

Best Practice of Medication Reconciliation

- A resident's home medication was recorded as Coreg[®] 25 mg twice a day on the admission order sheet when the patient was actually only taking 6.25 mg twice a day at home. The patient received 4 doses of the excessive strength and developed leg edema. A leg ultrasound test was ordered to rule out deep vein thrombosis before the error was discovered.
- A resident had been taking propranolol 20 mg/5 mL twice a day, but the admitting orders were written as propranolol 20 mg/ mL give 5 mL (which equates to 100 mg) twice a day. The patient received five doses of the 100 mg strength before the error was discovered.
- Discharge orders listed glucophage 500 mg, 1 tablet twice a day. A nurse transcribed the order as glucophage 500 mg daily on MAR. Several days later, the resident was readmitted to the hospital with a blood sugar level of 387, chest pain, shortness of breath, and atrial fibrillation with a rapid ventricular response. The resident was upset and told hospital staff that the "facility nurse changed my medications." The resident required sub-shock insulin to achieve normal blood glucose levels and was placed back on the twice-a-day dosing schedule.
- After being discharged, the resident returned to the emergency department several days later complaining of shortness of breath. Hospital staff found discharge prescriptions for antibiotics were never given to the resident.
- A resident's Primidone[®] (barbiturate for epilepsy) was discontinued during the resident's hospitalization and not renewed upon discharge to the facility. The resident later experienced 3 grand mal seizures while at the facility.

What the regulations say about Medication Management and the Frequency of citations in ALF/RHCF in calendar year 2011

KAR 26- (41,42,43)-205 Medication Management

3200 = 23

(d) Facility administration of resident's medications. If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations. The administrator or operator shall ensure that all of the following are met:

(1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.

(2) Medication aides shall not administer medication through the parenteral route.

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3201 = 8

(3) A licensed nurse or medication aide shall perform the following:

(A) Administer only the medication that the licensed nurse or medication aide has personally prepared;

(B) identify the resident before medication is administered;

(C) remain with the resident until the medication is ingested or applied; and

(D) document the administration of each resident's medication in the resident's medication administration record immediately before or following completion of the task.

If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.

3202 = 3

(4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.

3210 = 0

(e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order.

(f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident's medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications.

3212 = 0

(g) Ordering, labeling, and identifying. All medications and biologicals administered by licensed nurses or medication aides shall be ordered from a pharmacy pursuant to a medical care provider's written order.

(1) Any resident who self-administers and manages personal medications may request that a licensed nurse or medication aide reorder the resident's medication from a pharmacy of the resident's choice.

3213 = 0

(2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14.

3211 = 1

(3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer's package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer's

package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer's medication package and the medication container.

3214 = 4

(4) Licensed nurses and medication aides may administer sample medications and medications from indigent medication programs if the administrator or operator ensures the development of policies and implementation of procedures for receiving and identifying sample medications and medications from indigent medication programs that include all of the following conditions:

(A) The medication is not a controlled medication.

(B) A medical care provider's written order accompanies the medication, stating the resident's name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions regarding administration.

(C) A licensed nurse or medication aide receives the medication in its original, unbroken manufacturer's package.

(D) A licensed nurse documents receipt of the medication by entering the resident's name and the medication name, strength, and quantity into a log.

(E) A licensed nurse places identification information on the medication or package containing the medication that includes the medical care provider's name; the resident's name; the medication name, strength, dosage, route, and frequency of administration; and any cautionary instructions as documented on the medical care provider's order.

Facility staff consisting of either two licensed nurses or a licensed nurse and a medication aide shall verify that the information on the medication matches the information on the medical care provider's order.

(F) A licensed nurse informs the resident or the resident's legal representative that the medication did not go through the usual process of labeling and initial review by a licensed pharmacist pursuant to K.S.A. 65-1642 and amendments thereto, which requires the identification of both adverse drug interactions or reactions and potential allergies. The resident's clinical record shall contain documentation that the resident or the resident's legal representative has received the information and accepted the risk of potential adverse consequences.

3215 = 13

(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.

(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.

(2) Each resident managing and self-administering medication shall store medications in

a place that is accessible only to the resident, licensed nurses, and medication aides.
(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility.
(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration.

3216 = 1

(i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.

(1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations:

(A) Two licensed nurses; or

(B) a licensed nurse and a licensed pharmacist.

(2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations:

(A) Two licensed nurses;

(B) a licensed nurse and a medication aide;

(C) a licensed nurse and a licensed pharmacist; or

(D) a medication aide and a licensed pharmacist.

3217 = 0

(j) Medications sent for short-term absence. A licensed nurse or medication aide shall provide the resident's medication to the resident or the designated responsible party for the resident's short-term absences from the facility, upon request.

3220 = 2

(k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the facility manages medication or prefills medication containers or syringes contains the following documentation:

(1) A medical care provider's order for each medication;

(2) the name of the pharmacy provider of the resident's choice;

(3) any known medication allergies; and

(4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident.

Step 1: Policies and Procedures

Each facility should have policies and procedures that outline the roles, tasks, and steps in the medication management process that include

- protocol for where medication information is kept
- protocols for accurate monthly review of orders and MARs

- process for transcribing and verifying staff to sign or initial the order sheet and the MAR to establish the identify of who completed the transcription and verification process
- Assignment of responsibility for resolving variances in medication orders to someone with sufficient expertise.
- specified time frames within which medications should be reconciled

Step 2: Address areas of High Risk

Admission/transfer/readmission

Admission from home

- Reconcile new orders with past medication
 - o Compare labels of all medications brought from home, including OTCs with orders
 - o Clarify discrepancies

Transfer from another facility

- Review copy of MAR, transfer form and physician order sheet -- do not rely solely on transfer form;
 - o Verify physician signature for orders

Readmission after hospitalization

- Compare transfer orders and information with previous medical record (MAR, POS) and clarify any discrepancies
 - o Do not administer previously ordered medications without a renewal order

New orders

Telephone orders

- Licensed nurse prepared to provide resident name, age, sex, weight, diagnoses, drug and food allergies, all current medications, recent signs and symptoms and recent lab data and listen and write down orders on appropriate document and read back to prescriber
 - o Fax telephone orders to prescriber for review and signature

Written orders

- May be hand written, computer generated or faxed
- Should include
 - o Resident's first and last name
 - o Date and time order written
 - o Full name of medication, dose, route, time of administration, and related diagnoses/indication and duration if appropriate – avoid abbreviations
 - o Note illegible, incomplete or questionable orders and get clarification immediately before transcribing or dispensing medication
 - o Fax original documents – not copies

Transcription of orders for medication

- Nurse enters complete order on MAR; consider review by 2nd nurse review within 24 hours

Receipt of medications at facility

- Match medication with corresponding records
- Properly safeguard medication

Administration and documentaton

Medication administration

- 6 rights – resident, medication, dose, route, time and documentation
 - o Staff education
 - o Approved abbreviations
 - o Initials and signatures to verify notations
- New medication – check POS to confirm accuracy before administering 1st dose; read and compare label

Controlled drugs

Additional steps to consider

- Consider having separate order for all controlled medications (not with other refills)
- Consider having nurse receive all controlled, check seal intact, note receipt in entry logbook
- One nurse responsible for putting controlled drugs in cart/med storage
- Consider having log to count all sheets so bubblepacks cannot be diverted along with sheets – nurse to add to count when drugs are added to carts
- Nurse removes drugs for destruction and update sheet count
- Keep destruction log
- Match all completed count sheets (drugs used up or destroyed) with entry log

Step 3: Follow up and Accountability

Establish policy and procedure for review and follow up:

- What will the surveyor look at?
- How will you determine that your policies and procedures are being followed?
- How address medication errors
- Ongoing education of staff