RA - MEDICATIONS: - MEDICATION MANAGEMENT

INTENT:

- To ensure medication is managed safely and responsibly, in accordance with the *BCCNP, British Columbia College of Nursing Professionals.*
- To ensure medication errors are reported and addressed promptly and effectively

POLICY

Medication is dispensed, administered and documented in accordance with the Practice Standards for registered nurses and licensed practical nurses.

Nurses are responsible for being familiar and complying with these and other standards set by the BCCNP.

Nurses work in concert with doctors, pharmacists, families and the program manager or designate to ensure medication is managed safely and accurately.

All medication errors are reported to the program manager and steps are taken to reduce the risk of future errors.

PROCEDURES

All medications require physician's orders and are administered according to these. Any deviation from that procedure, is handled in accordance with BCCNP standards of practice and the direction of the program manager.

Medications are administered by the nurse responsible, who is able to identify the child receiving the medication with certainty and who remains with the child until the medication has been taken. When preparing and administering medications, take steps to reduce interruptions that may lead to error.

Nurses administer only medications they themselves or a pharmacist have prepared, except in an emergency.

Nurses are responsible for administering medications within their scope of practice.

Nurses are knowledgeable about the effects, side effects and interactions of medications and take action as necessary. This includes handling, administration, safe storage, and disposal. Medications can be researched via the BCCH Online Formulary to assist in accessing this information. If this resource is inaccessible, contact your Program Manager/Nursing Supervisor.
****NOTE** Concentrations on liquid medications need to be checked carefully as these are subject to change depending on dispensary.**

Nurses act upon verbal and telephone orders only when circumstances require doing so and if there are no other reasonable options. Read back any verbal or telephone order to the prescriber to confirm it is accurately recorded.

Medication is administered according to standards of practice, including confirmation of the "seven rights" of medication administration **(BCCNP, 2019)**

- Right Client
- Right Medication
- Right Dose
- Right Time
- Right Route
- Right Reason
- Right Documentation

Nurses verify that medication orders, pharmacy labels and/or medication administration records are complete and include the name of the client, the name of the medication, the medication strength and the dosage, route and frequency with which the medication is to be administered prior to each dose.

Timed critical scheduled medications are defined as medications and drugs with a dosing schedule more frequent than every 4hrs. Time critical medications must be administered at the exact time indicated when necessary (eg insulin), otherwise within 30 minutes before/after scheduled time.

Non-time critical scheduled medications are defined as daily, weekly, monthly medications. Adminster these medications a the time prescribed or within 2hrs (before/after) the scheduled time.

Non-time critical scheduled medications are also defined as medications prescribed more frequently than daily, but no more frequently than every 4hrs. Adminster these medications at the time prescribed or within 1 hour (before/after) the scheduled time.

When a medication error or near miss occurs at any point in the process of prescribing, compounding, dispensing or administering a medication, nurses take appropriate steps to resolve and report it in a timely manner.

All medications are documented on the Medication Administration Record (MAR) and all PRN medications will be documented on the MAR and in the nursing notes to provide further explanation.

All medication entries on MAR records must be verified against the physician's orders monthly and with any new entries to the MAR. All MAR entries require a two nurse check, indicated by initialing in the provided space beside the entry.

If there are alterations to a medication prescription, the MAR requires a new entry and a discontinuation of the previous order. Discontinued orders are to be crossed off and noted "d/c as of (insert date)" to indicate they have been discontinued.

It is the nurse's responsibility to check the MAR to the medication prior to the administration of the medication.

Medication is kept in the original labelled containers provided by the dispensing pharmacist until immediately prior to administration. If a child is away from the typical site of service (e.g., home), the nurses may pre pour medications for later administration by themselves and must be prepared to ensure the right person is administered the right medication in the right dose at the right time and by the right route. **ALERT:** You should avoid pre-pouring medications as it can blur the accountability for making sure the seven rights are met and/or increases the possibility of errors. However, in the event that this is required:

- Nurses must clearly label the container with the child's name or initial, medication name, medication dose, time and route of administration.
- In situations if pre-poured medications are required (ie. School), this is documented in the Care Plan. Otherwise, all pre-poured medication will be recorded as such in the Nurses Notes.
- If client care is being provided temporarily away from the home (eg. physcian's appointments, trips to the park, etc.), the MAR must accompany the pre-poured medications to meet medication administration practice standards. Proper storing and handling techniques will apply.

In the community, residential and rural settings, or when working alone, independent double checks for **high risk medications** are not always possible. Nurses need to be aware of medications that have a high risk of causing serious injury or death if not used correctly. They include heparin, warfarin, insulin, chemotherapy, concentrated electrolytes, narcotics, neuromuscular blocking agents, thrombolytics, and adrenergic agonists. Health care providers administering high risk/high alert medications will:

- the nurse will conduct an individual double check by repeating their medication calculations and safety check (7 Rights) a second time just prior to administration.
- When a nurse is the only healthcare professional on duty, an independent double check can be performed with someone else. For example, in a pediatric homecare situation, it could be done with a client's family member. **ISMP, Medication Safety Consultant, 2019)**

Telephone orders may be obtained by both Registered Nurses and Licensed Practical Nurses. Nurses accept verbal or telephone orders only when there is no reasonable alternative, and when doing so is in the best interest of the client. Nurses repeat the order back to the ordering health professional to confirm that it is accurate. Nurses promptly document any verbal or telephone orders. Telephone orders require a cover order to be obtained by the Regional Manager as soon as possible. Telephone orders must be communicated to the Regional Manager via email immediately.

Medication errors are reported to the program manager immediately, and the proper course of action determined and followed. Errors are fully documented on an Unusual Occurrence report, and that report is submitted to the Regional Manager. (This policy also has a form, Notes for Medication Error that can be used to make notes in preparation for the report.) A thorough review of all medication errors, omissions, and adverse effects is undertaken as needed; corrective action is taken and documented, and followed up to assess and ensure that these actions are effective.

Nurses inform family members about discarded, spoiled or expired medication and encourage them to return the medication to the pharmacy for proper disposal.

RESOURCES

Medication Administration Module
Medication Administration Resources
BCCNP Medication Administration Workbook

REFERENCES:

British Columbia Children's Hospital: Medication Administration – General Guidelines. January 2016. Retrieved on November 18, 2019 from: http://policyandorders.cw.bc.ca/resource-gallery/Documents/BC%20Children's%20Hospital/CM.03.01%20Medication%20Administration%20-%20General%20Guidelines.pdf

College and Association of Registered Nurses of Alberta: Medication Guidelines. March 2019. Retrieved on October 24, 2019 from: https://www.nurses.ab.ca/docs/default-source/document-library/guidelines/medication-guidelines.pdf?sfvrsn=230ccadd_14

Nursing Standards for Registered Nurses and Nurse Practioners – RN Scope of Practice – Part 2: Scope of Practice Standards – Acting with Client Specific Orders – Standards with Acting for Client Specific Orders. October 2019. Retrieved from: https://www.bccnp.ca/Standards/RN_NP/StandardResources/RN_ScopeofPractice.pdf

Practice Standard for Registered Nurses and Nurse Practioners: Documentation. British Columbia College of Nursing Professionals. July 2019. Retrieved October 24, 2019 from: https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Pages/documentation.aspx

Practice Standard for Registered Nurses and Nurse Practioners: Medication Administration. British Columbia College of Nursing Professionals. July 2010. Retrieved October 24, 2019 from: https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Lists/GeneralResources/RN_NP_PS_MedicationAdmin.pdf

FORMS: Medication Administration Record
Notes for Medication Error
Unusual Occurrence Form

WHRC
WESTERN HUMAN RESOURCE CORP

RESOURCE ABILITY & NURSING SOLUTIONS

Medication Administration Record

Month________________

Name: ________________ Allergies: Weight: ___________ Updated:

PRN MEDICATIONS TO DOCUMENTED IN NURSING NOTES

Verified By:	Medication Order	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Nursing Signatures & initials				

NSS MEDICATION ADMINISTRATION

P = Given by Parent R = Medication Refused ***Nursing Note Required*** * Check Med Concentration

NOTES FOR MEDICATION ERROR:

For employee use if desired – this is in addition to and does not replace Unusual Occurrence Reports

Date: ____________________________

Time: ____________________________

Type of Incident: ____

Health Professional Contacted: ____

Time Contacted: ____

Direction Given:

Action Taken:

Follow up:

Date and Time Manager contacted:

UNUSUAL OCCURRENCE FORM

Program/Site: ____

Date of Occurrence: ____________ **Time**:________ **Location:** ______________________

Name of individual(s): ____

Details of Occurrence:

____
____
____
____

Result of Occurrence/Action Taken:

____
____
____
____

Review and Recommendations:

____
____
____
____
____

NSS and Others Informed:

____
____

Unusual Occurrence Form Forwarded To:

____

Occurrence report completed by: ____
Witness/Attending Staff: ____
Manager Signature: ____
Completed by manager or designate
☐ **Follow up needed**
ActionTaken/Planned:____
____
____
____
Person Responsible: __________________________________**Target date:** ______________
Date completed: ____