## TriStar Southern Hills Medical Center Instructor/Student Medication Administration Process

## **PURPOSE**

To direct and standardize instructor and/or student medication administration practices.

## POLICY:

- 1. Patient care areas that instructors and/or students are not allowed to prepare and administer medications
  - A. Cardiac: Invasive (CCL and EP)
  - B. Cardiac: Non-Invasive
  - C. Endoscopy
  - D. OR
  - E. PACU
- 2. Patient populations that instructors and/or students may not administer medications
  - A. Neonatal
- 3. Classifications of medications that instructors and/or students may not administer
  - A. Chemotherapeutic Agents
  - B. High Alert Medication Infusions: Anticoagulant and Heparin
  - C. High Alert Medication as outlined in the TSHMC policy, except subcutaneous insulin and anticoagulants
  - D. IVIG
  - E. Medications Associated with Moderate Sedation
- 4. Routes for medication administration that instructors and/or students may not use
  - A. Epidural
  - B. IV Push (excludes saline flush before and after infusion and contrast agents administered in Imaging Departments)
    - i) Intravenous (IV) Push Medications: Time factor: 5 minutes or less. The administration of intravenous push medications refers to medications administered from a syringe directly into an ongoing intravenous infusion or into a saline or heparin lock.
  - C. Intraperitoneal
  - D. PCA
- 5. The following persons may have access to medication dispensing systems

A. Instructors: Yes
B. Students: No

6. The following persons may have access to narcotic keys

A. Instructors: Yes
B. Students: No

7. Students may not prepare and administer medications alone: An instructor or TSHMC staff member and/or a credentialed/privileged staff member must be present. If in a preceptorship <u>may</u> be waived. Will involve consensus of hospital and school leadership staff.

See Attachment A: Student Medication Administration Processes Checklist

## Attachment A: Instructor/Student Medication Administration Processes Checklist

Start of Shift (All Except		Provide daily report to unit regarding the types of medications the
Where Indicated)	_	students will and will not be administering (nursing instructor).
		Attend bedside report and walking rounds as applicable (assigned and
		new - admission & transfer).  Agree on plan that clarifies and details the responsibility for
		administration of each ordered medication.
		Agree on plan that clarifies and details the responsibility for how <b>NEW</b>
		medication orders received during the shift will be handled.
		Agree on plan that clarifies and details the responsibility for how <b>HOLD</b>
		medication orders received during the shift will be handled.
		Agree on plan that clarifies and details the responsibility for how
		<b>DISCONTINUED</b> medication orders received during the shift will be
	_	handled.
		Agree on huddle times to review medication administration record MAR for administration and omissions.
During the Shift (All)		Review all sources of documented drug administration (patient transfer
		from a different level of care or unit).
		Use MAR (facility policy) when preparing and administering medications
	_	(NO WORK SHEETS).
		Avoid unsafe abbreviations, minimally includes, U, IU, QD (in all formats)
		QOD (in all formats), a trailing zero, lack of a leading zero, MS, MSO4, MgSO4.
		Verbalize appropriate indication/use for medication including any
		contraindications, side effects or potential for adverse reactions.
		Check vital signs before administering medications that may alter heart
		rate and/or blood pressure.
		Check laboratory values before administering electrolytes.
		Bring the patient's MAR to the bedside and scan the medication and
	_	patient bracelet before administering the medication.
		Use two unique identifiers before drug administration (name and birth date).
		Observe "No Interruption Zone" around persons preparing medications.
		Prepare one patient's medications at a time, at the patient's bedside and
		administer those medications before preparing another patient's
		medications.
		Use correct type of syringe when preparing medications (oral,
	_	intramuscular, subcutaneous and parenteral).
		Date multi-dose vials are dated when opened according to organizational
		policy (28 Days).
		Double check high risk medications with a qualified person (instructor or staff nurse) (concentrated electrolyte, heparin and insulin)
		Administer the medication as scheduled
		Trace a tube or catheter from the patient to the point of origin before
		connecting any new device or infusion (administration of medications or
		enteral feedings via tubing).
		Tell patient the purpose of the medication (every time – always).
		Tell patient the side effects of the medication (every time – always).
		Observe the patient take the medication(s). Leave no medications at the
		bedside.  Document drug administration immediately after the patient has taken
		the medications (real time).
		Lock medication carts/rooms when not in use.
		Assess patient within 2 hours (minimum) after administration of new or
		pain medication. Assessment and documentation should include desired
		effects and adverse drug reactions.
End of Shift (All)		Review MAR with staff nurse assigned to patient to confirm medications
	1	that were administered, started, held and discontinued.