River Valley Therapeutic Residence Policy and Procedure		
Medication Administration		
Effective: 4/28/2023	Revised: 7/13/2023	Due to Review: 7/13/2025

POLICY

To ensure resident safety and therapeutic treatment, the River Valley Therapeutic Residence (RVTR) seeks to ensure that all resident medication orders are received, reviewed, and documented accurately and precisely, and that all medications and treatments are reviewed, performed/administered, and recorded accurately and within best practices.

PROCEDURE

Medication Orders:

- All medication orders shall be reviewed, signed, or co-signed by a Registered Nurse (RN).
- Medication orders may only contain identified abbreviations.
- If the resident is allergic to specific types or classes of medication, RNs are responsible for ensuring that this information is written prominently on the cover of the resident's medical record and on all Physician Order sheets when they are placed in the resident's medical record.
- 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.
- When a medication order is changed, the existing order shall be discontinued, and a new replacement order written.
- Orders for scheduled medication must include the reason the medication is being given. Orders for PRN medications must include specific indications for when the medication is to be administered.
- 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, then read the order back to the physician, word for word, for confirmation. After the physician has confirmed the order as read by the

RN, 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.

- A physician shall countersign each telephone order when available.

- Verbal orders shall be used only to meet the care needs of the resident when it is impossible or impractical for the ordering physician to write the order without delaying treatment.

- When a verbal order or telephone order is necessary, the RN shall repeat the verbal or telephone order back to the physician before transcribing the order.

- A physician shall countersign each verbal order as soon as possible, within 15 days.

Processing Medication Orders:

The RN shall:

- Fax orders to the pharmacy if requested.

- Stamp the order that has been faxed.

- At least daily an RN shall review or assign a review of the Physician Order section of all residents' records to ensure that all new orders have been processed completely.

- If orders have not been processed completely at the end of a shift, the departing RN shall ask and receive confirmation from the oncoming RN, that they assume responsibility for completing any remaining processing of orders written on the previous shift.

- Authority to transcribe to the Medication Record and Treatment Record is given to RNs licensed in Vermont.

- Transcribing includes writing the original Doctor's Order in the Medication Record and Treatment Record, including medication name, dose, route of administration, frequency, and administration times, whether the medication is scheduled or PRN, as well as any special instructions.

- Only RNs may verify (provide nursing approval) orders. Verifying includes checking the transcription for accuracy, completeness, and possible relevant allergies.

- A RN who transcribes and/or verifies a medication order shall sign, including their professional designation, date, and time to indicate the action taken.

- Transcribe scheduled and PRN medication orders into the Medication Record and Treatment Record. Enter times of doses due on the Medication Record and Treatment Record in the appropriate shift box. If the order has a start date/time after the current Medication Record and Treatment Record, indicate no doses due.

- If a discrepancy or ambiguity is found, an RN shall contact the prescribing physician. If the discrepancy or ambiguity remains unresolved, contact the nurse manager for assistance, and do not administer the medication until the question is resolved.

Creation and Management of the Medication Record and Treatment Record:

Medication Record and Treatment Record will be generated by Health Direct Institutional Pharmacy Services. Both the Medication Record and Treatment Record will be updated as needed by RVTR RNs.

Medication Availability:

Scheduled and PRN medications will be provided for RVTR from the Health Direct Institutional Pharmacy Services as ordered.

Administering Medication:

- Medications may be administered by RNs and medication delegated staff who have demonstrated competency and who have been delegated by an RN to administer medication(s).

- Medications and treatments administered shall be documented in the Medication Record or Treatment Record.

- An RN or medication delegated staff who administers, or who oversees administration of, a medication shall sign, including their professional designation, date, and time, to indicate the action taken.

- Proper administration of a medication consists of the following:

  - Right resident
  - Right drug
  - Right dose
  - Right time
  - Right route
  - Right reason
  - Right documentation
  - Right to refuse

- The RN or medication delegated staff will inform the resident about what medications they are receiving.

- All medications to be administered must have a resident specific pharmacy label.

- Medications must not be administered if an RN or medication delegated staff has any concerns regarding consistency, color, odor, or the presence of precipitates. The RN or medication delegated staff shall communicate any concerns regarding quality of medications to the nurse manager and pharmacy and shall communicate any such concerns by also completing a Medication Error/Event Form.

- Medications may not be pre-poured (removed from package or bottle) before the resident is present to receive them. The RN or medication delegated staff who pours the medication may administer it to the resident and document on the Medication Record. There may be instances when the RN or medication delegated staff may pour the medication and observe another staff (who has also reviewed the Medication Record) administer the medication, and then document it in the Medication Record.

- After a dose of injectable insulin for subcutaneous administration has been drawn up, the RN, or medication delegated staff or resident who drew up the insulin will ask a second RN, or medication delegated staff to check the prepared insulin syringe against the Physician's Order. If the second RN or medication delegated staff confirms that the prepared dose is accurate, the second RN or medication delegated staff shall co-initial that dose in the Medication Record under "confirmed" in the Medication Record.

- Medications shall be administered within 120-minutes before or after the scheduled administration time unless a Physician Order allows broader parameters.

- In the event that a resident 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 medications outside the 120-minute limit.

- When a resident only takes a partial dose of the prescribed medication or refuses the prescribed medication, the RN or medication delegated staff shall note the partial dose/refusal of the medication. The RN or delegated staff will circle their initials and include the corresponding code on the Medication Record by initialing the correct box and placing a corresponding chart code. The medication, dose and reason for the partial dose/refusal will be documented on the reverse side of the resident's Medication Record. There may be instances when a doctor's order indicates the need to notify the nurse manager and/or the physician if a partial dose in administered (ex. Insulin).

- Any unused portion of any single dose medication or diluent vial shall be discarded.

- The RN or medication delegated staff shall administer the medication to the resident, after identifying the resident by photograph, along with one other identifier (either self-identification or identity confirmation by another staff member).

- The RN or medication delegated staff shall monitor the resident's response (therapeutic/untoward) to the medication(s) administered.

- If symptoms appear that suggest an adverse drug reaction (ADR) may be occurring, the RN or medication delegated staff shall report the reaction to the nurse manager, physician/prescriber immediately, or initiate emergency medical response. The RN or medication delegated staff shall also complete a Resident Event Form for an ADR.

- A "med watch" may be ordered by a physician. "Med watch" is defined as directly observing a resident for a prescribed period in an attempt to ensure that they do not dispose of the medication after having placed it in their mouth. When a med watch is ordered, it shall be noted on the Medication Record.

- A "med watch" means that a staff person shall be assigned to observe the resident from the moment of administration until the end of the ordered med watch period. If a resident disposes of the medication or attempts to dispose of the medication, the staff member assigned to the med watch will immediately inform the RN or medication delegated staff who administered the medication. If possible, the staff person shall also retrieve the medication, and return it to the RN or medication delegated staff who administered the medication for identification and disposal.

- A "mouth check" may be ordered by a physician. A "mouth check" is defined as directly observing a resident's mouth by asking the resident to open their mouth and to have them move their tongue up and down and side to side to ensure the medication has not been left in their mouth. A tongue depressor may be used if needed. When a

mouth check is ordered, it shall be noted on the Medication Record.

- All Narcotics will be accounted for at the change of each shift by the outgoing and oncoming medication administrators.

Medication Documentation:

- The RN or medication delegated staff shall document scheduled medication administered in the Medication Record by initialing the correct box. The RN or medication delegated staff shall document the exact time of administration when a medication is administered outside the four-hour time parameter.

- When an injectable medication is administered, the RN shall write the Injection Site Code Number next to the administration time.

- When a resident only takes a partial dose of the prescribed medication or refuses, the RN or medication delegated staff shall note the refusal of the medication. The RN or delegated staff person will circle their initials and include the corresponding code ("B" for a refusal or "E" for a partial dose given) on the Medication Record by initialing the correct box and placing a corresponding chart code. The medication, dose and reason for the partial dose/refusal will be documented in Nurses' Medication Notes on the reverse side of the resident's Medication Record. There may be instances when a doctor's order indicates the need to notify the nurse manager and/or the physician if a partial dose in administered (ex. Insulin).

- When a medication order includes parameters that overlap into the next shift or the next Medication Record (e.g., "dose may be given until 0200"), the RN or medication delegated staff shall follow these steps:

    - Document as normal if the resident takes the medication at the time prescribed.

    - If the dose has not been given by the end of the shift, the medication administrator shall circle their initials, and indicate corresponding chart code "D" and indicate that the dose may be given until XXXX in the Nurses' Medication Notes located on the reverse side of the resident's Medication Record. The outgoing medication administrator will communicate the omission to the oncoming medication administrator. The medication administrator on the next shift shall then write the exact time of administration or indicate the refusal by circling their initials and indicate corresponding chart code "B" and indicate reason for refusal in Nurses' Medication Notes located on the reverse side of the resident's Medication Record.

- PRN medication administered shall be documented by noting the exact time of administration, along with their signature. The RN or medication delegated staff must observe or inquire about the effectiveness of a PRN medication within 60-minutes of administration and must document the results on the PRN Medication Record.

- All STAT, NOW or one-time medication orders shall be entered on the scheduled medication sheet. After being administered or refused, the order shall be highlighted in pink after initialing and timing, to show that the order is no longer active.

- If a medication is written with vital sign parameters, the RN or medication delegated staff shall document the required vital signs on the reverse side of the resident's Medication Record under the appropriate date and vital sign column. The RN does not necessarily need to perform the vital sign assessment him/herself but may receive the information from a medication delegated staff.

- When giving insulin from a sliding scale, the RN or medication delegated staff shall document the exact dose given on the Medication Record, in addition to writing initials and the injection site code. The blood glucose levels shall be documented by the RN or medication delegated staff.

- All wasted medications will be crushed/poured and placed in the waste medication container labeled Pharmaceutical Waste in the medication room, and controlled medications will be disposed of in the same fashion with the exception that two RNs or medication delegated staff will observe the waste and document this on the Control Medication Utilization Sheet.

- Expired non-narcotic medications will be collected by the designated Pharmacy in an identified receptacle located in the medication cart. All expired narcotics and controlled medications will be crushed and placed in Pharmaceutical Waste container.

- AIMS will be completed by an RN within 48 hours of admission and yearly, unless otherwise ordered. In the event that side effects are observed between AIMS assessments, the ADR form will be completed, which is located in each resident's Medication Record.

Approved by	**Signature**	**Date**
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	7/14/2023

Appendix A: STANDARDIZED TIMES AND ABBREVIATIONS

Order	Standard Administration Times			
Daily	0800			
b.i.d.	0800	2100		
t.i.d.	0800	1200	1700	
q.i.d.	0800	1200	1700	2100
q 6 hours	0600	1200	1800	0000
q 8 hours	0800	1600	0000	
q 12 hours	0800	2000		
Every evening	1800			
HS	2100			

STAT: An emergency medication that must be given immediately, to protect the life and/or safety of the resident.

NOW: An urgent medication that should be given as soon as possible, within a 60-minute time frame.

One-time: A medication that will only be given once and then discontinued.