Pharmacy Services
&
I.V. Therapy

Policy and Procedures Manual

TABLE OF CONTENTS

ORGANIZATIONAL ASPECTS (5-39)

ORDERING AND RECEIVING MEDICATIONS (40-56)

TABLE OF CONTENTS

MEDICATION ADMINISTRATION – GENERAL (57-66)

MEDICATION ADMINISTRATION – SPECIFIC (67-83)

DISPOSAL OF MEDICATIONS, SYRINGES, AND NEEDLES (84-89)

MISCELLANEOUS SITUATIONS (90-105)

TABLE OF CONTENTS

MISCELLANEOUS SITUATIONS CONT (90-105)

ORGANIZATIONAL ASPECTS

PROVIDER PHARMACY - REQUIREMENTS

Policy

Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. A written agreement with a provider pharmacy stipulates the terms of the services provided.

Procedures

1. The Facility maintains a written agreement with the provider pharmacy, signed by the administrator and an authorized representative of the provider pharmacy.
2. The provider pharmacy is responsible for rendering the required service in accordance with local, state, and federal laws and regulations, facility policies and procedures, and community standards of practice and professional standard of practice.
3. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to:
   A. Accurately dispensing prescriptions based on authorized prescriber orders.
   B. Providing medications packaged in accordance with the facility's needs and equipment requirements.
   C. Supplying only USP and NF approved medications, biologicals, and supplies, other than extemporaneously compounded medications or investigational new drugs.
   D. Labeling all medications dispensed in accordance with all applicable laws.
   E. Providing routine and timely pharmacy service seven (7) days per week and emergency pharmacy service 24 hours per day, seven days per week.
   F. Providing emergency after-hours phone numbers where a pharmacist may be contacted.
   G. Providing for emergency backup coverage when unavailable. It is the responsibility of the provider pharmacy to notify the facility of changes-
   H. Maintaining a medication profile on each resident that includes all medications dispensed and facility-provided information on the resident's age, diagnoses, medication allergies, and any other pertinent information.
   I. Screening each new medication order for an appropriate indication or diagnosis; for drug interactions with other medications ordered for the resident; for duplication of therapy with other drugs in the same therapeutic class ordered for the resident; and for appropriate drug dose, dosing interval, and route of administration, based on resident and other pertinent variables.
   J. Providing medication information and consultation to the facility's nursing staff.
   K. Providing, maintaining, and replenishing in a timely manner an emergency medication supply in a sealed and properly labeled container.
   L. Where appropriate, assisting the physician in documenting the need for a "non-covered" or non-formulary medication ordered for a resident otherwise eligible for medication benefits through Medicaid or other third-party programs.

The provider pharmacy provides the facility with a copy of its pharmacy permit and liability insurance policy, upon request.

ORGANIZATIONAL ASPECTS

CONSULTANT PHARMACIST SERVICES PROVIDER - REQUIREMENTS

Policy

Regular and reliable Consultant pharmacist services are provided to residents. A written agreement with a Consultant pharmacist stipulates financial arrangements and the terms of the services provided.

Procedures

1. The Consultant pharmacist agrees to render the required service in accordance with local, state, and federal laws, regulations, and guidelines facility; policies and procedures; and community standards of practice.
2. The Consultant pharmacist provides consultant pharmacist services, including but not limited to the following:
   A. Checking the emergency medication supply at least monthly to ascertain that it is properly sealed and stored and that the contents are not outdated.
   B. Checking the medication storage facilities at least monthly, and the medication carts at least quarterly, for proper storage of medications, cleanliness, and removal of expired medications.
   C. Submitting a written report and recommendations for each review of medication storage.
   D. Reviewing the medication regimen of each resident at least monthly, utilizing federally mandated standards of care in addition to other applicable standards, and documenting the review and findings in the resident's medical record.
   E. Communicating to the responsible physician potential or actual problems detected relating to medication therapy orders, as well as recommendations for changes in medication therapy.
   F. Reviewing medication administration records (MARs) and physician orders (at least monthly) to assure proper documentation of medication orders and administration of medications to residents.
   G. Submitting a written report of findings and recommendations resulting from the review of medication regimen and nursing documentation records to the administration of the facility.
   H. Assessing the performance of the nursing staff in medication administration through the process of medication pass observation, as requested by nursing and administration, and as necessary.
   I. Assisting in the accounting, destruction, and reconciliation of unused controlled substances and non-controlled substances as required by state and federal law.
   J. Assisting the administrator and Pharmaceutical Services Subcommittee in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, control, and use of medications and related equipment and services in the facility.
   K. In conjunction with the facility's Quality Assessment and Assurance Committee, establishing quality assurance activities to be undertaken regarding medication prescribing, administration, and storage in the facility; compiling required data; and providing analysis and feedback to the medical and nursing staffs of the facility. For each quality assurance study, preparing a written report summarizing appropriate medication therapy statistics for the facility.
   L. Serving on facility committees as required or requested, including but not limited to Quality Assessment and Assurance Committee.
   M. Helping resolve problems with non-contract pharmacy suppliers at the request of the Administrator.
   N. Identifying one or more current medication references to facilitate identification of medications and information on contraindications, side effects, and/or adverse effects, dosage levels, compatibility, and other pertinent information.
   O. Identifying educational and informational needs about medications and medication use

ORGANIZATIONAL ASPECTS

DRUG REGIMEN REVIEW

Policy

Drug Regimen Review consists of a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. The Consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director of Nursing, the responsible physician, and the Medical Director, where appropriate.

Procedures

1. The facility assures that the Consultant pharmacist has access to residents and the residents' medical records; the provider pharmacy's resident medication profiles, if requested; the facility's records of medication receipt and disposition; medication containers and storage areas; and controlled substances records and supplies.
2. The Consultant pharmacist documents the date each medication regimen review is completed in the resident's medical record on the appropriate form and briefly notes the findings.
3. The Consultant pharmacist documents potential or actual medication therapy problems and communicates them to the responsible physician and the Director of Nursing. In the event of a problem requiring the immediate attention of a physician, the responsible physician or his designee is contacted by the Consultant pharmacist or the nurse caring for the resident, and the physician response is documented on the Consultant pharmacist review record or elsewhere in the resident's medical record.
4. The Consultant pharmacist documents all potential or actual significant nursing documentation problems found relating to medications and communicate them in writing to the Director of Nursing within five working days of the review. In the event of a problem requiring immediate attention, the Director of Nursing or the nurse caring for the resident is informed, and the response is documented on the Consultant pharmacist review record or elsewhere in the resident's medical record.
5. The Consultant pharmacist drug regimen review and nursing medication documentation review reports are processed as follows
    1. Drug Regimen Review recommendations to physician
        1. A copy of the report is kept by the facility until the physician's signed response is returned.
        2. The physician response is provided to the Consultant pharmacist for review and then filed by the facility.
        3. The facility maintains copies of signed reports on file for at least one year.
    2. Nursing Documentation Review
        1. The Consultant pharmacist provides the report within five working days of review.
        2. Nursing personnel provide a written response to the review within two weeks after the report is received.
        3. A copy of the report is kept by the facility until the nurse's response is returned.
        4. Nursing staff response to the report is provided to the Consultant pharmacist for review and then filed by the facility.
        5. The facility maintains copies of completed reports on file for at least one year.
6. A copy of the drug regimen review notification form is sent to each attending physician new to the facility, with an explanatory cover letter.
7. In performing drug regimen review, the Consultant pharmacist utilizes federally-mandated standards of care, in addition to other applicable standards.

ORGANIZATIONAL ASPECTS

INFUSION THERAPY

Policy

The facility maintains an agreement with a pharmacy provider qualified in infusion therapy preparation and distribution for infusion therapy products other than stock IV solutions and for consultation on the use of such products. If required, a supplier other than the contract pharmacy is used.

Procedures

1. The infusion therapy provider provides solutions, medications, and supplies on a timely basis.
2. The infusion therapy provider maintains a medication profile for each resident to whom infusion therapy products are provided and reviews it prior to dispensing any infusion therapy product or solution.
3. Infusion therapy hood compliance maintenance is monitored by the pharmacist in charge.
4. Infusion therapy product preparation is done in a laminar flow clean air center, by personnel with the necessary qualifications and training. The necessary qualifications and training of the provider personnel includes but is not limited to:
   A. principles and methods of maintaining sterility
   B. aseptic techniques and procedures
   C. use and limitations of the laminar air flow hood
   D. formulation, production, and control of parenteral admixture fluids
   E. storage requirements, stability considerations, and problems with sterile products
   F. commercial intravenous administration systems
   G. reconstitution of injectables
   H. sterility control measures
   I. records and reports
   J. standards, laws, and regulations
   K. labeling considerations
5. Determining appropriate equipment and packaging to meet the infusion therapy needs of the patient and the facility.
6. Stringent infection control procedures are followed during preparation and distribution of infusion therapy products and solutions, and the provider has a quality assurance program for determining sterility of completed solutions.
7. The infusion therapy product provider contacts the facility daily to obtain updates on resident infusion therapy product needs and to validate supplies required before delivery to the facility.

A knowledgeable pharmacist is available 24 hours a day to the charge nurse and attending physician for consultation on infusion therapy product compatibility, dosing, and other information.

ORGANIZATIONAL ASPECTS

INFECTION CONTROL STANDARDS

Policy
Prevent the occurrence of IV infections within the long-term care facility.

Procedure
IV infections have many causative factors and adherence to infection control standard as set forth by the Centers for Disease Control can help prevent the occurrence of these infections.

Universal Precautions:
Hand washing shall be done prior to and immediately after all clinical procedures. Non-latex gloves will be worn when performing venipuncture or performing any procedure where exposure to blood or body fluids is possible. Sharps will be disposed of in a puncture and tamper proof container.

Skin Preparation:
A 30-second prep with chlorhexidine is preferred for site disinfection, using a back and forth motion beginning at the insertion site and extending outward.
Alternative skin preps:
A 30-second prep with povidone iodine or a 60-second prep of 70% isopropyl alcohol. Make sure the patient is not allergic to iodine or shell fish before using iodine prep.
IV site shaving is not recommended due to possibility of introduction of skin organisms should dermabrasion or nicking occurs.

Dressing Changes:
1. Central lines
   A. dressing changes will utilize sterile dressing kits and sterile techniques as an infection control measure or per facility policy
   B. transparent, semi-permeable membrane dressing will be the preferred site dressing; changed every seven days, as ordered by the physician or when clinically indicated or per facility policy
   C. gauze dressings will be changed upon admission, every 7 days, when soiled or wet, as needed, or per facility policy
2. Short peripheral IV site
   A. dressing changes will utilize strict aseptic techniques
   B. transparent, semi-permeable membrane dressing, the preferred site dressing (gauze is not recommended per the Infusion Nurse Society), will be changed every 96 hours, as ordered by the physician, when clinically indicated on all peripheral IV sites, or per facility policy

Tubing changes:
Primary continuous tubing is changed every 96 hours and immediately upon suspected contamination, allergic reaction or when the integrity of the tubing has been compromised.
All tubing will be tagged with date, time and nurse's name.
Primary intermittent or secondary tubing is changed every 24 hours and immediately upon suspected contamination, allergic reaction or when the integrity of the tubing has been compromised.

INFECTION CONTROL STANDARDS (cont)

If patient has had a peripheral infusion and has a central line placed, all previous tubing used must be discarded and new tubing used. IV tubing which has been used as a peripheral IV is **NOT** to be used on a central line.
If connected to the primary line, secondary tubing may be considered primary continuous tubing. This tubing is changed with the primary continuous tubing.
If disconnected from the primary line, the tubing is considered intermittent and is changed every 24 hours.
Tubing must be changed with IV catheter change or if phlebitis, infection or allergic reaction is present/suspected.
Tubing used for parenteral nutrition administration with or without Lipids will be changed every 24 hours.

Needleless Injection Caps:
Injection caps are changed upon admission, every week, as needed, after blood withdraws, or per facility policy.
Facility trained licensed nursing staff may change injection caps on both peripheral and central IV catheter using sterile procedures.
Injection caps are cleaned with an antiseptic wipe before accessing. Needleless injection caps on peripheral IVs will be changed every 96 hours (when relocating IV catheter) per facility policy or immediately should there any be any concern about possible contamination, allergic reaction or phlebitis.

Filters:
A 0.22 micron filter is considered air eliminating and particle eliminating and may be used on IV tubing.
A 1.2 micron filter is required when infusing lipids or TPN with lipids added.

Catheter Site Assessment
The frequency for monitoring an IV site is determined by the prescribed therapy, access device and patient's age and condition. IV sites should be monitored a minimum of every two (2) hours.
The catheter site will be assessed for signs of infiltration, phlebitis and infection including redness, tenderness, swelling or drainage. If any of these signs are present, the IV is to be re-sited and the physician notified.

Catheter Changes:
Short peripheral catheters will be re-sited every 96 hours or immediately when clinically indicated.
Mid-line catheters will be changed every 28 days or immediately upon suspected contamination or complication.
Central line changes are done based on placement, type of catheter, and presence of complications. Consideration may be given to extending the dwell time of peripheral catheters if the following criteria is met:

A. The site is free of complications.
B. There is documentation of the reason for extension of dwell time.
C. There is documentation of ongoing monitoring of site for any complications.
D. A physician's order must be obtained to extend the catheter site for an additional 24 hours.
Under no conditions should the catheter be allowed to remain for more than 96 hours.

Other:
Clean work areas will be provided for IV set-up.
Sterile technique will be utilized for all CVAD dressing changes.
Strict aseptic technique will be used when changing connections, accessing catheters, giving IV push medications, changing bags, handling supplies, changing dressings, flushing, and starting an IV.

ORGANIZATIONAL ASPECTS

APPROVED LIST OF FLUIDS AND MEDICATIONS

Policy

To establish a list of fluids and medications appropriate for use in the facility and IV push medications to be administered within the facility.

Procedure

1. The facility will establish a specific list of drugs which may be given by the IV push method. The facility will designate by license and training, nurses who may administer IV medications by this route. Documentation of said nurse's training will be kept on hand.
2. Medications not on the approved list will be considered on an individual basis and approved by the Medical Director and/or Director of Nursing Services.
3. The facility will obtain appropriate lab work as ordered by the physician prior to initiating IV therapy and periodically until therapy is discontinued.
4. The physician must order the drug, dose, and method of infusion, frequency of dosing, flush solutions and length of therapy.
5. Small volume intermittent IV medication doses, the solution type, volume and recommended safe infusion rate can be determined by either the physician or the pharmacist based on FDA and manufacturer recommendations.
6. KVO rates must be specifically ordered in mL/hr rates by the physician.
7. Recommended rates: Minimum 10mL/hr Maximum 42mL/hr
8. Potassium administration:
   A. Recommended limits for the administration of potassium to long term care patients without cardiac monitoring are:
      - No more than 40 mEq/liter
      - No more than 60 mEq/24 hours
      - No faster than 10 mEq/hr (rates higher than 10mEq/hr require cardiac monitoring)
      - Include potassium given by other routes when calculating the hourly dosing.

   B. All potassium infusions are recommended to be infused on an infusion pump

ORGANIZATIONAL ASPECTS

INSERTING A PERIPHERAL IV CATHETER

Policy

To safely and aseptically start a peripheral IV 2”in length or less for the continuous or intermittent infusion of non-irritating parenteral solutions and medications.

Intravenous therapy is initiated using strict aseptic technique by nurses who have documented intravenous therapy education and competency.

INS standards recommend that nurses perform venipuncture only on hands and arms in the elderly. Lower extremity use is discouraged and requires a physician’s order.

Intravenous catheter may not be inserted into an extremity that has an A-V shunt or in a mastectomy side.

INS standards recommend no nurse attempt a venipuncture more than twice or per facility policy.

A new catheter is used for each venipuncture attempt. A dislodged catheter is never reinserted.
A stylet is never re-inserted into the catheter.
A no-touch technique will be used when inserting the IV catheter. With no-touch technique, the insertion site is not palpated after skin cleansing, unless sterile gloves are worn.

Antibiotic ointment is not applied at the insertion site.
Universal precautions will be used throughout the procedure.

Self-sheathing catheters will be used. If unavailable, do not recap IV catheter needles.
No labs will be drawn through indwelling peripheral IV catheters.

Dressings will be changed when relocating the catheter and PRN.
Transparent semi-permeable membrane dressings will be used.

Equipment:

IV start kit
Extension with clamp OR needleless injection cap
Saline flush (in 10cc or larger syringe)
IV Catheter (22 or 24g is adequate for most infusions in a long-term care facility).

Procedure

1. Obtain and review physician order.
2. Explain procedure to patient and obtain verbal consent and document it.
3. Perform hand hygiene.
4. Attach needleless injection cap to extension if applicable.
5. Attach saline flush syringe to needleless cap, prime extension, and clamp.
6. Assess patient’s venous access. Consider drug or solution to be administered, condition of patient’s veins

and duration of therapy. Select appropriate vein for insertion.

INSERTING A PERIPHERAL IV CATHETER (cont)

7. Place limb selected for catheter placement below heart level.
8. Apply tourniquet 4-6" above puncture site. Tourniquet should be applied to occlude venous flow only. If an arterial pulse cannot be palpated below or distal to the tourniquet, the tourniquet is too tight.
9. Have patient open and close fist several times. Lightly tap (with two fingers only) or gently rub the site. If unable to dilate vein adequately, remove tourniquet and wrap entire limb in warm, moist towels for 10-20 minutes. (Microwaved towels may cause burns). Remove tourniquet when a suitable vein is located. If an optimal venous site is not found, repeat steps 7-9.
10. Don non-latex gloves.
11. Prep site
    A. Alternative skin preps:
        - A 30-second prep with chlorhexidine is preferred for site disinfection, using a back and forth motion beginning at the insertion site and extending outward.
        - A 30-second prep with povidone iodine or a 60-second prep of 70% isopropyl alcohol. Make sure the patient is not allergic to iodine or shell fish before using iodine prep.
    B. ALL SKIN PREPS SHOULD BE ALLOWED TO DRY ON THE SKIN BEFORE INTRODUCING THE CATHETER.
    C. IV site shaving is not recommended due to possibility of introduction of skin organisms should dermabrasion or nicking occurs.
12. Reapply tourniquet.
13. Stabilize the vein below the insertion site by holding skin taut. Insert catheter at a 20-45 degree angle. When a blood return is visualized, lower then angle of the catheter slightly and advance the catheter into the vein an additional (approximate) 1⁄16". Then, advance the catheter off the stylet until the catheter is fully inserted. **DO NOT ADVANCE THE STYLET - ONLY THE CATHETER ITSELF.** (If using a Saf-T-Intima, insert according to manufacturer directions.)
14. Remove needle or stylet. **Release tourniquet**.
15. Attach primed extension with attached flush to catheter, flush using positive pressure, close clamp, and remove syringe. A stabilization device is applied to catheter hub.
16. Apply dressing and label with date, time and name. Remove gloves and wash hands. All sharps should be placed in a sharps container.
17. Document procedure in patient's chart. Suggested charting:
    A. Date and time
    B. Patient/family teaching
    C. Verbal consent
    D. Condition of site/extremity PRIOR to IV insertion
    E. Location of site
    F. Prep used
    G. Number of insertion attempts with catheter gauge
    H. Flush used
    I. Type of dressing
    J. IV medication or solution infusing with rate, and type
    K. Patient's response/tolerance of procedure.

ORGANIZATIONAL ASPECTS

SETTING UP A PRIMARY INFUSION

Policy

Correctly and aseptically set up the primary IV bag and tubing.
IV bags and tubing will be set up by a nurse with documented IV education.
IV bags and tubing will be changed according to CDC infection control guidelines.

Equipment

IV bag containing medication or fluids for hydration.
Medication administration pump
Primary IV administration set.
Antiseptic wipes
If intermittent IV: 10cc Saline flush syringes

Procedure

1. Verify label on IV bag with physician's order. If fluids from emergency stock, attach label (with date, time, and nurse's initials) to tubing and bag.
2. Wash hands.
3. Clamp IV tubing. Spike bag. Hang on IV pole.
4. Squeeze drip chamber until ¼ to ½ full.
5. Open clamp. Prime tubing until no air bubbles remain in tubing. Close clamp.
6. If administering medication, flush patient's IV catheter with saline. Aspirate for blood return.
7. If using pump, thread tubing into pump according to directions. Program pump.
8. If injection cap is in place on catheter, scrub port for 15 seconds with antiseptic wipe prior to accessing.
9. Attach IV tubing to needleless injection cap or direct to catheter hub.
10. Open clamps on IV tubing and begin infusion.
11. If administering medication, when infusion is complete, disconnect IV tubing from patient's catheter, cap tubing and flush according to flush procedure.
12. Document according to facility procedure.

ORGANIZATIONAL ASPECTS

SETTING UP A SECONDARY INFUSION

Policy

To correctly and aseptically set up the secondary infusion.

- IV bags and tubing will be set up by a nurse with documented IV education.
- IV bags and tubing will be changed according to CDC infection control guidelines.
- **Compatibility between the primary and secondary infusion must be verified prior to initiating the infusion.** Secondary medications that are incompatible with the primary infusion cannot be piggy-backed.
- OSHA regulations mandate use of needleless connectors.

Equipment

Secondary IV administration set
IV bag with medication
Antiseptic wipe
Needleless connector (Lever lock connector)
Infusion pump

Procedure

1. Verify label on IV bag with physician's order. If using emergency stock, attach label (with date, time and nurse's initials) to tubing and bag.
2. Wash hands.
3. Clamp secondary tubing and spike secondary IV bag, open clamp and flush until no air bubbles are visible. Close clamp.
4. Hang primary solution bag on hook provided with secondary administration set so that primary solution is hanging lower than the secondary solution. Secondary bag must be higher than primary bag.
5. Wipe upper port on primary tubing with antiseptic wipe.
6. Attach secondary tubing to upper port above pump on primary tubing with needleless connector.
7. Open clamps. Hold secondary bag below primary bag to back prime secondary tubing. When drip chamber is ¼ – ½ full, hang secondary bag on IV pole.
8. Program pump for Piggy Back infusion according to directions. Begin infusion.
9. Monitor infusion for any signs of incompatibility, infiltration, extravasation or allergic reaction.
10. When secondary infusion is completed, the primary infusion will resume at its pre-programmed rate.

ORGANIZATIONAL ASPECTS

NEEDLELESS INJECTION CAP/EXTENSION SET CHANGE

Policy

To safely and aseptically change the injection port or extension set to prevent leaking. Needleless injection caps are changed a minimum of weekly or PRN if compromised on all central lines. Peripheral line caps or extension sets are changed when IV is re-sited or PRN if compromised.

Equipment

Needleless injection cap
Heparin and/or saline flush syringes
Antiseptic swabs
Non-latex gloves

Procedure

1. Explain procedure to patient/family.
2. Wash hands.
3. Attach saline flush syringe to new injection cap. Pre-fill injection cap with flush solution.
4. Don non-latex gloves.
   A. *Central Line Caps Changes*:
      - Verify all lines are clamped.
      - Unscrew/remove the old cap from lumen and discard
      - Cleanse the junction between the lumen and the cap with the antiseptic wipe for 30 seconds. Allow to dry 15-30 seconds.
      - Screw primed injection cap onto lumen.
      - Open clamp on tubing and flush per physician orders or resume IV infusion. If line not in in use, close clamp. Use positive pressure flushing technique when clamping and disconnecting syringe.

   B. *Peripheral IV Catheters Cap/Extension set Changes:*
      - Verify extension set is clamped.
      - Unscrew/remove the old cap/extension set and discard
      - Cleanse the junction between the catheter and the cap with the antiseptic wipe for 30 seconds. Allow to dry 15-30 seconds.
      - Screw new injection cap/extension set onto catheter.
      - If extension set being used, open clamp on tubing and flush per physician orders or resume IV infusion. If not infusing fluids in the line, clamp extension tubing. Use positive pressure flushing technique when clamping and disconnecting syringe.
5. Remove gloves and wash hands.
6. Document procedure.

Notes:
If peripheral venous catheter, injection caps and extension tubing sets are discarded whenever the IV is resited.
If patient's I&O's being recorded, document flush volumes in intake records as appropriate.

ORGANIZATIONAL ASPECTS

DRESSING CHANGE FOR VASCULAR ACCESS DEVICES

Policy

To prevent local and systemic infection related to the IV site.
Dressing changes will be done at established intervals for Vascular Access Devices (VAD):

1. Transparent membrane dressings (without gauze) are changed upon admission, every 7 days, as needed, when wet or soiled, or per facility policy.
2. Gauze and tape dressings are changed every 24-48 hours and PRN.
3. Initial dressings will be changed in 24 hours after insertion of midlines, PICCs and CVADs.
4. A dressing is changed immediately if:
   A. dressing is non-occlusive or soiled.
   B. drainage or moisture is present under the dressing.
   C. any signs of irritation or inflammation are present at the insertion site.
5. Sterile procedure for central lines.

Equipment

IV Start Kit (for short peripheral catheter)
CVC Dressing kit (for midlines and central lines)
Clean gloves
Sterile Gloves (for midlines and central lines)
Petroleum gauze 2x2 for central lines

Procedure

1. Wash hands.
2. Explain procedure to patient/family.
3. Using clean gloves, remove old dressing.
4. Use care to prevent skin tear, shearing or bruising.
5. Press skin away from dressing vs. pulling up on dressing. Use of alcohol will loosen adhesive.
6. Properly dispose of gloves and old dressing materials.
7. Wash hands, don new non-latex gloves; sterile gloves for central lines.
8. Assess insertion site and sutures (if present) for: erythema, induration, swelling and drainage.
9. If PICC line, document external length of catheter.
10. If excessive hair is present, clip carefully with sterile scissors or clippers to insure dressing adherence. When clipping, use caution to avoid damage to catheter, skin, or anchoring sutures.

Follow the appropriate steps depending upon type of vascular device.

DRESSING CHANGE FOR VASCULAR DEVICES (cont)

For Short-Term Peripheral Catheters:

1. Wash hands and don non-latex gloves
2. Clean site as follows or per facility policy:
   A. (Preferred) Chlorhexidine: cleanse with a back and forth motion for a minimum of 30 seconds
   B. Alternative cleansing:
      - Povidone iodine: starting from the center moving outward in an increasing spiral pattern for a minimum of 30 seconds
      - Alcohol: starting from the center moving outward in an increasing spiral pattern for a minimum of 30 seconds

Clean an area larger than dressing to be applied.
If patient is allergic to iodine, repeat alcohol prep.

For All Central Lines:

1. Wash hands and open central line dressing tray, maintaining sterility of kit.
2. Clean site with alcohol swabs starting from the center moving outward in an increasing spiral pattern.
3. Clean an area larger than dressing to be applied.
4. Prep site with chlorhexidine swab with a back and forth motion for at least 30 seconds.
5. If chlorhexidine scrub is not available, a betadine scrub may be used if patient is not allergic to iodine.
6. Start cleansing from insertion site to the outer periphery in a spiral pattern.
7. Clean an area larger than dressing to be applied.
8. If the patient is allergic to iodine obtain physician's order for specific prep. Recommendations include:
9. Repeat triple alcohol prep.
10. If using Biopatch, apply (blue side down) around catheter at insertion site after prep solution has dried. (Biopatch is a small dressing containing chlorhexidine) A transparent dressing must be placed over the Biopatch dressing.

Notes:
Allow prep solutions to dry completely prior to applying dressing. Povidone iodine products require 2 minutes of skin contact time to ensure effectiveness.
Transparent dressings increase catheter stability and allow for ease of insertion site assessment.
Do not stretch film while applying dressing. (Stretching will cause skin tears.)
Smooth dressing from center out to edges to prevent air pockets.
Seal edge of dressing around catheter using additional tape if needed.
Secure catheter and IV tubing using tension loop taping to prevent tension on device or sutures.
Label dressing with date and nurse's initials.
Suggested charting:

- Site assessment
- Prep used
- Type of dressing
- Suture integrity
- External length, if PICC
- Patient response to procedure

ORGANIZATIONAL ASPECTS

EXTENSION SET CHANGE

Policy

To safely change the extension set.
Extension sets will be attached aseptically and changed with administration set change and/or PRN for contamination or break in integrity.
If the extension set is added under strict sterile conditions, it may be considered as part of the catheter and changed only if compromised.

Equipment

Extension set
Needleless injection cap
Heparin or saline flush syringe (if changing extension on a midline or central line, use a 10cc or larger syringe)
Antiseptic swabs (3)
Non-sterile gloves

Procedure

1. Explain procedure to patient.
2. Wash hands.
3. Attach new injection cap to new extension.
4. Attach flush syringe to injection cap.
5. Prime extension set and close clamp.
6. Don gloves.
7. Unscrew and remove the old extension.
8. Cleanse the junction between the catheter and the extension set with the antiseptic wipe, allow to dry.
9. Screw the new extension onto the catheter.
10. Open clamp on catheter and flush using positive pressure.
11. Resume infusion or clamp catheter. Always clamp extension tubing before removing syringe.
12. Remove gloves, and wash hands.
13. Document procedure.

CATHETER REMOVAL

Policy

To safely remove an infusion catheter after completion of therapy or any condition that necessitates removal.

- A nurse with documented infusion therapy education and training may remove short peripheral IV catheter.
- A registered nurse with documented infusion therapy education and training* including midline catheter placement and as designated by the facility, may remove a midline catheter.
- Only registered nurses with documented infusion therapy education and training* may remove central venous catheters including non-tunneled devices. The RN must have demonstrated competency in the removal of central line catheters.
- Only PICC certified RNs who have completed added PICC line training may place or remove PICC line catheters according to the Arkansas Nurse Practice Act. It is not within the scope of practice for nurses to discontinue tunneled catheters or its implanted ports.

*please refer to your facility administration for this training

Short-term peripheral catheter:

Equipment:

Non-sterile gloves
Sterile 2x2 gauze
Band-Aid/tape

Procedure

1. Wash hands. Don gloves
2. Explain procedure to patient/family
3. Remove old dressing. Discard appropriately
4. Grasp catheter wings or hub; gently pull until catheter is out. Apply gentle pressure to site with 2x2. Inspect skin/catheter junction for signs of breakdown or infection. Apply band-aid/tape.
5. Inspect catheter for damage. Discard appropriately
6. Remove gloves and wash hands
7. Document procedure

FLUSHING PERIPHERAL AND CENTRAL VASCULAR ACCESS DEVICES

Policy

To maintain the patency of all peripheral and central vascular access devices (VADs)

- All VADs will be flushed routinely (every shift) when not in use to maintain patency.
- Each lumen of a multi-lumen catheter must be flushed with individual syringes.
- Surgically implanted ports will be flushed monthly when not in use.
- Do not use syringes smaller than 10cc. Never forcibly flush against resistance.
- Positive pressure technique will be used for ALL catheter flushes.
- All vascular access devices used for intermittent medication administration will be flushed using S-A-S-H or S-A-S technique according to policy/physician order.
- All vascular access devices will be flushed after blood sampling according to policy/physician order.
- Variations from recommended flush are based on physician orders.

Equipment

Saline flush syringe(s) – one for each lumen
Heparin flush syringe(s) – one for each lumen
Alcohol or chlorhexidine wipes

Procedure

1. Obtain MD/NP order for appropriate flush solutions.
2. Perform hand hygiene. Don gloves.
3. Assemble prefilled flush syringes or draw up appropriate flush solutions.
4. Keep syringe tips sterile and covered until ready to use.
5. Purge air from each syringe prior to use.
6. Scrub port caps prior to each entry with alcohol for 15 seconds.
7. Attach saline flush syringe to injection cap.
8. Open clamp. Gently aspirate until blood is returned. Flush with appropriate volume for device. When appropriate, use positive pressure flushing technique when clamping and disconnecting syringe.
9. Close clamp and disconnect syringe.
10. Scrub needleless injection cap with alcohol and attach heparin flush syringe.
11. Open clamp, flush with appropriate heparin volume and concentration for device.
12. Close clamp and remove syringe from injection cap.
13. Repeat for each individual lumen as needed.
14. Dispose of syringes per facility policy.

ACCESSING/DE-ACCESSING IMPLANTED CENTRAL VENOUS ACCESS PORT

Policy

To maintain the patency of surgically implanted ports and to minimize the risk of infection, damage, displacement and other complications associated with the care and use of a surgically implanted central venous catheter (CVC).

- The access of surgically implanted ports is a skilled procedure to be performed by a registered nurse trained in the use of surgically implanted CVCs. An LPN who has completed CVC training may maintain the implanted port once accessed by an RN.
- Hand hygiene must be strictly adhered to for all aspects of port use and care.
- All aspects of port care require utilization of aseptic technique, including sterile gloves and mask. Equipment needed for tasks should be dumped onto sterile field. Sterile glove wrapper may be utilized for sterile field.
- Dressings changes will be performed every 7 days or when clinically indicated for transparent dressings. If gauze dressings are used, dressing changes will be performed every 48 hours or when clinically indicated. All dressing changes will follow central line dressing change policy.
- Only non-coring (aka Huber) needles are used to access implanted vascular access ports. The non-coring needle is replaced every 7 days. The bend of the needle should rest as close to the skin as possible. If a gap greater than ¼ inch exists, a shorter needle should be utilized for future port access. Flush non-coring needle extension and clamp prior to insertion.
- Maintenance flushing and locking of implanted vascular access ports is every 4 weeks. With continuous access, follow facility policies or physician orders. Flushing should be done in a pulsatile push and stop method. If using a topical or intradermal anesthetic prior to needle insertion, a physician order will be required.
- A no-touch technique will be used when inserting a non-coring (aka Huber) needle. With no-touch technique, the insertion site is not palpated after skin cleansing, unless sterile gloves are worn.
- Universal precautions will be used throughout the procedure.

Equipment:

Safety non-coring needle with extension
Extension with clamp OR needleless injection cap
Saline flush (2) in 10cc or larger syringe
Central line dressing kit
IV solution/intravenous medication
3-5ml heparin (100u/ml) in 10cc syringe (if needed per physician order)
Gloves, tape

ACCESSING/DE-ACCESSING IMPLANTED CENTRAL VENOUS ACCESS PORT (cont)

Procedure

Accessing implanted central venous port:

1. Obtain and review physician order. Identify patient using 2 independent factors.
2. Explain procedure to patient and obtain consent.
3. Perform hand hygiene.
4. Place patient in position of comfort with head turned away from side with port.
5. Palpate port to locate septum. Access skin surrounding port.
6. Set up supplies on sterile field. The central line dressing kit when opened may be used as a sterile field.
7. Don sterile gloves and mask.
8. Cleanse port access area with preferred antiseptic. Allow for solution to dry completely.
9. Prime non-coring (aka Huber) needle with extension with 0.9% sodium chloride.
10. Using non-dominant hand, palpate and stabilize port. With dominant hand, insert needle into septum at a 90 degree angle. Advance the needle until the needle makes contact with the back of the port.
11. Aspirate for blood return to confirm access placement and port functionality. Flush with attached saline.
    A. After positive blood return, detach syringe, and stabilize needle (see 12. below) before beginning infusion.
    B. If no infusion is ordered at time of access, flush with 5-10 ml 0.9% NS 3-5ml of 100u/ml heparin. Close clamp on extension before disconnecting syringe.
    C. *Do not attempt to infuse through a port without a blood return, even if it flushes easily. Contact the physician*.
12. Stabilize the non-coring (aka Huber) needle with sterile tape, place 2x2 gauze under needle wings (to prevent skin breakdown). Use caution not to obscure needle insertion.
13. Dispose of used supplies in appropriate containers.
14. Remove gloves. Perform hand hygiene.
15. Document procedure in patient's chart. Suggested documentation:
    A. Date/time
    B. Patient/family teaching
    C. Verbal consent
    D. Condition of site PRIOR to insertion
    E. Location of site
    F. Non-coring needle size/length
    G. Prep used
    H. Flush used
    I. Type of dressing
    J. IV medication or solution infusing and rate
    K. Patient's response/tolerance of procedure

ACCESSING/DEASSESSING IMPLANTED CENTRAL VENOUS ACCESS PORT (cont)

De-accessing implanted central venous port:

1. Obtain and review physician order. Identify patient using 2 independent factors.
2. Explain procedure to patient and obtain consent.
3. Perform hand hygiene.
4. Place patient in position of comfort with head turned away from side with port.
5. Don non-sterile gloves.
6. Flush port with 5-10 ml of preservative-free 0.9% sodium chloride and lock port with 3-5 ml of 100u/ml heparin.
7. Remove and discard old dressing in appropriate receptacle, noting condition of skin at needle insertion site.
8. Using non-dominant hand, stabilize port using thumb and forefinger.
9. Using dominant hand, grasp needle and remove needle, engaging safety mechanism. Discard in sharp container.
10. Apply gauze to site, should bleeding occur. Cover site with transparent dressing.
11. Remove gloves and perform hand hygiene.
12. Document procedure in patient's chart. Suggested charting:
    A. Date and time
    B. Condition of site after needle removal
    C. Flush/lock used
    D. Type of dressing
13. Document patient's response/tolerance of procedure.

ORGANIZATIONAL ASPECTS

HYPODERMOCLYSIS (CONTINUOUS SUBCUTANEOUS ACCESS)

Policy

To provide guidelines in initiating, maintaining, and monitoring the administration of fluids continuously and/or intermittently via hypodermoclysis.

Hypodermoclysis is an alternative infusion route for rehydration fluids and some medications (opioids, immune globulin). Candidates for hypodermoclysis are those with limited venous access, mild to moderate dehydration where slow rates are acceptable, palliative care management, and those patients who are able to self-care while being medicated or rehydrated. Contraindications to hypodermoclysis include circulatory failure, electrolyte imbalance, severe dehydration, coagulopathy, fluid volume excess. hypoalbuminemia with gross edema or fluid requirements greater than 3 L in 24 hours.

The subcutaneous access device dwell time factors include: types of devices, integrity of the site, and volume to be infused. Patients receiving higher volumes of fluids will have the site rotated every 2 days (or after the infusion of 1.5 L in a single site) and when clinically indicated. The site will be rotated when any of the following findings are noted: erythema, swelling, leakage of fluid at the insertion site, bruising, bleeding, pain or when clinically indicated.

Subcutaneous accepted infusion solutions are normal saline and D5W. Opioids, immunoglobulin, and terbutaline are the only medications acceptable for subcutaneous infusion therapy. LPNs may not administer opioids via hypodermoclysis.

The physician or practitioner may order hyaluronidase (as a sub-q injection prior to infusion and/or as an additive prior to the infusion. Hyaluronidase increases absorption and dispersion of subcutaneous fluids/medications in some clinical studies. Intradermal testing with hyaluronidase is recommended prior to use. Intradermal test dose is 0.02 ml (3U) of a 150 U/ml solution.

Accepted infusion rate:

- 1.5 L/24 hours per injection site (1ml/min)
- up to 3L/day per 2 sites
- 1 L/8hours during nocturnal infusion
- not exceed 60 ml/hr per site

Equipment:

- Non-sterile gloves
- IV start kit
- Subcutaneous needle or subcutaneous infusion set
- 10cc syringe
- Manual flow regulator

HYPODERMOCLYSIS (cont)

Procedure

1. Obtain and review physician order.
2. Identify patient by at least 2 methods.
3. Explain procedure and obtain consent.
4. Perform hand hygiene.
5. Gather supplies.
6. Don non-latex gloves.
7. Locate acceptable infusion site:
    A. Areas with intact skin and adequate subcutaneous tissue
    B. Consider patient's mobility and comfort
    C. Accepted sites may include upper arm, subclavicular chest wall, abdomen, upper back and thighs.
8. Cleanse insertion site following policies for vascular device site care.
9. Prepare subcutaneous device for insertion – attach saline flush; flush and leave syringe attached.
10. Grasp skin between them and forefinger, lift up into a small mound and insert device.
11. Aspirate the device to confirm the absence of blood:
    A. If blood is aspirated, remove device, discard, and start with new subcutaneous device.
12. Occlude/clamp clysis line, remove saline flush. Attach administration set and begin infusion therapy as ordered by gravity or manual regulator.
13. Cover site with transparent dressing. Label tubing as "sub-q infusion" near insertion and at bag.
14. Dispose of used supplies in the appropriate containers.
15. Remove gloves and perform hand hygiene.
16. Document procedure and response:
    A. Include size and length of device site location, type of dressing, type of infusate, rate administration, complications noted (with interventions), patient assessment and response to therapy
17. Monitor infusion for development of complication(s) every 2 hours:
    A. Bleeding, erythema, swelling, leakage of fluid, bruising, burning
    B. If any are present, remove device and re-site.
    C. Document findings; advise physician.

*****Utilize universal safety precautions when using hypodermoclysis needles. They ARE NOT safety needles.*****

ORGANIZATIONAL ASPECTS

IV PUSH MEDICATION ADMINISTRATION

Policy

To safely administer small volume IV bolus medications.

- State Board of Nursing in Arkansas requires additional training by the facility for LPN's to perform this procedure. Competency validation should be documented by the facility.
- IV medications approved for bolus administration by the facility may be administered by nurses who have documented infusion therapy education and IV push documentation on each drug to be administered.
- Additional documentation will include but is not limited to: understanding indications, usual dosage range, infusion rate (push rate), actions, potential side effects and appropriate interventions should side effects occur.
- A drug reference text must be available for use by nurses administering IV push medications.
- A physician's order is required for all IVP medications.
- Universal precautions will be used when administering IV push medications.

Equipment:

Proper dose of medication in syringe
Saline flush syringes (2)
Heparin flush syringe (1)
Alcohol wipes

Procedure

1. Consult with IV pharmacist as needed.
2. Verify medication order and patient's allergy history.
3. Review lab work and patient's condition.
4. Review administration guidelines and precautions for the specific drug in an appropriate reference text. Review administration rate and dilution.
5. Check medication label for expiration date; inspect for clarity.
6. Review side effects, age related precautions and IV solution compatibility.
7. Explain procedure to patient.
8. Wash hands.
9. Verify patency and blood return prior to administration.
10. Administer medication.
11. Flush per facility policy/physician order.
12. Document in MAR: date, time, route, patient tolerance and device used. Nurse administering will sign and date.

IV PUSH MEDICATION ADMINISTRATION (cont)

To administer directly through the IV catheter:

1. Perform hand hygiene.
2. Dilute medications according to manufacturer's recommendations.
3. Wipe injection cap with alcohol.
4. Confirm patentcy prior to administration:
   A. Solution/flush infuses without resistance
   B. Aspirate for blood return
   C. Site is without signs and symptoms of infection, phlebitis or other complications
5. Wipe injection port with alcohol.
6. Attach medication syringe to injection cap and slowly administer the medication following guidelines. Remove syringe.
7. Wipe injection cap with alcohol.
8. Attach saline syringe to injection cap and flush. Remove syringe. Wipe injection cap with alcohol.
9. Attach heparin syringe to injection cap and flush. Remove syringe. (Peripheral catheters do not require heparin lock.)

To administer through the Y-site of the IV tubing:

1. Perform hand hygiene.
2. Open IV clamp to be sure IV flows freely.
3. Wipe injection port closest to IV site with alcohol.
4. Attach medication syringe to port, and slowly administer the medication according to guidelines, stopping intermittently to allow IV fluid to flow. Remove syringe.
5. Confirm patentcy prior to administration:
   A. Solution/flush infuses without resistance
   B. Aspirate for blood return
   C. Site is without signs and symptoms of infection, phlebitis or other complications
6. Pinch IV tubing. Flush slowly with 3cc of NS (or volume ordered by physician for IV flushing). Return to prescribed infusion rate.
7. Dispose of all equipment and supplies appropriately.
8. Wash hands.
9. Document procedure according to facility policy.

SAFE HANDLING OF PATIENTS POST CYTOTOXIC THERAPY

Policy

To provide for safe handling of patient's post Cytotoxic therapy, and the protection of patient and staff.

Handling body fluids after chemotherapy administration:

Universal precautions are used when handling blood, vomitus or excreta of patients who have received chemo within the past 48 hours. A gown and goggles are worm when appropriate and if splashing is expected.

For incontinent adults, a protective ointment will be applied to the diaper area to avoid painful chemical burns when voiding. The skin must be cleaned well with each diaper change and diapers should be changed frequently.

The toilet will be flushed twice after disposing of body excreta from patients who have received chemotherapy within the past 48 hours.

New urinal and bed pan will be provided for patient (if old ones where used during 48-hour period) after the 48-hour post therapy period.

Linen Disposal:

Universal precaution must be used when handling linens soiled with blood or body fluids.

Linens contaminated with chemotherapy or excreta from patients who have received chemotherapy within the past 48 hours should be contained in specially marked impervious bags. Linens should be pre-washed and then added to facility laundry for a second wash.

Supplies and Equipment:

All supplies will be disposed of according to facility policy for biohazardous waste materials.

Needles, syringes and breakable items must be placed in a puncture proof container marked "biohazardous waste."

Contaminated re-usable items (i.e. pumps, etc.) are washed by trained personnel wearing double surgical unpowdered gloves.

Accidental Exposures:

Appropriate personal protective equipment (gown, gloves, eye protection, masks) should be worn for the following:

- Withdrawing needles from vials
- Transferring drugs using needles or syringes
- Opening ampules
- Expelling air from a drug-filled syringe
- Injecting the drug
- Changing IV bags or tubing of continuous infusion
- Priming IV tubing
- Handling leakage from tubing, syringe, connection site, and contaminated personnel items

In the event of an accidental exposure, follow facility policy such as contaminated gloves or gown will be removed immediately and discarded in a hazardous waste container. Wash the contaminated skin with soap and water. If an eye is involved, flush the eye with water or isotonic eye wash for at least five (5) minutes. Dispose of contact lenses if applicable. Obtain a medical evaluation as soon as possible and document the incident according to facility policy.

Spills (including spilling of urine from patient 48 hours post therapy):

- A commercially prepared spill kit should be available at all times in the facility, if the facility has a patient receiving chemotherapy. Follow manufacturer's instructions provided in kit or refer to facility policy regarding spills.

GENERAL POLICY PN: PARENTERAL NUTRITION

Definitions

Peripheral Parenteral Nutrition (PPN): Administration of a partial nutritional solution of low enough osmolarity and glucose concentration (<10%) to be infused through a peripheral vein.

- Patient specific solutions may be mixed by the pharmacy consisting of dextrose (<10%), amino acids, lipids, electrolytes, vitamins and trace elements.

Total Parenteral Nutrition (TPN): Infusion of a parenteral nutrition containing high concentrations (>10%) of dextrose, amino acids, lipids, electrolytes, vitamins and trace elements delivered through a central line.

Policy

To provide short term or supplemental nutrition support, a PPN order will need to be faxed to the pharmacy before the patient is due to arrive at the facility. Consult with the pharmacy to ensure timely delivery.
Nurses administering PPN will have documented training in IV therapy.
PPN may be administered through a peripheral or central line.
An infusion pump will be used for the administration of PPN.
Lab monitoring both pre- and post-therapy will be ordered per physician. Do not draw labs from PN line.
Medications are not added to or co-infused with PPN solutions or emulsions.
No additives should be made to PN solutions except in the pharmacy according to USP 797 standards.
Filter PN solution without lipids with 0.2 micron filter.
Do not exceed hang time of 24 hours. Replace administration sets for PN solutions every 24 hours. Change administration set with each new PN container.
Keep refrigerated and protected from light until shortly before use.
Monitoring the patient receiving PN includes: body weight, F/E balance, glucose, organ functioning, infection (local & systemic), and phlebitis.
Avoid unplanned disruption in PN administration.

GENERAL POLICY: TPN: TOTAL PARENTERAL NUTRITION

Definition

Total Parenteral Nutrition (TPN) is the infusion of a parenteral nutrition containing high concentrations (>10%) of dextrose, amino acids, lipids, electrolytes, vitamins and trace elements delivered through a central line.

Policy

To provide complete nutrition for patients requiring long-term nutritional support with calorically dense solutions.
TPN will be initiated in an acute care hospital. Patients will be stabilized before being transferred to a long-term care facility.
A TPN order will need to be faxed to the pharmacy before the patient is due to arrive at the facility. Consult with the pharmacy to ensure timely delivery.
Nurses administering TPN will have training in IV therapy, including central line care and TPN administration.
TPN will be administered through a central venous catheter with the tip terminating in the superior vena cava (SVC)

NOTE: *X-RAY VERIFICATION OF THE TIP PLACEMENT IS NECESSARY BEFORE ADMINISTERING TPN*

An infusion pump will be used for the administration of TPN
Lab monitoring will be ordered by the physician. TPN orders will be adjusted accordingly.
If the central venous catheter has more than one lumen, the same lumen should be used consistently for TPN and labeled for "TPN Only"
Patients receiving TPN will have an order for 10% dextrose; including rate and length of infusion should the TPN be interrupted for any reason.
If necessary to stop a TPN infusion, a rate greater than 50ml/hour should be tapered down over a period of time, usually ½-1 hour.
TPN will be filtered unless contraindicated. Solutions without lipids will be filtered using a 0.22 filter.
Solutions with lipids will be filtered with a 1.2 filter.
For maintenance, refer to central venous line policies. Tubing used to administer piggyback lipids will be discarded immediately after administration.
Cycled TPN (given over a period of time less than 24 hours) schedules will be ordered by the physician.
NOTE ***Cycled TPN must be ramped to prevent possible dextrose related complications.***
The central venous catheter will be flushed according to type of catheter and type of TPN administration.

GENERAL POLICY: FAT EMULSIONS (LIPIDS)

Definition

Fat emulsions are administered to provide a concentrated source of calories and/or essential fatty acids to patients unable to take in or tolerate oral and/or enteral feedings.

Policy

To provide for the safe administration of fat emulsions when administering independently of PN.
The physician's order must include:
Percentage of lipid-available in 10% and 20% solutions
Volume and frequency
Rate of administration
Lipids can be administered:
Via a peripheral or central venous access-fat emulsions are iso-osmolar
In conjunction with PN via Y-connector or injection port below the filter (as close to injection site of IV access as possible)
Via an infusion pump with inline 1.2 micron filter.
Lipid tubing is changed every 24 hours.
Emulsions will be checked for signs of instability, i.e. inconsistent texture or discoloration.
Never shake or add anything to the fat emulsion bottle.
DO NOT refrigerate lipids.

INITIATING PARENTERAL NUTRITION (PN) INFUSION

Policy
To infuse TPN appropriately and safely per physician's orders.

TPN will be administered via an infusion pump following strict aseptic technique. Cycled TPN and the initial infusion of continuous TPN will be ramped due to possible dextrose-related complications.

Equipment
One (1) bag PN solution
Alcohol wipes
Administration set with 0.2 micron inline filter (if doesn't have lipids)
Normal saline flush
One (1) 10ml (or larger) syringe
Needleless injection cap

Procedure
1. Remove parenteral nutrition from the refrigerator one hour/liter prior to administration.
2. Check label on PN for correct formula against physician orders. (Double-checking/verification should be done)
3. Wash hands with soap and water
4. Assemble administration set. Remove protective cap on PN bag. Spike bag. Prime tubing.
5. Load and program pump according to instructions.
6. Flush lumen to be used for PN with saline and confirm patency. Attach tubing to needleless injection cap on tubing.
7. Open all clamps. Begin infusion.

DRAWING BLOOD FROM A CENTRAL VENOUS CATHETER

Policy

To obtain blood specimens when the patient has a central venous catheter in place.
A nurse with documented education and training in central line care, including blood draws may draw blood from a central venous catheter. Please refer to facility policy.
All infusions being administered through any lumen must be stopped before the blood sample is obtained.
Do not draw PTT (partial prothrombin time) through a heparin line. **Do not** draw electrolytes through a TPN line.
Waste the first 10cc of blood sample drawn, and then draw blood needed for lab sample. Exception: when obtaining blood cultures from CVAD, do not discard the first 10cc sample. This sample is to be sent for C&S.

Equipment:

Using Vacutainer:

- Non-sterile gloves
- Vacutainer tubes
- Vacutainer holder
- Vacutainer adapter
- Heparin flush syringe
- Saline flush syringes (2)
- Antiseptic swabs
- Needleless injection cap

Using syringes:

- Non-sterile gloves
- 10ml syringes (at least 2)
- Heparin flush syringe
- Saline Flush syringes (2)
- Antiseptic swabs
- Vacutainer tubes and needle
- Needleless injection cap

Procedure

Using Vacutainer:

1. Obtain physician's order for lab
2. Stop infusions one minute prior to drawing blood.
3. Wash hands
4. Prepare Vacutainer holder and adapter
5. Don gloves
6. Cleanse needleless injection cap 15 seconds on lumen to be used for blood draw.
   (If a multi lumen catheter, one lumen should be designated for blood draws.)
7. Unclamp catheter
8. Flush catheter with saline

DRAWING BLOOD FROM A CENTRAL VENOUS CATHETER (cont)

9. Insert Vacutainer set-up into needleless injection cap
10. Insert Vacutainer tube and withdraw 10cc blood. Remove the tube and discard specimen (if collecting specimen for culture do not discard; submit to lab.)
11. Insert subsequent tubes into holder until all specimens are obtained.
12. Remove Vacutainer set-up and wipe injection cap with alcohol.
13. Flush catheter with 10 mL saline. Clamp catheter and remove syringe.
14. Open clamp and resume infusion. If not a continuous infusion, follow with heparin flush per policy
15. Remove gloves and wash hands
16. Label specimen containers
17. Document procedure
18. Change needleless injection cap after blood sampling.
19. Before new cap application, wipe connection of catheter and injection site with alcohol.

Using syringes:

1. Follow above steps: 1-3 and 5-8
2. Attach subsequent syringes to needleless injection cap and withdraw blood until all specimens are obtained. Transfer to correct Vacutainer tubes.
3. Follow above steps 13-19

NOTE: *If you encounter difficulty withdrawing blood:*

- Position the patient flat in bed
- If using a syringe, use a syringe with a volume less that 10mL
- Turn patient to opposite side.
- Extend arm on side of IV catheter out to the side or over the patient's head
- Have the patient cough
- Try flushing again using brisk/turbulent (NOT FORCEFUL) technique
- Notify physician if unable to obtain blood through catheter

When feasible, routine labs should be obtained from a peripheral vein to minimize infection risks.

PRESCRIBER MEDICATION ORDERS

Policy

Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by licensed nurses or pharmacists and countersigned by the prescriber within 7 days.

Procedures

Elements of the Medication Order.

1. Medication orders specify the following:
   A. Name of medication.
   B. Strength of medication, where indicated.
   C. Dosage and dosage form.
   D. Time or frequency of administration.
   E. Route of administration, if other than oral.
   F. Quantity or duration (length) of therapy. If not specified by prescriber on a new order, the duration is limited by automatic stop order policy.
   G. Diagnosis or indication for use, if not known to nurse accepting order.
   H. Any allergies to medications.
2. Any dose or order that appears inappropriate considering the resident's age, condition, or diagnosis is verified with the attending physician.
3. PRN (as-needed) orders also specify the condition for which they are being administered, e.g., ''as needed for pain," ''as needed for sleep."
4. The prescriber is contacted to verify or clarify and order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, or the directions are confusing).
5. The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available.

Documentation of the Medication Order.

1. Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the physician order sheet or the telephone order sheet if it is a verbal order, and the Medication Administration Record (MAR).
2. The following steps are initiated to complete documentation:
   A. Clarify the order.
   B. Enter the orders on the medication order and receipt record.
   C. Call, fax, or electronically transmit the medication order to the provider pharmacy.
   D. Transcribe newly prescribed medications on the MAR or treatment record. When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing "DC'd" and the date and yellowing through the entry.
   E. Enter the new order on the MAR.
   F. After completion, document each medication order noted on the physician's order form with date, time, nurse's signature and physician's name. Example: "Noted 1:15 p.m., 5/17/05. M. Jones, R.N., DR. Johnson."
3. The attending physician may authorize standing orders for prescription medications or treatments.

PRESCRIBER MEDICATION ORDERS (cont)

Specific procedures for the four types of Medication Orders. The following steps are completed prior to implementing medication orders.

1. New handwritten orders, signed by the prescriber. The charge nurse on duty at the time the order is received notes the order and enters it on the physician order sheet if not written there by the prescriber. If necessary, the order is clarified before the prescriber leaves the nursing station.
2. New verbal orders. The nurse documents an order by telephone or in person on the telephone order sheet and the physician's order sheet and completes the following steps.
   A. Mail or deliver the appropriate copy of the telephone order form to the prescriber for signing.
   B. Transmit the appropriate copy to the pharmacy for dispensing.
   C. Obtain prescriber signature within 7 days.
   D. Place the signed copy on the designated page in the resident's medical record.
3. Written transfer orders (sent with a resident by a hospital or other health care facility).
   A. If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending physician before medications are administered. The nurse documents verification on the admission order record by entering the time, date, and signature. Example: "Order verified by phone with Dr. Smith/M. Jones, R.N."
   B. Obtain a diagnosis for each medication ordered.
   C. The nurse who transcribes the orders to the physician order sheet and MAR documents on the admission form that the orders were noted, as follows: "Noted 3:00 p.m., 5/17/05, M. Jones, R.N."
4. Renewed or recapitulated (recapped) orders (to continue a medication therapy beyond a previous order with limited duration, whether by prescriber or stop order policy).
   A. The prescriber renews the order either by repeating the entire order process or with a statement such as "continue medication' A' for ten days." The prescriber writes a new order for continued therapies that require different directions, dosage form, or strength.
5. Medication orders are recapped on a monthly basis when the prescriber signs the computer physician order summary. This is reviewed by a designated nurse each month before giving to the prescriber to sign.

Scheduling new medication orders on the medication administration record.

1. Non-emergency Medication Order. The first dose of medication is scheduled to be given after the regularly scheduled pharmacy delivery to the facility.
2. Emergency Medication Order (Medication contained in ER Box*). Remove appropriate quantity of medication from ER Box, document, and administer. Notify provider pharmacy of ER Box use and place order for remaining quantity needed.
3. Emergency medication order (Medication not contained in ER Box*). An emergency order is placed with the provider pharmacy, and the medication is scheduled to be given as soon as received or within 4 hours, whichever is sooner. Subsequent doses are scheduled according to facility policy.

Receipt of orders from physician assistants and nurse practitioners.

1. Orders may be accepted from a physician assistant or nurse practitioner licensed to work with resident's physician, if state law permits. The orders must comply with all the requirements of a physician's medication order. The responsible physician countersigns the orders within 7 days. Applicable formularies or prescribing guidelines are kept on file in the facility and adhered to.

*See Emergency Medication Box policy and procedure

STOP ORDERS

Policy

All new medication orders are subject to automatic stop orders unless the medication orders specify the number of doses or duration of medication. A time limit is included in recapped orders.

Procedures

1. The following classes of medications are stopped automatically after the indicated number of days, unless the prescriber specifies a different number of doses or duration of therapy to be given.
   A. Anti-infectives for acute conditions (10 days).
   B. Ophthalmic antibiotic and steroid preparations for acute problems (10 days).
   C. Decongestants and antihistamines for acute conditions (10 days).
   D. Controlled substance analgesics for acute conditions (10 days).
2. All other medications are stopped automatically after 180 days unless reordered.
3. All PRN medications orders, except for nitroglycerin, are discontinued in 30 days if not utilized at all during that time, unless the prescriber specifically orders them to be continued indefinitely or for a specified period of time. The prescriber is notified of this discontinuation through the completion of a telephone order form, sent to the prescriber's office for signature. The D/C order is also entered on the Physician's Order Sheet and noted on the MAR.
4. All medication orders that are not specific as to duration or number of doses are automatically discontinued in accordance with the Stop Order Policy. When the prescriber gives the order for a medication covered by the Stop Order Policy, the nurse requests a specific duration of therapy for that order. This then supersedes the Automatic Stop Order Policy.
5. When implementing the Stop Order Policy for routine medications, the prescriber is notified before the administration of the last dose to allow the alternative of continuing the medication without interruption of the medication regimen.
6. When entering medications covered by the Stop Order Policy on the MAR, the automatic stop date is recorded in the appropriate area on the MAR. The blocks of time before the medication is given are "X"ed out, and the blocks of time after the medication is given are "yellowed" out and "D/C" written in, once the last dose is given.
7. A current copy of the Automatic Stop Order Policy is kept in the front of each Medication Administration Book.
8. A copy of the facility "Automatic Stop Order Policy" is sent to all physicians with an explanatory cover letter.
9. Certain medications should not be discontinued before consulting with the prescriber and determining a taper schedule (e.g. beta blockers, ACE inhibitors, anti-epileptics, corticosteroids, nitrates, warfarin, and etc.).

STANDING ORDERS

Policy

Certain self-limited conditions that occur frequently among residents are often amenable to treatment with nonprescription medications, using good nursing judgment. To facilitate prompt treatment of such conditions, and to avoid unnecessary telephone calls to those prescribers who approve, standing orders are utilized.

Procedures

1. Standing orders are utilized by licensed nurses only. Professional judgment is used in the initiation and administration of standing orders.
2. The order is written up following the procedure for verbal physician orders. In indicating the source of the order, the abbreviation "s.o." is used to indicate a standing order.
3. Documentation of the situation requiring the use of the standing order is placed in the Nursing Notes section of the resident's medical record prior to initiation of the order.
4. All standing orders are countersigned by the attending physician within 7 days of initiation.
5. The automatic stop order listed for each condition and treatment is used when ~ initiating a standing order.
6. Standing orders are not renewable. If the condition persists after the stop order deadline, or sooner if professional judgment warrants it, the physician is contacted.
7. A copy of facility "Standing Orders" is sent to all physicians with an explanatory cover letter. The facility "Standing Orders" are posted at each nursing station for reference and are placed in each residents CHART and MAR.
8. A signed physician authorization to use standing order is maintained on file by the facility for each responsible physician who authorizes it.

ORDERING & RECEIVING MEDICATIONS

PHARMACY HOURS AND DELIVERY SCHEDULE

Policy

A schedule of pharmacy hours and delivery times is established and posted in all medication rooms in the facility.

Procedures

1. The administrator, director of nursing, and provider pharmacy establish a daily delivery and pick-up schedule for medication orders.
2. The schedule lists the pharmacy's regular and after business hours, applicable telephone numbers, routine medication order and delivery times, and other pertinent information, e.g., poison control center telephone number.
3. The schedule is posted at all nursing stations.
4. Routine delivery schedule (see Appendix)
5. Pharmacy hours and telephone numbers (see Appendix)

ORDERING & RECEIVING MEDICATIONS

MEDICATION DELIVERY SYSTEM: PUNCH CARD SYSTEM

Policy

Medications will be accepted from only provider pharmacies that package medications in accordance with this policy to facilitate accurate administration of the medication.

Procedures

1. All solid oral dosages of prescription medications will be packaged in a 31-day punch card, with blisters being numbered beginning in the top left corner with the number 31(thirty-one) and ending at the bottom right with the number 1 (one).
2. Non-prescription medication (OTC) will be accepted in bulk packaging.
3. All non-controlled maintenance prescription medication will be packaged in a cycle-in format depending on the change-out date of the facility (unless your facility has chosen not to participate in the pharmacy's cycle fill program). The punch card will be filled beginning with the date of the next scheduled use after pharmacy delivery and ending with the last date prior to the change-out date. One punch card will be delivered for each scheduled time pass. Medication to be administered shall be retrieved from the numbered blister corresponding to the calendar date.

   (Example: An order is received on Jan. 5th, scheduled to be given BID. The change-out date of the facility is the 20th. One card will be packaged with dosages in blister #5 through #19, the other card will be packaged with dosages in blister #6 through #19.)
4. All non-controlled prescription medications that are not to be administered on a maintenance schedule will be dispensed for the prescribed duration only. The punch cards will be loaded by the calendar date.

   (Example: An order is received on Jan. 15th for an antibiotic to be given QID for 10 days. The change-out date is the 20th. Four punch cards will be packaged; each containing a 10-day supply.)
5. All controlled solid oral dosage forms (CII, CIII, CIV, or CV), will be dispensed in a 31 dose, 62 dose, or 90 dose punch card. These punch cards will be packaged starting with the number 1 blister and ending with the last blister corresponding with the quantity dispensed. These medications will be punched out and administered in reverse order. (Example: An order is received for a medication to be administered TID for 5 days. One punch card of 15 will be packaged with a dosage in blister number 1 through number 15).
6. All controlled liquid medication will be packaged in a graduated container.

ORDERING & RECEIVING MEDICATIONS

MEDICATION DELIVERY SYSTEM: UNIT DOSE SYSTEM

Policy

Medications will be accepted from only provider pharmacies that package medications in accordance with this policy.

Procedures

1. All solid oral dosages of prescription medications will be packaged in a unit dose box, measuring 4 ¾" X 2 ½" X 1 5⁄8".
2. Non-prescription medication (OTC) will be accepted in bulk packaging.
3. All non-controlled maintenance prescription medication will be packaged in a cycle-in format depending on the change-out date of the facility. The only exception is Medicare Part A prescriptions which will be filled per facility refill policy. The unit dose box will be filled with the amount of medication needed beginning with the date of the next scheduled use after the pharmacy delivery and ending with the last date prior to the change-out date.
4. All non-controlled prescription medications that are not to be administered on a maintenance schedule will be dispensed for the prescribed duration only. The unit dose box will contain the number of dosages indicated on the prescription label.
5. All controlled solid oral dosage forms (CII, CIII, CIV, or CV), will be dispensed in a 31 dose, 62 dose, or 90 dose punch card. These punch cards will be packaged starting with the number 1 blister and ending with the last blister corresponding with the quantity dispensed. These medications will be punched out and administered in reverse order. (Example: An order is received for a medication to be administered TID for 5 days. One punch card of 15 will be packaged with a dosage in blister number 1 through number 15).
6. All controlled liquid medication will be packaged in a graduated opaque container.

ORDERING & RECEIVING MEDICATIONS

ORDERING AND RECEIVING MEDICATIONS FROM PHARMACY

Policy

Medications and related products are received from the pharmacy supplier on a timely basis. The facility maintains accurate records of medication order and receipt.

Procedures

Ordering Medications:

1. Medication orders are phoned or faxed to the pharmacy and written on a medication order form provided by the pharmacy for that purpose. If an order is phoned to the pharmacy it will be followed with the faxed order. Information is entered in the appropriate sections A, B, C, D, or E. (see Appendix).
2. All orders must contain the facility name, nursing station, date, nurse's signature, and name of the pharmacy.
3. New medication orders are written in section (8) of the medication order form (see Appendix) as follows:
   A. Resident's name
   B. Medication name and strength
   C. Dosage and duration, that is, directions for administration and length of therapy.
   D. Name of physician.
   E. Name of nurse ordering medication and date.
   F. If necessary the original order may be faxed to the pharmacy for interpretation.
   G. Directions for use, if it is a new order, or direction changes to a previous order with indications to weather a new supply is needed from the pharmacy.
4. New medications, except for emergency or "stat" medications, are ordered as follows:
   A. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt, followed by a fax order. Inform pharmacy of the need for prompt delivery and request delivery.
   B. Fax new order to pharmacy in a timely manner so that medication delivery and administration is not delayed. Use the emergency kit when the resident needs a medication prior to pharmacy delivery.
5. Repeat medications (refills) are written in section (A) of the medication order form (see Appendix) as follows:
   A. Prescription number (or reorder label) of medication to be reordered.
   B. Residents name and other identifying information, when necessary.
   C. Medication name and strength
   D. Name of nurse ordering medication and date.
   E. Reorder medication three to four days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (e.g., Schedule II controlled substances, V A prescriptions), order at least seven days in advance of need.
   F. The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling changes.
   G. The refill order is called in, faxed, or otherwise transmitted to the pharmacy.

ORDERING AND RECEIVING MEDICATIONS FROM PHARMACY (cont)

6. "Stat" and emergency medications are ordered as follows:
   A. Stat or emergency orders for a new prescription should be designated as such by a physician.
   B. During regular pharmacy hours, phone the emergency or "stat" order to the pharmacy followed with the faxed order. Inform pharmacy provider of the need for prompt delivery. If available, obtain the initial dose from the emergency kit, when necessary.
   C. After scheduled business hours, contact pharmacy following the emergency protocol. If available, obtain the initial dose from the emergency kit, when necessary.
7. New admission orders:
   A. Resident information is written in section (C) of the medication order form (see Appendix), which contains resident name, room, D.O.B., allergies, pay type, Medicare/Medicaid numbers, or other insurance information, and guarantors name and address.
   B. Original admission document may be faxed to pharmacy if it contains the needed information.
   C. Prescription information is completed in section (B) of the medication order form (see Appendix) following protocol.
   D. Dosage changes for discontinued medications are written in section (D) of the medication order form (see Appendix) and these should be transmitted to the pharmacy on a daily basis, even if this does not involve ordering a medication.
   E. Resident status changes are written in section (E) of the medication order form (see Appendix) and transmitted to the pharmacy on a daily basis, these changes would include room number changes, discharged residents, hospitalized residents, or deceased residents.

Receiving Medications:

1. A licensed nurse receives medications delivered to the facility and documents delivery on the medication receipt record (see Appendix). This nurse verifies medications received and directions for use with the medication order and receipt record. Discrepancies and omissions are reported promptly to the issuing pharmacy and the charge nurse/supervisor.
   A. Pharmacy delivers medications with a delivery receipt or check-off sheet on days other than the scheduled medication replacement day. A report of all medications delivered is provided with the scheduled replacement delivery.
   B. Nurse's documentation on delivery sheet is to include name, date, and time.
   C. Delivery personnel must also sign with name, date, and time.
   D. A change-out report of all medications delivered is provided with the scheduled replacement delivery. Report will include patient name, room number, drug name, strength, prescription number, quantity, and doctor.
   E. These delivery records are retained for 10 years or per facility policy.
   F. Ordering and receiving records are retained for 10 years or per facility policy.

ORDERING & RECEIVING MEDICATIONS

CONTROLLED MEDICATIONS - ORDERING AND RECEIPT

Policy

Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations.

Procedures

1. The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications.
2. Schedule II controlled medications prescribed for a specific resident are delivered to the facility only if a written prescription has been received by the pharmacy prior to dispensing. In an emergency situation, the provider pharmacy can accept a telephone order. A follow-up written (original) prescription is sent or faxed to the provider pharmacy by the facility or the prescriber within 7 days.
3. New and refill orders for controlled medications other than those in Schedule II are ordered as detailed in the procedure for ordering and receiving medications.
4. Medications listed in Schedules II, III, IV, and V are dispensed by the pharmacy in readily accountable quantities and containers designed for easy counting of contents. When ordered for injection, controlled substance medications are provided in ampules or vials of the smallest available dosage unit.
5. A controlled medication accountability record is prepared when receiving or checking in a controlled substance medication for a resident. This record is maintained in a bound ledger with consecutively numbered pages. The following information is completed:
   A. Name of resident
   B. Prescription number
   C. Drug name, strength (if designated), and dosage form of medication
   D. Date received
   E. Quantity received
   F. Name of person receiving the medication supply
6. Medications listed in Schedules II, III, IV, and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. This locked cabinet or safe can be stored in the medication cart. The access key/code to controlled medications is not the same key giving access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. The Director of Nursing or their designee keeps back-up keys to all medication storage areas, including those for controlled medications.
7. Schedule II controlled substance medications are reordered when a seven-day supply remains to allow for transmittal of required original written prescription to the pharmacist.
8. From time to time the pharmacist and facility may designate a particular drug, which is not mandated as a controlled substance by State or Federal Laws and subject to abuse or diversion, to be handled under these procedures for controlled medications.
9. Controlled substances that are stocked as part of the emergency/stat box will be kept with other controlled substances and should be counted at each shift change.

ORDERING & RECEIVING MEDICATIONS

TRANSMITTING PHARMACY ORDERS VIA FACSIMILE MACHINE

Policy

The facility may use a fax machine to transmit pharmacy orders, to reduce errors, improve communication, decrease nursing time, and to provide the pharmacy supplier with a copy of the original physician's order.

Procedures

1. The order to be sent is placed face down on the facsimile (fax) machine, and the transmittal button is pushed. Once copied, the original comes back out of the machine. If the receiving machines at the pharmacy are busy, the fax machine will redial the call after a period of several minutes. When the order is successfully transmitted, the facility will receive a “fax back” on the fax machine that will show a condensed version of the pages received by the pharmacy. This will give the facility an opportunity to make sure the pharmacy successfully received all pages of the fax.
2. For new orders: complete medication order form following protocol (see Appendix).
3. For reorders (refills): complete medication order form following protocol (see Appendix). Refills are reordered at least 48 hours before needed to prevent avoidable delays in getting the medication to the resident.
4. Emergency orders may be faxed at any time during regular pharmacy hours following protocol. After hours emergency orders must be faxed and the pharmacy must be notified. Faxing routine orders is assigned and completed according to facility protocol.
5. Routine orders that are needed at the next scheduled medication delivery time should be faxed at least one hour prior to the next delivery time for your facility. Emergency orders obtained outside of the provider pharmacy's regular hours are called in to the provider pharmacy's emergency number.
6. All orders, for each day only, may be transmitted to the pharmacy on the same medication order form. However, as many forms may be used as necessary. New orders may be added to the medication order form as they occur and transmitted to the pharmacy as frequently as necessary. A new medication order form must be initiated each day.

ORDERING & RECEIVING MEDICATIONS

EMERGENCY PHARMACY SERVICE

Policy

Emergency pharmaceutical service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply, which each provider pharmacy must supply, or by special order from the provider pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, and controlled substances are supplied by the provider pharmacy in limited quantities in compliance with applicable state regulations and the Arkansas Board of Pharmacy.

Procedures

1. After hours and emergency telephone numbers for each provider pharmacy are posted at nursing stations (see Appendix).
2. When an emergency or "stat" order is received, the charge nurse:
   A. Determines that the order is a true emergency, i.e., cannot be delayed until the scheduled pharmacy delivery.
   B. Ascertains whether the ordered medication is contained in the emergency kit by referring to the list of contents posted at the nursing station or on the box.
   C. If the medication is not available, calls the pharmacy, using the after-hours emergency number(s) if necessary.
3. Each provider pharmacy supplies emergency or "stat" medications according to the provider pharmacy agreement.
4. Medications are not borrowed from other residents. The required medication is obtained either from the emergency box or from the resident’s provider pharmacy.
5. The resident’s provider pharmacy is called if an emergency arises requiring immediate pharmacist consultation, using the after-hours emergency number(s), if necessary. In the event that the provider pharmacy is unable to supply essential information regarding the appropriateness of a new drug order, the consultant pharmacist is contacted.

ORDERING & RECEIVING MEDICATIONS

HOUSE-SUPPLIED (FLOOR STOCK) MEDICATIONS

Policy

The facility maintains a supply of commonly used non-legend (OTC) medications considered as floor stock medications.

Procedure

1. The CQI Committee establishes a list of non-legend medications to be utilized as floor stock.
2. The floor stock medications list is posted in medication rooms.
3. Floor stock medications are labeled as "floor stock" and kept in the original manufacturer's container with expiration date and lot number clearly exposed.
4. Stock medications shall not be transferred from original container.
5. Floor stock label should also include:
   A. Medication name and strength
   B. Quantity

ORDERING & RECEIVING MEDICATIONS

PRIOR AUTHORIZATION POLICY

Policy

When insurance requires a Prior Authorization for a medication, the pharmacy will notify the facility and/or doctor via fax and telephone. The facility and/or doctor must complete and submit a Prior Authorization Form (see Appendix).

Procedure

When the pharmacy receives an insurance rejection due to a medication requiring a Prior Authorization, the following steps will take place:

1. The PA Notification Form and Medication Change Form will be sent to both the facility and the doctor, unless you request the forms be sent to facility or doctor only.
2. When the fax is sent, you will receive a call from our Claims Department (from the hours of 8:00am to 10:00 pm) notifying you the medication is not covered.
3. If there is not a medication change, the facility will need to continue with the Prior Authorization process.
4. The pharmacy can send a **14-day supply** allowing the facility and doctor ample time to complete necessary paperwork. Our claims department will follow up with you during this 14-day period.
5. If the medication cannot be dispensed as a 14-day supply, such as a cream, inhaler, eyedrops, etc., or the cost exceeds $250.00 (we can raise or lower this limit for your facility if requested), the medication will not be sent unless someone from your facility authorizes it and the pharmacy has been given permission to bill the facility. If possible, the claims department will dispense a smaller amount to mitigate cost.
6. Once we have reached day 15 and Prior Authorization is not complete, **no more medication will be sent** unless the medication has been changed, a prior authorization is complete or authorization has been given to bill the facility.

ORDERING & RECEIVING MEDICATIONS

MEDICATION INFORMATION

Policy

The licensed nursing staff has access to reference materials that include current information on medication effects, cautions, available strengths, dosage forms, recommended doses, and nomenclature.

Procedures

1. Reference material is kept at each nursing station. A general pharmacology text is available to the nursing staff and kept (in the director of nursing's office). If IV solutions are administered in the facility, a reference relating to IV medication administration is readily available to nursing personnel.
2. For unusual nonprescription medications, information on safe and effective use is kept with the medication. Do not cover manufacturer information on the label unless the medication is dispensed as a prescription. In such cases, the provider pharmacy label supersedes manufacturer directions.
3. When information about a medication is not available, the charge nurse requests it from the provider pharmacy.
4. Package literature obtained from the provider pharmacy is kept at the nursing station with other medication information.
5. Reference materials or the pharmacist are consulted before administering an unfamiliar medication.
6. The responsible party is given patient appropriate information for discharge/take home information.

ORDERING & RECEIVING MEDICATIONS

EMERGENCY MEDICATION BOX

Policy

An emergency supply of medications is maintained in the facility in limited quantities by the provider pharmacy in portable, sealed containers and replaced using an exchange method, including emergency drugs, antibiotics, and controlled substances are supplied by the provider pharmacy in limited quantities in compliance with applicable state regulations and the Arkansas Board of Pharmacy.

Procedures

1. Emergency medication box (ER Box) is kept in designated med. room.
2. A list of emergency box contents is signed by the medical director once yearly and posted on the outside of the box and at other locations at each nursing station so that the information is readily accessible.
3. The ER box is maintained on a floating inventory list.
4. The ER box will remain sealed at all times. The ER box is delivered by the provider pharmacy secured with a red breakaway seal.
5. When the box is opened it will be immediately sealed with a yellow breakaway seal indicating that a medication has been used. The medication used will be logged by resident name and date used, then the provider pharmacy will be notified.
6. The provider pharmacy will issue a replacement ER box on the next scheduled delivery.
7. When the new ER box is delivered the opened ER box will be returned to the provider pharmacy or exchanged for a new ER box.
8. On a monthly basis, the consultant pharmacist will check the ER box and verify that the inventory list and contents are correct.
9. The Director of Nursing, Medical Director, and Consultant Pharmacist are responsible for establishing the list of medications to be maintained in the emergency medication box.
10. Attending physicians are informed regarding the availability of emergency medications in the facility.

ORDERING & RECEIVING MEDICATIONS

CONTROLLED SUBSTANCES EMERGENCY SUPPLY

Policy

An emergency supply of controlled substances may be maintained as approved by the Arkansas Board of Pharmacy in limited quantities in the facility.

Procedures

1. The controlled substances emergency supply is kept under double lock in a clear plastic container and only the Administrator, Director of Nursing, and Charge Nurse has access to the keys.
2. When an emergency or stat dose is needed, the nurse opens the double lock area and removes the required medication.
3. All controlled medications approved for ER box stock will be stored in the narcotic lock box on a designated medication cart or in a locked cabinet within the medication supply room that is locked at all times.
4. These controlled PO medications will be dispensed in unit dose packaging sealed in a clear plastic container. ER box stock controlled medications will be counted each shift as with all other controlled medications.
5. When the situation calls for the use of a controlled ER medication, the dose used is signed out to the resident in the Med Count Book for the specific medication page.
6. The provider pharmacy shall be notified and a replacement Controlled ER box shall be delivered on the next regular scheduled delivery.
7. When the replacement Controlled ER box is received by the facility:
   A. Remove the plastic sealed controlled ER box inside the sealed transport box.
   B. Fill in the quantity of the medication being returned in the opened Controlled ER box on the enclosed form.
   C. Sign and date on the appropriate line and write in the number of the yellow breakaway seal with which the transport box was sealed.
   D. Place this completed sheet, the used Controlled ER box, and any ER charge slips inside the transport box prior to sealing with the yellow breakaway seal.
8. Use of tape on controlled medications:
   A. At the request of the Arkansas Department of Health Pharmacy Services Division, D.E.A., and the Arkansas Board of Nursing, the following policy will be in effect immediately.
   B. As there is no way to know if the removal of the medication was an act of tampering or if the removal of medication was inadvertent, each taped dose of controlled medication will be treated as if it were a case of tampering.
   C. Each nurse signing the Med Count Book at the change of shift is responsible to be sure that no taped controlled medications are accepted.
   D. All taped controlled medications will be the responsibility of the nurse on whose shift they are discovered.
   E. All taped controlled medications will be reported to the Director of Nursing, Consultant Pharmacist, and the Arkansas Department of Health -Pharmacy Services Division.

ORDERING & RECEIVING MEDICATIONS

MEDICATIONS BROUGHT TO FACILITY BY RESIDENT OR FAMILY MEMBER

Policy

Refer to state and federal guidelines to determine whether or not a medication brought into the facility by a resident or family member is permitted.

ORDERING & RECEIVING MEDICATIONS

MEDICATION LABELS

Policy

Medications are labeled in accordance with facility requirements and state and federal laws. Only the provider pharmacy modifies or changes prescription labels.

Procedures

1. Each prescription medication label includes:
   A. Resident's name
   B. Specific directions for use
      - Due to the complexity and length of some instructions, some medications may be labeled “use as directed” and refer the person administering the medication to the MAR for instruction details.
   C. Brand or generically equivalent name
   D. Description of medication dispensed
   E. Strength of medication
   F. Route of administration
      - Injectables: strength per milliliter (or cubic centimeter). Directions for use are expressed on the label in the dosages and the equivalent milliliter amount to be given.
        Example: When furosemide 40mg is ordered and the pharmacy supplies it in an ampule containing 40mg/mL, the directions on the label read "Inject 40mg (1 mL)."
      - Liquids: strength per milliliter. Directions for use are expressed on the label in milliliter and the equivalent dosage.
        Example: Directions on the label would read, "Give 2.5mL (250mg)."
   G. Physician's name
   H. Date medication is dispensed.
   I. Quantity
   J. Expiration date
   K. Name, address, and telephone number of provider pharmacy
   L. Prescription number
   M. Auxiliary labels indicating storage requirements and special procedures. Example: "Shake well"; "Refrigerate"
2. Improperly labeled medications are rejected and returned to supplier.
3. The provider pharmacy permanently affixes labels to the outside of prescription containers.
4. Nonprescription medications stored at bedside for self-administration are kept in the manufacturer's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information is not covered.
5. Nonprescription medications that are administered to a resident by nursing personnel, other than those taken from floor stock, are dispensed by the provider pharmacy with a label meeting all the requirements of a prescription label.
6. Medication labels shall not be altered, modified, or marked in any way by nursing personnel. Contents shall not be transferred from one container to another. Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacist may place a label on the medication container.

MEDICATION LABELS (cont)

7. If the physician's directions for use change or the pharmacy types an error on the label and it is impractical to return the medication to the pharmacy for relabeling, the nurse shall place a signal label (such as “Refer to MAR”) on the container or label indicating there is a change in directions for use.
8. When such a label appears on the container, the medication nurse checks the resident's current medication administration record (MAR) or the physician's order for up-to-date information.
9. Other important information is not covered up when placing a signal label on a medication container.
10. If directions for use change, the provider pharmacy is informed immediately so the new container will show a corrected label.
11. Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacy for relabeling or destroyed in accordance with medication destruction policy.
12. Medications dispensed by physicians must conform to the above labeling requirements.
13. If the pharmacy or a dispensing physician has labeled medication incorrectly, a medication incident report is completed.
14. Floor stock medications are labeled as "stock" and kept in the original manufacturer's container with the expiration date and lot number clearly evident.

ORDERING & RECEIVING MEDICATIONS

INFUSION THERAPY PRODUCTS LABELS

Policy

Infusion therapy products are labeled in accordance with facility requirements and applicable state and federal laws. The label includes sufficient additional information as required to assure safe and efficient administration to residents.

Procedures

1. Infusion therapy products are labeled with:
    - Resident name
    - Physician name
    - Pharmacy name, address, and telephone number
    - Contents of solution (name and volume of solution)
    - Date dispensed
    - Directions for administration, Flow rate, Prescription number
    - Storage instructions
    - Expiration date
        - Infusion rate

MEDICATION ADMINISTRATION – GENERAL

MEDICATION STORAGE IN THE FACILITY

Policy

Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or designated administrative personnel.

Procedures

1. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Transfer of medications from one container to another is done only by a pharmacist.
2. Only licensed nurses, the consultant pharmacist, and designated administrative personnel are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.
3. Orally administered medications are kept separate from externally used medications, e.g., suppositories, liquids and lotions.
4. Intravenously administered medications are kept separate from orally administered medications.
5. Eye medications are kept separate from ear medications.
6. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area.
7. Medications labeled for individual residents are stored separately from floor stock medications.
8. Potentially harmful substances (e.g., urine test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in a locked area separately from medications.
9. Medications requiring storage at "room temperature" are kept at temperatures ranging from 15°C (59°F) to 30°C (86°F).
10. Medications requiring "refrigeration" or "temperatures between 2°C (36°F) and 8°C (46°F)" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label.
11. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated, and separate from and stored below fruit juices, applesauce, and other foods used in administering medications. Other foods (e.g., employee lunches, activity department refreshments) are not stored in this refrigerator.
12. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists.
13. Medication storage areas are kept clean, well lit, and free of clutter, and extreme temperatures.
14. Schedule II, III, IV, and V controlled medications are stored separately from other medications under a double lock.
15. Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified.

MEDICATION ADMINISTRATION – GENERAL

INFUSION THERAPY SOLUTION STORAGE

Policy

Infusion therapy products and supplies are stored separately from other medications and biologics, under appropriate temperature and sterility conditions, and following the manufacturer's recommendations or those of the supplier.

Procedures

1. Infusion therapy products prepared by the infusion therapy provider are stored at a temperature of 36°F to 46°F (3°C to 8°C) refrigerator.
2. One liter infusion therapy solution containers are removed from the refrigerator one (I) to two (2) hours before use. Smaller containers are removed up to one (I) hour before use. Some infusion therapy products may be stored frozen. Frozen products should be thawed six to eight hours in the refrigerator before administration.
3. Infusion therapy solutions not prepared or modified by the infusion therapy products provider ("stock solutions") are stored at temperatures not exceeding 86°F (16°C).
4. The infusion therapy product storage area is kept clean and free of clutter.
5. Infusion therapy products expiration dates and storage conditions are monitored by the consultant pharmacist during the inspection of medication storage areas.

MEDICATION ADMINISTRATION – GENERAL

MEDICATION ADMINISTRATION - GENERAL GUIDELINES

Policy

Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The medication should be administered without unnecessary interruptions.

Procedures

1. Medications are prepared, administered, and recorded only by licensed nursing and medical personnel authorized by state laws and regulations to administer medications.
2. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the physician and pharmacist is contacted for clarification prior to the administration of the medication. This interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate.
3. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with facility procedures for self-administration of medications.
4. Medications are administered at the time they are prepared. Medications are not pre-poured.
5. All current medications and dosage schedules, except topicals used for treatments, are listed on the resident's medication administration record (MAR).
6. Topical medications used in treatments are listed on the treatment administration record (TAR).
7. Residents are identified before medication is administered. When in doubt:
   A. Check identification band
   B. Check photograph attached to medical record.
   C. Call resident by name.
   D. If necessary, verify resident identification with other facility personnel.
8. Except for single unit dose packet distributions systems, only the licensed or legally authorized personnel who prepare a medication may administer it. This individual records the administration on the resident's MAR at the time the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.
9. Medications are administered within a range of 60 minutes prior to or after the scheduled time, except before or after meal orders, which are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility.
10. The resident's MAR is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided.

MEDICATION ADMINISTRATION – GENERAL

MEDICATION ADMINISTRATION – GENERAL GUIDELINES (cont)

11. When PRN medications are administered, the following documentation is provided:
    A. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site.
    B. Complaints or symptoms for which the medication was given.
    C. Results achieved from giving the dose and the time results were noted.
    D. Signature or initials of person recording administration and signature or initials of person recording effects, if different from person administering.
12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. If a dose of a vital medication is withheld or refused, the physician is notified.
13. Medications supplied for one resident are never administered to another resident.
14. For residents not in their rooms or otherwise unavailable to receive medication on the pass, a process per facility policy is used to flag absence so the nurse can return to the missed resident to administer the medication at a later time.
15. During routine administration of medications, the medication cart is kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Carts should be kept locked per facility policy.
16. An adequate supply of disposable containers (e.g., soufflé cups) is maintained on the medication cart for the administration of medications. Disposable containers are never reused.
17. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.
18. Liquid dosage forms are used whenever practical in place of solid tablets that would have to be crushed and especially for administration through enteral feeding tubes. The nurse checks with the provider pharmacy to determine if a liquid form is available and covered by the applicable payment program. The physician is contacted for a new order before changing the dosage form.
19. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines:
    A. A physician order is required to alter (or crush) a medication.
    B. Long-acting or enteric coated dosage forms should not be crushed.
    C. Each medication preparation area includes a device that is specifically used for crushing medications.
    D. For residents able to swallow, tablets may be ground coarsely and mixed with the appropriate vehicle (e.g., applesauce) so that the resident receives the entire dose ordered.
    E. If the resident is tube-fed, medications are crushed finely to prevent clogging tubes or pump.
    F. The need for crushing medications is indicated on the resident's MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate, during MAR reviews.

MEDICATION ADMINISTRATION – GENERAL

MEDICATION ADMINISTRATION – GENERAL GUIDELINES (cont)

20. If breaking tablets is necessary to administer the proper dose, hands are washed with soap and water or alcohol gel prior to handling tablets, and the following guidelines are adhered to:
    A. A tablet-splitter is used to avoid contact with the tablet.
    B. If the tablet is scored, every attempt is made to break along score lines.
    C. Unused tablet portions are disposed of per facility procedure.
    D. The administration of partial tablets is clearly identified or highlighted on the resident's MAR.
    E. Since unscored tablets may not be accurately broken, their use is discouraged if a suitable alternative is available (e.g., liquid, half strength tablet).
    F. The provider pharmacy is required to package the medication dosages already divided for administration.
21. When administering potent medications in liquid form or those requiring precise measurement, such as digoxin, devices provided by the manufacturer or obtained from the provider pharmacy are used to allow accurate measurement of doses.
22. Controlled liquid doses are measured with a calibrated syringe.
23. Details for administering specific dosage forms are detailed in the Medication Administration specific section of this manual.
24. Hands are washed before and after administration of topical, ophthalmic, optic, parenteral, enteral, rectal, and vaginal medications.

MEDICATION ADMINISTRATION – GENERAL

SELF-ADMINISTRATION OF MEDICATIONS BY RESIDENTS

Policy

Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility.

Procedures

1.Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facility's interdisciplinary team. The facility may prohibit self-administration until the interdisciplinary team has made a determination.

2.If resident indicates no desire to self-administer medications, this is documented on the appropriate form, placed in the resident's medical record, and the resident is deemed to have deferred this right to the facility. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility prior to allowing self-administration.

3.The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis.

A. The resident is instructed in the use of the package, purpose of the medication, reading of the label, and scheduling of medication doses.

B. The resident is then requested to read the label on each package and indicate at what time the medication should be taken and any other special instructions for use.

C. The resident is asked to demonstrate the removal of the medication from the package and, in the case of nonsolid dosage forms such as an inhaler, to verbalize the steps involved in administration.

D. The resident is asked to complete a bedside record indicating the administration of the medication (if bedside storage is to be used).

4.The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record.

5.If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted.

6.Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. The following conditions are met for bedside storage to occur:

A. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy and must be locked up at all times.

B. The bedside medication record is reviewed on each nursing shift, and the administration information is transferred to the MAR kept at the nursing station.

7.All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary.

8.Medications stored at the bedside are reordered in the same manner as other medications. The nursing staff is responsible for proper rotation of bedside stock and removal of expired medications.

9.When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication cart or medication room. The resident requests each dose from the medication nurse, who provides the medication to the resident in the unopened package for the resident to self- administer. The

nurse then records such self-administration on the MAR in the manner described above.

MEDICATION ADMINISTRATION – GENERAL

ENTERAL TUBE MEDICATION ADMINISTRATION

Policy

The facility assures the safe and effective administration of enteral formulas and medications. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and consultant pharmacist.

Procedures

1. Enteral formulas, equipment, route of administration, and rate of flow are selected based on a nursing assessment of the resident's condition and need and with physician, pharmacist, and dietitian involvement in planning.
2. Interactions between medications and feeding formulas, and interactions of multiple medications, are considered before administering medications through the enteral tube. If necessary, information is obtained from the provider pharmacy or consultant pharmacist.
3. In-service training on bacteriological safety, administration, and monitoring of enteral solutions and medications via the enteral tube is provided by the facility to nursing personnel.
4. The manufacturer's written recommendations regarding suggested time period for hanging of the product are consulted when determining the schedule for enteral feeding administration.
5. Caloric content per milliliter is verified before administration to assure that the correct dosage is given to achieve caloric objectives.
6. When new medication orders are received from the prescriber, the intended route of administration is also obtained. The provider pharmacy is informed that the resident is receiving medications through the enteral tube. Medications for enteral administration are obtained in liquid form whenever possible. The provider pharmacy is consulted to determine the best method for preparing dosage forms for enteral tube administration when liquid formulations are not available. If alternative medications or dosage forms are deemed necessary, the prescriber is contacted for a new order.
7. Prior to crushing tablets for administration through the enteral tube, the Crushing Guidelines and of the facility must be followed.
8. The provider pharmacy or consultant pharmacist is consulted when changing to a different formulation or when initiating enteral therapy for necessary dose scheduling adjustments of the medications or feeding schedule adjustments.
    A. If on continuous feeding, it may be necessary to change to intermittent feeding to avoid an interaction between enteral solution and some medications.
    B. If on intermittent feeding, it may be necessary to delay feeding up to two hours to avoid a medication interaction (e.g., phenytoin) with enteral solution.
9. Medications that are GI irritants (e.g., potassium chloride solution) are diluted as recommended for oral administration, since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes.
10. Enteral tubes are flushed before administering medications and after all medications have been administered per physician order.

** See also the detailed procedures for administering medication through enteral feeding tubes in section labeled “Enteral Tube Medication Administration Procedures” on page 76.

MEDICATION ADMINISTRATION – GENERAL

IRRIGATION SOLUTIONS

Policy

Irrigation solutions are used in accordance with label directions for storage, use, and disposal.
Aseptic technique is used in the handling and application of irrigation solutions.

Procedures

1. Irrigation solutions are labeled with the date and time immediately upon opening.
2. Solutions prepared by the provider pharmacy, if unopened, are kept until the expiration date indicated.
3. Solutions prepared in the facility (e.g., Neosporin G.U., hydrogen peroxide solutions) are limited to single doses and disposed of within 24 hours.
4. Solutions without preservatives, in the original manufacturer's container (e.g., water and sodium chloride for irrigation), are disposed of per manufacturer guidelines.
5. Aseptic/sterile technique is used in the handling and application of irrigation solutions.

MEDICATION ADMINISTRATION – GENERAL

VIALS AND AMPULES OF INJECTABLE MEDICATIONS

Policy

Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal.

Procedures

1. Vials and ampules sent from the provider pharmacy in a box or container with the label on the outside are kept in that box or container.
2. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials.
3. Ampules and single-use vials (containing no preservative) are discarded immediately after use.
4. The solution in multi-dose vials is inspected prior to each use for unusual cloudiness, precipitation, or foreign bodies. The rubber stopper is inspected for deterioration. Medication may be used until the manufacturer's expiration date if inspection reveals no problems or refer to the corporate policy.
5. If a multi-dose vial shows visible evidence of precipitation or contamination prior to the manufacturer's expiration date, its use is discontinued immediately, and it is returned to the provider pharmacy. A replacement vial is ordered from the provider pharmacy. The provider pharmacy determines the need for reporting a defective solution to the manufacturer and/or filing a Drug Product Problem Report.

MEDICATION ADMINISTRATION – GENERAL

EQUIPMENT AND SUPPLIES FOR ADMINISTERING MEDICATIONS

Policy

The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents.

Procedures

1. The following equipment and supplies are acquired and maintained by the facility for the proper storage, preparation, and administration of medications:
   A. Lockable medication carts and medication cabinets, drawers, or rooms with well-lit dose preparation areas.
   B. A refrigerator with a thermometer.
   C. Counter space for medication preparation with access to a convenient water source.
   D. Oral syringes, parenteral syringes, needles, droppers, soufflé cups, water pitchers, and calibrated glass or plastic medication cups.
   E. A device for crushing tablets.
   F. The charge nurse on duty makes sure equipment and supplies relating to I medication storage and use are clean and orderly.
   G. The charge nurse is notified if supplies are inadequate or equipment fails to work properly. The charge nurse reports equipment and supply deficiencies to the appropriate party.
   H. If carts are furnished by the provider pharmacy, upon notification of a problem with a medication cart, the pharmacy repairs or replaces the cart. If carts belong to the facility, the cart manufacturer or distributor is notified promptly if a problem with a medication cart occurs, and a repair or replacement is secured immediate.

MEDICATION ADMINISTRATION – SPECIFIC

ORAL MEDICATION ADMINISTRATION PROCEDURE

Policy
Administer oral medications in an organized and safe manner.

Equipment Required
Medication Cart with Medications
Medication Book containing Medication Administration Record
Medication Cups
Drinking Cups
Mortar and Pestle/Tablet Crusher/Tablet Splitter
Pitcher of Water
Controlled Substances Records
Towelettes or Handwashing Solution

Special Considerations
1. Refer to "Do Not Crush List" prior to crushing any medication for assurance that it can be pulverized.
2. Refer to medication reference text for administration of any medication when is added to any substance, i.e., applesauce, juice, milk, etc.
3. Observe for medication actions or reactions and record on the PRN effectiveness sheet when appropriate.
4. Medication cart is to be kept locked at all times unless in use and within nurse's sight.
5. Medication Room is to be kept locked at all times.
6. Tablet Crusher/Tablet Splitter should be cleaned after each use.
7. Maintenance of cart and room and stocking of supply items is the responsibility of the medication nurse.
8. Only one resident's medication at a time should be taken into resident's room.
9. Bring medication cart in the vicinity of the resident's room. The cart must always be visible to nurse administering medications
10. Unlock medication cart. Cart may remain unlocked only when in direct line of sight.
11. Cleanse hands per facility policy.
12. Open MAR to the appropriate resident and note the first medication to administer.
    A. Nurse is responsible for noting any changes on Medication Administration Record.
    B. Nurse is responsible for noting any allergies prior to administering any medications to residents.
13. Read label three times before administering medication. First when getting medication, second when putting medication in cup, and third when returning medication to the cart.
    A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label
    B. If medication is discontinued or outdated, remove medication for proper disposal.
14. Pour the correct number of tablets or capsules into the medication cup.
    A. Crush medications if indicated for this resident only after checking the Do Not Crush List. Crush in tablet crusher or with other appropriate device and clean immediately after use.
    B. Never touch any of the medication.
    C. For tablets that appear on the "Do Not Crush List," check with pharmacist regarding a suitable alternative, and get new order from physician if appropriate.

ORAL MEDICATION ADMINISTRATION PROCEDURE (cont)

15. If medication is liquid, pour correct amount directly into a graduated medication cup or measuring device provided with liquid.
    A. Shake well if needed prior to pouring.
    B. Pour liquid medication away from label and pour at eye level.
    C. Wipe rim and sides of bottle with tissue or towelette and replace cap after pouring.
    D. Liquid medications may be diluted in any fluid indicated by the physician's order. Liquid potassium supplements, bulk laxatives, and liquid stool softener may be diluted in juice at nurse's discretion.
16. Identify resident before administering medication. Check armband or photograph, call resident by name, or check with other staff members if necessary.
17. Explain to resident the type of medication to be administered. Resident has the right to be informed of all medications that are administered.
18. Obtain and record any vital signs as necessary prior to medication administration.
19. Administer medication and remain with resident while medication is swallowed. Never leave a medication in a resident's room. If resident is in bed, head of bed should be elevated to>45°prior to administration of medication.
20. Follow all medication with appropriate fluids per physician order.
21. Return to medication cart and document medication administration with initials in appropriate space on Medication Administration Record (MAR)
22. If a resident refuses medication, indicate on MAR by documenting.
    A. Note refusal or ingestion of less than 100% of dose in the "Nurse's Medication Notes."
    B. Once removed from the package or container, unused doses should be destroyed per facility policy.
    C. Controlled medications that have to be destroyed by this method must be signed by 2 (two) licensed personnel.

MEDICATION ADMINISTRATION – SPECIFIC

SUBLINGUAL MEDICATION ADMINISTRATION PROCEDURE

Policy
Administer sublingual medications under the resident's tongue safely and accurately.

Equipment Required
Medication Administration Cup
Medication Administration Record (MAR)
Medication
Towelettes or Handwashing Solution

Procedure
1. Cleanse hands.
2. Read label three times before nurse administers medication, checking MAR with label.
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
   B. If medication is discontinued or outdated, remove medication for proper disposal.
3. Pour proper number of sublingual doses into medication cup.
4. Identify resident before administering medication. Check armband or photograph, call resident by name, or check with other staff members if necessary.
5. Explain to resident what medication is being administered. Resident has the right to be informed of all medications he/she receives.
6. Obtain and record any vital signs as necessary prior to medication administration.
7. Place medication under resident's tongue (allow resident to do this if capable), and instruct resident to leave medication there until dissolved. Sublingual medications are generally not properly absorbed if swallowed. If resident is unable to comply with instructions, contact physician for alternative dosage form or medication.
8. Instruct resident to close his or her mouth and to not swallow or chew until the tablet has completely dissolved. Eating, drinking, and smoking should be avoided while tablet is dissolving.
   A. Instruct the resident to avoid rinsing the mouth for several minutes after the tablet has dissolved.
9. Cleanse hands.
10. Return to medication cart and document medication administration with initials in appropriate space on Medication Administration Record (MAR)
11. If a resident refuses medication, indicate on MAR by initialing in appropriate space and circling initial.
    A. Note refusal or ingestion of less than 100% of dose in the "Nurse's Medication Notes."
    B. Once removed from the package or container, unused doses should be destroyed per facility policy.

MEDICATION ADMINISTRATION – SPECIFIC

ORAL AND NASAL INHALATIONS ADMINISTRATION PROCEDURE

Policy
Administer oral and nasal inhalation medications in a safe and accurate manner in accordance with the manufacturer guidelines and accepted standards.

Equipment Required
Inhalation Medication
Medication Administration Record (MAR)
Spacer where applicable

Procedure
1. Wash hands.
2. Read label three times, comparing with MAR.
3. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
4. If medication is discontinued or outdated, remove medication for proper disposal.
5. Identify resident before administering medication. Check armband or photograph, call resident by name, or check with other staff members if necessary.
6. Explain procedure to resident and inform about what medication is being administered. Resident has the right to be informed of all medications he/she receives.
7. Obtain and record any vital signs as necessary prior to medication administration.
8. Administer medications as follows:
   A. **Oral Inhalation**
      - Shake inhaler well and remove cap from mouthpiece, place the cap on a clean dry surface.
      - Have resident breathe out fully to expel air from lungs.
      - Place mouthpiece completely into mouth, closing lips around it.
      - While resident breathes in deeply, depress medication canister with your index finger to assure that medication reaches lungs and is not deposited in throat.
      - Instruct resident to hold breath for as long as possible, at least 5 to 10 sec.
      - To maintain medication contact with lung tissue.
      - When resident begins to breathe out, remove finger from canister and mouthpiece from resident's mouth.
      - If more than one inhalation is ordered, wait one minute, then repeat steps above for each inhalation ordered.
      - If more than one inhaled medication is ordered wait at least 5 minutes between the administration time of each medication. If both a bronchodilator and a steroid are ordered to be administered at the same time, give the bronchodilator first for better medication distribution.

ORAL AND NASAL INHALATIONS ADMINISTRATION PROCEDURE (cont)

B. **Nasal Inhalation**
- Have resident gently blow nose to clear the nostrils to assure that nasal passages are not blocked by mucous material.
- Shake inhaler well and remove cap from nozzle.
- Hold the inhaler in upright position between second and index fingers, with thumb on bottom of canister.
- With resident's head tilted back, carefully insert nozzle into one nostril and close the other nostril with one finger.
- While resident gently inhales through open nostril, press medication canister up with thumb.
- Instruct resident to hold breath, and breathe out through the mouth.
- Remove finger from canister and nozzle from resident's nostril.
- If more than one inhalation is ordered wait at least 1 minute and, repeat steps above in each nostril for the number of inhalations ordered.

9. Clean inhaler as directed in package, thoroughly and frequently.
10. Replace the protective cap.
11. Wash hands.
12. Return to medication cart and document medication administration with initials in appropriate space on Medication Administration Record (MAR).
13. If a resident refuses medication, indicate on MAR.
    A. Note refusal or administration of less than 100% of dose in the "Nurse's Medication Notes."
14. Order replacement before solution in canister is completely gone to prevent unavailability of medication to resident.

MEDICATION ADMINISTRATION – SPECIFIC

EYE DROPS ADMINISTRATION PROCEDURE

Policy
Administer medication into the eyes in a safe and effective manner.

Equipment Required
Medication in Dropper Bottle for ophthalmic administration.
Medication Administration Record (MAR)
Tissue

Procedures
1. Read prescription label three times before administering, checking with the MAR
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to med label
   B. If medication is discontinued or outdated, remove medication for proper disposal.
2. Identify the resident before administering the medication. Check arm band or photograph, call resident by name, or check with other staff members if necessary.
3. Explain the procedure to the resident and inform about what medication is being administered.
4. Wash hands.
5. Shake the eye drop container if needed.
6. Remove the cap, taking care to avoid touching the dropper tip. Place the cap on a clean, dry surface.
7. Position resident properly.
8. If medication is refrigerated warm to room temperature.
9. If the bottle has a separate dropper, draw required amount of solution into the dropper, holding the bottle upright.
10. Pull the lower eyelid down and away from the eyeball to form a pocket.
11. Hold the dropper tip directly over the eye, taking care to avoid touching the eye or eyelid.
12. Instruct resident to look upward, and place one drop into the pocket, continuing to hold the eyelid for a moment to allow the medication to distribute.
13. Release the eyelid and instruct the resident to close the eye slowly and keep it closed for one or two minutes. Do not allow the resident to squeeze the eye shut or rub the eye. If stinging or burning occurs, reassure the resident that this is temporary.
14. Use tissue to remove any excess drops on the resident’s face.
15. Replace the cap on the container.
16. If more than one drop is ordered per eye wait at least 3-5 minutes prior to administering additional drops or per manufacturer guideline.
17. Document medication administration with initials in appropriate space on MAR.
18. If a resident refuses medication, indicate on MAR.
    A. Note refusal of less than 100% of dose in the “Nurse’s Medication Notes.”

MEDICATION ADMINISTRATION – SPECIFIC

EAR DROPS ADMINISTRATION PROCEDURE

Policy
Administer medication into the auditory canal.

Equipment Required
Medication in Dropper Bottle
Cotton Balls
Medication Administration Record (MAR)

Procedures
1. Read label three times before administering, checking with MAR
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
   B. If medication is discontinued or outdated, remove medication for proper disposal.
2. Identify resident before administering medication. Check armband or photograph, call resident by name, or check with other staff members if necessary
3. Explain procedure to resident and inform about what medication is being administered. Resident has the right to be informed of all medications he/she receives.
4. Wash hands.
5. Instruct resident to lie down and to turn head with affected ear in upward position.
6. If medication was refrigerated, allow the medication to warm to room temperature.
7. Open the container and position the dropper tip near, but not inside, the ear canal opening, to avoid contamination.
8. Gently pull the resident’s ear backward and upward to open the ear canal.
9. Place the proper number of drops into the ear canal. Do not touch the tip of the dropper to any surface, including the ear.
10. Replace cap on container. Do not rinse the dropper after use. Keep container tightly closed.
11. Gently press the small, flat skin flap over the ear canal to force out air bubbles and encourage drops down the ear canal.
12. Instruct resident to remain in position approximately 5-10 minutes with affected ear upward.
13. Cleanse reusable items and discard disposable items, wash hands.
14. Return to medication cart and document medication administration with initials in appropriate space on Medication Administration Record (MAR).
15. If a resident refuses medication, indicate on MAR.
    A. Note refusal or administration of less than 100% of dose in the "Nurse's Medication Notes."

MEDICATION ADMINISTRATION – SPECIFIC

NOSE DROPS ADMINISTRATION PROCEDURE

Policy

To relieve inflammation and/or congestion of the mucous membranes through the administration of medications into the nasal cavity.

Equipment Required

Prescribed Solution
Tissues or Sterile Gauze
Medication Administration Record (MAR)

Procedure

1. Read label three times before administering, checking with MAR.
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
   B. If medication is discontinued or outdated, remove medication for proper disposal.
2. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
3. Explain procedure to resident and inform about what medication is being administered.
   A. Resident has the right to be informed of all medications he/she receives.
4. Wash hands.
5. Shake the nose drop container, if needed.
6. Position resident properly.
   A. If up in chair, instruct resident to hold head well back.
   B. If in bed, place pillow under shoulders to allow head to drop back so forehead will be lower than chin.
7. Instill prescribed number of drops into nostril(s), directing flow toward floor of nasal cavity.
   A. Avoid touching nasal cavity to prevent damage to tissue.
   B. Use aseptic technique to prevent contamination of dropper.
8. Replace bottle cap. Wash hands.
9. Return to medication cart and document medication administration with initials in appropriate space on Medication Administration Record (MAR).
10. If a resident refuses medication, indicate on MAR.
    A. Note refusal or administration of less than 100% of dose in the "Nurse's Medication Notes."

MEDICATION ADMINISTRATION – SPECIFIC

RECTAL SUPPOSITORY ADMINISTRATION PROCEDURE

Policy

To administer medication rectally in a safe and accurate manner; to maintain and regulate a therapeutic regimen of bowel evacuation.

Equipment Required

Rectal Suppository as ordered
Disposable Glove
Lubricant
Tissue
Paper Towel
Medication Administration Record (MAR)
Bedpan or Commode where applicable

Procedure

1. Wash hands
2. Read label three times before administering, checking with MAR
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
   B. If medication is discontinued or outdated, remove medication for proper disposal.
3. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
4. Explain procedure to resident and inform about what medication is being administered.
   A. Resident has the right to be informed of all medications he/she receives. Alleviate resident anxiety.
5. Provide privacy.
6. Assist resident in turning to lateral position.
7. Put gloves on both hands and remove wrapper from suppository.
8. Lubricate index finger and suppository.
9. Separate buttocks and insert suppository gently into rectum beyond sphincter.
   A. Ask the resident to take a deep breath, to relax the anal sphincter.
10. Apply pressure with tissue over anus briefly until desire to expel suppository has passed.
    A. Instruct resident to retain suppository for 10-15 minutes if possible.
11. Place tissue and gloves in paper towel.
12. If suppository was for bowel evacuation, assist resident onto a bedpan, commode, or toilet. Make the resident comfortable.
    A. Leave call signal with resident or check back at intervals.
13. Elevate HOB to Fowler's position if the resident remains in bed.
14. Remove soiled articles. Place in covered, plastic-lined container in utility room.
15. Wash hands.
16. Return to medication cart and document medication administration by placing initials in appropriate space on Medication Administration Record (MAR).
17. If suppository was an as-needed order for bowel evacuation, note results, including color, amount, and consistency on the MAR.
    A. Nursing Assistants may document results.
18. If resident refuses medication, indicate on MAR.
    A. Note refusal or administration of less than 100% of dose in the "Nurse's Medication Notes."

MEDICATION ADMINISTRATION – SPECIFIC

VAGINAL MEDICATION ADMINISTRATION PROCEDURE

Policy
Administer vaginal medication safely and accurately for therapeutic effect.

Equipment Required
Medication
Sterile Glove
Water-Soluble Gel, if appropriate
Applicator, if appropriate
Tissue
Paper Towel
Medication Administration Record (MAR)

Procedure
1. Wash hands.
2. Read label three times before administering, checking with MAR.
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
   B. If medication is discontinued or outdated, remove medication for proper disposal.
3. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
4. Explain procedure and purpose of medication to resident.
   A. Resident has the right to be informed of all medications he/she receives. Alleviate resident anxiety.
   B. Provide privacy.
5. Place tablet/suppository in applicator or draw cream/gel into applicator.
6. Have resident lie on back with knees flexed and legs spread apart.
7. Wearing sterile gloves, examine perineum.
   A. Clean area if discharge is noted.
8. With one hand, spread apart the labia.
   A. Lubricate tablet, suppository or applicator prior to administration, if required.
   B. Place applicator into vagina and advance the plunger to instill gel or cream or to release tablet or suppository.
   C. If without applicator, insert lubricated tablet or suppository into vaginal area.
   D. Wipe lubricant from vaginal area with tissue.
9. Advise resident to remain lying down for about 30 minutes.
10. Place tissue and glove in paper towel.
11. Place wrapped, soiled articles in covered, plastic-lined container in utility room.
12. Wash hands.
13. Return to medication cart and document medication administration by placing initials in appropriate space on Medication Administration Record (MAR).
14. If resident refuses medication, indicate on MAR. Note refusal or administration of less than 100% of dose in the "Nurse' s Medication Notes."

MEDICATION ADMINISTRATION – SPECIFIC

ENTERAL TUBE MEDICATION ADMINISTRATION PROCEDURES

Policy
Safely and accurately administer oral medications through an enteral tube.

Equipment
Medication
Feeding (50cc) Syringe
75-100 ml water
Clamp
Stethoscope
Drinking cup

Procedures

1. Wash hands.
2. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
3. Explain procedure and purpose of medication to resident.
   A. Resident has the right to be informed of all medications he/she receives. Alleviate resident anxiety.
   B. Provide privacy.
4. Place resident in proper position.
   A. If resident is in bed, elevate head of bed per facility policy.
5. Turn off pump to stop continuous feeding 1-2 hours prior to medication administration if medication is associated with an incompatibility or thirty minutes if the medication should be given on an empty stomach.
6. Verify tube placement.
   A. Unclamp tube and use either insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds or aspirate stomach contents with syringe per facility policy.
   B. Reclamp tube to maintain a closed system. Check that breathing tube is not clamped.
7. Read medication label(s) three times before administering, checking with MAR
   A. If label is incorrect, nurse is responsible for applying "direction change" sticker to medication label.
   B. If medication is discontinued or outdated, remove medication for proper disposal.
8. Prepare medications for administration.
   A. Crush tablets and dissolve in appropriate amount of liquid per physician order.
   B. Empty capsule contents into appropriate amount of liquid per physician order.
   C. *Consult "Do Not Crush Guidelines" before crushing tablets.*
      - Dilute gastric irritants in water per manufacturer guidelines.
9. Flush the tube before administration of medication per physician order.
   A. Do not allow air to enter the tube.
10. Administer medication and allow to flow down tube via gravity.
    A. Give gentle boosts with the plunger if the medication will not flow by gravity. Repeat if necessary. Do not push medications through the tube.
11. Flush the tube after medication administration per physician order to prevent tube lumen from clogging.
12. Leave head of bed elevated for 30 minutes- Prevents aspirations of stomach contents.
13. Document medication administration on MAR, problems in Nursing Notes, and flushes on I&0 sheet.
    A. Record controlled substance administration on inventory sheet.
14. Clean feeding syringe and return to bedside stand.
    A. Syringes should be replaced after 24 hours or per facility policy.

MEDICATION ADMINISTRATION – SPECIFIC

INTRAMUSCULAR MEDICATION ADMINISTRATION PROCEDURE

Policy
Administer an aqueous suspended medication into the intramuscular tissue.

Equipment Required
Medication as ordered
Syringe capable of holding the medication
Sterile Needle (size depends on the size of the resident, viscosity of drug, comfort of the drug)
Alcohol Wipes

Sites

- Ventriogluteal (front of hip area)
- Deltoid (arms)
- Dorsogluteal (back buttock)
- Vastus lateralis (upper lateral area of leg)
  Rectus femoris (medial upper leg)

Procedure

1. Wash hands thoroughly.
2. Compare medication label with MAR and check medication expiration date.
3. Prepare medication as follows:
   A. Calculate correct amount of medication.
      - *If drug is a suspension, mix well before withdrawing. Call pharmacy if there is any question about drug.*
   B. Prepare syringe and needle.
   C. Swab rubber cap with alcohol wipe.
   D. Pull back plunger to draw a volume of air into the syringe equal to volume of medication to be given. Inject air into vial and withdraw correct amount of medication.
   E. Create air lock in syringe.
4. Identify resident before administering medication.
5. Explain procedure and purpose of medication to resident. Resident has the right to be informed of all medications he/she receives. Alleviate resident anxiety.

SITE	CODE
Left Buttock	LB
Right Buttock	RB
Left Arm	LA
Right Arm	RA
Left Thigh	LT
Right Thigh	RT
Additional sites or applicable abbreviations may be used.	

   A. Provide privacy.
6. Select an appropriate site for injection. Be sure to give medication in muscle as opposed to subcutaneous tissue.
7. Adjust resident's position.
8. Cleanse site with alcohol wipe.
9. Expel air from syringe.
10. Stretch the skin so that it is taut for easier needle insertion.

11. Using the other hand to hold the syringe, insert the needle quickly at a 90-degree angle.
    A. Aspirate for blood return. If present, withdraw needle, secure new equipment and medication, and repeat procedure.
12. Hold the needle steady and inject the medication at a slow, even rate to ensure proper distribution.
13. Withdraw needle rapidly. This increases distribution and facilitates absorption.
14. Swab the area with an alcohol wipe.
15. Wash hands.
16. Document the injection on the MAR along with site used.
17. Discard syringe and needle in designated area. Do not recap needle.
18. If resident refuses medication, indicate on MAR by initialing in appropriate space and circling initial.
19. Note refusal or administration of less than 100% of dose in the "Nurse's Medication Notes."

MEDICATION ADMINISTRATION – SPECIFIC

SUBCUTANEOUS MEDICATION ADMINISTRATION PROCEDURES

Policy

To administer a parental medication into the subcutaneous tissue in order to promote slow medication absorption and prolong medication action.

Equipment Required

Sterile Syringe and No. 35 or 23 Gauge l-inch Needle
Alcohol Wipes
Medication Container

Procedure

1. Wash hands thoroughly.
2. Compare medication label with MAR and check medication expiration date.
3. Prepare medication as follows: (If medication is a suspension, mix well before withdrawing. Check with pharmacy if there is any question about appearance of drug.)
   A. Calculate correct amount of medication. Read MAR again and compare with label on medication.
   B. Prepare syringe and needle.
   C. Swab rubber cap with alcohol sponge.
   D. Pull back plunger to draw a volume of air into the syringe equal to volume of medication to be given. Inject air into vial.
   E. Withdraw correct amount of medication. Create air lock in syringe-
   F. Check medication label with MAR a third time.
4. Obtain alcohol wipe for skin preparation.
5. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
6. Explain procedure and purpose of medication to resident.
   A. Resident has the right to be informed of all medications he/she receives. Alleviate resident anxiety.
   B. Provide privacy.
7. Select an appropriate site for injection (Be sure to give medication in subcutaneous tissue as opposed to muscle.) and adjust resident's position.

SITE	CODE
Left Buttock	LB
Right Buttock	RB
Left Arm	LA
Right Arm	RA
Left Thigh	LT
Right Thigh	RT
Additional sites or applicable abbreviations may be used.	

8. Cleanse the site with alcohol wipe using circular motion.
9. Expel air from syringe.
10. Gently tap the area to stimulate nerve endings, minimizing initial pain.
11. Grasp and pinch a cushion of flesh.

12. Hold needle with bevel side up and insert quickly at a 45-degree angle.
13. Pull back on plunger to see if needle is in a blood vessel. If so, withdraw needle, secure new equipment and medication, and repeat procedure.
14. Inject medication slowly then remove needle quickly.
15. Wipe area with alcohol wipe. Apply pressure over the injection site.
16. Wash hands.
17. Document the injection on the MAR along with site used.
    A. Chart immediately to avoid error. If medication is controlled, also chart on Narcotics sheet.
18. Discard syringe and needle in designated area. Do not recap needle.
19. If resident refuses medication, indicate on MAR by initialing in appropriate space.
    A. Note refusal or administration of less than 100% of dose in the "Nurse's Medication Notes."

MEDICATION ADMINISTRATION – SPECIFIC

INFUSION THERAPY ADMINISTRATION PROCEDURES

Policy
Provide for the safe and accurate administration of parenteral medications through the vein.

Equipment Required
Infusion therapy product prepared by provider pharmacy.
Alcohol wipes

Procedure
1. Wash hands thoroughly.
2. Obtain infusion therapy product. If for a medication from emergency kit or one with stability issues:
   A. Check containers for correct product and expiration date.
   B. Gather supplies.
   C. Remove protective tab from infusion therapy solution.
   D. Remove protective tab from medication.
   E. Reconstitute medication if required
   F. Draw required amount of medication into syringe and inject into rubber stopper of infusion therapy solution container.
   G. Check medication with MAR 3 times before adding to infusion therapy solution.
   H. Complete "Infusion Therapy Solution/Additive" label and place on IV bag or bottle
   I. Clamp tubing.
3. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
4. Explain procedure to resident.
   A. Resident has the right to be informed of all medications he/she receives. Alleviate resident anxiety.
   B. Provide privacy.
5. Wipe rubber stopper of infusion therapy solution container with alcohol swab.
6. Remove plastic cover from spike.
7. Push spike firmly into rubber stopper.
8. Hang container on IV pole.
9. Gently squeeze drip chamber until half full
   A. Prime tubing to prevent entrapment of air.
10. Remove protective cap at other end.
11. Unclamp tubing and allow fluid to flow through.
12. Clamp tubing.
13. Connect tubing to infusion therapy product insertion device.
14. Tape IV line to secure.
15. Regulate flow of medication infusion as prescribed.
16. Document in Nursing Progress Notes:
   A. Type of solution and medication.
   B. Report any complications to physician.
   C. Duration of medication infusion.

MEDICATION ADMINISTRATION – SPECIFIC

INSULIN INJECTION ADMINISTRATION PROCEDURES

Policy

To aid oxidation and utilization of the blood sugar by the tissues and to control the blood sugar levels in residents with diabetes mellitus through the correct administration of insulin.

Equipment Required

Insulin Syringe
Insulin as ordered
Alcohol wipes

Procedure

1. Check prescriber's order.
2. Obtain insulin from refrigerator and allow it to warm to room temperature.
   A. All insulin must be stored in a cool place.
3. Wash hands.
4. Rotate vial of insulin gently between hands to mix. **Do not shake vial.**
5. Compare medication label with MAR
   A. Check medication expiration date.
6. Prepare injection as follows:
   A. Check with pharmacy if there is any question about appearance of insulin. Determine correct amount of insulin to be withdrawn.
   B. Read MAR again and compare with label on medication.
   C. Prepare syringe and needle.
   D. Swab rubber cap with alcohol sponge.
   E. Hold insulin syringe with correct calibration in view and withdraw ordered dosage of insulin.
   F. If the prescriber has ordered two types of insulin to be given, draw up the regular or clear insulin first, then the NPH or any of the cloudy insulins.
   G. Pull back on plunger to admit a bubble of air to prevent the loss of insulin.
   H. Place protector on needle.
   I. Check medication label with MAR a third time.
7. Return insulin to refrigerator.
8. At bedside identify resident; explain procedure.
   A. Alleviate resident anxiety.
   B. Provide privacy.
9. Cleanse injection site with alcohol wipe.
10. Expel air from syringe.
11. Insert needle quickly at 45-degree angle.
12. Pull plunger back slightly.
    A. Check that needle is not in blood vessel. If blood is aspirated, remove needle and prepare a new dosage.
13. Inject insulin slowly.
14. Remove needle and apply firm pressure over site to prevent seepage of insulin. Do not rub area.
15. Discard syringe and needle in appropriate syringe disposal container. Do not recap needle.
16. Wash hands.
17. Document administration on MAR.
    A. Include site of administration to ensure rotation process and dosage given if using a sliding scale.

INSULIN INJECTION ADMINISTRATION PROCEDURES (cont)

18. If resident refuses medication, indicate on MAR by initialing in appropriate space.
    A. Note refusal or administration of less than 100% of dose in the "Nurse' s Medication Notes."

Characteristics of Insulin*

Insulin	Onset	Peak	Duration	Notes
Rapid Acting				
Lispro (Humalog)	15 min	30 to 90 min	129 ± 14 min	If mixing with NPH, rapid acting insulin should be drawn into syringe first. Mixture should be given immediately to avoid effects on peak action. -Humalog Kwik Pen or Vial available -Novolog FlexPen or Vial available -Apidra SoloStar or Vial available
Aspart/Fiasp (Novolog)	15 min	1 to 3 hrs	3 to 4 hrs	
Glulisine (Apidra)	15 min	60 to 100 min	3 to 5 hrs	
Short Acting				
Regular (Novolin R or Humulin R)	30 min (range: 10-75 min)	3 hrs (range: 20min to 7 hrs)	8 hrs (range: 3 to 14 hrs)	May be mixed with NPH in same syringe. Mixing order should be the clear regular drawn up first, then the cloudy NPH (ie "clear to cloudy"). -Humulin R Vial available only. -Novolin R Vial available only.
Intermediate Acting				
NPH (Novolin N or Humulin N)	1 to 4 hrs	4 to 10 hrs	10 to 18 hrs	-Humulin N Pen or Vial available. -Novolin N Vial available only.
Long Acting				
Glargine/ Basaglar (Lantus/Toujeo)	4 to 6 hrs	Same action throughout the day	24 hours	Do not mix with other insulins. -Lantus Solostar Pen or Vial available. -Levemir FlexPen or Vial available.
Detemir (Levemir)/Degludec (Tresiba)	2 to 3 hrs	No pronounced peak (max conc reached btwn 6 to 8 hrs)	Dose-dependent 7.6 to > 24 hrs	
Combinations				
Humulin or Novolin 70/30	30 to 60 min	2 to 12 hrs	10 to 18 hrs	70/30 = 70% NPH + 30% regular insulin Insulin action includes 2 peaks (1 from each formulation). -Novolin 70/30 Vial only available -Humulin 70/30 Pen or Vial available
Novolog Mix 70/30	10 to 20 min	30 to 90 min	15 to 18 hrs	Novolog Mix 70/30= aspart protamine 70% + aspart 30% Insulin action includes 2 peaks (1 from each formulation). -Novolog Mix 70/30 FlexPen or Vial available
Humalog Mix 75/25	10 to 30 min	1 to 6.5 hrs (median 2.6 hrs)	14 to 24 hrs	Humalog Mix 75/25= 75% lispro protamine + 25% lispro Insulin action includes 2 peaks (1 from each formulation). -Humalog Mix 75/25 Kwik Pen or Vial available
Humalog Mix 50/50	15 min	30 to 90 min	10 to 16 hrs	Humalog Mix 50/50= 50% lispro protamine + 50% lispro Insulin action includes 2 peaks (1 from each formulation). -Humalog Mix 50/50 vial only available

*Table above based from manufacturer prescribing information (package inserts). Table prepared Jan 2018.

MEDICATION ADMINISTRATION – SPECIFIC

TRANSDERMAL DRUG DELIVERY SYSTEM (PATCH) APPLICATION PROCEDURES

Policy
To administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application sites.

Equipment Required
Medication Patch
Alcohol Wipes

Procedure
1. Wash hands.
2. Check package expiration date then remove patch from package and envelope.
3. Check package label with MAR 3 times before applying patch to resident.
   A. If inconsistencies are found, determine correct order and flag medication package with "direction change" sticker.
4. Identify resident before administering medication.
   A. Check armband or photograph, call resident by name, or check with other staff members if necessary.
5. Explain procedure and purpose of medication to resident.
   A. Resident has right to be informed of all medications he/she receives.
   B. Provide privacy.
6. Select an appropriate site for application, if patch remains application.
   A. Observe site of previous application. Rotate sites of placement and remove. In the case of a controlled medication such as Duragesic, two licensed personnel must witness and sign the removal and destruction.
   B. Consult package information with patch for acceptable placement sites. Generally, extremities and hairy areas of the body should be avoided.
7. Adjust resident's position/ clothing and swab area for application with alcohol wipe. Allow to dry.

SITE	CODE	SITE	CODE
Left Upper Arm	LA	Left Chest	LC
Right Upper Arm	RA	Right Chest	RC
Left Upper Thigh	LT	Left Upper Back	LB
Right Upper Thigh	RT	Right Upper Back	RB
Behing Left Ear	LE	Behind Right Ear	RE
Additional sites or applicable abbreviations may be used.			

8. Label patch with date, time, and nurse’s initials.
9. Remove adhesive backing from patch and apply patch.
10. Document administration on MAR
    A. Include site of administration to ensure rotation process.
11. Wash hands.
12. If resident refuses medication, indicate on MAR by initialing in appropriate space.
    A. Note refusal or early removal of patch by the resident in the "Nurse's Medication Notes."

DISPOSAL OF MEDICATIONS, SYRINGES, & NEEDLES

CONTROLLED MEDICATIONS-DISPOSAL

Policy

Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.

Procedures

1. The administrator, Director of Nursing, and consultant pharmacist are responsible for the facility's compliance with federal and Arkansas State Health Department laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications.
2. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason.
3. All controlled medications remaining in the facility after a resident has been discharged, or the order discontinued, are returned to the Arkansas State Health Department. All returned medications are listed on form PhA: DC-l (#645048) and returned to: Pharmaceutical Division, Arkansas State Health Department, 4815 West Markham, Little Rock AR 72205, via certified mail.
4. A copy of this form should be retained by the facility.

DISPOSAL OF MEDICATIONS, SYRINGES, & NEEDLES

DISCHARGE MEDICATIONS

Policy

Medications are sent with the resident upon discharge only under conditions that protect the resident and assure compliance with the law.

Procedures

1. Medications are sent with the resident on discharge only upon the physician's order to do so per facility policy.
2. The labels of discharge medications are verified for completeness and accuracy by checking them against the most recent physician's orders.
3. Directions for use are reviewed with the resident or responsible party. If current directions for use are not the same as those on a prescription label, the medication name, strength, and the correct directions for use are written on a separate piece of paper. The handwritten directions are given to the resident or responsible party. A change of directions sticker may be applied to container.
4. If the discharging nurse is unable to answer a question about these medications, the provider pharmacy is called for the information before releasing the medications.
5. The telephone number of the provider pharmacy is given to the resident or responsible party to use in the event that additional information is needed regarding drug therapy.
6. Discharge medications are counted or the volume of liquid estimated, and the following information is entered on the discharge medication documentation form:
   A. Date
   B. Prescription number, if any
   C. Name and strength of each medication
   D. Quantity or amount
7. The resident or responsible party is informed if the container is not child-resistant and told that they can take it to the issuing pharmacy for repackaging. Both the nurse releasing the medication and the person receiving the medication must sign the record acknowledging transmission of this information.
8. If medications were brought into the facility by a resident or responsible party and not returned or destroyed, the nurse returns and documents return of the medications to the resident or responsible party along with other property or valuables upon discharge per facility policy.
9. Document disposition of medications in nurses note as per state regulation and/or per facility policy.

DISPOSAL OF MEDICATIONS, SYRINGES, & NEEDLES

DISCONTINUED MEDICATIONS

Policy

When medications are discontinued by physician order; a resident is transferred or discharged and does not take medications with them; or in the event of resident's death, the medications are marked appropriately and destroyed per facility policy.

Procedures

1. Medications are removed from the medication cart immediately upon receipt of an order to discontinue to avoid inadvertent administration. These medications are recorded in a bound and numbered drug destruction book prior to being put in the tote for destruction.
2. Medications awaiting disposal are stored in a locked secure area designated for that purpose until disposal.
3. Discontinued medications are destroyed in accordance with destruction policy and procedure.

DISPOSAL OF MEDICATIONS, SYRINGES, & NEEDLES

MEDICATION DESTRUCTION

Policy

Discontinued medications and medications left in the facility after a resident's discharge, if not qualifying for return to the pharmacy for credit, are destroyed.

Procedures

1. Controlled substances are returned to Arkansas State Health Department as detailed in the policy and procedures outlined elsewhere in this manual (see pg_____).
2. All discontinued medications (except controlled medications) shall be destroyed on the premises of the facility. Medication destruction occurs only in the presence of licensed nurses and the consultant pharmacist. An exception may be made in the case of the destruction of an individual dose of a controlled medication, in this event, two licensed nurses must witness and sign the medication count book.
3. The nurse or pharmacist witnessing the destruction ensures that the following information has been entered in the medication disposition book (bound ledger with consecutively numbered pages):
   A. Date of destruction
   B. Resident's name
   C. Name and strength of medication
   D. Prescription number
   E. Amount of medication destroyed
   F. Date of destruction
   G. Signatures of witnesses
4. The Medication Disposition form is kept on file in the facility for 10 (ten) years or per facility policy.

DISPOSAL OF MEDICATIONS, SYRINGES, & NEEDLES

RETURNING MEDICATIONS TO PHARMACY

Policy

Non-narcotic medications must be returned within 72 hours per Arkansas State Board of Pharmacy Reg. 04-00-0004(b) for credit to be given. Narcotic medications must be refused upon delivery, otherwise they may not be returned.

Medications may be returned for credit if the following conditions exist:

1. Full and unopened cards or unit dose boxes may be returned.
2. Liquids may be returned if seal has not been broken.
3. Injectables, that do not require refrigeration, may be returned if the seal has not been broken.
4. I.V. Prescriptions may not be returned.
5. Compounded prescriptions may not be returned.
6. Partial prescriptions may not be returned for credit.

All narcotic medications must be returned to the State Health Department for destruction.

Procedures

1. A “Return Medication Form” must be filled out and faxed to the pharmacy to request a medication pick-up. These forms are provided to each facility by the pharmacy.
   A. The facility name and date must be written at the top of the form.
   B. All columns of the form must be filled out.
      - RX Date
      - Patient Name
      - RX#
      - Drug and Strength
      - QTY
      - Nurse
      - Reason for Return
   C. The reason for returning the medication must be indicated in the “Reason for Return” column in order for the medication to be considered for credit. Acceptable reasons include:
      - Patient in Hospital/Discharged
      - Medication was discontinued
      - Medication dosage was changed
      - Patient is now in a Medicare/Skilled bed
      - Patient now uses another pharmacy for medications
      - Other (must specify)
2. The nurse's initials must be included as an indication that the medication is full and unopened.
3. Upon pick-up, the pharmacy driver must sign and date the bottom of the “Return Medication Form.”
4. Medications not meeting these criteria will be destroyed.

DISPOSAL OF MEDICATIONS, SYRINGES, & NEEDLES

SYRINGE AND NEEDLE DISPOSAL

Policy

Used syringes and needles are disposed of safely in conformance with applicable laws and safety regulations.

Procedures

1. To avoid risk of needle-sticks, needles are not recapped after use.
2. Immediately after use, syringes and needles are placed into puncture resistant, one-way containers specifically designed for that purpose. Do not deliberately bend or break a needle or syringe.
3. Whether kept in the medication room or affixed to the medication cart, the disposal containers are fitted with a lid that prohibits reaching into the container. While awaiting disposal, full containers of discarded needles are kept where residents and unauthorized staff do not have access (e.g., in medication room).
4. When containers are two-thirds full, they are sealed and disposed of in the same manner as other infectious waste.

MISCELLANEOUS SITUATIONS

OUT-ON-PASS MEDICATIONS

Policy

The charge nurse on duty assures that residents have their necessary medications before leaving the facility on pass or therapeutic leave.

Procedures

1. When receiving a physician's order for a resident to go out on pass, the charge nurse on duty reviews the resident's medication orders and directions for use with the physician. It may be possible to alter administration times to eliminate the need for out-on-pass medications if the resident's physician concurs and gives an order to do so.
2. All medications provided to the resident or responsible party for administration while on pass are properly labeled with full directions for use. At least twenty- four (24) hours' notice is given to the provider pharmacy so that the medications can be prepared.
3. Current medication orders and directions for use are reviewed with the resident or responsible party before the resident leaves the facility. If there is a question about the medication that the charge nurse is unable to answer, the provider pharmacy is called for the information before releasing the medication.
4. If the resident will need more than one dose of any one medication and an entire medication container is to be taken on pass, the resident or responsible party must sign out for it on a record of medication release.
5. If the provider pharmacy has advance notice of the resident's intent to go out on pass, the pharmacy may dispense a portion of the resident's medication in a separate container for that purpose. In no case may a nurse repackage medications in this manner, since this constitutes dispensing.
6. The out-on-pass medication(s) taken by the resident are recorded on the reverse side of the resident's current medication administration record (MAR). Doses are never documented on the front of the MAR unless the nurse administers the medication. However, the licensed nurse on duty at the time the resident returns to the facility may enter, in the nurse's notes, a Summary of the resident's or responsible party's report of compliance with the dosage instructions. Example: "5/17/05, 7:00 p.m., Sally Johnson, daughter of Mrs. Johnson, states that resident took digoxin, as directed, each morning. (signed) M. Jones, R.N."
7. A circled initial is placed on the MAR for each dose of regularly scheduled medications that would normally have been administered by the facility while a resident is out on pass. The reason for the circled initial is explained in the nursing comments section on the back of the MAR for each medication dose due.
8. Medications may be self-administered by residents participating in facility-sponsored activities away from the building under the following conditions:
    1. A self-administration order was given by the resident's physician.
    2. The medications are kept by a facility staff person until time for administration.
    3. A staff member observes self-administration and notes it in the resident's medical records. If the staff member is lawfully authorized to administer medications, administration is noted on the MAR. If not, the charge nurse initials and side documents the staff member's comments.
9. For facilities using electronic MARs, they will make all entries in the e-MAR as required per facility policy.

MISCELLANEOUS SITUATIONS

MEDICATION DISCREPANCIES AND ADVERSE REACTIONS

Policy

Medication discrepancies and adverse medication reactions are documented and reported to the resident's attending physician and the Pharmaceutical Services Subcommittee and/or the Quality Assessment and Assurance Committee. In addition to reporting discrepancies that result in the patient receiving an incorrect medication, medication discrepancies that have the potential for but do not actually result in the patient receiving an incorrect medication are documented and reported.

Definitions

Medication Discrepancy: An inappropriate or incorrect medication prescribed for, dispensed for, or given to a resident. It is also an omission of a vital medication due to a prescribing, dispensing, or administering error.

Adverse Medication Reaction: An undesirable or unintended harmful effect occurring as a result of a medication (e.g., heavy sedation, extra pyramidal symptoms, agitation, psychotic manifestations, severe cramping, nausea, vomiting, diarrhea, ataxia, etc.); an allergic reaction in a patient with no documented history of allergy to the medication.

Procedures

1. In the event of a medication discrepancy or adverse medication reaction, immediate action is taken, as necessary, to protect the resident's safety and welfare.
2. The attending physician is notified promptly of the error or significant adverse medication reaction.
3. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed.
4. The following information is documented in the resident's medical record: Factual description of the error or adverse reaction. Name of physician and time notified. Physician's subsequent orders. Resident's condition for 24 to 72 hours or as directed.
5. A medication discrepancy/adverse drug reaction report is completed.
6. The incident is described on the shift change report.
7. The follow-up medication discrepancy report is completed per facility policy.

MISCELLANEOUS SITUATIONS

MEDICATIONS NOT COVERED BY THIRD-PARTY PAYERS

Policy

When a non-covered (nonformulary) medication is ordered for a resident eligible for medication-related benefits under Medicaid, Medicare Part D Plans, or other third-party payer programs, the provider pharmacy attempts to have the order changed to a covered (formulary) medication or to have the medication covered under a medical necessity waiver or prior authorization.

Procedures

1. When non-covered medications are ordered, the provider pharmacy or licensed nurse consults with the resident's physician to seek a change to a covered item.
2. If the physician elects not to change the order, and if appropriate, the physician is asked to document medical necessity. The pharmacist then attempts to obtain coverage following third-party payer procedures.
3. If reimbursement is not available the pharmacy bills the resident or responsible party, or the facility.

MISCELLANEOUS SITUATIONS

DRUG PRODUCT PROBLEM REPORTING

Policy

Problems with medication product formulation, packaging, and/or therapeutic effect are reported to the Food and Drug Administration (FDA), in consultation with the provider pharmacy.

Procedures

1. Medications are inspected prior to administration to a resident.
2. If problems are detected with the medication (e.g., crumbled tablets, melted or broken capsules, congealed liquid, or other possible indicators of poor quality), the medication is not administered, and the provider pharmacy is contacted.
3. In consultation with the provider pharmacy, a determination is made of the likely source of the problem (e.g., manufacturing problem versus incorrect handling of the medication during shipment, repackaging or storage at the pharmacy or the facility).
4. If a determination is made that a manufacturing defect is the most likely problem, an FDA Drug Quality Report Form is completed and sent to the FDA. A copy of the form is retained by the facility so that the information is available in the event of a follow-up request by FDA.
5. Drug Quality Report forms filed by the facility or by the provider pharmacy at the facility's request are reviewed and acted upon as appropriate.

MISCELLANEOUS SITUATIONS

BEDSIDE STORAGE OF MEDICATIONS

Policy

Bedside medication storage is permitted for sublingual and inhaled emergency medications, for residents who are able to self-administer medications upon the written order of the prescriber, and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team.

Procedures

1.A written order for the bedside storage of medication is placed in the resident's medical record.

2.Bedside storage of medications is indicated on the resident medication administration record (MAR) for the appropriate medications.

3.For residents with bedside emergency medications, bedside medications are stored in a drawer or cabinet at the resident's bedside where they are readily available for emergency use or are kept in the resident's immediate possession when out of the room. In the event such storage poses a hazard to other residents who may wander into the resident's room, bedside storage may be discontinued.

4.For residents who self-administer all medications, the following conditions are met for bedside storage to occur:

A. The manner of storage prevents access by other residents. Lockable drawers) or cabinets are required only if unlocked storage is ineffective.

B. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.

C. The bedside medication record is reviewed on each nursing shift, and the administration information is transferred to the MAR kept at the nursing station. Notation of each dose self-administered is made by placing a check mark in the appropriate space and noting in the nursing comments the initials of the nurse who obtained the information from the resident. Only one signature per shift is required by the nurse documenting the resident's report of self-administration.

5.The resident is instructed in the proper use of bedside medications, including what the medication is for, how it is to be used, how often it may be used, proper cleaning of inhalers, where applicable, proper storage of the medication, and the necessity of reporting each dose used to the nursing staff. The completion of this instruction is documented in the resident's medical record. The nursing staff as deemed necessary undertakes periodic review of these instructions with the resident.

6.At least once during each shift, the nursing staff checks for usage of the emergency medications by the resident, with the exception that the resident is not awakened to obtain this information. If the resident remains asleep at the end of the shift, the incoming shift nurse is informed that this information was not obtained so that the resident may be questioned upon arising.

7.Upon notification of the use of bedside emergency medication by the resident, the medication nurse records the self-administration in the PRN section of the MAR. Notation of each dose self-administered is made by placing a check mark in the appropriate space and noting in the nursing comments the initials of the nurse who obtained the information from the resident, the symptoms for which the resident used the medication, and the reported effect. The nurse documenting the resident’s report of self-administration requires only one signature per shift.

8.Medications stored at the bedside are reordered in the same manner as other medications. The nursing staff is responsible for proper rotation of bedside stock and removal of expired medications.

9.Candy, cough drops, mouthwashes, aftershave lotions, colognes and perfumes, hair sprays, dentifrices, deodorants, lotions, and dry skin creams not considered medications may be stored at the bedside in small quantities in accordance with the facility's policy and procedures for personal items.

10. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy

when necessary.

**See also Self-Administration of Medications by Residents page _____.*

MISCELLANEOUS SITUATIONS

DRUG PRODUCT RECALLS

Policy

The provider pharmacy maintains a record of all medications dispensed to the facility. In the event of a recall by the manufacturer or the Food and Drug Administration (FDA), the facility is notified by the provider pharmacy to return the affected product to the provider pharmacy for disposition.

Procedure

1. The provider pharmacy maintains a record of all medications dispensed to the residents of the facility in sufficient detail to enable recall, if necessary.
2. Upon receipt of a recall notice from the manufacturer or FDA, the provider pharmacy notifies the facility with instructions for the return of the affected drug product to the provider pharmacy.
3. The facility is responsible for locating and returning the affected product to the provider pharmacy. The provider pharmacy is responsible for the disposition of the affected product as directed by the manufacturer or FDA.
4. The provider pharmacy replaces the recalled drug product with a new supply, if available. In the event a replacement supply is not available, the provider pharmacy contacts the prescriber to discuss alternative medication therapy.
5. If a replacement supply of medication is not available from the manufacturer, the charge nurse obtains instructions from the prescriber, including a new prescription for alternative medication therapy, if appropriate.
6. If prior use of the recalled drug product may result in adverse consequences, the resident or responsible party is provided this information by the prescriber or the facility. The charge nurse indicates in the resident's medical record what information was transmitted, to whom it was given, and by whom it was provided.

MISCELLANEOUS SITUATIONS

GUIDELINES FOR CARE OF THE LONG-TERM CARE PATIENT WITH CONTINUOUS SUBCUTANEOUS INSULIN INFUSION PUMPS

Policy

Nursing Home patients may receive continuous subcutaneous insulin infusion pump therapy as long as the patient, a family member and nursing staff demonstrate a level of familiarity and comfort with pump therapy, and close supervision is maintained by an experienced health care professional.

Procedures

Pump Basics:

1. Continuous Subcutaneous Insulin Infusion (CSII) or "insulin pump" is an alternative method of insulin delivery.
2. CSII or insulin pumps use only fast acting insulin in a cartridge (syringe) located inside the pump. Insulin is delivered SZ through a needle or catheter connected to the cartridge by flexible tubing. Each insulin pump is equipped with multiple alarms to notify the patient of problems. The patient is usually well educated on troubleshooting the pump.

Programming Terms:

1. Basal: Continuous 24-hour delivery of insulin designed to meet insulin requirements when patient is not eating. Takes the place of long acting insulin such as glargine, Lente or NPH
2. Bolus: a dose of insulin given to cover food requirements (meals/snacks), or to correct for hyperglycemia
3. Target glucose value:
4. ISF: Insulin sensitivity factor
5. IOB: Insulin on board

Patient Assessment:

1. Patient is mentally alert and able to manage own pump functions
2. Appropriate supplies are available
3. A plan for recording blood glucose values and insulin doses has been established with the inpatient team
4. A plan is in place for managing hypo and hyperglycemias

Patient Responsibilities:

1. Bring adequate supplies, including infusion sets, reservoirs, batteries, specific tapes or dressings
2. Provide programming information
3. Inform staff of glucose values and insulin doses during nursing home stay
4. Inform staff of hypoglycemia symptoms
5. Troubleshoot alarms

Staff Responsibilities:

1. Assess patient's mental, physical, and cognitive capabilities.
2. Verify that insulin pump is functioning, that infusion site is securely in place.
3. Verify basal and bolus doses with the patient.
4. Obtain physician orders for insulin doses, target glucose values and frequency of glucose testing.
5. Inspect infusion site daily for sign of infection.
6. Document blood glucose values and insulin doses in medical record.

MISCELLANEOUS SITUATIONS

GUIDELINES FOR CARE OF THE LONG-TERM CARE PATIENT WITH CONTINUOUS SUBCUTANEOUS INSULIN INFUSION PUMPS (cont)

Treatment of Hypoglycemia: (per Nursing Home Guidelines)

Removing a patient from an insulin pump:

1. Consider length of time patient will be disconnected from CSII
2. If longer than 60 minutes – consider an alternative source of insulin
3. IV drip can be started at time CSII is stopped

Transitions from IV insulin to an Insulin Pump:

1. Patient should be mentally and physically able to manage CSII.
2. Restart CSII at previous dose or calculate new dose based on IV requirements for the previous 24 hours
3. Discontinue IV insulin after 30-60 minutes of CSII

Special Considerations:

1. MRI: Pump should be disconnected and placed outside the room during the procedure.
2. CT SCAN: Disconnect and leave pump outside the room during procedure.
3. Procedures involving x-ray: Do not expose pump to x-ray beam. Disconnect and leave in locked dressing room.
4. Ultrasound/Echocardiogram: Transducer should not be pointed directly at the pump or site.
5. EEG: no known interference

MISCELLANEOUS SITUATIONS

ARRANGEMENTS WITH NONCONTRACT PHARMACY

Policy

A resident or responsible party may request that medications be obtained from a pharmacy other than the facility's (primary/contract) provider pharmacy. Such noncontract pharmacies will adhere to facility medication policies and procedures and assure delivery on a timely basis. This and other relevant policy and procedures are provided to the noncontract pharmacy provider.

Procedures

1. The facility provides a copy of relevant policies and procedures to residents or responsible parties who wish to purchase medications from a noncontract pharmacy. A second copy is mailed to the designated pharmacy.
   A. The person distributing these copies documents this activity and signs and dates the entry.
   B. Notification of agreement by the noncontract pharmacy to strictly adhere to the facility policy and procedure for pharmacy services is documented in the resident's business office record.
2. The (primary/contract) provider pharmacy is informed about the arrangement with the noncontract pharmacy.
3. The business office representative notifies the charge nurse of the resident's choice of a noncontract pharmacy after the noncontract pharmacy has agreed to the terms of this policy.
4. The charge nurse prominently marks the resident's current medication administration record (MAR) with the name of the selected pharmacy.
5. The facility orders and receives medications from the noncontract pharmacy in accordance with the procedures for ordering and receiving medications from the dispensing pharmacy
6. The noncontract pharmacy provides medications, herbals, biologicals, supplies and services in accordance with all applicable requirements of federal, state, and local laws, rules and regulations, and standards of practice and utilizes similar dispensing systems as the contract provider pharmacy in order to provide safe and accurate medication administration by the facility nursing staff.
7. The noncontract pharmacy provides routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week.
   A. All other new medication orders are received and available for administration on the day they are ordered by the physician or before the time the first dose is needed.
   B. If the noncontract pharmacy declines to promptly supply an emergency medication for any reason, the facility shall be notified as to the reason.
      - The (primary/contract) provider pharmacy for the facility may then be requested to fill an emergency order that complies with facility policy and procedure.
      - If the request is for a Schedule II medication, the following applies:
        i. The provider pharmacy will obtain verbal authorization from the prescriber and an emergency supply quantity will be dispensed.
        ii. A follow-up written (original) prescription is sent to the provider pharmacy by the facility or the prescriber within (7 days). A facsimile order may be sent to the provider pharmacy if the prescriber writes it.

ARRANGEMENTS WITH NONCONTRACT PHARMACY (cont)

- The facility will assist the provider pharmacy by furnishing the necessary information for performing this service by:
    i. Providing billing information for the resident and/or noncontract pharmacy.
    ii. Providing information on resident's current medications to enable the provider pharmacy to perform a drug use evaluation and clinical screening before filling the prescription.

8. Medications and related supplies are delivered to the appropriate authorized personnel by the noncontract pharmacy in accordance with the pharmacy delivery policy.
9. All medications are dispensed by the noncontract pharmacy in containers that meet legal requirements for stability and that are compatible with the medication packaging system in use in the facility.
10. Each medication provided by the noncontract pharmacy is labeled in accordance with the policy on medication labeling, facility requirements, and state and federal requirements. Any medication improperly labeled is rejected and returned to the pharmacy that issued it.
11. Controlled medications listed in Schedules II, III, and IV are provided by the noncontract pharmacy in easily accountable quantities and in containers designed for easy counting of contents to facilitate inventory control.
12. Schedule II medications that cannot be refilled and that can be dispensed only upon the receipt of an original written prescription are reordered when a (seven-day) supply remains. The noncontract pharmacy then has the responsibility to obtain a valid prescription from the physician; however, the facility assists in the acquisition of the prescription if possible. If unable to obtain the prescription and provide the medication prior to the depletion of the current supply, the noncontract pharmacy will notify the facility immediately. The provider pharmacy for the facility may then be asked to obtain and fill the prescription.
13. All medications are ordered and received by the facility in accordance with the policy on ordering and receiving medications from the dispensing pharmacy
14. All medications are delivered to the facility in accordance with the policy on pharmacy delivery
15. The noncontract pharmacy bills the resident or responsible party directly for all medications and supplies provided. If the resident is insured through the state Medicaid program, applicable state laws for payment of the noncontract pharmacy apply. If the resident is insured through Medicare Part D, a non-Medicaid managed care, or other type of insurance program, methods of payment are ascertained at the time of admission to the facility.
16. The noncontract pharmacy provides the facility with a delivery and on-call schedule and notifies the facility immediately of any changes in the schedule.

MISCELLANEOUS SITUATIONS

MULTIPLE SOURCE DRUG PRODUCTS

Policy

The cost of medications is controlled, in part, by the use of multiple-source drug products, when appropriate. All provisions of state law, Food and Drug Administration (FDA) bioequivalence guidelines, and the physician's therapeutic objectives are followed in choosing multiple-source drug products.

Definitions

Pharmaceutically Equivalent Drug Products: Drug products that contain the same active ingredient(s), in identical amounts, in identical dosage forms, administered by the same route of administration and that meet existing standards in the United States Pharmacopeia (USP). The products may differ in characteristics such as color, flavor, shape, packaging, inert ingredients, and the method of manufacture.

Multiple-Source Drug Products: Pharmaceutically equivalent drug products that are marketed by different pharmaceutical companies.

Innovator Brand Products: A drug product manufactured and marketed by the pharmaceutical company that introduces it to the market. In most cases, this is the same company that conducted the research and obtained the patent for the drug product. Often referred to as "brand name" product.

Non-Innovator Multiple Source ("Generic") Drug Product: A multiple source drug product that is marketed by a company other than the one that introduced it to the market, generally after the patent for the product has expired. Often referred to as "generic" product.

Certification: The process by which a prescriber communicates the medical necessity for an innovator brand product for a particular resident. This usually involves writing the phrase "Brand necessary" or "Brand medically necessary" on the (prescription/order) in the prescribers own handwriting.

Procedures

1. The provider pharmacy dispenses non-innovator multiple-source ("generic") drug products whenever feasible and when required according to Medicaid, Medicare, or other third-party payer programs that dictate multiple-source drug product use in place of innovator products, unless the prescriber complies with item B. below.
2. Physicians may indicate refusal of innovator product substitutes when ordering medications. In the case of a Medicaid resident, the physician complies with the required paperwork to document the necessity of an innovator product, as required by OBRA '90 revisions to Title XIX of the Social Security Act and other state-specific rules/regulations, as follows:
   A. On prescriptions:
      - The prescriber must certify in his or her own handwriting that a specific brand is "medically necessary" for a particular recipient. The handwritten phrase ("brand necessary" or "brand medically necessary") must appear on the face of the prescription.
      - The prescriber must also document in the resident record the reason why the drug is medically necessary.

   B. On facility orders:
      - In addition to the above, the prescriber certification must be made on each order written for that drug for that resident. The certification is good only for the length of time that the order is valid. Updated written certifications are required for each new prescription order written. A cover letter or blanket order for "brand medically necessary" is not sufficient to cover individual residents or individual drugs.
      - The provider pharmacy uses sound professional judgment and prudent buying concepts when selecting non-innovator multiple-source ("generic") drug product substitutes for innovator products, including bioequivalence data, FDA comparative data, etc.
        i. The provider pharmacy labels non-innovator multiple source ("generic") drug products as detailed in the medication labels policy and in keeping with applicable state laws.

MISCELLANEOUS SITUATIONS

CONTROLLED MEDICATION STORAGE

Policy

Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations.

Procedures

1.The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications.

2.Schedule II, III, IV, and V medications and other medications subject to abuse are stored in a separate area under double lock or in the Medication Cart under a double lock. The access system to controlled medications is not the same as the system giving access to other medications. If a key system is used, the medication nurse on duty maintains possession of the key to controlled medication storage areas. Back-up keys to all medication storage areas, including those for controlled medications, are kept by the director of nursing.

3.A controlled medication accountability record is prepared for all Schedule II, III, IV, and V medications including those in the emergency supply. The following information is completed:

A. Name of resident, if applicable
B. Prescription number, if applicable
C. Name, strength, and dosage form of medication
D. Date received
E. Quantity received
F. Name of person receiving medication supply

4.At each shift change, a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record.

5.Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator.

A. If a major discrepancy or a pattern of discrepancies occurs or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately.
B. The administrator, the consultant pharmacist, and/or the director of nursing determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel.
C. The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met

6.Current controlled medication accountability records are kept in the bound narcotic book. When completed, accountability records are submitted to the director of nursing and kept on file for 10 years at the facility or per facility policy.

7.Controlled medications are not surrendered to anyone, including the resident's physician, other than releasing controlled medications for a resident on pass or therapeutic leave to a resident or responsible party upon discharge from the facility, or to the DEA or other law enforcement officials functioning in a professional capacity in exchange for a receipt documenting the transaction.

8.Controlled medications remaining in the facility after the order has been discontinued are retained in the facility in a securely locked area with restricted access until destroyed per state law (see pg _____)

9.The consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspection.

MISCELLANEOUS SITUATIONS

USE OF INVESTIGATIONAL MEDICATIONS

Policy

A medication designated an “investigational new drug” by the Food and Drug Administration (FDA) is given to residents only when the use of the drug is in compliance with FDA rules and regulations, and when the facility determines the drug may be safely and correctly administered by facility personnel. Investigational medications are used per physician and facility policy.

MISCELLANEOUS SITUATIONS

RECONSTITUTION OF MEDICATION FOR PARENTERAL ADMINISTRATION

Policy

To provide for the safe and accurate reconstitution of parenteral medications prior to administration, manufacturer information is reviewed and aseptic technique is observed.

Procedures

1. Read medication package literature, medication label, or other appropriate reference to determine the correct diluent and quantity of diluent to be used.
   A. Note any special steps required (such as shaking).
2. Wash hands thoroughly.
3. Break and remove seal from vial of medication.
4. Break and remove seal from vial of diluent and wipe rubber stopper with alcohol swab.
5. Inject into diluent bottle with syringe an amount of air equal to the amount of fluid to be withdrawn for reconstitution of medication.
   A. Do not allow needle to touch any surface other than stopper.
6. Withdraw the appropriate amount of diluent into syringe.
7. Swab rubber stopper on medication vial with alcohol wipe. Inject diluent into medication bottle slowly and observe resulting solution or suspension for clarity, unusual color, or large particles, such as precipitation. If there appears to be a problem, do not administer medication without consulting pharmacist for further information.
   A. Administer medication as directed and complete documentation.

MISCELLANEOUS SITUATIONS

PREPARATION OF EMERGENCY OR UNSTABLE INFUSION THERAPY PRODUCTS

Policy

Infusion therapy products are prepared and delivered by the infusion therapy product provider except in emergencies or when product instability precludes preparation away from the facility. Infusion therapy products are prepared in the facility only by a registered nurse who follows infection control measures.

Procedures

1. The infusion therapy product provider notifies the charge nurse about any instability of an infusion therapy product.
2. Such notification is documented and the need for a nurse to prepare the admixture is indicated on the infusion therapy record and on the care plan.
3. The infusion therapy product provider supplies complete preparation and handling instructions along with the products to be mixed, and a label to be completed and affixed to the infusion therapy product container Label should also include the time of infusion therapy product preparation.
4. Date and time of preparation of the infusion therapy product is documented in the resident's medical record as well as the time that the infusion was started.
5. Infusion therapy products are prepared in accordance with infection control standards and with equipment and medication manufacturer's recommendations.
6. The area in which infusion therapy supplies and products are stored and prepared for use is kept clean and free of clutter.

ALPHABETICAL INDEX OF POLICIES

ALPHABETICAL INDEX OF POLICIES

APPENDIX

AllCare Pharmacy Hours and Numbers (Arkadelphia)

Regular Hours

Monday thru Friday 9:00 am to 6:00 pm
Saturday 9:00 am to 4:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

David Burris or Rebecca Hutson

APPENDIX

AllCare Pharmacy Hours and Numbers (Danville)

Regular Hours

Monday thru Friday 8:00 am to 6:00 pm
Saturday 8:00 am to 2:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Chuck Wilson

APPENDIX

AllCare Pharmacy Hours and Numbers (El Dorado)

Regular Hours

Monday thru Friday 8:30 am to 6:00 pm
Saturday closed
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Lynn Bates

APPENDIX

AllCare Pharmacy Hours and Numbers (Fort Smith)

Regular Hours

Monday thru Friday 9:00 am to 6:00 pm
Saturday 9:00 am to 4:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Howard Miller

APPENDIX

AllCare Pharmacy Hours and Numbers (Jonesboro)

Regular Hours

Monday thru Friday 9:00 am to 5:00 pm
Saturday 9:00 am to 4:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Greg Davis

APPENDIX

AllCare Pharmacy Hours and Numbers (Little Rock)

Regular Hours

Monday thru Friday 9:00 am to 6:00 pm
Saturday 9:00am to 4pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Bruce Mason or Garry Reinhardt

APPENDIX

AllCare Pharmacy Hours and Numbers (Mountain Home)

Regular Hours

Monday thru Friday 9:00 am to 6:00 pm
Saturday 9:00 am to 4:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Danny Ponder

APPENDIX

AllCare Pharmacy Hours and Numbers (Paris)

Regular Hours

Monday thru Friday 8:30 am to 6:30 pm
Saturday 8:30 am to 3:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Jonas Strobel

APPENDIX

AllCare Pharmacy Hours and Numbers (Rogers)

Regular Hours

Monday thru Friday 9:00 am to 6:00 pm
Saturday 9:00 am to 4:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists

Brandon Coggins

APPENDIX

AllCare Pharmacy Hours and Numbers (Texarkana)

Regular Hours

Monday thru Friday 9:00 am to 6:00 pm
Saturday 9:00 am to 3:00 pm
Sunday closed

Phone: (870) 403-9400 or 877-420-9400
Fax: (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of "long-term care pharmacy" (option one) or "assisted living facility" (option three). If there is no answer, this means all of the lines are busy. Please call back in 10 minutes.

Pharmacists:

Jason Creek

ARKANSAS DEPARTMENT OF HEALTH
Pharmacy Services
4815 West Markham Street
Slot 25
Little Rock, AR 72205-3867

Telephone Number: (501) 661-2325 Fax Number: (501) 661-2769

REPORT OF LOSS OF CONTROLLED SUBSTANCES FORM
FOR NON DEA REGISTRANTS

NAME AND ADDRESS OF FACILITY:
_____ **Telephone number:** _____ **COUNTY:** _____

_____

NAME OF CONSULTANT PHARMACIST: **Telephone number:**

***TYPE OF LOSS: (describe)** **Date loss occurred:** _____

WAS LOSS REPORTED TO THE OFFICE OF LONG TERM CARE? ☐ **YES** ☐ **NO**

Loss was also reported to: _____

***SECURITY MEASURES WHICH HAVE BEEN TAKEN TO PREVENT FUTURE LOSSES:**

***LIST OF CONTROLLED SUBSTANCES LOST**	**QUANTITY**

NAME OF PERSON FILING THIS REPORT: (PLEASE PRINT) _____

DATE OF REPORT: _____ Signature: _____

REPORT OF THEFT, LOSS OR DIVERSION SHOULD BE MADE IMMEDIATELY UPON DISCOVERY, BY TELEPHONE AT (501) 661-2325, AND THEN SUBMITTED BY FAX AT (501) 661-2769, OR BY U.S. MAIL.

***IF MORE ROOM IS NEEDED PLEASE ATTACH ANOTHER SHEET.**

PHA-21 (revised 09/08/09)
JJ:mmy/theft/loss report form

MEDICATION DAILY ORDER FORM

Nurse's Signature _____ Orders rec _____ the Pharmacy

Facility: _____ Date: _____

NEW PATIENTS AND READMISSION INFORMATION

Patient Name	Room#	D.O.B.	Allergies	Medicare/Medicaid/Insurance#

NEW PRESCRIPTION AND REFILL ORDERS

Patient Name	Prescriptions to Include (New Order: Dose, Route, Frequency, Strength Reorder: Prescription# / Place Refill Label Below)	Qty.	Doctor	Ordered By	Received By	Date
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					

DOSAGE CHANGE AND / OR DISCONTINUED MEDICATIONS

PATIENT NAME	MEDICATION	OLD DOSAGE	NEW DOSAGE	DC'D DATE	DOCTOR

RESIDENT STATUS CHANGE

NAME	ROOM	WING	DISCHARGED	DECEASED	HOSPITAL STATUS

Notify Allcare of dose changes, discontinued medications, room changes, and/or discharges. Fax all orders to (877) 420-9410 or (870) 403-9410.

PRIOR AUTHORIZATION

When the pharmacy receives an insurance rejection due to a medication requiring a Prior Authorization, the following steps will take place:

1. The PA Notification Form and Medication Change Form will be sent to the facility and the doctor, unless you request the forms be sent to facility or doctor only.
2. When fax is sent, you will receive a call from our Claims Department (from the hours of 8:00am to 10:00 pm) notifying you the medication is not covered.
3. If there is not a medication change, facility will need to continue with the Prior Authorization process.
4. Pharmacy can send a **14-day supply** allowing facility and doctor ample time to complete necessary paperwork. Our claims department will follow up with you during this 14-day period.
5. If medication cannot be dispensed as a 14-day supply, such as a cream, inhaler, eyedrops, etc., or the cost exceeds $250.00 (we can raise or lower this limit for your facility if requested), the medication will not be sent unless someone from your facility authorizes it and pharmacy has been given permission to bill facility. If possible, the claims department will dispense a smaller amount to mitigate cost.
6. Once we have reached day 15 and Prior Authorization is not complete, **no more medication will be sent** unless medication has been changed, prior authorization is complete or authorization has been given to bill facility.

Please list the person(s) with permission to authorize billing to the facility.

_____	_____	_____
Printed Name	Title	Signature
_____	_____	_____
Printed Name	Title	Signature
_____	_____	_____
Printed Name	Title	Signature

I have read and understand the Prior Authorization process stated above.

_____	_____
Name of Facility	City
_____	_____
Print Name of Authorized Agent	Signature of Authorized Agent
_____	_____
Title of Authorized Agent	Date

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