POLICY MANUAL

Subject: Medication Documentation **Effective Date:** 9/5/90

Initiated By: Cinde Stewart-Freeman
Director of Nursing

Approved By: William C. Anderson
Chief Medical Officer

Review Dates: 4/96, 10/02, 12/02 CSF, 07/08 DT, 01/10 NC, 04/12 NC, 03/13 NC, 02/14 NC

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POLICY:

Nursing staff shall enter and document all medications in TIER in a timely, consistent and accurate fashion. Additional information relevant to medication administration is recorded in a progress note.

PROCEDURE:

1. All medications are transcribed into the Electronic Medical Record (EMR) as ordered by the physician. (see related policy on ordering medications)
2. All medications have start date completed. Stop date is completed as appropriate.
3. Nurses document medication administration by documenting the time given and their initials. (this is documented by the EMR electronic signature.)
4. Those medications which require extra information documented (such as pulse rate with Lanoxin or blood glucose result with sliding scale insulin) shall have this information documented in EMR in narrative form.
5. Medications not given at the scheduled time should be documented in the electronic medical record and shall include a reason why medication was not given. Example: 10 AM/CS refused.
6. Self-administered medications require a physician's order and a documented note that patient has demonstrated accurate administration technique. Document date ad time that the medication is given to the patient in progress notes in the EMR, as follows: 7:30 am/per pt/df. (See related policy on Self-Administration of Medication.)
7. Cumberland Heights has a list of first dose medications. These medications when given as a first dose require the patient to stay in Medical for thirty (30) minutes to ensure there are no adverse or allergic reactions.