

## MEDICATION PASS REVIEW

OBRA initiated the observation of a medication pass process in the early 1990's. They identified the consultant pharmacist as the person responsible for teaching the nursing staff at long term care facilities. This process is to assess the entire system a facility utilizes from the time the medication order is received through the resident consuming the medication.

Excerpts from the interpretative guidelines for surveyors:

"Drugs are administered in accordance with written orders of the attending physician."

1. Was the drug administered according to the physician's orders? strength? route? valid order? correct drug?
2. Are there orders for drugs which should have been administered but were not? omitted doses?

The surveyors should be minimally interactive. If at anytime the process is intrusive and you feel it is a distraction, which could lead to an error, then close the cart and describe the situation with your supervisor. There have been reports of surveyors using intimidation to force an error. If the surveyor states you have made an error in technique which you are not in agreement, again lock the cart and discuss this immediately with your supervisor. They should only intervene if they feel the resident is at risk of receiving a medication error. You should be able to recite why the particular resident is receiving any particular medication (diagnosis or symptom) and a few side effects for each medication. If this process is too distracting during the observation state to the surveyor:

"I will gladly answer those questions after the medication pass is complete, but to answer them now is distracting and I'm afraid I may lose the concentration needed to avoid an error."

### **Error rate**

Licensing will allow no more than a 5% (5 errors with 100 medications being administered) error rate during a survey. A nurse or pharmacist from the state will follow the facility nurses for approximately 25 medications. If a resident takes on average 4-5 medications during the morning medication pass, then the nurses will be followed for 5-6 residents. Perhaps only 1-3 residents per nurse.

If there is one error during the first 25 medications administered, then this equates to a 4% error rate. If there is a second error during the first 25, then this would be an 8% error rate. This would then trigger another 25 medications to be observed. If a third error occurred (3 in 50) the error rate would be 6%. This would mean the facility did not meet the standard and could trigger a resurvey in 30 days.

## **BE METHODOICAL DURING THE OBSERVATION.**

### **Resident identification**

Residents must be identified prior to administration. Follow any facility policy first. Familiarity or a photograph may be alternatives to checking the arm or wrist band. Ask the resident to recite their name. Do not ask them if they are a certain person. A demented resident may state they are the person the nurse is searching for, when actually they are not. Inform the surveyor the length of time you have worked on this particular cart\station. Tell them you will be identifying the resident visually. If the resident is new or you are new to the station, you must use the arm band, picture or other staff who know the resident.

### **Resident's condition**

The resident's condition must be taken into consideration prior to pouring the medication. The nurse must greet the resident and ask if the resident is ready to take their medications at that time. If the resident wishes to take the later or is in a situation which is not appropriate to accept medications (bed bath, changing, restroom) then the nurse must not pour the medications until the resident is ready to accept them. The medications may be placed in the medication cart, identified with the resident's name, until the end of the medication pass. It may then be reoffered. The medication may not be kept in the medication cart past the time of the medication pass. It must be documented as refused and the physician notified of the refusal, as per facility policy.

If there is an order for a conditional vital, the nurse may either:

- 1) check all vital signs for all residents prior to beginning the medication pass.
- 2) check the vital for one resident prior to pouring the medication, or
- 3) pour the medication with the conditional vital sign into a separate cup from the other medications, check the vital, and determine if the medication is to be administered.

There should be no medication cups with medications in them in the cart, unless the resident refused after initially agreeing to take them earlier. The nurse administering the medication must also be the one who poured them, do not accept medications already poured.

### **Observe swallowing**

The nurse administering the medication must also ensure the resident swallows the medication before the nurse may leave. All doses of all medication passes must be observed as being consumed by the resident in the presence of the nurse passing the medication. If "cheeking" of the medication is suspected, a change to liquid form is indicated. The exception to the above is if the resident has been approved by the I.D. team for "self-administration". Medications may not be left at the bedside for the resident to take at a later time.

### **House stock formulary**

The use of over the counter medications are usually reserved for MediCare, managed care, or MediCal residents. These medications are not resident specific. The nurse pouring the medications must ensure the bottle matches the order exactly. There are many variations of vitamins and calcium products.

Example: An order for multivitamins with minerals is not the same as an order for multivitamins with iron. Calcium citrate 500mg is not the same as calcium citrate 315mg. If the facility has a defined formulary, then when any new order is noted the nurse noting the order must ensure the medication order is one listed on the formulary. If it is not, then the physician must be contacted to change the order to a product which is on the facility formulary.

If the resident uses an outside pharmacy, do not accept medication the family brings in which do not match the order on the chart. Families will purchase over the counter medications based upon what is on sale and not realize the product they bring in to you does not match the product ordered by the physician.

## **BE METHODOICAL DURING THE OBSERVATION**

## **Confidentiality – Dignity**

Greet the resident and identify yourself. The medication administration record (M.A.R.) must not be visible to any passerby. The med book must either be closed or the pages flipped to a section where no patient specific information can be observed. Otherwise, this would violate patient confidentiality. Before beginning and medication administration ask the resident where they prefer to accept their medication. If the resident cannot respond, then we must assume maximum privacy is desired. This would include the applying or removing of patches, administration of eye drops, any injectable or enteral administration would occur in the resident's room and in some cases behind a drawn curtain or closed door.

## **Right to refuse**

Residents have the right to refuse medications. This includes the demented resident. Refusal may include non-verbal manifestations of refusal. A nurse may not give medications against a residents will, unless there is an LPS conservatorship or if the resident agrees to an IM administration form. If the resident is conserved, there must still be a PO version of the medication to available to be offered before an IM form is administered. A nurse may not hide medications in food for the purpose of concealing the fact it is medication.

If the medication is placed in a resident's food, then the entire contents of the container must be consumed with the nurse remaining next to and watching the resident. A small amount of a resident's food may be utilized as a vehicle for administration. Problems arise when a nurse gets "too creative" in trying to comply with a physicians order to administer medications. .

Nurses should not get too creative in attempting to coax the resident into taking the medication. Try to encourage the resident into taking the medication, but do not violate their right to refuse. Repeat an attempt at administration before the end of the medication pass. Once the time of the medication pass has expired, the poured medication must be destroyed. We cannot administer a medication beyond the medication pass time frame.

## **Documentation of refusal**

The nurse should notify the physician and/or family and document this notification in the chart. To document each dose refused, circle the initials on the front of the MAR and chart on the back of the MAR the refusal, any statements the resident may have made, or what actions the nurse may have done (i.e. "offered 3 times"). In some cases, one refused dose may be significant enough to warrant a call to the physician. The nurse should evaluate the current condition/diagnoses of the resident with respect to the consequences of the medication being refused. If there is a "standard of practice" for this environment, it would be to document that the physician was notified after 3 consecutive doses were refused or when the refusal occurs a few times every week. Again, significance of the refusal should be evaluated with regards to the resident's condition.

If the refusals are on a chronic basis, the I would suggest a care plan be started to document what action the physician wishes in terms of further notification (i.e. "Notify MD is a change of condition occurs.")

## **Pouring medication**

There must be a minimum of handling when pouring medication into the soufflé cup. If there is a method available to pour the medication into the med cup without the nurse's hands coming in contact with the medication, then this is the method the nurse should follow, although there is no regulation, state or federal, governing this.

## **BE METHODOICAL DURING THE OBSERVATION**

### **Accurate measurements**

Liquids and powders measurements must be accurate. The med cups and syringes must be graduated. There can be no estimates between the graduations. If there is no mark on the med cup, then a syringe needs to be utilized. Teaspoons on the med cart are not acceptable for measurements. The volume must be viewed and evaluated at eye level before administration. The volume should be evaluated at the lowest point, middle liquid meniscus, on the med cup.

### **Correct route of administration**

Is the correct route of administration being utilized? Nurses must observe if the residents chew long-acting, sub-lingual, or enteric-coated products. If chewed, then these medications need to be changed to short-acting or liquid formulations. If the medication is ordered "sublingual", then we must watch to insure the resident does not chew or swallow this medication. There are now inhalers and sprays to be administered intranasally. Physicians may at times order eye drops to be administered otically. Ear drops should never be administered into the eye. Some oral tablets may be ordered rectally, as in hospice patients who can no longer swallow.

### **Triple check**

There must be a careful examination of medication sheet and label orders. The nurse must show evidence the pharmacy label or house stock label is being read and compared to the order on the medication order sheet. The surveyors will be watching to see if the label and orders are being compared. If the pharmacy label and the order on the medication administration record (MAR) do not match, the nurse should check the physician order sheet. It is the ultimate document. If the pharmacy label is incorrect, a direction change sticker should be placed over the label. Do not write on the label.

### **Pouring-administration-charting**

Licensing cannot mandate that pre-pouring cannot occur. Most facilities have policies which do not allow this practice, Check your policy manual. If there is a policy which does not allow pre-pouring then the following should occur.

Administration, charting, and pouring must be completed for one resident prior to administration to the next resident. The sequence is not significant, unless there is a facility policy dictating a certain order. All charting should be complete by the end of the med pass. Nursing schools teach one or more of the following sequences:

**pour->administer->chart,**  
**chart->pour->administer,**  
**pour->chart->administer**

These three actions must be done for one resident before they are begun for the next resident. There are two exceptions:

- 1) Traditionally psychiatric facilities where the safety of pouring medications in the hallway makes it not feasible. Here they are poured and charted for all residents, then administered for all residents.
- 2) where a resident refuses medications after they have been poured and are kept in the cart until the end of the medication pass to be offered one more time.

The nurse must utilize the same sequence for the entire medication pass. Charting should not be done at the station after the medications have been passed.

**BE METHODICAL DURING THE OBSERVATION**

### **Solid medications**

With solid medications in a vial, they should be poured into the lid of the vial until the desired amount has been obtained in the lid. Only medications poured into the lid may be returned to the original container, except for pills which need to be cut (see below). If medications are poured into the med cup, then these medications may not be returned to the original container. The nurse may not pour the medications into his/her hand. Nor may the nurse place his/her finger into the vial to pull a medication out. A second cup may be utilized to titrate between the two cups to obtain the desired amount. The excess must be disposed of in the sharps container. It may not be placed in the garbage, sink, or toilet. With solid medications in a punch card system, the med cup should be placed directly under the medication and punched directly into the cup. It should not be punched into the hand then dropped into the cup. With a unit dose system, the package should be opened and the medication dropped in to the cup without the nurse touching the medication. A nurse may handle a medication, such as a capsule, to empty the contents into a med cup.

### **Cutting medications**

If a medication is to be cut, this should be done only if there is a scored mark on the tablet. If there is no score, then the physician order would have to have the following wording "approximate ½ tablet...". If a pill cutter is available, it must be cleaned prior to use. There should be no powder residue present from previous medications. The unused half tablet may be replaced back into a multidose container (vial), but not a unit dose or punch card container. If the medication is not amenable to be cut in a cutter or if a cutter is not present, then the nurse may attempt to break the tablet using tissue. If the medication cannot be broken with tissue, the nurse may, with or without gloves, handle the medication to break it in half. If the half to be returned is observed not to be exactly half or is in pieces, it should be wasted, with supporting documentation if it is a controlled medication.

### **Enteral**

Enteral administration of medications requires a check of the placement of the tube and residual. There should be a 30ml flush with water then medication administration, then a final 30ml flush. Extra fluids may be used to facilitate the flow of medications down the tube. Facility policy may dictate whether each medication needs to be administered one at a time or if all of the medications can be mixed and flushed together. Nursing schools teach both methods of administration via a tube. Medication should be changed to liquids as much as is possible. Tube administration of medications should be conducted in a private location.

### **Crushing medications**

An order from a physician is not required to crush medications, unless the medication is one which should not be crushed. These would include long-acting and enteric coated products. See the "Do not crush list". Crushing medications in med cups should be done with two cups. Any residue on the bottom of the upper cup should be scraped off before thrown away. Applesauce should be placed in a plastic med cup and the crushed medications placed on top of the applesauce. Watch for "double dipping" in the applesauce, thus contaminating the applesauce.

## **BE METHICAL DURING THE OBSERVATION**

### **Puncturing medications**

Gelatin capsules which may need to be opened should be done so with a new lancet every time. The nurse should be aware the contents are often distasteful (DSS). If the capsule is hard and the contents cannot be squeezed out entirely or consistently (Procardia 10mg), the order should include the following “may cut and squeeze”.

### **Medication administration with/without food**

Medications ordered “ac” or “pc” must be given at correct times with regards to food consumption. Even though the administration may be within the two hour time limit, if the resident has consumed or not yet consumed food before or after the medication is administered, it will be considered an error. A medication ordered “ac” should be administered 30-60 minutes before the meal. Medications ordered “pc” or “with meals” may be given up to 90 minutes after the resident has begun to eat. Certain antibiotics should always be given on an empty stomach – P.A.C.T. The only exception would be if the physician ordered to give these medications with food or pc. If the resident receives the above medications via a tube, then orders for the above medications would have to be clarified with the physician if the feedings should be held before and after the medication administration. Nitrofurantoin (MacroDantin, MacroBid), cefuroxime (Ceftin), and clavulanic acid\amoxicillin (Augmentin) should always be given “pc” or “after meals”, unless otherwise ordered by the physician. The other antibiotics may be given with or without food, unless the physician orders them in a specific manner.

Be sure appropriate antibiotics are given on an empty stomach (P.A.C.T.). Review the “Times of administration” sheet before writing the time on the M.A.R. NSAIDS should be given after food has been consumed. (penicillin, ampicillin, ciprofloxacin, tetracycline)

### **Fluids**

Fluids must be given with certain medications to avoid adverse effects or bring about the desired effect. Septra without a sufficient amount of fluid will lead to crystals forming in the kidney. DSS\Surfak without water is ineffective. It is a soap, which requires water to be effective. Metamucil without water will be ineffective and potentially dangerous. The number of ml’s of fluid needs to be stated on the Metamucil order. Manufacturers state to use 8 ounces for every teaspoonful of Metamucil. Thus if there is a 15ml Metamucil order with no amount of fluid stated, the amount of fluid required would be 24 ounces. Many of the elderly find it difficult to swallow the Metamucil in even 8 ounces of fluid. The percent not consumed needs to be documented. The risk of not enough water is the formation of fibro bezoars in the intestines, which requires surgery to remove.

### **Dosage form**

The dosage form administered must match the form ordered on the physician order sheet. If the resident starts refusing tablets or capsules, the liquid may not be utilized until the order is changed. If the order does not state a form, then either product could be utilized. Not all solid products are interchangeable with liquids (see Dilantin). Ensure the form ordered is administered by the correct route. Sublingual tablets should not be swallowed or chewed. Watch for residents who chew long-acting or enteric-coated forms. Liquids should be shaken prior to administration, except injectables. This includes eye drops and inhalers. Eye drops in which the drops are not clear are suspensions and should be shaken.

## **BE METHICAL DURING THE OBSERVATION**

## **Self-administration**

A physician's order alone is not sufficient to allow a resident to self-administer. There must be an assessment (minimum of six questions the resident must answer, as per OBRA) and approval by the I.D. team prior to initiation of self-administration. It is the obligation of the nursing staff to continually assess the resident's technique and retrain the resident if indicated. If the technique is less than ideal and the resident either cannot comply (physically or cognitively) the nurse should notify the I.D. team who is then responsible to notify the physician and reassess. If the physician allows the resident to continue with a less than an ideal technique, the facility administration would have to determine if the facility would be able to continue to care for this resident. Documentation of poor technique should be done to protect the facility from potential future negative outcomes (licensing and civil liability). Example: Overuse of bronchodilators can cause bronchoconstriction and/or sudden death. If a resident has an IPPB treatment, then this should be assessed for self-administration. If the resident cannot be approved, then either the treatment would need to be completed at the nursing station or the nurse would have to remain with the resident until the treatment is complete. Family members who administer the medications instead of nursing must be approved under self-administration. No other non-licensed person may administer medications in lieu of a nurse.

## **Bedside storage**

Bedside storage of solid dosage forms requires a "program flexibility" from the State. Title XXII allows only inhalation, eye drops (Health and Safety Codes) and sublingual meds for "emergency use". OBRA allows all types of meds, but we must follow the most stringent of the two until we get program flexibility. The facility has the primary obligation to ensure their most vulnerable resident is protected. This is most often, the wandering confused resident. The final decision to allow bedside storage lies with the administrator. Inhalers are considered safe with regards to a confused resident getting access to an inhaler. The danger with bedside storage of an inhaler is with the resident who has the order for the inhaler. They tend to use the inhaler more often than what is prescribed. This can lead to a worsening of the symptoms of COPD/asthma. NTG is too difficult to keep in compliance (the tablets need to remain in the original container, the number of tablets need to be counted to verify compliance needs to be checked, overuse). The only safe items at bedside are non-medicated topical products.

**BE METHODOLOGICAL DURING THE OBSERVATION**

## **Inhaler administration**

Determine if the resident prefers to administer the medication them self. If so, watch and instruct on the proper technique. If the resident does not comply with proper technique ask the physician for further instructions. Either the physician will not want the resident to self-administer or the physician will allow the resident to continue, even if less than optimal. If the resident continues with a less than optimal method, then nursing must document (care plan?) the physician's awareness of the situation. Similarly, if there is a resident who cannot understand the nurses' direction or cannot cooperate with the inhaler administration, then there should be similar documentation showing the physician is aware of the situation and nursing has attempted proper technique. Proper technique is as follows: Shake the inhaler. Ask the resident to exhale completely, after the resident begins to inhale, activate the inhaler COMPLETELY. Ask the resident to try to hold their breath as long as possible, and then exhale. Rest about one minute; let them catch their breath. The reason is two fold: The inhalers with metal plungers often become frozen with each puff and a minute is needed to thaw. The time between puffs also allows the prior puff to take effect. Reshake the inhaler and repeat the above process. If the resident has difficulty in holding their breath or understanding the process, a spacer may be of assistance. If a second inhaler is ordered then wait at least 1 minute before beginning. This may be a good time to prepare and administer this resident's oral medications. Administer the second inhaler in the same manner as the first. If there is a third inhaler, a 1 minute wait after the second inhaler is required. It may be necessary to go to another resident, then return to administer the third inhaler. Remember, do not chart the third inhaler until returning to the resident. The optimum order of inhalation is first the bronchodilator (albuterol [Ventolin, Proventil], metaproterenol [Alupent, Metaprel], isoproterenol [Isuprel], pirbuterol [Maxair], salmeterol [Serevent], formoterol [Foradil], terbutaline [Brethine, Brethaire]), then the anticholinergic agents: ipratropium [Atrovent] or tiotropium [Spiriva], or the miscellaneous agents: nedocromil [Tilade], cromolyn [Intal]. You may find a new order in which the Atrovent is first. The thought is that this medication works on the larger airways and the albuterol is effective on the smaller airways. Lastly, the steroids should be administered – beclomethasone [Beclovent, Vanceril], triamcinolone [Azmacort], flunisolide [Aerobid], budesonide [Pulmicort], or fluticasone [Flovent]. The resident should rinse their mouth after the steroid inhalation to prevent the occurrence of thrush. Inspect the mouthpieces to determine if rinsing is required. Clogging of the mouthpiece does not occur often when the mouthpiece is replaced with every refill. An inhaler is considered to be empty of active ingredient is when the canister floats when placed in water.

## **Insulin**

Lispro/Aspart insulins must be administered no more than 15 minutes before meals, Regular insulin no more than 30 minutes before a meal, and NPH no more than 60 minutes. Residents with diabetes should receive their trays first to ensure the above time requirements are met. Regular insulin should be drawn into the syringe before the NPH or similar (clear->cloudy). The insulin bottle should be dated when opened and placed in the sharps container 30 days later. If there is no date opened, then the dispensing date shall be assumed to be the date opened. Lantus should not be mixed in the same syringe with any other insulin.

## **Ophthalmic administration**

Eye drop administration should occur only after the nurse has washed his/her hands prior to administration. Gloves may be utilized, but most facility policies still require hand washing prior to the gloves being worn.

Hand washing should occur after the administration also. The object is to prevent the transmission of organisms to and from the resident in question. The resident's head should be tilted either to the side or back to a comfortable degree. A seated position, rather than standing, may be preferable due the likelihood of the resident experiencing dizziness from the head being tilted. If the resident is in bed, the head of the bed may be lowered to aid in administration. The times of administration may need to be adjusted to coincide when the resident is in the best position to aid in administration. The drop should enter the eye without hitting the eyelashes. If the drop entered partially, let the resident (and surveyor) know the situation and that you will attempt a proper administration. Some residents who are resistive to administration of eye drops and subsequently the optimum technique may not be achievable. This should be care planned stating the resistance and that the physician is aware of the situation and what he wishes the nursing staff to accomplish. Often the physician will state to "do your best" and "keep trying". Words of this type should be included in the care plan. The eye can hold only one drop at a time. A minute or two should elapse between drops. Eye drops should be administered before eye ointments. Workflow might be served well if the nurse administers one eye drop, then the oral medication, and then the second eye drop. If there is a third eye drop, the nurse will have to either wait there or proceed to another resident (do not chart this third eye drop until administered) and return (washing hands before and after again).

## **Dilantin**

Dilantin capsules are long acting and the liquid is short acting. They are not interchangeable. The liquid and tablet dosing should be split to at least a "bid" basis, according to the manufacturer, though many physicians choose not to follow "bid" dosing. If Dilantin is administered via the enteral route, there is a potential binding interaction with soy-based solutions. One dose could be given during the "off time" (often 10:00AM-2:00PM) with the second dose in the evening either with the feeding on or off. The dose can be increased to compensate for any decrease in serum level seen. Alternatively, feedings can be held one hour before and after the second dose in an attempt to avoid potential binding of phenytoin by soy-based enteral products. Liquid phenytoin provides erratic serum levels even with oral administration. The bottle should be shaken thoroughly @20 times or 20 seconds. The syringe should be used for administration and washed clean by the end of the med pass. The physician may chooses not to change dosing based upon serum levels alone. The history of seizures may determine whether doses are going to be adjusted. A sub-therapeutic result on a lab slip is not necessarily a clear indication or prudent practice to lead to an adjustment of the dose. Doses at or above 400mg per day often lead to levels above the maximum recommended level.

## **Injectables**

The expiration date of injectables may vary for each facility. This may vary from 30 days, to the date printed on the bottle by the manufacturer. If there is a date limitation, then the bottle or packaging should be dated with the date opened. This product should then be removed, sharps container, from use and its destruction documented.

## **BE METHODOICAL DURING THE OBSERVATION**

### **Time limit**

Medications must be given within one hour of the time stated on the medication sheet. Accuracy is a priority over going beyond the time limit. Starting and ending 5-15 minutes before or after is acceptable. If the time states "9:00 am", then the medication may be administered anytime between 8:00 am and 10:00 am.

This one hour on either side of the printed hour does not apply to prn orders. If the prn order states "q4 hours", then it cannot be given 3 hours after the last dose. Also, orders written with specific hour requirements do not fall under this one hour leeway. If there is an order to give a medication "1 hour after meals", then it must be exactly 1 hour, not 30 minutes before or 2 hours after. Starting on time is the key. A patient workload of 30-35 residents is close to the maximum a nurse should be expected to be able to pass within two hours. Do not let other staff "steal" your time away from the medication pass. Have the receptionist take messages for phone calls during this time (physicians may not agree). Having a portable phone available on the medication cart saves time. Leave a tablet on the cart in which other staff may write messages which can be accomplished after the med pass. There will be circumstances (emergencies, transfers, family, inservices), which will not allow a nurse to stay within the time limit. It takes about two weeks of working on one station for a nurse to get the med pass within two hours. Enteral resident time of administration may need to be at a different time, after the standard med pass. Medications not administered during this 2 hour time window may not be given later in the day even if ordered "qd" without an additional physician's order to do so. Some medications may need to be given to another shift or time to ease the load of one particular med pass time.

### **Patches and NTG ointment\paste**

Nitroglycerin ointment must be measured accurately. Measure out on the papers the full length ordered. Do not smear the ointment across the paper to the length ordered. The ointment can only be measured in increments no smaller than ½ inch. Place the ointment on the side of the paper without the ink. The site of the removed product should be wiped if there is any residue present. The site where the new patch is going to be applied should be clean. If the area is dirty – extremely rare if the resident has been in the facility and has taken a shower within the past week – wipe the skin with water only – do not use soap or alcohol. If you traditionally wipe the skin with a tissue prior to applying the patch, tell licensing the skin has moisture on it and that it is not dirty. This is a new item licensing is now writing a deficiency. They are assuming the nursing staff is trying to clean the skin without water. The resident should have the applications and removal done only in a private area, not in the hallways or dining rooms (dignity issue). Remember to remove the old paper or patch if it was not ordered to be removed earlier. The removed patch or paper should be folded upon itself and placed in the sharps container. Document on the M.A.R. the site the patch\ointment was applied.

### **Catapres patches**

The box contains four active medication patches and four overlays, which provide protection for the patch. The patch should be applied to a non-hairy area of the body once a week, usually the upper torso. The overlay should be applied over the medicated patch if the medication patch alone does not remain attached for one week. Some facilities may want to leave a portion of the active medication patch showing under one side of the overlay patch and to have the patch dated. REMOVE THE OLD PATCH.

**BE METHODICAL DURING THE OBSERVATION**

### **Irrigation solutions**

Bottles of solutions used for catheter or wound irrigation should be dated when opened and destroyed 24 hours later.

### **Xalantin and Epifrin**

Store in the refrigerator until first opened, then store in the medication cart until empty. Date when opened. They are good for only 45 days once opened.

### **Miacalcin Nasal Spray**

Store in the refrigerator unassembled until needed for use. Once assembled, it may be stored outside the refrigerator, in the cart, for 30 days. It must be stored in an upright position to keep the pump working correctly (primed). Date when opened.

### **Do not borrow**

Do not borrow medications from other residents. Call the pharmacy and ask them to send it 'stat' due to the survey in process. It is not better to give a medication from another resident, than it is to wait for the medication to be delivered. If a medication is not available, it is the responsibility of the nurse on duty resolved the problem by the end of the medication pass or end of shift, depending upon the significance of the medication. This can be by either having a delivery occur (family, other staff, pharmacy delivery, taxi) on time or calling the physician to get orders to cover the missing doses. The nurse on duty should notify the supervisors of the situation to aid in obtaining the medication and set in motion a QA process to identify how this can be avoided in the future.

### **Disposal**

Medications may no longer be wasted or disposed of in the sink, toilet, or garbage. It must be placed either in a designated incinerator box or sharps container. During the medication pass and old patches (Catapres, Duragesic, NTG, or estrogen), NTG paper, half-tablets, or refused medications may be placed in the sharps container. All other medications must be removed from the cart after being discontinued. No medications may leave a facility unless they are: 1). Returned to the contracted pharmacy for credit. 2). Ordered by the physician to go with the resident upon discharge 3) Pass medications. Family members may not take medications out of the facility after the medication has been discontinued.

### **Safety and Security**

When unlocked, the treatment or medication cart should be under physical control of licensed staff. This should allow the licensed staff to be able to deter anyone from obtaining medications stored within the cart. The cart should be locked at all other times. Only licensed staff should have access to the compartments of a medication or treatment cart where prescription medications are stored. Non-licensed staff may have access to these compartments when a licensed staff is present and observing.

### **Cleanliness**

The top of the medication cart must be in a clean state whenever medications are poured. It must be free from stickiness, tape, or other residue whereby bacteria could accumulate. All liquid medication bottles should be cleaned after the pass. Any residue should be removed. Syringes used for oral liquid administration should be rinsed, at least by the end of the medication pass. They should not remain in the cart with residue.

**Date and refrigerate applesauce and juices**

Food being used as a vehicle for administration may be utilized for 24 hours or the length of time stated in the facility policy. Whether it is the duty of the dietary department or nursing, the nurse using the product is responsible for ensuring a date is present. If the products being used are perishable, then she should be refrigerated between med passes and discarded after 24 hours.

**Side effects**

The nurse administering the medication is expected to be able to recite side effects each of the medications administered can cause. Almost all medications can cause nausea, vomiting, diarrhea, constipation, rash, and frequently confusion. Keep these side effects tucked away in your mind for easy retrieval. Additionally, if one considers the diagnosis for which the medication is prescribed and if too much medication was administered, what effects could be predicted. This exercise can provide many more potential side effects. An antihypertensive medication can cause hypotension, dizziness, falls, bradycardia, or fainting.

**Expert**

The nurse who practices day-in and day-out at the minimum level as stated above will accomplish the medication pass review with no errors. The surveyors and the pharmacist are not the experts, it is the daily practicing nurse who sets the standard. Be confident with what you know is correct. You are the expert.

**BE METHODOLOGICAL DURING THE OBSERVATION**