Management of Medications and Carts

Concerns	Recommendations
Routine medications not available. Contributing factors: • Medications not being ordered soon enough. Medications being ordered after last dose given. • Deliveries are not being reconciled with refills requested. • Refill requests made by CMA require a nurse's verification. Any handwritten refill request is a red flag to the nurse that there is no card available.	1. Order refills sooner – when you have 4-5 days supply left. Allow for weekends and holidays! 2. When you give the next to the last dose off a card, immediately pull the next card from the overflow and rubber band them together. If you don't have another card, order immediately, requesting delivery on the next run. 3. Call the pharmacy if you do not receive a medication when you expect it. 4. Pour meds in the order on the MAR. If you are missing a med., you will know it.
PRN medications were not available or were expired. Contributing factor: There in not a procedure in place to check PRN medications at least monthly.	1. Store cards of PRN medications separately in alphabetical order by resident name. This will make the audit much easier. 2. Avoid storing PRN meds in the med room. They get forgotten. 3. The staff should compare the MAR to the meds on hand at least monthly. If you are missing a PRN med, either get it discontinued for non-use or request a refill. 4. Review expiration dates monthly. Replace if needed.

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Medications on MARS are not on the corresponding cart. This can easily cause an error if you can't trust your MAR to know what meds are ordered and be able to find them.	1. Decide which cart you want what meds on and be consistent.
Medications appear to not be administered as ordered. Multiple medication cards dispensed in the past 3-4 months are still on carts. These overflow of medications usually were for doses that required 2 or more tabs. Contributing factors: • Not reading the MAR • Not checking the MAR to the label • Not using the cards in date order • Refilling without checking the overflow.	1. Highlight the number of tabs on the label Write beside the label the number to give. Do not write in the label or over the expiration date. 2. Highlight or underline in red the number of tabs. on the MAR. 3. Slow down and read!!!
Change in Direction stickers are not being used. Often the current dose can be used to make the new dose ordered, such as with a change in frequency or if the dose is doubled. The change in direction stickers show that the order change has been verified, the label is wrong and you should pour by the MAR. Without this sticker, the nurse or CMA pouring would have no way of knowing which is correct – the MAR or the pharmacy label.	1. The nurse taking the order is responsible to affix a change in direction sticker to *all remaining cards* of the med. if you are going to continue to use the supply on hand. 2. The CMA must take the cards to the nurse if she forgets!

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Refill stickers are used to reorder meds that have a change in direction. The wrong dose or quantity is being sent by the pharmacy because they scanned the refill sticker, printed and filled by the old label. You either have too many cards left in the overflow or you are being told it's a "refill too soon"	1. Never peel and use the refill sticker if there is a change in direction. The pharmacy staff will scan the bar code and you will get the wrong label and supply of medication again. 2. On the fax, write "direction change" and the new order. Use a separate refill page – do not write on a page with refill stickers.
MARS do not match the pharmacy labels - name of drug dispensed, dose form, or number of tabs. to make the dose, spelling errors. Remember that CMAs cannot calculate dose. The MAR must match the label and what it actually being dispensed and given. For example: 1. The MAR has the generic name only, the pharmacy dispensed the brand name. There is no way to identify the drug. 2. The MAR says tabs., the pharmacy sent liquid 3. The number of tabs. Differs - MAR – KCl 20meq. 1 Tab. po qd. Label – KCl 10meq. 2 Tabs (20meq) po qd. 4. MAR has the dose in mg., Label has mcg. (Digoxin, Levothyroxin) As you pour by the MAR, if you do not check the label carefully, you could, in error, give the wrong number of tabs., omit a dose or give the wrong medication.	1. CMA staff must identify these differences as soon as they receive the med from the pharmacy and have their nurse correct the MAR. 2. A clarification order must be written to notify medical records to also have the change made in the computer.
Two cards of the same med are being used at the same time If you are not carefully pouring by the MAR there is a great risk of double dosing!	Pull cards in order by oldest date. Use 1of3, 2of3, 3of3 in order. Store remaining meds in the overflow.

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Discontinued meds were found on the cart. There is the potential for error as these meds. can be mistakenly given by the CMA or nurse if they do not carefully pour by the MAR.	The nurse receiving the d/c order is responsible to pull the discontinued med from the cart. Remember to pull them from the overflow as well. **Coumadin storage** – It is common practice to keep all doses of Coumadin because the orders change so frequently. However, only the current dose should be with the current meds. All other cards must be stored in the med. room or a separate drawer on the cart. Be consistent!
Overflow meds are stored in 2 places – in a separate drawer and with the routine meds. This can cause errors when refilling and cause you to use cards out of date order.	Store overflow cards either in a separate drawer, organized by resident's name, or turned backwards behind the meds in use.
Transcription errors 1. New orders are not always dated on MAR. 2. Orders received the end of the month are missing from the next month's MAR.	• Always write the date the new order is received on the MAR. • Review your end of the month process for the change out of new MARS. Be sure there is a double-check system in place. .
Delegation of Medication Administration 1. When did you last read the Licensing rules for med aides? 2. Nurses – when did you last observe a med pass (20 – 25 doses)? 3. Nurses – do you monitor timeliness of refills (date on refill sticker)? 4. Med. Aides – have your nurses explained their expectations for reporting to them, monitoring, etc.?	Think about you licenses! Who is ultimately responsible for medication administration?

Concerns	Recommendations
Maintenance of Med Carts 1. Appropriate medications not dated when opened. (Eye drops, Inhalers, Insulin, Xopenex etc,) 2. Expired OTC meds. – often 'stored" in the bottom drawer. 3. Drawers are dirty with loose pills and pill dust. Bottles are sticky and leaking in drawers. 4. Meds are not separated by route of administration.	CLEAN AND ORGANIZE!!! 1. Date meds as appropriate. Check the date every time you give the med. You must know the number of days to expiration date on short life drugs!!! 2. Have a system to check expiration dates of OTC meds monthly. Replace anything that will expire in the next 30-60 days.