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| Origination | 2/1/2009 | Owner | Victoria Yutko |
| Last Approved | 11/30/2021 | Policy Area | Nursing |
| Effective | 11/30/2021 | Applicability | Rees - Sharp |
| Last Revised | 11/30/2021 | References | Medications, SRS, policy & procedure |
| Next Review | 11/29/2024 | | |

# Medication Administration and Documentation of Medication Administration (at SRS), 43204.99



## I. PURPOSE:

To provide guidelines to administer the prescribed amount of medication safely and effectively.

## II. DEFINITIONS:

A. **AAAHC:** Accreditation Association for Ambulatory Health Care

B. **Clinical Staff:** Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Assistant (MA), Ophthalmic Technologist, Physical Therapist & Occupational Therapist

C. **EHR:** Electronic Health Records

D. **Independent Verification:** An independent double check requires two licensed staff to separately check each component of the work process. This situation applies to the administration of selected high-risk medications (e.g. Heparin, Insulin).

E. **Licensed Staff:** For the purposes of medication verification, "licensed staff" includes physicians, advanced practice providers, RNs and LVNs only.

F. **Look Alike Sound Alike (LASA) Drugs:** Drugs with similar names and/or packaging which may increase the risk of incorrect drug selection. May require special safeguards to reduce the risk of errors.

G. **Medication Error:** "…any preventable event that may cause or lead to inappropriate medication use or patient harm…" (National Coordinating Council for Medication Error Reporting and Prevention, 2016).

H. **No Interruption Zone (NIZ):** An area where medications are prepared and clinical staff are to be fully engaged in the medication preparation process without interruptions. Signage is clearly displayed. Staff do not interact during medication preparation.

I. **Real Learning Solutions (RL Solutions):** Sharp HealthCare's online patient safety incident reporting system. This is where users can report patient safety events or hazardous conditions that could impact patient safety. Staff should report events that reach the patient as well as near misses/great catches - events that could have caused harm but were intercepted before reaching the patient. All RL

events at Sharp can be reported anonymously, or with contact information.

## III. TEXT:

Clinical staff may administer medications within their scope of practice under the following criteria:

A. Clinical staff may administer medications within their scope of practice and as defined in this policy and procedure. Clinical staff are responsible for knowing their scope of practice and operating within that scope regarding administration of medication.

B. A physician or mid level provider order is needed to administer any medication UNLESS competency validated RNs are operating under a standardized procedures. The order must contain name of medication, dose, route, frequency and patient name and patient's date of birth.

    1. Competency validated RN's may follow their department's Standardized Procedures where applicable.

C. Ophthalmic technicians may administer oral medications and eye ointments or drops with a physician order.

D. Clinical staff are responsible for becoming familiar with new medications that are administered in their designated work areas: for usual dose, proper administration techniques, therapeutic response and possible side effects.

E. All medications shall be prepared in a "No Interruption Zone".

F. LASA Drugs: As part of the 2015 AAAHC Survey, SRS was required to place the LASA Medication List wherever medications are stored. It can be posted either inside the cabinets that contain the medications, or on the wall in the medication rooms. Further recommendations:

    1. Place LASA medications in red bins or bins that have been labeled as LASA with the drug name.
    2. Use look alike, sound alike labels on LASA medications
    3. Place LASA labels on unopened boxes of LASA vials.
        a. If the labeled box is open: and the vials remain in the opened, labeled box, *each vial does not need* to be labeled with a LASA tab.
        b. If vials are removed from the labeled box: *each vial* will need to be labeled with the LASA tab

G. Medication may only be prepared and documented by the clinical staff administering it. Clinical staff shall not draw up medications including, but not limited to normal saline or lidocaine for providers to administer.

H. MAs will have ALL medication they prepare verified by a licensed staff member PRIOR to administration of the medication. The process for MA medication verification is as follows:

    1. The MA will print two copies of the order and give one copy to the licensed staff member for verification and documentation in EHR:
        a. One copy will be used by the MA to verify the two patient identifiers and conduct the 7 patient rights at bedside.
        b. The second copy will be used by the licensed staff to verify the prepared medication against the order.
    2. The licensed staff member will verify that the medication and dosage is correct compared to the printed provider's order then document in the EHR they have verified the medication.

3. MAs shall print out the patient's immunization Record, along with the order, to provide to licensed staff when having vaccines verified.
4. The MA will present the patient's allergies, including type of reaction, to the licensed staff member as described in section IV. B.
5. NOTE: If the order is for a child, the licensed staff member shall review the age and dose appropriateness of the medication that has been ordered and prepared.
6. It is the responsibility of **both** the medical assistant **and** the verifying licensed individual to ensure their verification is documented. For example: "Order, allergies and medication verified prior to administration. J. Doe RN"

I. Newly Hired Clinical Staff
    1. All new hire clinical staff (RNs, LVNs, MAs, and MAAs) are to have medications verified, prior to administration, by a licensed staff member for their first 90 days.
    2. All new hire RNs and LVNs are not to verify medications for their first 90 days.

J. All clinical staff (RNs, LVNs, MAs, MAAs) are to have testosterone and progesterone medications verified by a licensed staff member prior to administration.

K. All clinical staff (RNs, LVNs, MAs, MAAs) are to document medications immediately after administration, while in the exam room when possible.

L. Verbal orders should be limited to emergency situations only. Only RN's and LVN's can accept a verbal and telephone order from a physician or advanced practice provider. It is not within a MA's scope of practice to accept verbal or telephone orders. If a verbal order is taken:
    1. The medication order is placed in EHR by the licensed nurse under new medication administration.
    2. EHR documentation should state that the order was ready back to the physician for verification.
    3. The provider must co-sign the order in the EHR within 24 hours or when he/she returns to the clinic by responding to the authorization task.
    4. If the order is a standing order written at a previous date, the documentation must reference that date and order. (i.e. See order xx/xx/xx).

M. In the Gastroenterology Department, RNs may give IV medication per physician verbal orders during procedures and document medication administration following the procedure.

N. Independent Verification by two licensed staff is required for insulin, methotrexate, anti-coagulants (such as Warfarin, Coumadin, Heparin and low molecular weight heparins (Lovenox, Fragmin, etc.)).
    1. The primary licensed staff member will prepare the medication.
    2. The second licensed staff member, away from influence by the primary staff member, will verify the physician order, two methods of patient identification, medication name, dose, route, applicable lab results and calculations.
    3. Once the above critical elements for verification have been met, the medication can be administered by the primary staff member.
    4. If the second licensed staff member is unable to verify the accuracy of the calculation or other critical elements, the medication is NOT administered and the process begins again with the original provider.
    5. Documentation that verification occurred is required independently by both licensed staff

that were present.

O. Wash hands thoroughly before preparing and administering any medication.

P. If reconstitution is needed prior to the delivery of the medication, clinical staff may reconstitute medications per manufacturer's recommendations, and in accordance to their Scope of Practice.

    1. Example: After receiving a written order and reviewing patient allergies, RNs and LVNs may reconstitute and administer IM Ceftriaxone with 1% lidocaine per manufacturer's instructions. Per their scope of practice, Medical Assistants may NOT administer lidocaine; therefore, they are to defer administration to a licensed staff member (RN or LVN).

Q. If clinical staff prepares one or more injectable medications away from the patient (e.g. – Non-code blue situation), each syringe shall be labeled immediately one at a time before preparing the next medication.

R. If a medication is drawn up into a syringe or a needle applied to manufacturer -filled syringe, it must be used immediately. If not used immediately, it must be discarded. Do not label and save for future use.

S. Whenever there is doubt, do not give medication without first verifying. Resources that can be used to verify medication and /or order are:

    1. Lexicomp
    2. Package insert of the medication
    3. Preceptor, charge nurse, lead, supervisor or nurse educator
    4. Provider
    5. Pharmacist



T. If an intramuscular (IM) injection is ordered, careful landmark identification is needed prior to administration.

    1. Whenever possible, clinical staff shall choose from the three primary IM injection sites: deltoid, vastus lateralis or ventrogluteal.
        a. Assist patient into a comfortable position that is appropriate for identifying the chosen injection site (e.g., sitting, or lying flat, on side, or prone). For patient and staff safety, patient may not stand during an IM injection.
        b. In the rare case that the dorsogluteal injection site is used, extra caution should be taken in positioning the patient and identifying landmarks. Document that the risks were discussed with the patient and that the landmarks were carefully identified prior to injection.
        c. When an alternate site is used, verify with approved resources or get clarification from nursing leadership or provider.
        d. Ensure alternate site selection is not contraindicated by the manufacturer.
    2. In limited instances where the appropriate site for the IM injection differs from the manufacturers recommendations, clinical staff shall collaborate with the provider for approval of the selected site. Clinical staff shall clearly document that the provider approved the alternate IM injection site.

U. CDC guidelines for vaccines:

    1. Vaccines do not require aspiration prior to administration.

2. Prior to vaccine administration, the most recent VIS flyers are to be given to the patient (caregiver).
3. Predrawing vaccines or saving vaccines after they have been drawn-up is not permitted. Once a vaccine has been drawn up into a syringe, or the syringe cap has been removed and needle applied to a manufacturer-filled syringe, it must be used immediately. If not used immediately, it must be discarded.

V. When administering vaccines an observation period is not required, unless recommended by the manufacturer. An example, but not limited to, is Gardasil. The manufacturer of Gardasil recommends observing the patient for 15 minutes after injection administered.

W. Documentation:

1. Document all medications in the medical record or EHR. Proper documentation includes:
    a. Patient name
    b. Medical record number
    c. Date and time medication administered
    d. Medication name
    e. Dose and route
    f. Two patient identifiers were used
    g. The patient's response to the medication
    h. The observation period and outcome if it was recommended by the manufacturer or ordered by the physician.
    i. Observation time and outcome if patient has received antibiotics, narcotics or new medications.
    j. If patient experiences any side effects, this should be reported to the provider as soon as possible and documented as such. Documentation should also include a description of the side effects, the name of the provider who was informed of the side effects as well as any actions taken and / or orders received, if any. Complete RL solutions if indicated.
2. **For ALL vaccines**: The Vaccine Information Sheet (VIS) should be given to patient/parent or guardian prior to administration of the vaccine. Document the following:
    a. Manufacturer's name
    b. Lot number
    c. Expiration date
    d. VIS publishing date
    e. Date given to patient or guardian
    f. Name and title of the health care provider administering the vaccine
    g. Document vaccine related adverse effects on a VAERS form and submit to the Risk Management Lead, Quality Improvement Department. Documents are available at: https://secure.vaers.org/VaersDataEntryintro.htm

**Note:** *Abbreviations used should follow the SHC P&P 01222 and the SRSMG P&P 4200. SRS will use the most current and approved SHC Abbreviation list and the most current and approved SHC Do Not Use Abbreviations list.*

X. To document an IV infusion or IV medication in the patient's chart:

1. Document date and start / stop times, name and dose of medication, route (e.g. IV push versus IV piggyback) type and amount of IV solution and rate of infusion. Include amount and type of flushing solutions.
2. Document discontinuation of infusion with time, amount of solution infused, site, site condition, and catheter condition.
3. Document patient's reaction to the procedure/infusion.

Y. Late Entries:

1. Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time events occurred if time is pertinent to the situation.
2. When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.
    a. Identify the new entry as a "late entry"
    b. Enter the current date and time – do not change the time stamp in order to give the appearance that the entry was made on a previous date or an earlier time.
    c. Identify or refer to the date and incident for which late entry is written
    d. If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.
    e. When using late entries document as soon as possible. All documentation should be completed immediately following patient being discharged.



Z. Pre-hire for clinical staff

1. The pre-hire Medication Calculation Written Assessment should be used as part of the overall interview process. This tool will help leaders to select the best qualified candidate. It should not be used as the only deciding factor for hiring. Passing score is 90%.
2. 2. A practice sheet may be provided to the clinical candidate ahead of time to prepare for the Pre-Hire Medication Calculation Written Assessment.
3. If a clinical candidate does not pass the Pre-Hire Medication Calculation Written assessment, the candidate may, at the the hiring supervisor discretion, return at a later date to retake the written assessment.
4. Contact the SRS Training and Education Department for the most up-to-date version of the Pre-Hire Medicaiton Calculation Written Assessment and practice sheet.

AA. When a medication error occurs, the following steps shall be followed:

1. Immediately inform provider and document.
2. Evaluate vital signs and document.
3. Assist provider with evaluation, and any treatments or antidote orders, if applicable.
4. Notify supervisor.

5. Complete RL Solutions per supervisor
6. Lead/Supervisor will contact the SRS Training and Education Department to schedule the clinical staff member for the Medication Refresher Class (See AB. Medication Administration Remediation below).

AB. Medication Administration Remediation

1. For Newly Hired Clinical Staff
    a. During Clinical Staff Orientation (CSO) or Urgent Care Clinical Orientation (UCCO), if a newly hired clinical staff member scores less than 90% on the role specific Medication Calculation and/or Medication Safety Test:
        i. The hiring supervisor will be notified via email and/or phone call.
        ii. The clinical staff member will be scheduled to attend the Medication Refresher Class prior to being sent out to their site for orientation.
    b. Upon completion of the Medication Refresher Class:
        i. if the newly hired clinical staff member passes the second Medication Calculation Test and/or Medication Safety Test, they will be instructed to go to their training site after class to begin orientation. The hiring supervisor will be notified via email.
        ii. if the newly hired clinical staff member fails the second Medication Calculation Test and/or Medication Safety Test (less than 90%), they will be instructed to go home and that they will be contracted by their hiring supervisor. The hiring supervisor and Human Resources will immediately be notified via phone call and email by the Staff Development Specialist.
        iii. The Staff Development Specialist will send original class documentation and tests to the hiring supervisor. Scanned copies will be kept in the Training and Education Department.
2. For Existing Clinical Staff
    a. Existing Clinical Staff will attend the SRS Medication Refresher class if:
        i. their Supervisor or Lead identifies a need for medication administration improvement; or
        ii. a medication error or medication near miss occurs and it is determined remedial action is required. The site leadership team determines this by performing an investigation, cause analysis and using the Just Culture algorithm.
    b. The Supervisor or Lead will contact the SRS Training and Education Department to register the clinical staff member for the Medication Refresher Class
        i. The clinical staff member shall attend the Medication Refresher Class within 30 days of the error/near miss
        ii. The clinical staff member shall have all medications verified from the time of the error/near miss until 30 days after attending the Medication Refresher class
        iii. The clinical staff member shall not verify medications for others from the time of the error/near miss until 30 days after attending the

c. After completion of the Medication Refresher Class, the Staff Development Specialist will send the original class documents (medication calculation test, Reflective Journaling) to their supervisor via interoffice mail. Copies will be scanned into RL Solutions and tasked to their supervisor/lead. Original documents will be sent to the hiring supervisor via interoffice mail. Scanned copies will be kept in the Training and Education Department.

AC. A temporary training protocol was in place during the 2020-2021 Flu Season, September 14, 2020 to April 2, 2021. This protocol was followed until the conclusion of the 2020-2021 Flu Season (See Attachment H).

## IV. PROCEDURE:

| **PROCEDURE:**<br>Procedure to be followed for all medication administration, regardless of route: | **RESPONSIBILITY:** |
|---|---|
| A. Follow the 7 Right of Medication Administration | A. Clinical Staff |
| 1. The right Patient<br>2. The right Medication<br>3. The right Dose<br>4. The right Route<br>5. The right TIme<br>6. The right Documentation<br>7. The right Reason | |
| B. Print the medication order (MAs - print two copies, one for self and one for licensed staff that verifies order). | B. Clinical Staff |
| C. Verify allergies in the EHR and follow the instructions below if allergies do no appear on the medication order printout: | C. Clinical Staff |
| 1. If no allergies are listed in the EHR, the clinical staff member will write "NKA" or "NKDA" on the medication order printout.<br>2. If a few allergies are listed in the EHR, the clinical staff member will write the allergies on the medication order printout.<br>3. If multiple allergies are listed in the EHR, the clinical staff member will print out an allergy sheet and will attach it to the medication order printout. | |
| D. If a vaccine is ordered: | D. Clinical Staff |
| 1. Check immunization record for appropriateness of order.<br>2. Review SRS Vaccine Administration Reference Binder or package insert<br>3. Provide patient/caregiver the Vaccine Administration Sheet (VIS) prior to administration. | |
| E. Perform the Three Checks. Check the medication label against the order: | E. Clinical Staff |

| | |
|---|---|
| 1. when you take it off the shelf<br>2. when you draw it up<br>3. when you put it/throw it away | |
| F. Check the medication against the order for: | F. Clinical Staff |
| 1. name<br>2. strength<br>3. appearance<br>4. expiration date<br>a. Note that some medications should be discarded BEFORE the manufacturer's expiration date (please refer to the Medication Discard Guide in "Handling of Multi-Dose Medication Vials and Topical Medications" SRS P&P #30111.01. | |
| G. Draw up the medication in the No Interruption Zone (NIZ) of the medication room/ area. | G. Clinical Staff |
| H. Ensure all syringes are labeled with the name of the medication. | H. Clinical Staff |
| I. Medical Assistants will have ALL medications that they prepare and give verified by licensed staff PRIOR to administration. The Medical Assistant and the licensed staff both note verification in the EHR. | I. Clinical Staff |
| J. Bring the medication and the printed order to the patient exam room | J. Clinical Staff |
| 1. Two patient identifiers must be verified before administering any medication per SRS P&P#30107.01<br>a. Ask the patient to state their full name and date of birth and verify with the chart, patient label or printed medication order.<br>b. Document that this was done | |
| K. Prior to administration of any medication recheck allergies with patient. | K. Clinical Staff |
| L. Verify patient understanding of medication and explain if necessary. | L. Clinical Staff |
| M. Administer medications per correct procedures as described in Elsevier Clinical Skills in the Sharp Intranet. *Exception: Transdermal medication via iontophoresis, which is not found in Elsevier Clinical Skills (see attachment A).* | M. Clinical Staff |
| 1. To access Elsevier Clinical Skills from Sharp Net: type "library" in the upper right hand search box à Click on → Click on "Library Services" → Click on "Clinical Skills", type in the skill you would like information about in the search box (e.g. intramuscular injection). | |
| N. Note patient's tolerance to medication & document. | N. Clinical Staff |
| O. Observe for possible side effects according to medication administered per Lexicomp, manufacturer guidelines or provider order. | O. Clinical Staff |
| P. Document all medications in medical record or EHR immediately after administration.. | P. Clinical Staff |

## V. REFERENCES:


A. Accreditation Association for Ambulatory Health Care (AAAHC). (2018). Accreditation handbook for ambulatory health care. Retrieved from SharpNet.

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## VI. ORIGINATOR:

SRS Nursing Services

## VII. LEGAL REFERENCES:

None

## VIII. ACCREDITATION:

A. Accreditation Association for Ambulatory Healthcare. (2018). *Accreditation handbook for ambulatory health care.*

1. 7.II.A.2.b (p. 72)
2. 11.F-G (p. 116)
3. 11.I (p. 118)

## IX. CROSS REFERENCES:

A. Blood and Body Fluid Exposure Control Plan (OSHA Bloodborne Pathogen Standard). #03230.00

B. Nursing Documentation of Medications and Procedures, # 30112.99
C. Verifying Patient Identification and Two Patient Identifiers Procedure # 30107.99
D. SRS Scope of Practice – Registered Nurse #30102
E. SRS Scope of Practice – Licensed Vocational Nurse #30114
F. SRS Scope of Practice – Medical Assistant #30109
G. SRS Policy and Procedure # 30111.01 Handling of multi-dose medication vials and topical medications

## X. APPROVALS:

### A. Ongoing:

A. SRS Nursing Policy and Procedure Committee: 07/08, 07/11, 10/13, 08/17, 01/19, 04/19, 07/19, 03/20, 10/21
B. SRS Policy and Procedures Committee: 10/08, 01/19, 04/19, 11/21
C. SRS Patient Care Managers: 04/13, 09/16, 01/19, 04/19, 11/21
D. SRS Patient Care Directors (Primary Care, Medical Specialties, Surgical Specialties & Urgent Care): 11/21

### B. Historic:

A. Policy & Procedure Steering Committee: 02/09
B. SRS Chief Nursing Officer: 4/14, 10/15
C. Patient Care Leadership Team: 8/08, 04/13, 9/16, 8/17, 1/19, 4/19
D. SRS Director of Nursing: 05/13, 12/13, 4/14, 10/15, 1/16, 4/16, 9/16, 8/17, 1/19, 4/19, 7/19
E. SRS Director of Urgent Care, Training and Education, Infection Control: 12/13, 4/14, 10/15, 1/4/16, 4/16, 9/16, 8/17, 4/19, 7/19



## XI. REPLACES:

None

## XII. HISTORY:

System #43204.99; originally dtd 02/09
Reviewed/Revised: 07/11; 05/13; 10/13; 12/13; 05/14; 10/15; 02/16; 04/16; 09/16; 04/18; 11/18

### A. Attachments

#### TECHNIQUE FOR ADMINISTERING TRANSDERMAL MEDICATION VIA IONTOPHORESIS

#### DEFINITIONS:

A. Iontophoresis: A drug delivery system that uses a small electrical charge to assist topically applied medications to move through the skin to underlying tissues. Medications used for iontophoresis include: Dexamethasone, Lidocaine, Salicylate. These medications are administered for their anti-

inflammatory or pain-relieving capabilities, primarily in treatment of inflammatory conditions (tendinitis, bursitis, and arthritis) or scar formation for a particular condition.
Iontophoresis provides an alternative to hypodermic injection of corticosteroids, with increased comfort, and decreased systemic, localized side effects, and risks. It allows administration of medication without the associated discomfort of needle insertion at an already tender area of tissue. Iontophoresis is a less invasive process, using a much smaller dosage of medication, pulsed into the tissue, over several short treatment sessions.

**TEXT:**

| **PROCEDURE:** | **RESPONSIBILITY:** |
|---|---|
| A. Verify two patient identifiers prior to the procedure | A. Physical Therapist/ Occupational Therapist |
| B. Before giving an iontophoresis treatment, determine if contraindicated for that patient. . Iontophoresis is contraindicated for patients with:<br>1. Known adverse reactions to the application of electrical current<br>2. Cardiac pacemakers or other electrically sensitive implanted device(s)<br>3. Known sensitivity to the drugs to be administered | |
| C. Explain procedure/risks of the procedure to the patient and/or family and obtain procedural consent.<br>D. Identify location/site to be treated and verify medication order /prescription to be administered. If prescription is not available, the physical therapist will contact patient's physician to obtain an order. | |
| E. Assemble Equipment:<br>1. Syringe – appropriate for amount of medication being administered.<br>2. Sterile Smart Tip cannula and syringe combo package for drawing-up medication from a vial<br>3. Alcohol wipe<br>4. Medication<br>5. Sharp container | D. RN/LVN/MA |
| F. Filling a Syringe from a Vial:<br>1. Remove Smart Tip cannula and syringe from packaging using aseptic technique.<br>2. Clean stopper of vial with an alcohol swab.<br>3. Insert SmarTip cannula into the rubber stopper of the vial. For best results place vial on counter. DO NOT angle cannula during insertion; hold perpendicular to vial and use quick, consistent pressure to penetrate center of vial.<br>4. If pressurizing vial, use air equal to amount of medication to be drawn to avoid over-pressurizing vial and expulsion of excess | E. RN/LVN/MA |

| | |
|---|---|
| fluid.<br>5. Turn the vial upside down and hold at eye level on an angel to keep the cannula beneath the level of fluid in the vial and slowly withdraw the desired amount of solution.<br>6. Remove cannula from vial and immediately discard in a sharp container. | |
| G. Applying Electrodes:<br>1. Follow manufacture directions and fill the opening of the electrode using a circular motion, completely saturate the entire surface of the reservoir pad. Do not overfill the electrode.<br>Empi Small Electrode - 1.5 in active area – 2 mL<br>Empi Medium Electrode- 2.1 in active area – 2 mL<br>Empi Butterfly Electrode- 1.25 in active are – 2 mL<br>2. Avoid applying electrodes over hair follicles or nevi. Do not shave the application areas; if necessary clip the hair.<br>3. Treatment Electrode: Clean skin site prior to placement of electrode with alcohol wipe and allow skin to dry.<br>4. Remove the treatment electrode from the backer and affix the treatment electrode directly over the treatment area and secure it by pressing around the adhesive border until a good seal is obtained all around the electrode. Do not press directly over the reservoir pad as this may cause leakage of solution.<br>5. Return Electrode: Remove return (Ground) electrode patch and activate adhesive before applying to clean skin. Clean skin with alcohol pad and allow to dry. Place over a major muscle, at least 4 inches away from treatment electrode on the same side of the body. Avoid placing return electrode over boney areas with little tissue thickness.<br>6. Check to make sure current is not flowing before attaching lead wires.<br>7. Leadwires: Attach leadwires to electrodes according to instructions accompanying the iontophoresis device. Do not apply excessive pressure over the snap connector on the drug delivery electrode as this may cause solution leakage.<br>8. Advise the patient to report any undue sensation of pain or burning. The current settings should never exceed the patient comfort level or recommended maximum current setting. Initiate treatment and adjust current settings as prescribed. | F. RN/LVN/M |
| H. Upon completion of treatment, turn off current, remove and discard electrodes | G. RN/LVN/MA |
| I. Document in patient chart:<br>1. medication name<br>2. dose | H. RN/LVN/MA |

| | |
|---|---|
| 3. location/site<br>4. modality current and mA-min<br>5. any observed effects | |

**REFERENCES:**

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**CROSS REFERENCES:**

**APPROVALS:**

A. Patient Care and Operations Management team
B. Sharp Rees-Stealy Policy and Procedure Committee

## Attachments



A: Administration of Injections

B: Administration of Ophthalmic Drops and Ointments

C: Administration of Optic Drops

D: Administration of Nasal Drops and Sprays

E: Administration of Rectal Medications

F: Intravenous Medication Administration (Via IV Push Method)

G: Transdermal Medication Via Iontophoresis

H: EXPIRED Medication Administration and Documentation of Medication Administration Addendum, 09/14/2020 - 04/02/2021

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Site Admin | Karen Whitten: POLICY & PROCEDURE COORD | 11/30/2021 |
| Regulatory | Anais Beltran: REGULATORY COMP COORD-SRS | 11/30/2021 |
| Editor | Victoria Yutko: PRGM MGR-TRAINING & EDU-SRS | 11/2/2021 |