Memorandum

The following has been sent on behalf of Christina Berlanda, Director, Professional Practice, Heather Rocheleau, Director, Clinical Informatics and Wendy Mitchell, Director, Medication Safety

Date: October 4, 2022

Re: Documenting Medication Administration

To: Any health care team member in Cowichan District Hospital inpatient areas who administers medication as consistent with their scope of practice and Island Health Limits and Conditions (e.g. RN, LPN, RPN, and Respiratory Therapist, etc., and respective student populations) for areas activated with clinical documentation. **This memorandum does not apply to medical staff.**

Purpose: To provide staff and leaders a practice update and direction on how and where to document medication responses and adverse events in the client record.

What do I need to know?

- This memorandum does not apply to medical staff
- Guidance provided is a general overview and there may be more specific practice-setting workflows based on specific care area standards
- Accurate and complete documentation of medication administration and related assessments and interventions in the client record contributes to quality, safe, and coordinated care by:
    - communicating medications administered and their effects,
    - preventing or minimizing potential for adverse drug events and near misses, and
    - reducing delays in delivery of therapy
- Health care professionals administering medications are responsible and accountable to:
    - practice in alignment with regulatory college and Island Health standards (see Resources and Standards),
    - document the actual time of administration, dose, site (when applicable), signature and designation,
    - document reason (assessment findings) for PRN medication, and
    - monitor, respond to and document in a timely way:
        - effectiveness of PRN medication
        - signs and symptoms of side effects
        - adverse reactions

What do I need to do?

- Document care provided in alignment with the applicable regulatory standards and Island Health standards

- Document medication related assessments, nursing diagnosis, and interventions in the appropriate location of the client record, as follows:

Type of documentation	Location	What to document and examples
Medication administration (regular and PRN medications)	cMAR	Time, dose, site when applicable, signature
PRN medication assessments and interventions pre- and post-administration	iView : focused system assessment	Assessment of affected system(s) and interventions e.g. vital signs, pain, nausea, agitation
Adverse drug reaction (ADR) assessments and interventions	iView : focused system assessment	Assessment of affected system(s) and interventions Note: Serious ADR requires reporting as outlined in Serious Drug Reaction and Medical Device Incident Reporting Policy 9.3.8 P and Procedure 9.3.9
Provider notification	iView provider notification function	Telephone call to ordering provider e.g. nausea assessment completed and no anti-emetic ordered
Context or additional information not captured in iView drop-down fields	iView chart annotation Title reflects the symptom, behaviour or event	Narrative documentation when required e.g. Title: Pain medication found in client bed Annotation content: Client continues to report pain and on further assessment pill found in bed…(*additional assessments and interventions included in annotation*) See Narrative Nursing Documentation in the EHR Guideline 9.1.45G

Resources and Standards:

- BCCNM Documentation Practice Standard and Medication Practice Standard
- Island Health Clinical Documentation Policy 16.1.3P
- Island Health Narrative Nursing Documentation in the EHR Guideline 9.1.45G
- Island Health Computerized Medication Administration Record (cMAR) Policy D.07

- Island Health Medication Administration intranet page
- Serious Adverse Drug Reaction (SADR) and Medical Incident (MDI) Reporting 9.3.8P
- Serious Adverse Drug Reaction (SADR) and Medical Incident (MDI) Reporting and Management 9.3.9PR

Need more information or support?

For questions pertaining to medication and documentation standards contact ProfessionalPractice@viha.ca or MedicationSafetyConsultants@islandhealth.ca

For questions about future state workflows after your Clinical Documentation training has completed please reach out to ClinicalInformaticsEducators@islandhealth.ca

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