

## **CHAPTER 14**

### **POLICY AND PROCEDURES**

## POLICY AND PROCEDURES

- Required for institutional permits
- Minimum content depends on specific practice setting
- Must meet minimum standards, held to language in P&P even if more stringent
- Reference for P&Ps = State and Federal regulations, Joint Commission Standards and Elements of Performance, Medicare Conditions of Participation, ASHP practice standards
- CHALLENGE: Must be kept current - regulatory and accreditation bodies compare practice with policy
- Available to staff at all times
  - Paper Manual
  - Intranet or other electronic system
- Reviewed /Updated annually (date/sign each policy or cover sheet)
- Archive old policies based on organization's P&Ps (e.g., 10 years)
- Standardized format and numbering system recommended
- Refer to Florida Records Retention Guidelines

### RECOMMENDED POLICY AND PROCEDURES

- Policies and procedures to *minimize drug errors* should include (reference §482.25):
  - High-alert medications - dosing limits, administration guidelines, packaging, labeling and storage;
  - Limiting the variety of medication-related devices and equipment. For Example limit the types of general-purpose infusion pumps to one or two;
  - Availability of up-to-date medication information;
  - Availability of pharmacy expertise. Pharmacist available on-call when pharmacy does not operate 24 hours a day;
  - Standardization of prescribing and communication practices to include:
    - Avoidance of dangerous abbreviations;
    - All elements of the order – dose, strength, units (metric), route, frequency, and rate;
    - Alert systems for look-like and sound-alike drug names;
    - Use of facility approved pre-printed order sheets whenever possible.
  - That orders to “resume previous orders” are prohibited;
  - A voluntary, non-punitive, reporting system to monitor and report adverse drug events (including medication errors and adverse drug reactions);
  - The preparation, distribution, administration and proper disposal of hazardous medications;
  - Drug recalls;
  - That patient-specific information is readily accessible to all individuals involved in provision of pharmaceutical care. The patient information must be sufficient to properly order, prepare, dispense, administer and monitor medications as appropriate;
  - Identification of when weight-based dosing for pediatric populations is required; and
  - Requirements for review and revision based on facility-generated reports of adverse drug events and QAPI activities.
- Drug *procurement, storage, distribution and control* of drugs, radiographic contrast media and blood derivatives to include how inventory is rotated (by oldest stock or by earliest expiration date)
- *Disaster* procedures to include assessment of medications and determination of usability, how medications will remain secured in event of crisis (fire, flood, natural disaster or local, state or national emergency)
- Drug *Recalls* and withdrawals to include quarantine

- **Outdated** prescription drugs are segregated until removed and documentation maintained 2 yrs
- **Controlled substance** storage, distribution, control and destruction
- **Investigational drug** storage, distribution and control
- Procurement of medications not on the formulary (**non-formulary medications**)
- Medical staff approval of **automatic expiration of medication orders** and mechanism to reinstate the order
- Distribution of drugs to patients at **discharge** (community permit/labeling requirements, return to pharmacy for pharmacist determination of disposition)
- Procedure for patients bringing **medications from home** & disposition. Under what circumstances can they be used?
- Procedure for obtaining medications when the **pharmacy department is closed** (single dose removed by charge nurse, pharmacist review process, limited access to medications)
- **Sample medications**
- **Employee competency and performance evaluation process** (reference JCAHO Human Resource standards) – resources available from ASHP
- **Technician responsibilities** (reference 64B16-27.410 and .420)
- **Medication Administration Record** (reference 64B16-28.108; sample policy included)
- **Patient specific information** (MM 01.01.01) – minimum information about the patient available to those involved in medication management.
- **Elements of a complete medication order, unacceptable abbreviations, requirements for medication orders** (MM 04.01.01)
- **Labeling of medications** (MM 05.01.09)
- **Who** may administer medications (MM 06.01.01)
- **Self-administration of medications** (MM 06.01.03)

State of Florida  
**GENERAL RECORDS SCHEDULE GS4 FOR**  
**PUBLIC HOSPITALS, HEALTH CARE FACILITIES AND MEDICAL PROVIDERS**



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## **SAMPLE POLICIES – REFERENCE ONLY**

### **EXAMPLE:** Departmental Competency Plan

#### **POLICY:**

Medications, if prepared, used, administered, or monitored inappropriately, can cause significant patient morbidity and mortality. Competency assessment is based on the knowledge and skills required to perform an employee's responsibilities in their work area and is intended to assess whether an individual employee is competent to perform specific functions regarding those responsibilities.

#### **PROCEDURE:**

##### **A. Probationary Competency**

1. During the recruitment/hiring process, the Personnel Recruiter will be responsible for validation of reported education and licensure status for all employees and shall include the obtainment of documentation of all degrees and licenses. The Personnel Recruiter will validate references and conduct pre-employment interviews according to Hospital policies.
2. Where pre-employment testing is required according to Hospital policies, the Personnel Recruiter will document competency (eg. typing test for secretarial positions).
3. New employees are responsible for attending the scheduled Hospital Orientation and completing the required documentation forms. Departmental orientation will be provided which is specific to the employee's position, knowledge, and skills.
4. The employee's performance will be evaluated for permanent status during the initial six-month probationary period.

##### **B. Annual Competency Assessment**

1. Annual competency assessments for technicians and pharmacists target high risk, problem prone areas and problem areas as identified through other assessment improvement activities. Competency standards also address, where appropriate, the effective use and safety of specific equipment, infection control, and cardiopulmonary resuscitation. Employees responsible for the assessment of patient's needs must also demonstrate competence in the following areas as appropriate to the age of patient's served:
  - (a) the ability to obtain and interpret information in terms of the patient's needs
  - (b) a knowledge of growth and development
  - (c) an understanding of the range of treatment needed by patients.
2. Competency assessment will be performed during the probationary period and at least annually by the Team Leader responsible for the area, or the Technician Supervisor as authorized by the Team Leader. A specific plan will be developed to correct any deficiency identified during the assessment. The specific areas of competency to assess will be determined by the Department of Pharmacy Quality Management Committee. Data may be provided by the employee, by reviewing departmental inservice attendance logs, review of

licensure status, direct observation, testing, completion of continuing education requirements, orientation checklists, or computer or chart review.

3. A competency checklist will be completed by the reviewer, dated, and signed by both the reviewer and the employee. Any plan to address deficiencies must be approved by the Team Leader responsible for the area, and include a time frame in which the deficiency must be corrected, and when the employee will be re-evaluated. The time frame may vary based on the specific deficiency identified. Specific deficiency areas will be trended to assess the need for more global or department-wide actions.

**C. Responsible Parties**

1. Department of Pharmacy Quality Management Committee -
    - a. Determines the areas of competency to be assessed. Reviews the plan annually.
    - b. Reviews trending data, recommendations and plans from Team Leaders and makes recommendations to address department-wide issues.
  2. Team Leader -
    - a. Develops mechanism for competency assessment for their area and assures appropriate policy and procedures exist, as required (ie. tasks required to use equipment, who may perform specific activities, etc.).
    - b. Is responsible for preparing a competency plan for each area of competency to be assessed which includes the pre-determined success rate, the method of evaluation, and who is authorized to perform the competency assessment.
    - c. Responsible for initial and annual assessments of individual employees' performance.
    - d. Includes results of the assessment in the employee's probationary and annual performance evaluation.
    - e. Approves plan to correct individual deficiencies.
    - f. Reports competency assessment trends to the Department of Pharmacy Quality Management Committee.
  3. Employee -
    - a. Provides requested information to adequately complete the competency assessment in a timely manner.
    - b. Is responsible for getting the required checklists completed in a timely manner.
    - c. Attends/completes required continuing education programs for licensure and can provide documentation upon request. Also attends/completes mandatory hospital educational requirements.
    - d. Provides current copy of pharmacist or intern license.
    - e. Notifies manager of any change in license status (suspension, revocation, reprimand) and/or and any legal actions requiring notification of the Board.
    - f. Renews license in a timely fashion. Any employee who fails to renew their license by the expiration date will not be permitted to work.
- D. Goal -** The goal is for employees to meet 100% of their competency assessment checklists. Lack of attainment of competency after re-training or within the time frame specified by the Team Leader or Technician Supervisor may negatively impact continued employment.

NAME: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

JOB CLASS: \_\_\_\_\_

METHODS:		STANDARD	LEVELS OF PERFORMANCE	
DATE	METHODS		PERFORMANCE SCORE/ INITIALS	
A. Review Policy B. Direct Observation C. Video Review D. Skills Lab/Return Demonstration E. Written Exam F. Other (QM, Post-Code Evals)		<i>Demonstrate Proficiency in Performing Procedures Safely in Accordance with Hospital Standards as Evidenced by Department/Unit-Specific Criteria</i>	0 - Has Not Performed 1 - Needs Assistance 2 - Performs Independently 3 - Resource/Instructor	
			Self Evaluation	Evaluator
	QM	1. <b>Demonstrates knowledge and skills necessary to provide care based on physical, psychosocial, educational, safety and related criteria, appropriate to the age of the patient.</b> <ul style="list-style-type: none"> <li>Demonstrate appropriate dose and dosage form or product selection based on knowledge of patient age, growth and development, or condition</li> </ul>	/	/
	B, QM	2. <b>Demonstrates ability to provide safe, knowledgeable delivery of medication and intravenous fluid therapy as evidenced by:</b> <ul style="list-style-type: none"> <li>Demonstrate accurate processing, checking, and dispensing of medications</li> <li>Demonstrate ability to identify medication-related problems and resolve/ follow-up in accordance with core responsibilities/standard practice activity guidelines</li> <li>Demonstrate knowledge of hospital formulary and adherence to P&amp;T and Medical Staff guidelines</li> <li>Demonstrate promotion of departmental mission to proactively identify, prevent, and resolve medication related problems to assure patient safety, increase patient satisfaction, and minimize cost</li> </ul>	/	/
	B, QM	3. <b>Demonstrates ability and knowledge to safely operate and troubleshoot the following equipment</b> Computer system, code beeper, automated dispensing cabinet, fax machine, laminar flow hoods, packaging equipment, labeling program	/	/
	A, Post-Code Evals, QM	4. <b>Demonstrates ability to provide appropriate skilled care to high risk patients and medical emergencies.</b> <ul style="list-style-type: none"> <li>Recite hospital policy and employee responsibility in reporting medical emergencies</li> <li>Demonstrate adherence to "Responsibilities of the Code Team Pharmacist" policy</li> </ul>	/	/

**COMPETENCY VALIDATION**

DATE	METHODS	STANDARD	PERFORMANCE SCORE/ INITIALS	
			Self Evaluation	Evaluator
	E  A, B    B  B	<p><b>5. Demonstrates ability to provide appropriate skilled care to specific patient populations.</b></p> <ul style="list-style-type: none"> <li>▪ <b>Nutritional Support</b> – Pass the ASPEN Self-Assessment program with a minimum score of 90%</li> <li>▪ <b>Oncology</b> <ul style="list-style-type: none"> <li>• Demonstrate accurate preparation of chemotherapy medications (i.e. parenteral syringe, IVPB, intrathecal)</li> <li>• Describe special needs for preparation of medications for the following procedures: limb perfusion, hepatic chemoembolization, intrathecal</li> <li>• Demonstrate compliance with requirement for special labeling</li> <li>• Verbalize Extravasation Guidelines</li> <li>• Demonstrate understanding of and compliance with chemotherapy preparation process (i.e. verification of order, double-check system)</li> </ul> </li> <li>▪ <b>Neonatology</b> – Demonstrate ability to correctly process neonatal medication orders</li> <li>▪ <b>Clinical Research</b> – Demonstrate procedure for randomizing patients and preparing study medications as outlined by protocol</li> </ul>	/	/
	B  B D  A B A B	<p><b>6. Demonstrates skill and safety in handling and preparing sterile and/or hazardous medications.</b></p> <p><b>Aseptic Technique</b></p> <ul style="list-style-type: none"> <li>▪ Demonstrate compliance with IV Therapy policies regarding aseptic technique, appropriate attire and conduct, and sterile product compounding and documentation</li> <li>▪ Demonstrate accurate preparation of sterile products</li> <li>▪ Pass the aseptic technique testing kit (biannually in even years)</li> </ul> <p><b>Hazardous Medications</b></p> <ul style="list-style-type: none"> <li>▪ Describe hazardous drugs in the pharmacy, potential risks, and measures for protection</li> <li>▪ Recognize the purpose and describe the location of the Material Safety Data Sheets</li> <li>▪ Describe procedures for handling hazardous drug spills</li> <li>▪ Demonstrate accurate preparation of hazardous medications</li> </ul>	/	/
	B, QM	<p><b>7. Promotes education of patient and family regarding medications.</b></p> <ul style="list-style-type: none"> <li>▪ Demonstrate ability to provide patient education that is appropriate based on the patient’s age, level of development, level of functioning, and mental status</li> </ul>	/	/

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**EXAMPLE ORIENTATION CHECKLIST  
DECENTRAL PRACTICE**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

**A. Patient care**

- \_\_\_ 1. Demonstrate accurate processing and dispensing of new and demand medication orders
- \_\_\_ 2. Demonstrate accurate processing and dispensing of IVPB's and syringes
- \_\_\_ 3. Demonstrate accurate entry and dispensing of new and demand LVP's, and recite the policy for ICU's (adult and Peds) and step-down units
- \_\_\_ 4. Demonstrate accurate processing and dispensing of new potassium orders, and recite the policy for ICU's, step-down units and floors
- \_\_\_ 5. Demonstrate accurate processing and dispensing of PICU drips, maintenance fluids and specialty infusions as LVP's and syringes, as appropriate
- \_\_\_ 6. Demonstrate accurate processing and dispensing of NICU IV fluids and IV immune globulin.
- \_\_\_ 7. Demonstrate knowledge of vaccine dosing and proper order entry, documentation and dispensing (including OPV, IPV, HIB, HBIG, DPT, Hepatitis B vaccine)
- \_\_\_ 8. Demonstrate appropriate dosage form or product selection based on knowledge of patient age, growth and development, or condition
- \_\_\_ 9. Demonstrate the ability to differentiate neonatal drug products as compared to pediatric and adult products (strength, size, formulation)
- \_\_\_ 10. Demonstrate ability to document pediatric weight in the Clinstar computer
- \_\_\_ 11. Demonstrate accurate processing and dispensing of extemporaneous medications
- \_\_\_ 12. Demonstrate accurate order entry for predefined orders and routine order sets (e.g., post-partum, post open heart, etc.).
- \_\_\_ 13. Demonstrate accurate processing of non-formulary and manual entry orders (including oral extemporaneous products such as ketoconazole susp)
- \_\_\_ 14. Demonstrate accurate entry of tapering dose orders, including verification with nurses of start/stop date/time
- \_\_\_ 15. Demonstrate ability to correctly process and fill orders for 4 South antipsychotic medications
- \_\_\_ 16. Demonstrate the ability to screen TPN orders for basic information
- \_\_\_ 17. Demonstrate the ability to access prescriber's beeper numbers and on-call schedules
- \_\_\_ 18. Demonstrate understanding of the Core Inpatient Practice Responsibilities

**B. Procedures**

- \_\_\_ 1. Recite circumstances that permit revision of orders
- \_\_\_ 2. Recite circumstances that permit cancellation of orders
- \_\_\_ 3. Demonstrate proper procedure for preop orders
- \_\_\_ 4. Demonstrate the proper procedure for transferred and post-op patients
- \_\_\_ 5. Demonstrate proper procedure for missing medications and solutions \_\_\_ 6.  
     Demonstrate proper procedures for follow-up and report
- \_\_\_ 7. Demonstrate proper procedures for opening and closing satellite
- \_\_\_ 8. Demonstrate understanding of responsibility for and operation of code beeper

- \_\_\_ 9. Demonstrate operation/uses of the fax
- \_\_\_ 10. Identify location of all nursing units, as well as location of medication refrigerator, pharmacy pick up bin, etc. for each unit
- \_\_\_ 11. Recite hospital policy and employee's responsibilities in reporting medical emergencies to initiate the Resuscitation Team
- \_\_\_ 12. Demonstrate adherence to the "Responsibilities of the code team pharmacist" policy and procedure
- \_\_\_ 13. Demonstrate medication acquisition procedures (e.g., borrow/loan, non-formulary medications)
- \_\_\_ 14. Discuss medication counseling/ chart documentation requirements (
- \_\_\_ 15. Discuss the hospital policy for telephone orders and verbal orders (for emergency only) - USE TELEPHONE ORDERS
- \_\_\_ 16. Discuss Pharmacist on call policy
- \_\_\_ 17. Discuss hospital policy for administering medications (self-admin, home med, herbal med, qualified personnel)
- \_\_\_ 18. Multidose vial policy -discuss what can be reused and where, and underlying principles as to why an item can or can not be reused. Also discuss documentation requirements to date/time and initial.

**C. Target drug/Cost avoidance/ADR programs (pharmacists and residents only)**

- \_\_\_ 1. Demonstrate proper documentation of target drugs
- \_\_\_ 2. Demonstrate proper documentation of cost avoidance activities
- \_\_\_ 3. Demonstrate proper documentation of non-formulary drugs
- \_\_\_ 4. Demonstrate proper procedures to report an adverse drug reaction
- \_\_\_ 5. Demonstrate proper procedures for the target and non-formulary reports

**D. P.C. programs (pharmacists and residents only)**

- \_\_\_ 1. Demonstrate ability to access the Network and Drugdex
- \_\_\_ 2. Demonstrate ability to utilize the Baby-Code program (Ped and Neonatal) (run at least 3 patients)
- \_\_\_ 3. Demonstrate ability to trouble-shoot the computer

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

Evaluator signature \_\_\_\_\_ Date \_\_\_\_\_

## **EXAMPLE POLICY: MEDICATION ADMINISTRATION RECORD**

### **POLICY:**

The Medication Administration Record (MAR) is the official record of medication administration documented in the patient's medical record. Medication orders printed on the automated MAR are from the patient's medication profile, which is continuously updated by pharmacists and verified by nurses using prescriber's orders documented in the patient's medical record.

### **PROCEDURE:**

#### **A. Preparing the new AMAR**

1. The daily Automated medication administration records (AMAR's) will be each day. Pharmacy technicians will separate the report according to nursing unit.
2. Pharmacy technicians will deliver the AMAR's to the nursing units by 2300 each day.
3. The Clerical Associate (CA) or PCA will be responsible for assuring that each patient on the unit has a MAR (by checking off the census) and separating the AMAR's according to patient by 2400 each day. The NCR copies will not be separated at this time. The blank forms will be kept on file to use for new admissions (see section A-4).
4. If there is no AMAR for patient (i.e., new admission or transfer), the CA or PCA will addressograph a blank form, indicate the date it will begin (after midnight) and allergy information.
5. Medication orders for newly admitted patients which are not entered into the computer by the time ITS prints the AMAR's will not appear, and must be manually transcribed by the RN.

#### **B. Nursing reconciliation of new AMAR**

The RN on the evening shift will be responsible for reconciling the new AMAR with the previous MAR for his/her assigned patients prior to administration of medications. Allergies (ADR) and hand written orders on the previous day's MAR must be reconciled. The RN must also assure that all active orders are included and that discontinued orders do not appear on the new MAR (it is helpful to refer to the order number). If an order has been omitted, the RN will transcribe to order. (Orders received in the Pharmacy after the ITS AMAR print command will not appear on the new AMAR and must be transcribed as in section A-5). If an order has been discontinued, the RN will highlight the order, and write "D/C'd and his/her initials as described in E-3 below. After reconciliation, she/he will date and initial the orders on the left-hand side of the new AMAR, and will initial and sign the back of the MAR.

#### **C. Filing**

1. After all corrections have been made, the Pharmacy copy (the yellow copy) of the new MAR will be separated and placed in the Pharmacy pick-up bin for all patients (i.e., whether

or not corrections were necessary). The chart (white) copy will be placed in the MAR notebook (wards) or on the clipboard (ICU's and step-down units).

2. After reconciliation (see section B above), the evening shift CA or PCA will transfer the previous MAR to the patient's chart daily in non-critical care areas. In critical care areas, the MAR will remain on the clipboard for 3 days, then will be transferred to the chart. The MAR will be placed in the graphic chart section on the chart, and kept together and in order by date, with the most recent on top. The MAR is a part of the patient's permanent medical record.

#### **D. Pharmacy reconciliation**

The Pharmacy copy of the AMAR will be forwarded to the Pharmacy, and the pharmacist will make all corrections in the hospital pharmacy system. The subsequent AMAR, which is printed that evening, will contain the corrected orders.

#### **E. Medication Orders**

1. When a new order is written, the RN, CA or PCA will transcribe the order on the MAR; the nurse will sign off the order in the chart and date, time, and initial the order on the left side of the AMAR. The administration times will be designated according to the Pharmacy & Therapeutics Committee approved standard administration schedule policy and procedure (Rx-11-016). The nurse will indicate an "X" or "H" for scheduled medications in the appropriate hour column(s) to indicate when **future** doses will be due. (If the time of administration has passed, the nurse will not indicate an "X" or an "H" for that particular dose). "H" refers to administration on the half hour e.g. 0130).
2. Stats and prn orders will be charted on the prn sheet.
3. When an order is discontinued, the CA, PCA, or RN will draw a horizontal line through the drug order extending from the date to the end of the page using a highlighter pen, write "D/C," and initial, date, and time next to the "D/C" (e.g., 10/278/92 0900 VST). The RN will sign-off the order.
4. For sliding scale insulin orders, a Diabetes Treatment Record (DTR) will be initiated and placed in the MAR notebook. The date of the order, the frequency of accuchecks, the glucose ranges, and the prescribed insulin dose will be transcribed on the DTR, along with the RN's signature to verify that information is correct. The dose of insulin that is administered will be documented on the MAR along with the RN's initials in the box under the corresponding time of administration.
5. The patient's medication orders are continuously updated in the patient's medication profile in the hospital computer system by pharmacists.

#### **F. Charting**

1. After the medication is administered, the RN or PCA (LPN) will immediately chart on the MAR in the corresponding column for the time by initialing the box. If a dosage range has been ordered, the RN will also chart the dose of the medication, which was administered. If a diluent for an IVPB appears (ie., Dextrose 5%, Sodium chloride 0.9%), the RN will also chart

this as administered along with the piggyback medication. For sliding scale insulin, the dose administered will be documented on the MAR (see section E-4).

2. The RN will indicate his/her name on the back of the MAR by full signature, status and initials daily.
3. The RN may indicate injection site, IV push, piggyback, or syringe pump by using the codes provided on the bottom of the AMAR.
4. Medications not administered or variances (e.g., administered late) will be indicated by initialing the MAR, circling the initials, and completing the “medications omitted/variance and reason” section on the back of the MAR.
5. All charting is to be done in black indelible ink only.
6. The PRN reason or outcome is documented on the back of the MAR or the nursing notes.

**G. Computer non-operational**

If the hospital pharmacy system becomes non-operational, the CA, PCA or RN will manually transcribe the orders. The RN will sign-off the orders onto a manual MAR.

## **EXAMPLE: MEDICATION ORDER WRITING**

### **SCOPE**

Policy is applicable to all practitioners who write medication orders.

### **PURPOSE**

Medication order writing standards are used to increase communication among caregivers and to reduce variation and errors.

### **POLICY**

Standards for writing medication orders are used by practitioners at NFRMC. Pharmacists and nursing staff contact the prescriber to clarify orders that are unclear.

### **PROCEDURE**

#### **A. Writing Medication Orders**

1. Prior to writing any medication order, prescribers should verify that the medication is available on the formulary, if applicable.
2. The patient's medication profile and medical record (e.g., relevant laboratory values such renal and hepatic function, height and weight, age, pregnancy/lactation status, etc.) should be reviewed prior to writing any medication orders. This will decrease the likelihood of any drug-drug or drug-disease interactions. Practitioners should also verify patient allergy information and past sensitivities.
3. Only medications needed to treat the patient's condition are ordered.
4. Medication orders are written clearly.
  - a) Prescribers should review all drug orders for accuracy and legibility immediately after they have been written and prior to sending them to the pharmacy.
  - b) Care must be exercised when using decimal points.
    - (1) Never use a zero after a decimal point. Use 1 mg, not 1.0 mg, since the later may be misinterpreted as 10 mg.
    - (2) Always use a zero in front of a decimal point. Use 0.5 ml, not .5 ml, since the later may be misinterpreted as 5 ml.
    - (3) Avoid the use of decimal points whenever possible. For example, use 125 mcg instead of 0.125 mg.
  - c) Abbreviations should be avoided in all possible circumstances in order to improve patient safety and avoid medication errors.
  - d) Medication orders should be written in legible handwriting preferably printed.
  - e) Felt-tip pens and pencils should not be used to write medication orders.
  - f) Chemical drug names (6-MP, AZT) and investigational names should not be used when writing medication orders.

- g) Do not use any coined names for drug preparations or cocktails not commercially available (e.g., yellow bag, SMOG enema, GI cocktail, etc.) unless otherwise described in approved procedures. These types of orders should state exactly what the prescriber wishes the preparations to contain in order to avoid medication errors. (Note: “Magic Mouthwash” is an approved compound at NFRMC with procedures defining its ingredients).
- h) Drug names should not be abbreviated as they may not be recognized or they may be misinterpreted or confused with another similar abbreviation. For example MgSO<sub>4</sub> (magnesium sulfate) and MSO<sub>4</sub> (morphine sulfate). (Reference policy 900-2.210 Abbreviations, Unacceptable).
- i) Avoid vague directions such as “use as directed”.
- j) To minimize the opportunity for errors with look-alike and sound-alike medications, prescribers are encouraged to supply the indication for medications that look-alike and/or sound-alike. The use of preprinted orders when available is also encouraged.
- k) Use proper spacing when writing orders. For example, propranolol20mg can appear to read as propranolol 120 mg.
- l) Include all necessary suffixes (such as XL, EC, XR, etc.) in order to ensure that the intended dosage form is dispensed.
- m) The use of slashes (/) should be avoided in medication orders as they can be misread as ones.
- n) All weights and volumes should be expressed in the metric system. The apothecary system (grains, drams, minims) should not be used.
- o) Avoid prescribing the dose of liquids in terms of milliliters, if possible. Instead indicate the dose in milligrams (or as appropriate). As an example, acetaminophen (Tylenol) 5ml is an incomplete order, as the dose is not clearly indicated; the Tylenol is available in several concentrations.
- p) Write out the dose in numerals, if applicable. For example write “2 tablets” instead of “ii tablets”.
- q) Avoid ordering medications by their dosage form (1 amp, 1 vial, 1 tablet, etc.). The order is unclear if several strengths are available.
- r) Indicate the total dosage to be administered rather than mg/kg unless an approved procedure exists to further define these orders (for example, an approved procedure exists for enoxaparin [Lovenox] rounding doses). For pediatric patients, the order should include both the mg/kg and the total dosage.
- s) Use standardized administration times whenever possible. Reference policy 900.1-440.02 Standard Times for Medication Administration.
- t) Include the desired stop dates when applicable.
- u) Use hospital-approved preprinted order forms whenever applicable (e.g., heparin protocol, chemotherapy order form, parenteral nutrition order form, PCA order form etc.)

5. All medication orders should include the following:
  - a) Patient's name and medical record or account number
  - b) Patient's allergies or sensitivities
  - c) **Generic or brand name\*** and **dose\*** or **strength\*** of the drug.
  - d) Number of units
  - e) Dosage form of the drug
  - f) Directions on **route\*** and **frequency\*** or **rate\*** of administration
  - g) Duration of therapy (specify if it is a one time order)
  - h) These requirements also apply to orders for medication-related devices (e.g., nebulizers and catheters).
  - i) Signature of the prescriber with printed name if unclear
  - j) Date and time that the order was written
  - k) (Bolded items [also marked with an “\*”] indicate the minimum required for a medication order. Orders that do not contain these elements cannot be carried out until completed by the physician. Reference: Medical Staff Rules and Regulations, section D5)
  
6. PRN orders must include (1) Frequency and (2) Reason if not evident by the nature of the drug. For example: Acetaminophen (Tylenol) orders must indicate the PRN reason such as “for pain” or “for a fever or temperature > XXX”, whereas bisacodyl (Dulcolax) 10mg suppository PRN orders are considered self-evident.
  
7. Range Orders: Nurses, pharmacists and other care providers will apply the following guidelines for consistent interpretation of range orders. Orders that do not fall within these guidelines must be clarified with the prescriber.
  - a.) Orders indicating a **dosage** range will begin with the smallest dose being administered. If symptomatic relief is not obtained within a time frame appropriate for the medication, the remainder of the next higher dose may be administered. For subsequent doses, the total amount administered to obtain relief may be given.

Examples:

“Percocet 1-2 tablets every 4 hours as needed for pain” – the nurse may administer one tablet; if the patient’s pain is not relieved after 1 hour, an additional tablet may be administered. For subsequent doses, 2 tablets may be administered at the appropriate time interval.

“Morphine 2-4mg IV every 4 hours as needed for pain” – the nurse may administer 2mg; if the patient’s pain is not relieved after 30 minutes, an additional 2mg may be administered. For subsequent doses, 4mg may be administered at the appropriate time interval.

- b.) Orders indicating a **frequency** range will be interpreted as the shortest frequency being allowable for “as needed” orders unless it conflicts with the maximum daily dosage of that medication.

Examples:

Percocet-5 1 tablet every 4-6 hours as needed for pain” – doses may be administered as frequently as every four hours.

Hydrocodone/APAP 5/500 1-2 tabs po q4-6h prn – giving 2 tabs (1000 mg) 6 times per day (q4h) would exceed the recommended maximum acetaminophen dose of 4000 mg/day. In this case a message would be placed on the MAR, which indicates the maximum dose to administer.

8. Orders for continuous infusions include the following:
  - a) Initial dose if any
  - b) Dose in units/time: for example ml/hr or mg/kg/hr
  - c) Objective or measurable parameters by which to change or titrate the dose within a specified range (refer to number 11, below). Orders such as titrate morphine to comfort are not acceptable.
9. Cancellation of Previous Orders - All previous orders are canceled when patients go to surgery or are transferred to or from a special care unit. New orders must be written once a patient is accepted to a new unit. Orders for blanket reinstatement of previous orders (such as "resume pre-op meds" or "resume home meds") are not acceptable and must be clarified with the prescriber and new orders written.
10. Taper orders – Orders for tapering of medications must include the dosing limits for tapering the medication and the time factors required to achieve the desired clinical state for the patient. Tapering requirements for commercially available taper medications (e.g., Medrol DosePak® and Z-Pak®) will be detailed on the medication administration record with the medication dispensed in unit-dose packaging from the pharmacy department.
11. Titration orders - Orders for medications that require titration must include the desired state the prescribing physician wants for the patient (for example titrate medication to achieve blood pressure of \_\_\_\_/\_\_\_\_). Dosage adjustment increments must be known before titrating medication to allow clinical staff to determine how much to increase or decrease the medication as attempts are made to achieve "ordered state" for the patient. Titration increments may vary depending on the patient's clinical status, co morbid conditions and other factors. The frequency of dose adjustments will vary with upward and downward adjustments generally being unequal.
12. Hold orders: Hold orders must specify a specific time period or number of doses in which to hold the medication otherwise the medication order will be discontinued.
13. Do not order Herbal medications. Reference policy: 900-1.440-01
14. Investigational medications: An attempt will be made to continue a patient's participation in an investigational drug study when the patient is admitted to the hospital unless otherwise contraindicated. The Principle Investigator will be contacted to obtain information about the medication and to answer any staff questions. The patient's attending physician will order the continuation of the investigational medication once an assessment has been made that the patient should continue on the investigational drug. Reference policies: 900-1.441-01 Investigational Medications, 900-1.440.03 Use of Patient's Personal Medications.
15. The prescriber is expected to write his/her own medication orders. Verbal and telephone orders should be minimized whenever possible. Verbal orders should be reserved for emergency situations or when unglouing is unpractical. Reference policies: 900-1.431.02 Verbal/Telephone Orders, 900-1.431.01 Valid Medication Orders, 900-1.431-02 Patient Care Orders, Medical Staff Rules and Regulations.
16. Medications to be continued after discharge must be written as a prescription by an authorized practitioner following applicable state and federal regulations. Document discharge prescriptions written for the patient in the patient's medical record. Medications previously dispensed to the patient for hospital use are not given to the patient.

## **B. Contacting the Prescriber for Clarification**

If the medication order is written in such a way as to create a potential for medication error (such as incomplete, illegible, or unclear), or there are questions about the appropriateness or other circumstances that could have an adverse outcome on the patient, the nurse or pharmacist receiving the order is responsible for contacting the prescriber for clarification prior to administering / dispensing any doses of the medication. Reference policies: Medical Staff Rules and Regulations, Dispensing and Labeling of Medications 900-1.432.03, 900-1.440.000 Medication Administration and Documentation.

**C. Modification of Written Medication Orders**

- a. Orders should never be altered once completed.
- b. To revise an order that has already been sent to the nurse / pharmacy, a new clarification order should be written.
- c. If the order has not been sent to pharmacy, simply draw a single line through the error, write "void" or similar above the line and initial the order.
- d. Do not erase or use "White Out" in the medical record.

**D. Standing Orders**

- a. The medical staff must approve all standing orders. When implemented a notation must be documented in the medical record. For example, when the nurse implements the "Hypoglycemic Protocol" he/she writes a physician order to initiate the Hypoglycemic Protocol.
- b. Preprinted orders are approved by the Forms Committee and become patient specific orders when completed and signed by the prescriber.

**E. Special Populations**

- a. When writing chemotherapy or pediatric orders, dose/m<sup>2</sup> or dose/kg should always be used. In addition, the patient's weight and/or height and the total calculated dose should be included.
- b. Any chemotherapy or pediatric medication order should always be double-checked for calculation or dosing errors.

## **EXAMPLE: MEDICATION PURCHASING**

### **PURPOSE:**

To establish written guidelines for purchasing and inventory control.

### **SCOPE:**

This is a departmental policy and procedure applicable to the Pharmacy Department.

### **BACKGROUND:**

This hospital uses a prime vendor in contracting and wholesaler depot to ensure a strong negotiating position for subsequent contracts and continuing improvement in quality, services and profit.

### **POLICY:**

The Pharmacy Department is responsible for the purchasing of all pharmaceuticals for the hospital and ensures all products purchased are FDA approved and have been purchased from manufacturers that adhere to the Good Manufacturing Practices standards. The hospital primarily purchases from a prime vendor following GPO contract pricing.

#### Group Purchasing Organization

The Group Purchasing Organization (GPO) is responsible for selecting drug products and soliciting bid prices for products awarded. These decisions are based on many factors, with quality and price being considered. The hospital's contract compliance goal is 98%.

#### Individual/Direct Manufacturer Contracts

The hospital occasionally requests an individual bid with a manufacturer. Usually, this occurs when the Pharmacy Department reduces the number of drug products on the formulary in a selected class. The hospital verifies all products purchased from manufacturers, not included in GPO contracts, are FDA approved and the manufacturer adheres to the Good Manufacturing Practices standards.

### **Prime Vendor**

The hospital will purchase from the primary wholesaler. Contract information and pricing are confidential and never disclosed to non-hospital employees.

### **Product Quality**

The corporate office maintains verification of product quality for each product contracted with the GPO. Manufacturers/vendors certify all products submitted pursuant to their contract proposal have been manufactured and packaged by the Manufacturer/Vendor under all the rules and regulations set forth by the United States Department of Agriculture, Food and Drug Administration, and have met all U.S.P. regulations and standards. All offers for multi-source pharmaceuticals must include the "Orange Book" ratings (current edition) for bioequivalence for each line item included in their proposals.

### **Purchasing Procedures**

Inventory ordering forms are used for direct order frozen and refrigerated items. All other items are ordered by entering item purchasing number and quantity into hand-held device. The information from the hand-held device is uploaded into the prime vendor's ordering software on the Buyer's computer. The Buyer prepares the order by evaluating bioequivalent, less-expensive alternatives for all items ordered.

#### Buyer Notification of Needed Items

- ❑ The Buyer evaluates the max and par levels for all items on the shelves on a daily basis. The max and par levels are periodically adjusted based on usage.
- ❑ The pharmacy will document necessary information on the Buyer ordering request form

- including patient name, drug name, dosage form, strength and quantity.
- Nursing staff request approved floorstock items by filling out a requisition form and forwarding it to the Buyer. (*Floorstock Procedures*)

### **Ordering Days**

Orders are placed Monday through Friday. Deliveries occur on Monday through Friday. Emergency shipments can be obtained the same day or on Saturday if needed. Controlled substances are routinely ordered for weekday delivery.

### **Payment Procedure**

The prime vendor sends an invoice with each shipment received by the Pharmacy Department. The Buyer compares the invoice to the purchase order, created during the ordering process, for accuracy. The invoice and purchase order is then forwarded to the Director of Pharmacy for signature approval. Once approved, the invoice and purchase order are forwarded to Accounts Payable for payment. The same process occurs for non-prime vendor items received.

### **Receiving Procedures**

Each item is received by scanning the product bar code using the prime vendor supplied hand held device. The invoice is signed and dated by the Receiving Technician and forwarded to the Buyer. Two separate individuals perform the purchasing and receiving tasks. Product is rotated such that the earliest expiration dated product is used first.

### **Product Expiration Monitoring**

All items are inspected at least quarterly for expired products. All expired products are placed in the Quarantine Area for the Reverse Distributor. (Reference Policy #900-1.432.01 Storage of Medications).

## EXAMPLE: DRUG STORAGE

### PURPOSE

To ensure consistency and appropriateness of medication storage

### SCOPE

This is a hospital-wide policy, which applies to all areas where medications are prepared or stored

### POLICY

All drugs and biologicals are stored properly with respect to temperature, light, humidity, and sanitary conditions. Policies and procedures are designed to ensure the safe and secure storage of medications throughout the hospital.

### PROCEDURE

1. Acquisition: The Pharmacy Department is responsible for the acquisition of pharmaceuticals for the hospital. Only those medications approved by the Pharmacy and Therapeutics Committee for use will be routinely stocked and stored. (Reference policy 900-1.430.100, Formulary Process)
  - Medications for distribution to patient care units are provided in the most ready-to-administer form available, in prepackaged patient unit doses whenever possible. (Reference Floor Stock Policy 900-1.432.06, Dispensing and Labeling of Medication Policy 900-1.432.03).
  - All medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates and appropriate warnings. (Reference policy 900-1.432.03. Dispensing and Labeling of Medications)
2. Storage: Medications are stored under proper conditions as stated by the medication manufacturer to assure stability of that medication.
  - **Refrigerators** intended for drug storage will be monitored daily by authorized personnel to ensure the correct temperature range. A record of monitoring will be posted on or near each refrigerator. If the temperature is below or above the acceptable range, the engineering department will be contacted immediately to evaluate the refrigerator. This should be recorded on the monitoring sheet. The refrigerator will be lockable if in an unsecured area. Refrigerator temperatures are kept between 2 and 8 degrees C (36 and 46 degrees F).
  - **Freezer** temperatures for drug storage are kept between –20 and –10 degrees C (-4 and –14 degrees F).
  - Controlled **room temperature** for drug storage is kept between 68 and 77 degrees F.
  - **Warmer** temperatures should remain 104 degrees F or less. IV solution, irrigation solutions and water or saline pour bottles are dated when placed in the warmer and stock is rotated so the oldest product is always in front. When the expiration date (see below) is reached these products must be removed from the warmer and identified as being warmed. They cannot be placed back in the warmer, however, can be used until the manufacturer's expiration date on the container.
    - IV solution and irrigation solutions – 14 day expiration date
    - Water and saline pour bottles for irrigation – 72 hours
  - Refer to expiration dating of Multidose Vials and Medication Containers (IC-134) policy

- IV and irrigation solutions taken out of their overwrap containers have a shorter expiration date due to solution evaporation.
    - Solution volume less than or equal to 50ml – 15 days
    - Solution volume greater or equal to 100ml – 30 days
3. **Security:** Medications are stored in a secure manner either locked or with a tamper evident seal (emergency medications), or under constant surveillance by authorized staff.
- Medicinal drugs and drug preparations are stored within the confines of the pharmacy. Access is limited to authorized personnel. A pharmacist is available in the hospital pharmacy 24 hours a day, 7 days a week.
  - Pharmacy personnel while in the pharmacy shall accompany all non-pharmacy personnel authorized admittance to the pharmacy. All deliveries or pick-ups, environmental service personnel, or representatives from service contracts (e.g. McKesson, Laminar Airflow Hood Certification, etc.) may be permitted to enter the pharmacy when authorized by pharmacy personnel after proper identification. The individual shall be in observation sight of pharmacy personnel at all times while in the pharmacy.
  - Lockable medication carts are used to store unit-of-use medications in the patient medication dose system. These carts will be locked when not under constant surveillance.
  - Medication rooms on patient care units used for storage of floor stock medications will remain locked or under constant supervision by authorized personnel. Access is limited to pharmacy, personnel authorized to administer medications, and those competent to handle medications. Others granted access to drug storage areas (such as environmental services or facility personnel) shall be in observation sight of the authorized personnel at all times.
4. **Safety:** Medications are stored in a manner to prevent medication errors.
- Medications stored in the Pharmacy Department will be stored first by category, i.e. injectable, topical, oral, then alphabetically to reduce the likelihood of dispensing errors.
  - High-risk drugs and drugs with a higher potential for dispensing error due to look-alike/sound-alike names, will be stored in a different color bin and labeled with a secondary caution label thereby alerting staff for the necessity of taking additional dispensing precautions.
  - Concentrated electrolytes will not be routinely stocked in nursing areas. Only sodium chloride in Dialysis and potassium chloride in OR for heart trays will stock concentrated electrolytes. These products will be stored in a separate container, display a cautionary label to prevent inadvertent administration and will be refilled by pharmacy personnel only.
- **Inspection:** Pharmacy personnel will inspect all drug storage areas within the hospital at least quarterly. A report of inspection will be maintained by the Pharmacy Department. Reports of discrepancies will be shared with the supervising professional of the unit involved. A copy of all discrepancies will also be forwarded to the Pharmacy and Therapeutics Committee.
    - Medications which are unused and discontinued or expired are returned to the pharmacy.
    - Expired, damaged and/or contaminated medications will be stored in a quarantine area in the Pharmacy that has been designated for the storage of such unusable drugs. The drugs shall remain there until proper disposal or pick up can be made. (Reference policies: Dispensing and Labeling of Medications 900-1.432.0, and 712-1.05.20 Hazardous Waste and Disposal)

## **EXAMPLE: PREPARATION AND DISPENSING**

### **PURPOSE**

Medications are prepared safely.

### **SCOPE**

This is a hospital-wide policy that applies to all areas where medications are prepared.

### **POLICY**

Wherever medications are prepared staff follow procedures designed to ensure patient and staff safety, and minimize errors.

The Pharmacy & Therapeutics Committee is responsible for oversight of Medication Use; ordering/prescribing, preparation/dispensing, administration, and monitoring. All policies concerning use of medications are reviewed and approved by the Pharmacy & Therapeutics Committee. Applicable policies are available to staff in area where medications are prepared.

Conditions and preparation of the work area are clean, uncluttered and functionally separate to minimize opportunity for contamination. Devices used in medication preparation (such as tablet splitting devices or mortar and pestles for crushing medications) are cleaned after each use whenever the device comes in direct contact with the medication.

Staff uses properly functioning equipment.

Staff is competent to perform the medication preparation.

Products used are within their beyond use or expiration date.

Clean or aseptic technique is used as appropriate. The pharmacy compounds all sterile medications, intravenous admixtures or other drugs except in emergencies or when not feasible (such as short stability compounds).

The staff that prepares the medication and the checking pharmacist, if applicable, visually inspects the integrity of medications.

Standardized labeling and documentation is used to minimize errors. Medications not administered immediately must be labeled with the drug name, strength, amount (if not readily apparent by the container), and expiration or beyond use date if not used within 24 hours. Additionally, if the person preparing the medication is different from the person administering the medication the label also includes the patient name, location, and any directions for use and any cautionary statements (such as "do not refrigerate"),

Staff has access to current drug information and the HOSPITAL Formulary.

Staff adheres to applicable laws, rules and regulations.

## **EXAMPLE: DISPENSING AND LABELING OF MEDICATIONS**

### *PURPOSE*

When medications are dispensed important information is considered. Medications are safely dispensed and appropriately labeled. Medication dispensing complies with state and federal laws.

### *SCOPE*

This is a hospital-wide policy applicable to all departments.

### *POLICY*

Medications are appropriately labeled.

Medications are dispensed in a timely manner to meet patients' needs (reference policy 900-1.437.02 Standards for Stat, Emergency and Priority Orders)

Medications are dispensed in quantities which minimize diversion.

Dispensing is consistent with State and Federal regulations and standards of practice.

Medications dispensed which are not used are returned to the pharmacy for proper disposition.

## **PROCEDURE**

### *LABELING*

A standardized labeling process is used to ensure labeling requirements are met and to minimize opportunities for error.

- a. Unit dose containers contain the following minimum information (reference policy 712.1-17.10 prepackaging, labeling, & bulk compounding, FL regulations 64F-12.006): medication name, strength, dosage form, manufacturer & lot number, beyond use/expiration date.
- b. Medications are labeled at a minimum with
  - i. medication name,
  - ii. strength
  - iii. amount (if not apparent from the container)
  - iv. expiration date when not used within 24 hours
  - v. expiration time when expiration occurs in less than 24 hours
- c. Compounded IV admixtures and TPN solutions include the date prepared and the diluent (reference policy 900-1.432.500 IV Admixture Service)
- d. Medications prepared for multiple patients or when the person preparing the medication is not the person administering the medication the label must include:
  - i. Patient name
  - ii. Patient location
  - iii. Directions for use and any applicable cautionary statements either on the label or attached as an accessory label (for example, "requires refrigeration", for IM use only")
- e. Multi-dose patient specific medications are labeled with the patient's name and location.
- f. Any time medications are prepared but not administered immediately, the medication container is appropriately labeled.
- g. The label for sterile products contains an expiration/beyond use date when the medication

is not used within 24 hours or when the expiration/beyond use date is less than 24 hours.

- h. Special labeling requirements include:
  - i. Methemoglobinemia warning when used in infants/children with Hurracaine/Cetacaine spray

## **DISPENSING**

Medications are dispensed from the pharmacy pursuant to a physician order. In general no more than a 24-hour supply is dispensed at one time unless the product is only available as a multi-dose container (such as creams, ointments, inhalers, eye and nose preparations, etc.). All “manual pick” and compounded preparations are verified by a pharmacist prior to dispensing. Ten percent of “robot fills” based on the cart fill process is validated by pharmacist.

Medications are dispensed in a ready-to-use form whenever possible.

A unit dose drug distribution system is used within the hospital. The pharmacist maintains a medication profile. Pharmacists review all orders and assess appropriateness for all ages of patients regarding dose, allergies, interactions, and therapeutic duplications.

A pharmacist will review all medication orders prior to medication access or administration by the nurse unless the following exceptions apply:

- a. Emergency situations that require immediate treatment of the patient (e.g., severe acute pain, hypertension, hypotension, arrhythmias, anaphylaxis, seizures, vomiting, etc.).
  - ◆ The medical record must contain documentation of the emergent situation.
  - ◆ Only a single dose may be removed prior to evaluation of the order by the pharmacist unless repeat doses are necessary to immediately manage the initial emergent situation and waiting for the pharmacist review would be detrimental to the patient.
- b. When a licensed independent practitioner (e.g., licensed physician) controls the ordering, dispensing and administration of the medication. The following areas meet this requirement at all times: Emergency Department, OR, PACU, Radiology, Cath lab, Endo.
- c. Over the counter medications with a low risk of adverse effects and with a low opportunity for pharmacist intervention (e.g., diaper cream, bisacodyl suppository, milk of magnesia, glycerin suppository, etc.) will be available in specific patient care areas.

Medications which are unused and discontinued or expired are returned to the pharmacy. The pharmacist is responsible for determining which medications may be placed back into stock. The medications determined to be unusable or expired are quarantined.

- a. Quarantined medications are either returned to the manufacturer or wholesaler, if applicable, or given to a Reverse Distributor. The Reverse Distributor manages returns and/or assures proper destruction.
- b. Hazardous medications are placed in a hazardous container and destruction is outsourced to an authorized waste company.
- c. Non-hazardous and diluted medications may be wasted (usually in a sink).
- d. Reference policy 712-1.05.10 Hazardous Waste and Pharmaceutical Disposal
- e. Medications dispensed for the patient in the hospital shall be returned to the pharmacy for proper disposition or disposed of on the unit as appropriate (such as partially used multiple dose items may be discarded on the unit). Medications previously dispensed to the patient for hospital use shall not be given to the patient for use out of the hospital.

## **EXAMPLE POLICY: MEDICATIONS FROM HOME**

### **PURPOSE**

To define the selected circumstances and procedures to follow when it is appropriate for a patient to use his/her own medication(s) from home to avoid interruption of therapy.

### **SCOPE**

This is a hospital-wide policy and procedure applicable to all established departments.

### **POLICY**

The nursing and pharmacy staff in collaboration with the medical staff is responsible for ensuring the security and appropriate use of medications brought into the hospital by patients.

In situations where it is necessary for patients to bring medications from an outside source to be administered by our staff, it is vital that we ensure, to the best of our ability, the identification, integrity and stability of the medication being administered.

It is not permissible to utilize a medication from home when the medication is available from the hospital pharmacy.

Dietary supplements are not FDA approved medications. Refer to policy 900-1.432.05.

When patient personal medications are to be administered during the hospital stay, the physician must write a specific medication order (i.e., drug name, strength, route, frequency, etc.) and indicate that the patient may use his/her medication supply in the order (such as “may use own medications” or “may use home supply”).

The patient’s personal medications must be identified prior to administration.

The patient will sign a Personal Use of Medication Waiver (refer to attachment).

The medications must be properly secured in the patient care area (e.g., in the medication cart). Medication administration is according to hospital procedures. The nurse may administer or supervise the administration of the medication and document accordingly.

### **PROCEDURE**

- I. The nurse should assess the availability of patient personal medications at the time of the admission assessment, which includes a medication history.
- II. When patient personal medications are NOT to be administered during the hospital stay:
  - A. Efforts should be made to give the patient’s personal medications to a family member or responsible guardian.
  - B. Medications not returned to the patient’s home should be maintained under secure conditions in the inpatient Pharmacy and returned to the patient at discharge. The pharmacy will destroy unclaimed medications 30 days after discharge.
    1. The nurse will take the patient’s medications to the inpatient pharmacy.
    2. A pharmacist will verify the medications.
    3. The nurse and the pharmacist will complete a patient’s valuables deposit slip noting the corresponding valuable pak number on the slip.
    4. A copy of the deposit slip will be given to the nurse to place in the medical

record. This will be used to reclaim the prescriptions when the patient is discharged.

5. The medications and the valuables slip will be placed inside the tamper proof valuable bag and sealed by the pharmacist.
6. The "Patients' Personal Medications from Home log will be completed by the pharmacist.
7. Upon discharge, the nurse will claim the patient's personal medications from the inpatient pharmacist by presenting the copy of the patient's valuables deposit slip.
8. The nurse will sign the "patients' personal medications from home log".
9. A log will be maintained in the pharmacy to document the final disposition of medications brought into the hospital by patients (see attached patients' personal medications from home log). Records will be maintained for 2 years.

III. When patient personal medications are to be administered in the hospital:

- A. The physician must write a specific order for each medication.
- B. A physician or a pharmacist must identify the medication prior to administration. The identification process includes visually examining the product to verify its integrity.
- C. The identification of the medication must be documented in the medical record.
- D. Information about the medication must be available in the facility.
- E. The patient will not be charged for the medication.
- F. The nurse will complete the "Use of Personal Medication Waiver" form and obtain the patient's signature on the form. The form will be kept in the patient's medical record.
- G. If the medication is deemed unusable (e.g., improper labeling, expired, deteriorated, etc), conversion to a formulary medication or anticipated delay in therapy will be discussed with the prescriber. The unusable medication will be stored in the pharmacy following pharmacy's patient medication procedures.
- H. For patients admitted with medication in process (e.g., Fentanyl patch, Insulin pump, etc.), the product will be replaced by one supplied by the hospital as soon as possible. A physician order is necessary.
- I. For specialty-compounded medications that are not available from the hospital pharmacy, the decision whether to continue the medication will be made after consultation between the physician and the Director of Pharmacy or designee.
- J. For investigational medications, every attempt must be made to contact the primary investigator or designee to verify the identity of the medication and obtain and affix to the medical record a copy of the following:
  - a. Copy of the signed informed consent
  - b. Drug information related to the study
- J. Nursing staff will continually assess whether the patient medication supply is an adequate amount to last while the patient is in the hospital. When the supply is running low, the patient's family or responsible guardian should be contacted to obtain an additional supply. The new supply must be identified as described above. If an additional supply cannot be procured, the nurse, pharmacist and physician should collaborate on options to assure optimal patient care PRIOR to running out.

## USE OF PERSONAL MEDICATION WAIVER

I, \_\_\_\_\_, request permission to use my own personal medications.

I have written its name, how often I use it, and why I use it below:

Medication Name and Dose	How often I Use It	Reason for Use

Since I am requesting that I be allowed to take this medication, I acknowledge the following being true:

- I have not altered the contents and have stored the product correctly according to the instructions that were provided to me.
- The quantity supplied by me is enough to last during my hospitalization.
- I have discussed my request with the physician who will be caring for me during my hospital stay and have received his/her approval of my request.
- I release the hospital, its personnel and the attending physicians from any responsibility or liability for any injury or unfavorable reactions due to this action. I understand the potential risks and consequences of using my own medications.

I will be taking the medication myself according to the hospital's self-administration of Medication policy.

Hospital personnel will administer the medication.

If for any reason, the pharmacist determines that the medication is not suitable for administration or if your physician is concerned about possible interferences of the medication with disease progression or treatment of the disease process, use of the medication will not be allowed and/or will be discontinued.

\_\_\_\_\_  
Patient/guardian/proxy signature

\_\_\_\_\_  
Patient's printed name

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

## **Policy and Procedure Manual In the Nursing Home**

**1. What is a policy and procedure manual?**

*The P&P manual is a facility specific document that spells out all facility policies and procedures involving the ordering, storage, administration, documentation and distribution of medications in the facility*

**2. Who is responsible for developing the manual?**

*The Consultant Pharmacist oversees the policies and procedures in the facility but these policies are reviewed and approved by the facility's Quality Assessment and Assurance Committee. The vendor Pharmacy is often the party that actually prepares, prints and distributes policies within the facility. Therefore, the Consultant Pharmacist must work closely with the vendor pharmacy and the QAA committee to ensure that policies truly reflect policies in use at the facility.*

**3. Why are they necessary?**

*The policy and procedure manual establishes standards of practice in the facility and should standardize these procedures for all nursing staff. This manual is an important tool for training new nursing personnel and agency nurses that have questions about procedures within the facility*

**4. What is the approval process for implementing a new policy?**

*A new policy (or a change in current policy) should be discussed with the Director of Nursing, the Charge nurses, the vendor pharmacy and possibly the Medical Director before the policy is implemented. Once there is consensus on the policy either the vendor pharmacy or the Consultant will prepare the final document. This new or changed policy is usually presented to the QAA committee for final approval however the facility administration may elect to implement a policy change immediately. Nursing staff should always be notified (either by memo or inservice) of policy changes prior to the implementation date.*

**5. How often should policies be reviewed?**

*Policies should be reviewed frequently to ensure that they reflect actual practice within the facility. Regulations require that the policy and procedure manual be reviewed at a minimum once each year and further requires that key staff sign off on their review. (See next page for sample of how this is accomplished)*

**6. As a minimum what policies should be included?**

*See sample index of a nursing home policy and procedure (later in this chapter)*

**SAMPLE POLICY & METHODS**

**Authority of Policies and Methods**

The Quality Assessment & Assurance Committee of SAMPLE Nursing Home is responsible for establishing pharmacy policies in this facility and has reviewed and approved the enclosed policies and methods

\_\_\_\_\_  
Administrator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Director

\_\_\_\_\_  
Director of Nursing

\_\_\_\_\_  
Consultant Pharmacist

\_\_\_\_\_  
Vendor Pharmacist

***(Note: This sample cover sheet will be signed at least annually by each of the persons listed above. This signature documents that the policies have been reviewed. Most policy and procedure manuals also have a "Review Date" on each page. These review dates should also be updated at least annually even if all policies remain the same.)***

SAMPLE  
**MODEL PHARMACY POLICY & PROCEDURE MANUAL**  
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**SAMPLE**  
**PROVIDER PHARMACY - REQUIREMENTS**

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

**PROCEDURES**

- 1) The Facility maintains a written agreement with the provider pharmacy (Appendix 3), signed by the administrator and an authorized representative of the provide 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.
- 3) The provider pharmacy agrees to perform the following pharmaceutical services including, but not limited to:
  - Assisting the facility, as necessary, in determining the appropriate equipment and packaging to meet the medication needs of the residents and the facility.
  - Accurately dispensing prescriptions based on authorized prescriber orders.
  - Providing medications packaged in accordance with the facility's needs and equipment requirements.
  - Supplying only USP and NF approved medications, biologicals and supplies, other than extemporaneously compounded medications or investigational new drugs.
  - Labeling all medications dispensed in accordance with all applicable laws.
  - Providing routine and timely pharmacy service (7) days per week and emergency pharmacy service 24 hours per day, seven days per week.
  - Maintaining a medication profile on each resident which includes all medications dispensed and facility provided information on the resident's age, diagnoses, weight, condition, medication allergies, diet and any other pertinent information.
  - 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, interval and route of administration, based on resident and other pertinent variables. If diagnosis or indication is not available, notifying the nursing staff of the need to obtain the information from the prescriber prior to administering the drug.

**SAMPLE POLICY & METHODS**

**Purpose of this Policies and Methods Manual**

The purpose of this pharmaceutical services policies and methods manual can be summarized as follows:

- 1) To standardize safe and effective methods for the use and control of drugs in the facility so everyone does the same thing.
- 2) To serve as a guide for the training and orientation of new employees.
- 3) To prevent errors resulting from the oral transmission of a policy from one employee to another.
- 4) To reduce the need for direct supervision by providing a clearly described procedure for each task performed.
- 5) To serve as a means of evaluating the quality of drug related services provided to our patients.

**SAMPLE POLICY & METHODS**

**Emergency Telephone Orders**

The following is a list of emergency telephone numbers to be used in emergency situations such as the need for medications after hours when needed immediately:

Sample Pharmacy .....	824-6511
Sample Pharmacy (jim)	829-5315

The following are numbers of the poison control centers in the area:

Florida Poison Information Center/Jax @  
University Medical Center, Jacksonville  
Telephone: 904/549-4480

Florida Poison Information Center/Tampa @  
Tampa General Hospital, Tampa  
Telephone: 904/251-7044

**Store Hours:**

Daily:	8:30 am to 9:00 pm
Sunday:	10:00 am to 9:00 pm
Closed:	Christmas
	New Years Day
	Easter
	Fourth of July

**SAMPLE POLICY & METHODS**

**Adverse Drug Reactions**

**POLICY:**

Any unusual or unexpected reaction to a drug shall be called an adverse drug reaction. The reaction shall be immediately reported to the physician.

**METHOD:**

An incident report shall also be completed and forwarded to the director of nursing. After appropriate investigation as described in the incident procedures, the consulting pharmacist shall be informed.

The consultant pharmacist shall present this adverse drug reaction case for discussion at the next pharmaceutical services committee meeting. If appropriate, the committee may direct the pharmacist to present this information to the FDA adverse drug reporting program.