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PHYSICIAN IV ORDERS

Policy

The purpose of this policy is to provide guidelines for IV medication orders to be consistent with principles of safe and effective order writing so that all prescribed medications are administered safely and accurately.

General Guidelines

1. Only authorized, licensed healthcare practitioners or individuals who are authorized to take verbal or telephone orders from practitioners, shall be allowed to write orders in the medical record. The pharmacy staff shall verify that individuals who prescribe medications are legally authorized to do so.
2. Only approved abbreviations and symbols shall be used when ordering and/or charting. Prescribing, nursing and pharmacy staff shall be given a list of approved abbreviations to be used when writing medication orders.
3. Each facility, in conjunction with the Consultant Pharmacist, MAC Rx Pharmacists and the Medical Director, shall identify and approve appropriate order writing practices and related policies. They shall also approve any modifications to the list of approved abbreviations.
4. Physicians shall provide timely, accurate, and complete orders.
5. Verbal or Telephone Orders in the facility:
    a. Verbal or telephone orders shall be given in an emergency situation or when the Attending Physician is not immediately available to write or sign the order.
    b. Verbal or telephone orders shall always be based on actual conversations with the prescribing practitioner or on approved written protocols.
    c. Verbal or telephone orders shall be reduced to writing, by the person receiving the order, and recorded in the resident’s medical record. Documentation on the physician’s order sheet shall include “v.o.” (verbal order) or “t.o.” (telephone order).
    d. Documentation shall include the instructions from the Physician, date, time and the signature and title of the person transcribing the information.
    e. Unless otherwise prohibited by law, verbal or telephone orders for Schedule II medications shall be permitted in accordance with facility policy.

Procedure

1. Order for IV medication shall be verified by the Nurse prior to administering a new medication or solution.
2. The Nurse shall verify medication orders with the Physician when there is a question regarding it. Any dose or order that appears inappropriate considering the resident’s age, allergy history, condition or diagnosis shall be verified with the Attending Physician.
3. Orders for infusion or IV medications should include the following elements:
    a. Resident name.
    b. Date ordered.
    c. Name of medication.
    d. Name of base solution, as appropriate for IV medication orders.
    e. Strength of medication, where indicated.
    f. Dosage.

g. Route of administration, including type of IV line.
h. Time, frequency or rate of IV administration.
i. Quantity or duration/length of therapy.
j. Diagnosis or indication for use.
k. Physician and/or Prescriber name.
l. Signature of Nurse noting order.

4. Additional resident information the Nurse should have on hand includes:
   a. allergies;
   b. age;
   c. height and weight; and
   d. pertinent laboratory results.
5. Orders "To Keep Open" (TKO) or "Keep Vein Open" (KVO) will not be accepted without a specific rate from the Physician.
6. Stat orders should be communicated from the facility to the pharmacy immediately upon receipt from the Physician. Stat infusion medications and supplies will be delivered to the facility within a timely manner whether during the pharmacy's regular business hours or after hours/emergency times.
7. Orders for flushing protocols should also be written at the time of IV medication order writing if not already present in the resident's medical record.
8. Dispensing Pharmacists may use the *Pharmacy Telephone Order Sheet* to transcribe verbal or oral medication orders or changes directly from Physicians or Prescribers. The Pharmacist then shall communicate the new order to the facility Nurse for transcribing onto the resident's medical record, if allowed by state law.

MEDICATION ORDERING, RECEIVING AND STORAGE

AUTOMATIC STOP AND DISCONTINUATION ORDERS

Policy

The purpose of this policy is to provide guidelines for new IV medication orders subject to automatic stop orders and for discontinuation orders for infusion therapy.

Procedure

Automatic Stop Orders:

1. The following classes of infusion medications are stopped automatically after the indicated number of days, unless the Physician specifies a different number of doses or duration of therapy.
    a. Anti-infectives for acute conditions, including antibiotics, antifungals and antivirals: 10 days
    b. Controlled Substance analgesics for acute conditions: 10 days.
2. When the Physician provides the order for a medication covered by this policy, the Nurse should request a specific duration of therapy for the order. This then supersedes the Automatic Stop Order Policy.
3. When implementing the *Automatic Stop and Discontinuation Orders Policy*, the Physician shall be notified of the discontinuation prior to the administration of the last dose. This allows the alternative of continuing the medication without interruption of the medication regimen if desired.
4. Any remaining medication should be removed from the resident's supply and disposed of appropriately to avoid a medication administration error.

Discontinuation Orders:

1. Upon receipt of a physician's order for discontinuation of infusion therapy, the Nurse shall communicate with the pharmacy staff for proper discontinuation in the pharmacy.
2. Upon receipt of a physician's order for discontinuation of infusion therapy, the Pharmacist or Technician shall discontinue the order in the pharmacy's computer system and on the resident's *IV Medication Profile*.
3. Any remaining medication should be removed from the resident's supply and disposed of appropriately to avoid a medication administration error.

MEDICATION ORDERING, RECEIVING AND STORAGE

ACCEPTING DELIVERY OF MEDICATIONS

Policy

All staff shall follow a consistent procedure in accepting medications.

Any errors noted in receiving medications shall be brought to the attention of the Pharmacist and Director of Nursing Services.

General Guidelines

1. A Nurse shall personally accept each medication delivery.
2. Before signing to accept the delivery, the Nurse must reconcile the medications in the package with the delivery ticket/order receipt.
3. If an error is identified when receiving medications from the pharmacy, the Nurse verifying the order shall:
    a. inform the delivery agent of any discrepancies and note them on the delivery ticket;
    b. return incorrect medications (e.g., wrong strength, form, etc.) to the dispensing pharmacy and reorder the correct medication;
    c. if the number of a medication or packages of medications is incorrect, and the medication is not an emergency order, return the order to the pharmacy; and
    d. if the number of a medication or packages of medications is incorrect, and the medication is an emergency order, the order may be accepted and the accepting Nurse shall write that information onto the delivery ticket/order receipt.
4. A Nurse shall sign the delivery ticket, indicating review and acceptance of the delivery, and shall keep a copy of the delivery ticket. Both the receiving Nurse and the delivery agent must sign any notations about errors.
5. The delivery ticket shall be archived in a designated location.
6. The dispensing pharmacy, Consultant Pharmacist, and Director of Nursing Services shall be notified of medication order errors.

MEDICATION ORDERING, RECEIVING AND STORAGE

CONTROLLED SUBSTANCES

Policy

The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances.

General Guidelines

1. Only authorized nursing and/or pharmacy staff have access to Schedule II controlled substances maintained on premises.
2. The Director of Nursing Services will identify staff members who are authorized to handle controlled medications.
3. Controlled substances will be counted upon delivery. The Nurse receiving the order, along with the person delivering the medication order, will count the controlled substances together. Both individuals will sign the designated narcotic record.
4. If the count is correct, a control sheet will be made for each substance. Do not enter more than one (1) prescription per page. This record will contain:
   a. name of the resident;
   b. name and strength of the medication;
   c. quantity received;
   d. number on hand;
   e. name of Physician;
   f. prescription number;
   g. name of issuing pharmacy;
   h. date and time received;
   i. time of administration;
   j. method of administration;
   k. signature of person receiving medication; and
   l. signature of Nurse administering medication.
5. Controlled substances will be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container will remain locked at all times, except when it is accessed with key or access code to obtain medications for residents.
6. All keys to controlled substance containers shall be on a single key ring that is different from any other keys.
7. The Charge Nurse on duty will maintain the keys to controlled substance containers. The Director of Nursing Services will maintain a set of back-up keys for all medication storage areas including keys to controlled substance containers.
8. Unless otherwise instructed by the Director of Nursing Services, when a resident refuses a non-unit dose medication or it is not given, or receives partial tablets or single dose ampules, or it is not given, the medication shall be destroyed, and may not be returned to the container.
9. Nursing staff will count controlled medications at the end of each shift. The Nurse coming on duty and the Nurse going off duty will make the count together. They will document and report any discrepancies to the Director of Nursing Services.

10. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties, and shall give the Administrator a written report of such findings.
11. The Director of Nursing Services shall consult with the provider pharmacy and the Administrator to determine whether any further legal action is indicated.
12. If a resident is discharged or transferred, follow the procedure for discharging medications with a resident *(Resident Discharge or Transfer)* in accordance with state law.
13. The Director of Nursing Services shall maintain and disseminate to appropriate individuals a list of staff who have access to medication storage areas and controlled substance containers.

MEDICATION ORDERING, RECEIVING AND STORAGE

EMERGENCY PHARMACY SERVICE AND EMERGENCY KITS

Policy

The purpose of this policy is to provide guidelines in order that adequate emergency infusion medications are available to meet the needs of residents.

General Guidelines

1. Emergency pharmacy service is available on a 24-hour basis. Telephone numbers for emergency pharmacy services are posted at each facility nursing station.
2. Emergency needs for infusion medications are met by using the facility's approved emergency medication supply, which may be limited quantities packaged as "kits" or stored in automated dispensing systems in accordance with state laws, or by special order from the pharmacy.
3. Automated medication dispensing systems may be used as approved by the State Board of Pharmacy or state laws for emergency medication use in the facility. Automated medication systems store, package, dispense and distribute medications or supplies. Examples of automated dispensing machines include ScriptPro® [1], Pyxis® [2], PHARMAssist® [3], AutoMed® [4], and BakerAPS® [5].
4. Attending Physicians and Prescribers will be informed as to the availability of emergency medications in the facility.
5. Medications and supplies deemed appropriate for emergency kits and storage shall be kept secure within the facility.
6. The medications contained in emergency kits and machines shall be checked periodically for integrity and expiration dating.
7. Emergency medications are only administered after a valid physician's order. The resident's allergy history should also be checked prior to medication administration.
8. Use of emergency medications is documented. The *Emergency Kit Tracking Log* may be used in conjunction with emergency kits for documentation purposes.
9. Due to potentially serious adverse effects attributed to the use of concentration potassium chloride (KCl), only premixed, diluted IV KCl solutions shall be stored in emergency kits.

Procedure

1. A list of medications and supplies approved for inclusion in the emergency kit or system shall be posted on the kit/system as well as available to facility and pharmacy staffs. This list should include:
    a. medication or supply name;
    b. quantity of item;
    c. expiration date of item; and
    d. pharmacy's name and phone number.

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[1] ScriptPro® is a trademark (or registered trademark) of ScriptPro LLC (www.scriptpro.com).
[2] Pyxis® is a trademark (or registered trademark) of Cardinal Health (www.cardinal.com).
[3] PHARMAssist® is a trademark (or registered trademark) of Innovation (www.innovat.com).
[4] AutoMed® is a trademark (or registered trademark) of Amerisource Bergen Technology Group (www.automedrx.com).
[5] BakerAPS® is a trademark (or registered trademark) of McKesson (www.mckesson.com).

2. A method of recording use of items from the emergency kit/system shall be in place. The *Emergency Drug Kit Slip* forms may be added to kits or available for Nurses to complete as items are removed from kits.
3. Emergency kits/systems shall be sealed or locked, whether by physical seal, key or code access.
4. Medications used from emergency kit/system or an entire kit shall be replaced per state laws.
5. If exchanging kits, the pharmacy shall deliver a sealed kit to the facility and pick up the opened and re-sealed kit within 72 hours of opening.
6. If replacing used doses of medication, the Nurse or pharmacy staff is instructed to replace the medication in the appropriate area of the kit/system within 72 hours of opening. A new seal is placed on the kit after the replacement medication has been added.
7. The kits/systems are inventoried by the pharmacy staff at least every thirty (30) days for completeness and expiration dating of the contents. The date of inventory is noted on the outside of the kit.
8. Emergency orders not available in emergency kits/systems, the Pharmacist:
    a. determines that the order is a true emergency and that the order cannot be delayed until the next scheduled pharmacy delivery; and
    b. if the medication is not available, the Pharmacist will arrange to provide the emergency medication as soon as possible.

Documentation

1. An *Emergency Drug Kit Slip* may be stocked by the pharmacy and/or the facility for facility Nurses to use indicating items used from the emergency kit for billing purposes.
2. An *Emergency Kit Tracking Log* may be utilized by the pharmacy to keep track of kit locations, expiration dates and seal numbers.

MEDICATION ORDERING, RECEIVING AND STORAGE

MEDICATION STORAGE

Policy

The facility shall store all medications and biologicals in a safe, secure, and orderly manner.

General Guidelines

1. Medications and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.
2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.
3. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.
4. If the facility has discontinued, outdated or deteriorated medications or biologicals, contact the dispensing pharmacy for instructions regarding returning or destroying these items.
5. Medications for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications.
6. Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications.
7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.
8. Medications shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.
9. Medications requiring refrigeration must be stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly.

MEDICATION ORDERING, RECEIVING AND STORAGE

MEDICATION STABILITY

Policy

The Nurse administering IV medication shall be aware of conditions of stability before using the medication.

Definition

Medication stability refers to the length of time that a medication/solution retains its original physical, chemical and therapeutic properties.

General Guidelines

1. Medication may arrive from the pharmacy as:
    a. premixed (ready to use);
    b. refrigerated premixed;
    c. vial that must be reconstituted and added to fluid bag; or
    d. medication attached to fluid bag that must be mixed just before being administered.
2. If the stability or condition of the medication has been compromised in any way, the medication will not be used.
3. Medications that are determined unstable cannot be returned to the pharmacy for credit unless the medications are delivered after the beyond-use date.

Factors Affecting Medication Stability

1. Type of container: Glass or plastic may affect medication stability.
2. Number and type of additives: The more medications/additives that are mixed in a container, the less stable the compound.
3. Dilution: The dose and concentration of medication that is mixed in solution can affect stability.
4. Time:
    a. The longer a medication remains in the solution, the less stable it is.
    b. Once the medication is mixed, it should be used within 2 hours.
    c. See *Medication Beyond-Use Dating*.
5. Temperature:
    a. Medication stability is affected by heat: refrigeration improves stability.
    b. If a medication arrives from the pharmacy refrigerated, it must stay refrigerated.
    c. Remove medication from refrigerator approximately 30 minutes before use.
    d. Allow the medication to come up to room temperature naturally. Do not put in the microwave, run under hot water, put in a sunny window, on a heating pad, or on a heating vent. These methods may destroy the medication.
    e. If the medication is found outside of the refrigerator and there is no way to know how long it has been out of refrigeration, discard it.
    f. Do not put back in the refrigerator OR return to the pharmacy.

6. Light:
    a. Some medications are light sensitive (stable in natural room light, but not in sunlight.)
    b. These medications will be covered in a brown plastic bag for protection from light.
    c. Once the medication is infused through the tubing, it becomes exposed to the light.
    d. When infusing these medications, do not hang the bag close to a window or allow the resident outside while medication is infusing.
7. Solution:
    a. The pH of the solution can affect stability of the medications: infusion medications usually are more stable in slightly acidic solutions.
    b. Not all medications can be mixed in normal saline or dextrose.
    c. Contact pharmacy to ask about mixing instructions if none are available with medication.

Signs of Medication Instability

Instability of medication is not always visible; therefore stability guidelines and beyond-use dating will be the determining factor of medication usability.

RESIDENT DISCHARGE OR TRANSFER

Policy

The purpose of this policy is to provide guidelines to facilitate the continuity of pharmaceutical and infusion care and services throughout the discharge or transfer process.

General Guidelines

1. Information about medications may be provided to residents at discharge according to procedures and in compliance with applicable laws and regulations for request of Protected Health Information (PHI).
2. Resident information may be provided upon request to the resident, their responsible party and to the pharmacy or other treatment provider to which the resident transfers following completion of appropriate HIPAA request for information. Pharmacy staff work with the facility staff in coordination of care and information.

Procedure

1. Infusion medications and supplies previously dispensed may be sent with the resident upon discharge or transfer to another healthcare institution with authorization from the Physician and the payment source per their policies.
2. Information that may be appropriate to communicate to the receiving facility Nurse upon resident transfer or discharge includes:
    a. medication history and profile;
    b. allergy history;
    c. infusion medication order;
    d. pharmacokinetic dosing information, if applicable; and
    e. pharmacy contact information.
3. The facility nursing staff shall educate the resident/responsible party on how the medication is to be used, possible adverse reactions, special precautions and proper storage of medications. If the directions for use are not the same as those on a prescription label, the Nurse should communicate this to the resident/responsible party.
4. Pharmacists are available for questions regarding medications upon discharge or transfer.

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DISCONTINUED MEDICATIONS

Policy

Staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy.

General Guidelines

1. A practitioner's order to discontinue a resident's medication will be documented in the resident's clinical record and on the medication administration record (MAR).
2. The Nurse receiving the order to discontinue a medication is responsible for recording the information (e.g., writing discontinued date, dating and initialing MAR) and notifying the dispensing pharmacy of the discontinuation.
3. Discontinued medications will be destroyed or returned to the issuing pharmacy in accordance with facility policy and state regulations.

DISCARDING AND DESTROYING MEDICATIONS

Policy

Medications that cannot be returned to the dispensing pharmacy (e.g., non unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) will be destroyed.

Policy Interpretation and Implementation

1. All controlled substances will be retained in a securely locked area with restricted access until authorized individuals destroy them.
2. Non-controlled and Schedule V controlled substances will be destroyed in accordance with state regulations regarding destruction of medications.
3. Schedule II, III, and IV controlled substances will be destroyed in accordance with state regulations regarding destruction of medications.
4. Ointments, creams, and other like substances may be discarded into the trash receptacle in the medication room.
5. Destroy all medications in accordance with state regulations regarding approved disposal methods.
6. Whoever witnesses the destruction/disposal of medications must sign and date the medication disposition record.
7. The medication disposition record must contain, as a minimum, the following information:
   a. The resident's name.
   b. Date medication destroyed.
   c. The name and strength of the medication.
   d. The prescription number (if any).
   e. The name of the dispensing pharmacy.
   f. The quantity destroyed.
   g. Method of destruction.
   h. Reason for destruction.
   i. Signature of witnesses.
8. Unless otherwise prohibited under applicable federal or state laws, individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition provided that:
   a. no medications covered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1976 are returned;
   b. all such medications are identified as to lot or control number; and
   c. the receiving Pharmacist and a Registered Nurse employed by the facility sign a separate log that lists the resident's name; the name, strength, prescription number (if applicable) and amount of the medication returned, and the date the medication was returned.
9. Completed medication disposition records shall be kept on file in the facility for at least two (2) years, or as mandated by state law governing the retention and storage of such records.
10. For emergency kit controlled substances disposal, complete the appropriate portions of the controlled medication accountability form.
11. Staff shall contact the provider pharmacy if they are unsure of proper disposal methods for a medication.

MEDICATION RECALLS

Policy

The facility shall honor medication recall notifications.

General Guidelines

1. The dispensing pharmacy and/or Consultant Pharmacist will notify the facility of any medication recalls.
2. Upon receiving a medication recall notification from any reliable source:
   a. the Director of Nursing Services or the Consultant Pharmacist will inspect the facility's medical supplies for the recalled item; and
   b. if the recall item is in stock, it will be removed from the inventory and returned to the supplier in accordance with the recall notice.
3. The Director of Nursing Services, or designee, will document inventory records concerning removal of such supplies.
4. In conjunction with the Consultant Pharmacist, the Director of Nursing Services and Medical Director will ensure that all Nurses and Attending Physicians are informed that a medication has been recalled, and will identify any specific precautions that should be followed, or symptoms that might result from the medication.
5. Nursing staff will withhold known recalled medications and will notify a Physician promptly. They will ask the Physician for an order to discontinue the medication, and discuss whether another medication is indicated and whether they should take any measures (e.g., intensified monitoring, lab tests, etc.) related to the recalled medication.
6. The nursing staff will closely monitor individuals who have been taking a recalled medication for problematic signs and symptoms for at least 24 hours after the last dose is given, or longer if indicated by the recall notice or the anticipated duration of effects or side effects of the recalled medication.