooperate.
B. Dosage will be determined by the prescriber based on age, weight and diagnosis.
C. All patients less than 14 years or <50 kg will have medication ordered by the prescriber in metric units per kilogram (g/kg or mg/kg or ml/kg) as indicated.

VI. EQUIPMENT

A. Computer with network connection and EMR.
B. Barcode medication administration equipment
C. Automated medication dispensing machine

VII. APPENDICES AND ATTACHMENTS

Appendices and Attachments	Title
Appendix 1	Time-Critical Medications
Attachment A	Restricted Drug List

VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION

A. Replaces: Medication Administration 424.1.3
New Title: Medication Administration 424.1.4

B. Authority/ Reference

1. B.K. Timby, RN BC BSN MA. Introductory Medical-Surgical Nursing, 12th Ed. LWW. 2017-11.

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APPENDIX 1
TIME-CRITICAL MEDICATIONS

Type of Time-Critical Medication	Clarification
Antibiotics	IV first doses for the treatment of sepsis only
Insulin	• Rapid-, short-, and ultrashort-acting insulin. • Not oral anti-hyperglycemic medications. • These times may need to be adjusted according to the actual meal delivery time and the time the patient eats their meal. If patient is NPO, on tube feeding or TPN, administer insulin based upon frequency ordered per MD.
Medications prescribed to be administered every 4 hours or more frequently	For example, anti-Parkinson's agents dosed every 4 hours.