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1. PURPOSE

To provide caregivers with uniform guidelines for all aspects of safe medication administration, including use of technology at the point of care.

2. SCOPE

This policy applies to all inpatient units and hospital based clinics or departments in any entity or facility owned, in whole or in part, and controlled by Aurora Health Care. Note: The medication administration times are out of scope for neonatal medications and Respiratory Department administered medications.

3. DEFINITIONS

Automated Unit Based Cabinet (AUBC) is a point of care system to support the safe, timely, and accurate distribution of medications to patients, generate billing and pharmacy inventory management information, and promote effective medication control.

Bar Code Medication Administration (BCMA) is a point of care technology used to verify patient identification and medications during the medication administration process. The use of BCMA provides another medication safety check in conjunction with the rights for safe medication administration. Note that BCMA is out of scope when the following circumstances are present:
   - Patient is receiving an emergent medication
   - Patient is taking personal medications from home
   - An investigational medication is being prescribed
   - Patient is self-administering medications
   - Medications prescribed during the intraoperative and intraprocedural phases
   - Patients are receiving photodynamic therapy

Computerized Provider Order Entry (CPOE) is a computer application in the electronic health record that accepts provider orders electronically.

Electronic Health Record (EHR) is the permanent electronic medical record.

Electronic Medication Administration Record (eMAR) is a computer application in the electronic health record that provides a permanent archived record of all medications a patient receives during an episode of care.

eMAR Downtime Form is a paper record of medications administered during an electronic health record downtime.

Licensed Independent Practitioner (LIP) is defined as any individual permitted by law to provide care and services, without direction or supervision, within the scope of the practitioner’s license and privileges (Joint Commission, 2011).
Medication Process described in the Centers for Medicare and Medicaid Services (CMS) regulations (2014) as a five-stage process that encompasses ordering/prescribing, transcribing/verifying, dispensing/delivery, administering, and monitoring/reporting.

Medications are defined as any prescription medications, sample medications, herbal remedies, vitamins, nutriceuticals, over-the-counter medications, vaccines, diagnostic and contrast agents used on persons to diagnose, treat or prevent disease, radioactive medication, respiratory therapy treatments, parenteral nutrition, blood derivatives, intravenous solutions (plain and with electrolytes and/or drugs), and any product designated by the FDA as a drug. This definition does not include oral or enteral nutrition solutions, or oxygen and other medical gases.

Medication Scheduling Terminology:

A. Scheduled Medications includes all maintenance doses administered according to standard administration times (See Appendix E) based on a repeated cycle of frequency for example, QID, TID, BID, daily, weekly, monthly, and annually (ISMP, 2011). The goal of standard medication administration times is to achieve and maintain therapeutic blood levels of the prescribed medications over a period of time.

B. Time Critical Scheduled Medications refers to medications where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dosing time, for a total window not to exceed 1 hour, may cause harm or result in substantial sub-optimal therapy or pharmacological effect (ISMP, 2011). Examples of time critical scheduled medications including but not limited to the following:
   1. Antibiotics
   2. Anticoagulants
   3. Anticonvulsants
   4. Immunosuppressive agents
   5. Immunosuppressive agents used to prevent solid-organ transplant rejection or to treat myasthenia gravis.
   6. Pain medications (non-IV) (e.g., Scheduled opioids used for chronic pain management)
   7. Medications given more frequently than every 4 hours
   8. Medications that must be administered apart from other medications for optimal therapeutic effect (e.g., antacids and fluoroquinolones)
   9. Medications that require administration within a specified time interval related to meals (e.g., insulin)

C. Non-time Critical Scheduled Medications refers to medications where early or delayed administration within a specified range of either 1 or 2 hours should not cause harm or result in substantial sub-optimal therapy or pharmacological effect (ISMP, 2011).
   1. Medications prescribed more frequently than daily but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled doing time, for a total window that does not exceed 2 hours.
2. Medications prescribed for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window that does not exceed 4 hours.

D. Medications Not Eligible for Scheduled Dosing Times:
The following is a list of medication orders or types of medications are not eligible for standard administration times.
1. STAT and Now doses
2. First doses and loading doses
3. One-time dose of a medication
4. Specifically timed doses based on existing protocols (e.g., antibiotics given before surgical incision)
5. On-call doses (e.g., pre-procedure sedation)
6. Time sequenced or concomitant medications (e.g., chemotherapy and rescue agents)
7. Drugs administered at specific times to ensure accurate peak/troughserum drug levels
8. Investigational drugs in clinical trials
9. PRN or medications prescribed for use on an as needed basis

Patient Controlled Analgesia (PCA) is a method of pain control designed to allow the patient to administer pre-set doses of an analgesic (usually an opioid), on demand (American Pain Society, 2008). **PAIN MANAGEMENT USING OPIOIDS DELIVERED BY PATIENT CONTROLLED ANALGESIA PCA OR CONTINUOUS INFUSION**

Standard Medication Order: Components of a standard order for a drug or biological (CMS, 2014):
1. Name of the patient
2. Age and weight of the patient, if applicable for dose calculations (Weight is recorded in kilograms)
3. Date and time of the order
4. Drug name
5. Dose, frequency and route
6. Dose calculation requirements when applicable (e.g., chemotherapy, PCA opioid dose)
7. Exact strength or concentration, when applicable
8. Quantity and/or duration of the medication
9. Specific instructions for use, when applicable
10. Name of the prescriber

Waste Disposal: Disposal of pharmaceutical waste is governed by pharmacy guidelines. **Black Boxes** are provided for hazardous pharmaceutical waste including warfarin or warfarin packaging, nicotine patches or nicotine foil packaging, chloral hydrate, loose tablets/pills/capsules, open liquid container with drug, a vial/ampule/ or syringe containing liquid medication, or a partially emptied IV bag that contains a drug. IV bags that contain residual IV fluids with electrolytes only may be emptied into a drain. Empty containers,
including IV/PCA/epidural bags, and vials/syringes without needles may be disposed of in the **general trash**, per pharmacy guidelines.

4. **POLICY**

4.1 Medications are administered in response to an order from a LIP, or on the basis of a standing order which is appropriately authenticated subsequently by the LIP.

4.2 Patient identification will be established prior to medication administration using approved patient identifiers (e.g., patient’s full name, an assigned identification number, and/or date of birth) in accordance with **PATIENT IDENTIFICATION** and by using BCMA.

4.3 Clinical personnel may administer medications based on state laws, licensure, scope of practice, and competency. (see Appendix A)

4.4 Caregivers may administer non-scheduled medications as directed by the LIP within their scope of practice, licensure (if applicable), and competency.

4.5 Clinical staff will ensure that medications are prepared and administered to their assigned patients and documented in compliance with statutory, regulatory, and organizational guidelines.

4.6 Medication orders are reviewed by a pharmacist prior to administration, unless given according to established, approved protocols or administered by the licensed prescriber.

4.7 Any questions or concerns about the medication (drugs or biologicals) including dose (too high or too low), route, timing of a medication, frequency of administration, or history of allergies must be resolved prior to preparing, dispensing, or administering the medication.

4.8 In general, dispensed medications are prepared by pharmacy or are commercially available unit dose products. If this is not feasible, there will be a designated area available in the patient care/clinic area for final medication preparation.

4.9 Standard medication administration times are used by caregivers to provide consistent medication scheduling during a patient’s episode of care in the inpatient setting unless an exception has been established or as requested by the ordering provider.

4.10 Clinical staff authorized to administer medications will be granted access to technology related to medication administration, including but not limited to, BCMA, AUBC, CPOE, and eMAR.

4.11 Clinical staff authorized to administer medications will consistently use technology related to medication administration, including but not limited to, BCMA, AUBC, CPOE, and eMAR unless otherwise directed (e.g., during a disaster).

4.12 Prior to administering a medication, caregivers will compare the medication with the medication administration record and verify the patient is receiving the right medication at the right dose via the right route and at the right time.
4.13 Caregivers will document the medications given after the actual administration has occurred, not prior to administration. Caregivers will document all medications administered during an episode of care on the eMAR creating a permanent record. If the eMAR is unavailable, documentation of medication administered is made on a print version of the medication administration record (MAR) and is retained per Aurora medical record documentation policies.

4.14 Caregivers will follow the guidelines for safe administration of high alert medications, which may include but is not limited to independent verification or specific patient monitoring (e.g., use of the Ramsey sedation scale) HIGH ALERT MEDICATIONS

4.15 Discipline specific training/education regarding medication administration will be addressed upon hire during orientation and periodically on an as needed basis. Education may include but is not limited to topics such as safe medication handling, medication preparation, medication indications, side effects, drug interactions, compatibility, and dose limits, equipment or devices, special procedures, or techniques.

4.16 Disposal of medication related waste (e.g. discarded medications or medication containers) will follow established pharmacy policies.

5. PROCEDURES:

Appendix A: Caregivers Authorized to Administer Medications
Appendix B: Basic Guidelines for Medication Administration
Appendix C: Assessment and Monitoring Associated with Medication Administration
Appendix D: Procedural Information Related to the Use of Automated United Based Cabinet Technology
Appendix E: Procedural Information Related to Standard Medication Administration Times

CROSS REFERENCES:
ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS
INFORMATION SECURITY-CAREGIVER REQUIREMENTS POLICY
PATIENT IDENTIFICATION
MEDICATION DISPENSING AUTOMATED DISPENSING CABINETS
Controlled Substances (Pharmacy S7.16)
HIGH ALERT MEDICATIONS
INCIDENT (PATIENT SAFETY EVENT) REPORTING/SENTINEL EVENT MANAGEMENT
PAIN MANAGEMENT
PAIN MANAGEMENT USING OPIOIDS DELIVERED BY PATIENT CONTROLLED ANALGESIA PCA OR CONTINUOUS INFUSION IMMUNIZATION ADMINISTRATION
UNDERGRADUATE STUDENT NURSE
Medication Teaching (#2000)
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**REFERENCES:**


PRIOR REVIEW / REVISION DATES: 11/11, 4/12, 06/14, 9/14
APPENDIX A
Caregivers Authorized to Administer Medications:

a. Licensed physicians

b. Licensed independent practitioners acting within the scope of employment, license, certification, training, experience, or collaboration/supervision agreement.

c. Registered Nurses and Licensed Practical Nurses may administer medications that are specifically ordered by a physician or other licensed independent practitioner or as outlined in specific protocols (e.g., influenza and pneumococcal immunization protocol).

d. A student nurse in an approved school of nursing is permitted to administer medications while under the direct supervision of a Registered Nurse/instructor and in accordance with the nurse practice act UNDERGRADUATE STUDENT NURSE.

e. In Aurora facilities that employ nurse externs, the nurse extern may administer medications, under the supervision of the RN after meeting site requirements for clinical knowledge and competency (See the Nurse Extern Policy).

f. Physician Assistants, Surgical Technicians, Anesthesia Technicians, Perfusionists, Pharmacists, Nuclear Medicine Technologists, Paramedics, Catheterization Laboratory Technicians, GI Technicians, Hyperbaric Technicians and Radiology Technologists may administer those drugs necessary for patient care within the scope of their practice while under the supervision of a physician.

g. Respiratory Therapists administer medications required for respiratory therapy treatments only on the orders of a physician, LIP or based on existing protocols. Medications will be administered based upon the manufacturer’s guidelines, site and/or system policy, if applicable, and physician’s order.

h. A Respiratory Therapy Student enrolled in an approved Respiratory Therapy program administers medications under the supervision of a licensed Respiratory Therapist or Respiratory Therapy instructor.

i. Sleep Lab Technicians administer medications required for treatment of sleep disorders as outlined in orders from a licensed physician unless there are site-based protocols that do not allow sleep lab technicians to administer medications.

j. Physical Therapists and Occupational Therapists may administer medications per physicians order for therapeutic treatment modalities.

k. A Medical Assistant in the clinic setting with established competencies may administer limited medications under the direction of a physician or LIP.
APPENDIX B
General Medication Administration Procedures

Basic Guidelines for Medication Administration:
The following is a summary of the basic actions that should be followed during the medication administration process.

1. Verify the patient’s identity is in agreement with the eMAR and medication labeling prior to administration (Right Patient).
2. Verify that the medication selected for administration is the correct product based on the medication order and product label. (Right Medication)
3. Verify the dose, route, and timing of the medication (Right Dose/Right Route/Right Time). Note if the medication is time critical or is not eligible for a scheduled dosing time.
4. Verify that the medication is stable based on visual examination for particulates or discoloration and that the medication has not expired.
5. Verify there are no contraindications or patient allergy.
6. Make sure the patient has receives the entire dose of medication according to the directions for administration and route (e.g., swallows all of the pills).
7. Educate the patient and, if appropriate, the patient’s family about the medications they are receiving (See system Medication Teaching policy #2000).
8. Discuss any unresolved, significant concerns about the medication with the patient’s physician, prescriber (if different from the physician) and/or relevant staff involved with the patient’s care, treatment and services. Notify the physician/prescriber if medication is held or not given and the reason why.
9. Complete all related documentation related to medication administration in a timely manner. (Right Documentation)

A. Medication Administration using automated unit based cabinet, BCMA and eMAR

1. Before Medication Administration
   a. Before administering any medications, the caregiver must follow electronic security procedures for accessing the AUBC, BCMA unit, and the eMAR.
   b. Verify that a pharmacist has reviewed new or revised medication orders.
   c. If an urgent or emergency situation exists, medications will be given using the “override pull” process. Override pull medications must be reconciled with the active orders in the eMAR.

2. Dispensing Medications
   a. Caregiver will consult the eMAR (or standard paper MAR if a downtime situation) to determine which medications need to be removed from the AUBC or other pharmacy approved storage area. Caregivers will not share their ID/password and are responsible for all activities performed using the unique ID/password. INFORMATION SECURITY-CAREGIVER REQUIREMENTS POLICY
   b. Standard medication administration times will be assigned. The caregiver will document medications not given within the parameters established by this policy. Medications will be
(e.g., refrigerator, medication cart and nurse server).

Priority will be given to time critical medications or medications with specific instructions or protocol for administration.

b. Verify the medication barcode is intact in order to use BCMA.

Staff will verify that medication packages are intact before scanning.

c. The caregiver will gather the medications to be administered to a patient at the designated medication administration time.

Medications must not be removed for more than one patient nor should medications be carried around/stored in anticipation of future use unless multiple doses are to be administered within minutes of each other.

d. The caregiver will log off of the AUBC after obtaining all of the ordered medications.

Caregivers will maintain system security.

3. Administering the Medications with BCMA

a. With the patient’s electronic chart open, the clinical staff member will use the bar coding scanner to scan the patient’s identification band.

Only medications that have an intact manufacturer’s label, pharmacy label, or EHR generated label with a barcode can be scanned. If the medication cannot be scanned, check to make sure the barcode is not wrinkled or torn. If a medication cannot be scanned, send a communication to pharmacy indicating the barcode that did not scan. The medication will have to be manually documented as given.

b. Then each medication will be scanned. The caregiver will verify that the medication that is scanned matches the information on the medication label and matches the medication information listed in the MAR.

Medications given outside of the window for the scheduled time will need to have a reason documented.

C. Prior to giving the patient the medication, the caregiver will verify the medication and apply the rights for safe medication administration including right patient, right drug, right dose, right time, right route, right reason and right documentation.

Caregivers will adhere to safety precautions to ensure that a patient receives only the medications the physician has prescribed and that no contraindications exist.

d. The caregiver will check the eMAR to make sure that all of the medications have been documented, including overdue, PRN, or unscheduled medications and any continuous infusions.

Approved methods of documentation include the eMAR, OR record, anesthesia record or medical record.
e. All medications dispensed from the AUBC or other approved pharmacy storage, barcoded, and administered to the patient must be documented using the approved method.

f. New medications that are eligible for scheduled administration times will be given as scheduled unless directed otherwise by the prescriber or established parameters in the order set.

Ensure the documentation is complete and accounts for the administration of all medications that are ordered for the patient, including new medications, or medications not given or held.

Missed or late medications include those medications that are missed or not given within the designated time frame. Common reasons for missed or late doses include:

i. Patient unavailable due to a scheduled test or procedure
ii. Patient refusal
iii. Patient preference for a different time schedule
iv. Patient inability to take the medication
v. Problems related to medication availability
vi. Lack of IV Access
vii. Medication scheduled to coincide with a meal/feeding

Medication events will be tracked and analyzed to determine the causes. If medication administration timing is determined to be a significant cause of late or missed doses, the standard administration times will be reevaluated.

eMAR entries are linked to the name of the caregiver that is logged into the computer. Logging out of the EHR is a security measure that prevents anyone else from entering the EHR while using the caregiver’s login and password.

4. Administering Medications Without BCMA

a. The patient’s identification will be verified utilizing 2 patient identifiers and comparison with the patient’s wristband. Staff will adhere to the system patient identification policy PATIENT IDENTIFICATION
b. All medications dispensed from the AUBC, patient medication drawer, or other approved pharmacy storage, and administered to the patient must be documented using the approved method.

Approved methods of documentation include the eMAR, OR record, anesthesia record or medical record.

c. Prior to giving the patient the medication, the caregiver will verify the medication and apply the rights for safe medication administration including right patient, right drug, right dose, right time, right route, right reason and right documentation.

Caregivers will adhere to safety precautions to ensure that a patient receives only the medications the physician has prescribed and that no contraindications exist.

d. If a medication is held or not given, clarify this action in the medication documentation and the reason why the medication is held or not given.

See Section A-3.
APPENDIX C
Assessment and monitoring of patients receiving medications:

This is generic information regarding the assessment and monitoring of patients receiving medications NURSING ASSESSMENT AND REASSESSMENT. Other Aurora policies contain information specific to classes of medications (e.g., pain medication PAIN MANAGEMENT or MINIMAL SEDATION (ANXIOLYSIS), MODERATE SEDATION or DEEP SEDATION and the required assessment and monitoring. Other resources such as Micromedex and the Aurora System Medication Administration Guidelines include monitoring information and are accessible to caregivers via Caregiver Connect.

1. Caregivers are responsible for the monitoring of patients to determine whether the medication has the desired therapeutic effect and to allow for early identification of adverse effects of medications and to allow initiation of the appropriate corrective actions.

2. Assessment and monitoring may include the following actions:
   
   a. Clinical and laboratory tests may be ordered by the physician/LIP to monitor the efficacy of medication therapy and to anticipate or evaluate toxicity and/or adverse effects.

   b. Vital signs may be assessed to monitor the effects of the medication on blood pressure, respiratory status, oxygenation and carbon dioxide levels, or heart rate.

   c. Additional physical signs or clinical symptoms (e.g., somnolence, confusion, agitation, unsteady gait, pruritus) may be assessed by the caregiver in conjunction with specific classifications of medications (e.g., sedating medications) or in conjunction with specific patient risk factors (e.g., patient weight, history of asthma, sleep apnea or smoking, altered liver or kidney function, or age).

3. Information related to the assessment and monitoring of patients will be communicated during the handoff communication process.

4. If an adverse reaction to a medication is identified during the assessment and monitoring process, the staff will initiate timely and immediate interventions based on emergency protocols. Examples may include and are not limited to responding to anaphylaxis, opioid induced respiratory depression, or a patient fall.

5. Caregivers will educate the patient and/or family member about the assessment and monitoring process and the medication side effects that may occur.

6. Adverse effects that are identified through assessment and monitoring of patients and are due to a medication or a phase of the medication process must be reported through the system incident reporting system INCIDENT (PATIENT SAFETY EVENT) REPORTING/SENTINEL EVENT MANAGEMENT.
APPENDIX D
Procedural Information related to use of AUBC

1. Pharmacy is responsible for maintaining the AUBC inventory, storage, and security. For detailed information, see MEDICATION DISPENSING AUTOMATED DISPENSING CABINETS.

2. Medication Returns:
   a. Medications removed from the AUBC and not administered must be returned to the AUBC. Only medications that have the tamper-evident seal intact can be returned.
   b. Medications removed from AUBC will be returned to bin labeled for “medication return” not the original location of the medication in the automated unit based cabinet. **NOTE:** Do not place anything other than medications for return in the return bin (e.g., medication keys).
   c. Injectable and oral medications that have been removed from their packaging cannot be returned and must be disposed of following the protocol for disposal of medication waste.

3. Wasting a Controlled Substance:
   a. The primary method of documenting waste for AUBC formulary opioids and other controlled substances will be in the AUBC machine using the waste function as directed by pharmacy (see also Controlled Substance Pharmacy policy S7.16).
   b. Exceptions may include documentation on the proof-of-use sheet, eMAR, OR/Anesthesia record, or medical record.
   c. The partial dose amount of any controlled substance medication must be recorded in an approved method in accordance with regulatory guidelines. If a partial dose is administered or the packaging is compromised, the destruction of the remaining medication must be witnessed at the time it is discarded in a sink with running water or flushed in a toilet.
      i. Used controlled substances patches must be disposed of by folding in half and placing in a sharps container.
   d. All wasted doses must have documentation in the AUBC that includes the name of the caregiver wasting the medication, name of the patient, quantity wasted, and name of the caregiver witness.

4. Controlled substance (e.g., opioids) monitoring, documentation, and discrepancy resolution:
   a. A discrepancy exists when the expected AUBC inventory and the actual physical inventory do not agree.
   b. Caregivers are expected to resolve all discrepancies before the end of the shift, to ensure that the appropriate staff is still available.
   c. All AUBC inventory discrepancies involving controlled substances will be investigated and may result in the caregiver losing their access to the AUBC unit.
   d. Loss Prevention will be contacted for follow-up investigation if the discrepancy is not resolved in 5 business days.

5. Controlled Substances **not** kept in an automated unit based cabinet.
Some facilities or units may have controlled substances or nonformulary medication kept in a double-keyed cabinet approved by Pharmacy Management. A controlled substances administration record is used to document controlled substance usage. Narcotic counts of all controlled substances stored outside the AUBC must be documented every shift.
b. The caregiver will record on the sheet any controlled substance that is wasted. The destruction of any controlled substance that is wasted will be witnessed by another caregiver at the time it is discarded in a sink with running water or flushed in the toilet.

c. All wasted doses must have an entry on the controlled substance administration record documenting the date, name of the controlled substance, quantity of medication wasted, signature of the caregiver wasting the medication and the signature of the caregiver witness.
APPENDIX E

Procedural Information related to standard medication administration times

Note: Respiratory Therapist administered respiratory medications and medications administered to neonates are exempt from standard administration times.

1. Medication administration scheduled based on military time.
2. The first dose may be given as soon as it is obtained. The second and subsequent doses will be given at the standard administration times assigned in the eMAR.
3. Priority will be given when a time critical scheduled medication is scheduled for a specific administration time. For example: Antibiotics that have associated medication serum assays (e.g., peak and trough measurement) or short-acting insulin that needs to be administered with a meal.
4. Nursing staff will adhere to standard drug administration schedules wherever possible. Exceptions may arise and the reason for the exception (e.g., giving a medication late due to patient absence from the nursing unit) must be noted in the eMAR.
5. In the absence of specific direction from the prescriber, nurse, or patient, the pharmacist will use their clinical judgment to schedule the medication appropriately. Medications, such as IV antibiotics, must not be scheduled by pharmacy for the same administration time unless compatible or multiple lines of access are available.
6. Special medication administration instructions listed on the electronic medication administration record (eMAR) must be observed.
7. Medication administration times scheduled in relation to food delivery on inpatient units are only estimates. The medication must be administered to coincide with the arrival of food trays on the unit.
8. The physician has the authority to request a medication administration time that varies from the standard times when writing a new medication order.
9. Nursing must contact the pharmacist if a patient specifically requests a home medication schedule that is significantly different from the standard medication times. If the request is accommodated, the eMAR will be updated to reflect the new scheduled time.
Examples of Standard Medication Administration Times Used at AHC

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DAILY-warfarin or epoetin 1800
QHS 2100
5X/day 0600 0900 1300 1700 2100

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### Scheduled

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### Examples

**Example: Q8H schedule**
- First dose given at 0800. The next dose will be 1400.

**Example: Q6H schedule.**
- Patient misses 1200 dose due to radiology procedure.
- Back on unit at 1330. Receives dose, next dose given at 1800.

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**Schedule is Daily in a.m. (09)**

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**Schedule is Daily in p.m. (2100)**

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**Schedule is BID (0900-1800)**

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<th>0000 0100 0200 0300 0400 / 0500 0600 0700 0800 [0900] 1000 1100 1200 1300 1400 / 1500</th>
</tr>
</thead>
<tbody>
<tr>
<td>1600 1700 [1800] 1900 2000 [2100] 2200 2300</td>
</tr>
</tbody>
</table>

**Schedule is QID (0900-13-17-21)**

<table>
<thead>
<tr>
<th>0000 0100 0200 0300 0400 / 0500 0600 0700 0800 [0900] 1000 / 1100 1200 [1300] 1400 / 1500</th>
</tr>
</thead>
<tbody>
<tr>
<td>1600 [1700] 1800 1900 2000 [2100] 2200 2300</td>
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**Schedule is 5x/day (06-09-13-17-21)**

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</thead>
<tbody>
<tr>
<td>1600 [1700] 1800 1900 2000 [2100] 2200 2300</td>
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**Schedule is Q4H (pick closest standard time)**

<table>
<thead>
<tr>
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<tbody>
<tr>
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**Schedule is Q12H (09-21)**

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<tbody>
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</table>

**Schedule is Q8H (06-14-22)**

<table>
<thead>
<tr>
<th>0000 0100 0200 / 0300 0400 0500 [0600] 0700 0800 0900 1000 / 1100 1200 1300 [1400] 1500</th>
</tr>
</thead>
<tbody>
<tr>
<td>1600 1700 1800 / 1900 2000 [2100] 2200 2300</td>
</tr>
</tbody>
</table>
Schedule is Q6H (00-06-12-18)
0000 0100 0200 0300 / 0400 0500 [0600] 0700 0800 0900 / 1000 1100 [1200] 1300 1400 1500 / 1600 1700 [1800] 1900 2000 2100 / 2200 2300

Schedule is Q4H 0000 – 0400 – 0800 – 1200 – 1600 - 2000