

Vermont Psychiatric Care Hospital Procedure

Medication Administration and Documentation

Revised: X

Date: 04/07/14

I. Medication Orders

1. All medication orders shall be reviewed, signed, or co-signed by a Registered Nurse (RN).
2. Medication orders may not contain prohibited abbreviations.
3. If the patient is allergic to specific types or classes of medication, nursing staff are responsible for ensuring that this information is written prominently on the cover of the patient's medical record and on all Physician Order sheets when they are placed in the patient's medical record.
4. Written orders may not be altered except to correct an error by drawing a single line through the error, accompanied by the signature, professional designation, date and time of the error correction.
5. When a medication order is changed, the existing order shall be discontinued and a new replacement order written.
6. Orders for scheduled medication must include the reason the medication is being given. Orders for PRN medications must include specific indications for when the medications is to be administered.
7. Court-ordered medications must be identified as such in the written physician order.
8. Only an RN may accept a telephone order from a physician. When taking a telephone order, the RN shall write the order in the physician order section of the medical record, and then read the order back to the physician, word for word, for confirmation. After the physician has confirmed the order as read by the nurse, the RN shall write, "TORB" (meaning "telephone order read back"), followed by his/her printed name and title, signature, forward-slash, physician's name and title (e.g., TORB Jane Doe, RN/Dr. Doe, MD). The order will then be processed and signed off in the usual manner.
9. A physician shall countersign each telephone order within 48 hours.
10. Verbal orders shall be used only to meet the care needs of the patient when it is impossible or impractical for the ordering physician to write the order without delaying treatment. When a verbal order is necessary, the RN shall repeat the verbal order back to the physician before administering the medication, and shall, as soon as possible, write the order as with a telephone order, using the abbreviation "VORB" ("verbal order repeated back").
11. A physician shall countersign each verbal order within 48 hours.

II. Processing Medication Orders

1. The unit clerk or RN shall:
 - 1) Fax the order to the Copley Hospital pharmacy in a timely manner.
 - 2) Stamp the order indicating that it has been faxed to the pharmacy, sign, date and time the fax stamp.
 - 3) Verbally inform an RN immediately of the new medication order.
2. At the end of every shift, the Nursing Supervisor or designee shall review or assign a review of the physician order section of all patient records to ensure that all new orders have been processed completely.
3. If orders have not been processed completely at the end of a shift, the departing Nursing Supervisor shall ask and receive confirmation from the oncoming Nursing Supervisor or designee that s/he assumes responsibility for completing any remaining processing of orders written on the previous shift..
4. Authority to transcribe to the MAR/TAR is given to student nurses (supervised by their clinical instructor or VPCH preceptor), GNs with provisional Vermont RN licenses, VPCH registered nurses, and traveling nurses approved by the VPCH Director of Nursing or Associate Director of Nursing.
5. Transcribing includes writing the original MD order onto the MAR/TAR, including medication name, dose, route of administration, frequency and administration times, whether the medication is scheduled or PRN, first and last doses, as well as any special instructions
6. Only RNs may verify (provide nursing approval) orders. Verifying includes checking the transcription for accuracy, completeness, possible relevant allergies, and so forth. The Nursing Supervisor or designee shall assign an RN to verify MARs and TARs.
7. A nurse who transcribes and/or verifies a medication order shall sign, including their professional designation, date and time to indicate the action taken.
8. Transcribe scheduled and PRN medication orders onto the MAR/TAR. Enter times of doses due during the MAR/TAR in the appropriate shift box. If the order has a start date/time after the current MAR/TAR, enter “no doses due” through the shift boxes.
9. For new admissions, or when additional MAR/TAR pages are needed, use a blank MAR/TAR form.
10. If the transcriber is not an RN, the person transcribing, or the RN clinical instructor overseeing nursing students, shall indicate this by drawing a line beneath the order and writing the date, time, “Noted by” signature and title.
11. If the transcriber is not an RN or a member of the VPCH nursing staff, a GMPCC RN must co-sign the physician order after verifying that the transcription on the MAR/TAR is complete and accurate.

12. If a discrepancy or ambiguity is found, an RN shall contact the prescribing physician or the Copley Hospital pharmacist. If the discrepancy or ambiguity remains unresolved, contact the Nursing Supervisor for assistance, and do not administer the medication until the question is resolved.

III. Creation of Medications Administration Record (MAR) and Treatment Administration Record (TAR); Managing the Medication Administration Record (MAR) and Treatment Administration Record (TAR)

MARs will be generated by the Copley Hospital pharmacy; TARs will be generated by RNs at GMPSS. Both the MAR and TAR will be updated as needed by VPCH RNs.

Medication Availability

Scheduled and PRN medications will be provided for VPCH patients as described in Copley Hospital Policy: III-03.10 Pyxis 3500 Policies and Procedures and Copley Hospital Policy: III-03.1 Medication Storage and Control.

VI. Administering Medication

1. Medications may be administered by RNs who have demonstrated competency, graduate nurses (GNs) with a provisional Vermont RN license who have demonstrated competency, and nursing students supervised by their clinical instructors or VPCH preceptor.
2. Medications administered shall be documented on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR).
3. The RN who administers, or who oversees administration of a medication shall sign, including their professional designation, date and time, to indicate the action taken.
4. Proper administration of a medication consists of the following:
 1. Right patient
 2. Right drug
 3. Right dose
 4. Right time
 5. Right route
 6. Right reason
 7. Right documentation
 8. Right to refuse.
5. The nurse will inform the patient about what medications s/he is receiving. The nurse shall incorporate patient participation and education into the medication administration process, and shall document medication education in the patient's medical record.
6. If a patient/family member questions a medication, the nurse will double-check the order before administering the medication.

7. All medications to be administered must have a patient specific Copley Hospital pharmacy label, unless the specific medication/s is obtained from the night closet or from unit stock medications stored in the pyxis.
8. Medications must not be administered if an RN has any concerns regarding consistency, color, odor, or the presence of precipitates. The RN shall communicate any concerns regarding quality of medications to the Copley Pharmacy Service and shall communicate any such concerns to VPCH Quality by reporting this to the Nursing Supervisor and by completing a VPCH Variance Report.
9. Medications may not be pre-poured (removed from package or bottle) before the patient is present to receive them. Only the nurse who pours the medication may administer it to the patient and document it in the MAR.
10. After a dose of injectable insulin for subcutaneous administration has been drawn up and before the dose has been administered the RN who drew up the insulin, the RN who drew up the insulin shall ask a second nurse to check the prepared insulin syringe against the physician's order without verbal prompting of the checking-RN by the dose-preparing-RN. If the second RN confirms that the prepared dose is accurate, the second RN shall co-initial that dose in the MAR, writing "dose confirmed by 'name, RN'" next to the time of that dose in the MAR.
11. Medications shall be administered within 60 minutes before or after the scheduled administration time, unless a physician order allows broader parameters.
12. In the event that a patient, for whatever reason, chooses to delay taking one or more medications, the RN shall request from a physician an order stating the conditions under which the RN should continue to offer any specific medications outside the one-hour limit.
13. When a patient only takes a partial dose of the prescribed medication; the RN shall notify the physician and the Nursing Supervisor, note it on the MAR and in a progress note. The RN shall complete an event report for a medication error (incorrect dose taken by patient).
14. Any unused portion of any single dose medication or diluent vial shall be discarded.
15. The RN shall administer the medication to the patient, after identifying the patient by photograph, along with one other identifier (either patient self-identification or identity confirmation by another staff member).
16. The RN shall monitor the patient's response (therapeutic/untoward) to the medications administered.
17. If symptoms appear that suggest an adverse drug reaction (ADR) may be occurring, the RN shall report the reaction to the physician/prescriber immediately. The RN shall also complete an event report for a Potential Adverse Drug Reaction.

18. A “med watch” may be ordered by a physician. “Med watch” is defined as directly observing a patient for a prescribed period of time in an attempt to ensure that s/he does not dispose of the medication after having placed it in his/her mouth. When a med watch is ordered, it shall be noted on the MAR.
19. A med watch means that a staff person shall be assigned to observe the patient from the moment of administration until the end of the ordered med watch period. If the patient disposes of the medication, or attempts to dispose of the medication, the staff member assigned to the med watch will immediately inform the RN who administered the medication. If possible, the staff person shall also retrieve the medication if possible, and return it to the RN who administered the medication for identification and disposal.

VII. Medication Documentation

1. The RN shall document scheduled medication administered on the MAR by drawing a line through the time due and initialing next to the time. The nurse shall document the exact time of administration when a medication is administered outside the two hour time parameter.
2. When an injectable medication is administered, the nurse shall write the Injection Site code number next to the administration time.
3. If a medication is not given, the RN shall circle the administration time and add a letter corresponding to the “Meds Not Given” reason codes inside of the circle. When the RN does not give a scheduled medication for any reason, the RN shall write a rationale in a progress note.
4. When a medication order includes parameters that overlap into the next shift or the next MAR (e.g., “dose may be given until 0200”), the medication nurse shall follow these steps:
 - i. Document normally if the patient takes the medication at the time prescribed.
 - ii. if the patient does not take the medication within the usual two-hour period, circle the dose time and indicate omission code, and then write in the exact time given if the patient takes the medication before the end of the shift.
 - iii. if the dose has not been given by the end of the shift, the medication nurse shall write in the next shift’s box for that medication, “dose may be given until XXXX.” The medication nurse on the next shift shall then write the exact time of administration, or indicate the omission in the usual manner.
5. PRN medication administered shall be documented by noting the exact time of administration in the appropriate shift box, along with initials. An RN must assess the effectiveness of a PRN medication within an hour of administration, and must document this assessment in the medical record.
6. Nicotine replacement therapy is an exception to “PRN medication” documentation above. When a patient is on nicotine replacement therapy, the patient’s use and response to its use may be documented in the nurse’s daily progress note rather than in multiple PRN notes.

7. All STAT, NOW or one-time medication orders shall be entered on the scheduled medication sheet. After administered or refused, the order shall be highlighted in pink after initialing and timing, to show that the order is no longer active.
8. If a medication is written with vital sign parameters, the nurse shall document the required vital signs in the same box in which the med is signed off. The nurse does not necessarily need to perform the vital sign assessment him/herself, but may receive the information from another nurse or psychiatric technician.
9. When giving insulin from a sliding scale, the nurse shall document the exact dose given on the TAR, in addition to writing initials and the injection site code. The blood glucose levels shall be documented by the nurse.
10. When administering court-ordered medications, the nurse shall complete Court-Ordered Involuntary Medication form for each dose given, in addition to documenting on the MAR.
11. Court-Ordered Involuntary Medication orders usually include a second, back-up order of a medication that is only to be given if the primary medication is refused by the patient. Back-up medication orders do not include dose times, because they are only given in this circumstance. When a primary court-ordered medication is refused, the nurse shall document the refusal in the usual manner, and then, if the back-up medication is administered, will write the dose time, site, and initials in the appropriate shift box to complete the documentation.

Approved by VPCH Policy Committee	Approval Date: April 7, 2014
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