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| SUBJECT: ADMINISTRATION OF MEDICATIONS | NO. |
| 1. All medications shall be kept and stored in the originally received containers in unit dose containers whenever possible and only be administered by licensed medical or licensed nursing personnel in accordance with their respective licensing requirements. All nursing personnel must have appropriate training and experience if duties include administering medication to residents.
2. Written procedure on using the unit dose system, provided by the pharmacy, shall be provided for each nurse’s station. Non unit-dose medications shall be administered as soon as possible after preparation, but only by the person preparing the dose.
3. The nurse’s stations / medication carts shall have necessary items and equipment readily available for the proper administration of medications. Medications will be locked at all times while being stored and only licensed nurses will have access to the medication keys.
4. Administration of drugs and biologicals shall be recorded on the Medication Administration Record (MAR), and if applicable, in the resident’s clinical record.
5. If for any reason a physician’s order cannot be followed, the physician shall be notified as soon as is reasonable, depending on the situation. A notation shall be made in the patient’s record.
6. Nursing staff will report immediately to the attending physician (and the consulting pharmacist, if necessary) medication errors and drug reactions.
7. An entry thereof shall be made in the patient’s clinical record and the error or reaction shall also be described in an incident report.
8. Medications brought to this facility by the patient or patient’s family should be used only under unusual circumstances and only in accordance with written physician’s orders. Such drugs must be properly labeled as set forth previously in section entitled “Drug Labeling”. It is encouraged that all orders undergo automatic drug allergy and interaction checks. The Pharmacy shall not label any medications it did not dispense.
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| Approved: | EffectiveDate: | RevisionDate: | Change No.: | Page: |
| SUBJECT: ADMINISTRATION OF MEDICATIONS, cont. | NO. |
| 1. Self-administration of medication shall not be permitted without the written order of the resident’s attending physician, and shall be limited to those types of medications for which it can be reasonably assured will be properly administered safely by the resident.
2. This facility shall check the Physician’s Order Sheet and Medication Administration Record (MAR) against the previous physician’s orders, to assure proper administration of medication to each resident. The MAR shall be accompanied by a recent photograph, whenever possible.
3. Medication Administration Records (MAR) contains the resident’s name, diagnosis, known allergies and current medication orders. If possible, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to this facility, shall be contained in the resident’s record.
4. Current reference materials on the use of drugs, such as the current edition of Physician Desk Reference and a Nursing Drug Reference Manual or comparable manual shall be readily available on a 24-hour basis, 7 days per week for drug information.
5. Medications for outpatient use are released to patient only upon written authorization by the attending physician. A notation of disposition of such medications (i.e. for away from facility) is entered in the resident’s MAR and /or clinical record. When medication is sent out of the facility with the resident, it shall be labeled by the nurse with the name of the resident, name and strength of the medication, instructions for administration and any other appropriate information.
6. Upon discharge from the facility, the licensed prescriber / physician shall approve the release of any medications to the resident or person responsible for the resident’s care. The quantity of medications released and their disposition shall be documented in each resident’s clinical record.
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| Approved: | EffectiveDate: | RevisionDate: | Change No.: | Page: |