Medication Order Processing in Residential Care

Site Applicability

PHC Residential Care sites

Practice Level

- Nurse (refers to Registered Nurses, and Registered Psychiatric Nurses) who have completed orientation to work in Residential Care at PHC.

- Unit Coordinators

Quick Links

1. Appendix A – MAR Format

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Need to Know

See B-00-13-10189 - Medication Administration and Delivery System for a complete explanation of medication management in PHC Residential Care.

Standards

1. The nurse verifies new Medication orders are transcribed directly in the Medication Administration Record (MAR) and in the Care Guide (as needed) at the time the order is processed.

   Note:

   Transcribing – refers to the copying of information e.g. onto the MAR or laboratory requisition. Transcription is only one part of processing an order. (Both Nurses and UCs transcribe orders)

   Processing – refers to when information is communicated from the Prescribers' Orders in all the appropriate places e.g. MAR, MI (MI signifies Medication Instructions are entered in Care Organizer software), F (Flagged for oncoming nurses), consults, SCM (lab orders), etc. To signify that the order has been processed, draw a blue/black line at the bottom of the

last prescribers' order and sign name and designation. Only RNs can completely process an order because they must verify accuracy.

2. **Discontinued medications are** stopped on the day the order is written

3. **The nurse verifies** that new medication orders on the "Prescriber's Orders" Form [PHC-PH099] are processed accurately at least once every 24 hours, preferably within the shift they were written.

4. The nurse is responsible for monitoring residents for both therapeutic effectiveness and side effects of medications as well as documentation.

5. The nurse is responsible for clarifying medication orders that raise any concern e.g. dose, drug interactions, etc. This may be done by consulting the Physician and/or Pharmacist.

6. Each site must check each Health Record (chart) weekly to ensure all Prescriber's orders have been processed and then verified by a nurse (Unit Coordinator responsibilities).

7. Use the format for entering information on the MARs agreed upon and described in Appendix A (Order processing illustrated) & Appendix D (Format for Med instructions)

Roles of Team Members

Unit Coordinator

- Transcribes orders and flags these health records using accepted format for the nurse to verify.

- Faxes orders to Pharmacy

- See Appendix A; Order processing illustrated for accepted format.

Nurse

- Processes orders according to accepted format (Appendix A)

- Ensures all prescriber's orders are processed accurately, by checking orders transcribed by the Unit Coordinator (Appendix A 3), on the day they are written.

- Verifies all new, modified and discontinued medication orders have been correctly processed in pharmacy by checking the daily report from Pharmacy against the MAR following the process outlined in Appendix F.

- Follows site process to ensure the oncoming nurses know about new medication orders.

Pharmacist /Pharmacy

- Enters all prescribed/discontinued medication orders into the AUD computer system.

- Sends out a daily list of **all** prescribed/discontinued medication orders for each neighborhood. (Daily Pharmacy Reports)

- Pharmacists serve as a consultant for nurses/physicians, residents and families for medication related questions

Equipment and Supplies

1. "Faxed" stamp
2. MAR
3. Prescriber's Orders (PHC-PH099) and/or MIMO
4. Blue/black pen
5. **STOP ORDER D/C** Stickers
6. Site communication tool(s) for communicating to oncoming nurses
7. Care Guide (Care Organizer Program on Computer)
8. Automatic Stop Orders (see pharmacy web site)
9. Ruler

Protocol and Procedures

1. Unit Coordinator (UC) transcribes orders using accepted format. (Appendix A-2)

    a. Nurse verifies that the medication order has been processed correctly and adds any Automatic Stop Dates.

    b. Nurse signs and writes the date on the Prescriber's Orders Form to indicate that the orders are verified.

2. In absence of a UC, the RN processes the order:

    a. Transcribes the order onto the MAR (Appendix A)

    b. Initials and dates the MAR to identify when the medication order has been processed and by whom

    c. Enters any designated or automatic stop order dates on MAR

    d. Writes "MAR", the date, and initial all medication orders on the Prescriber's Orders sheet

    e. Faxes the order to Pharmacy

    f. Stamps order sheet with "Faxed" when transmitted OK

    g. Writes time faxed in stamp

    h. Alters medication delivery instructions on the Care Guide as appropriate.

    i. Flags /communicates new orders for oncoming nurses.

    j. Draws a blue/black line at the bottom of the last prescribers' order and signs name date and designation.

Documentation

*   The nurse uses the MAR to document all medications administered.

- The RCA initials the Daily Flowchart to indicate the completed the task of medication delivery as assigned.

- The nurse documents adverse and/or therapeutic effects, concerns and follow up in the Progress Notes as appropriate.

- The nurse uses the appropriate code on the MAR (indicating reason) to document any regularly scheduled medication not administered or refused by the resident.

- The nurse prepares Discharge/Transfer Medication for Reconciliation (PHC-PH395 when a resident is transferred.

- The Nurse initiates an Incident Report in **PSLS** for identified delays in processing orders (more than 24 hours) and for identified discrepancies between the MAR, prescriber orders or the daily Pharmacy Report. The handler for the Incident Report is the Clinical Nurse Leader.

Resident and Family Education

- The Nurse (in consultation with the pharmacist and physician) is responsible for educating residents and/or families about the resident's medications.

- For repeated questions, the Nurse may write a 'script' in Special Instructions on the Care Guide for the RCA to use.

Evaluation

- Nurses report discrepancies /errors and correct them. Report incidents in PSLS.

- Clinical Nurses Leaders receive all unit PSLS reports, investigating issues and factors contributing to errors.

- Regular safety huddles identify general practitioner and system issues to address. Safety huddles are conducted regularly on each unit by the educator together with the CNL.

Related Documents

1. Resident Care Attendant Medication Delivery Education Guide

2. B-00-13-10189 - Medication Administration and Delivery System

References

1. British Columbia College of Nursing Professionals. (July 2010). *Practice Standard for Registered Nurses and Nurse Practitioners: Administration of Medications. Publication Number 408.* Retrieved from https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Lists/GeneralResources/RN_NP_PS_MedicationAdmin.pdf#search=administration%20of%20medications

2. British Columbia College of Nursing Professionals. (May 2013, Revised March 2016). *Practice Standard for Registered Psychiatric Nurses: Administration of Medications.* Retrieved from https://www.bccnp.ca/Standards/RPN/PracticeStandards/Lists/GeneralResources/RPN_PS_MedicationAdministration.pdf#search=administration%20of%20medications

3. *Medication Administration. .* (2019). St. Louis, MO. Elsevier. Retrieved January 2019 from www.elsevierskills.com

Persons/Groups Consulted:

Residential Nurse Educator Group (October, 2018)

Residential Pharmacy Nursing Committee (November, 2018)

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PHC Residential Pharmacy Services

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Appendix A: Illustrations of Accepted format on Medication Administration Record (MAR) and Prescribers Order Sheet

Key Points

1. There are three sections to the MAR.
   Ensure that you are transcribing an order in the correct section.

   - Regular Scheduled Medications – Non-AUD (Strip) Packaged
   - Regular Scheduled Medications – AUD (Strip) Packaged
   - PRN Medication

2. All medications in AUD packages are for oral administration.

3. Nurses use blue or black ballpoint pen when processing orders onto the MAR, when initialing when medications have been administered or entering an omission code, and on the Prescriber's Orders Sheet.

   Unit Coordinators use red ink on the Prescriber's Orders Sheet and blue/black ink on the MAR.

4. For all regularly scheduled medications, the times for administration must be written in the "Times" column.

   - **Four Times Daily**: breakfast, lunch, supper, HS (e.g. 0800, 1200, 1700, 2100 **or** 0900, 1300, 1700, 2100)
   - **Three Times Daily:** breakfast, lunch, supper e.g. 0800, 1200, 1700 - If medication is to be equally spaced: e.g. 0800, 1400, 2200
   - **Two Times Daily:** breakfast and supper e.g. 0800, 1700 -If medication to be spaced: e.g. 0800, 2100
   - **Daily:** depends on medication and how other meds are scheduled. RN to assess. Aim for minimum med passes: could be at breakfast **OR** lunch **OR** supper **OR** HS
   - **Medications to be given on an empty stomach:** ½ (half) hour before meal time

5. Abbreviations used when processing orders (agreed standard for residential care):

   - **MAR** – Medication Administration Record
   - **D/C** – indicates order discontinued (for use *only* on MAR)
   - **MI** – Medication Instructions (to guide RCAs delivering medications, entered into Care Organizer software). Indicates that the nurse has considered the delivery time(s) of the new orders. Either they are not different from the existing times for the resident or the nurse has updated the RCA Medication Delivery Instructions to include the new time(s). Endeavour to keep the resident's daily medication times to the minimum.
   - **Req'd** – Requisitioned (Requisition made out)

- ♦ **SCM** – Entered into SCM e.g. lab orders all sites and at some sites consults
- ♦ **F** – Flagged: indicates that the new order(s) are communicated to on-coming nurses as per site practice e.g. RN Reminder Sheet, flagging the MAR, etc.
- ♦ **Re-ordered** – no abbreviation acceptable

Note: "UC noted" – indicates that the Unit Coordinator is aware of lab work that needs to be repeated on a regular basis and will enter the lab work monthly into SCM.

Appendix A - 1   Complete Process by Nurses

Including MIMOs (moving-in medication orders)

A.   Transcribing Medications onto the MAR

Example: Nurse administered medication for the first 48 hours

Medication/Strength/Directions	Times	F 1	Sa 2	Su 3	M 4	T 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	T 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Amlodipine 5 mg PO daily September 2/18 CRS	*0900*	→		RS	RS	7							

- ◆ Write drug name, dose and frequency in the "Medication/Strength/Directions" box in blue/black ink
- ◆ In the bottom **left** hand corner of the box write the date the order is processed and your initial
- ◆ Enter the exact times the medication is to be given in the "Times" column
- ◆ Draw an arrow to indicate when the first dose is to be given
- ◆ Enter the number 7 when medication appears in AUD package and is given by the RCA –after this point, the MAR will not have nurse initials as the RCA is delivering the medication.

Note: Remove the medication from the RN Reminder Sheet or nurse flagging system once it appears in the AUD package.

B.   Transcribing Orders with Specified Short Duration

Example: RN administers ALL medications.

Medication/Strength/Directions	Times	F 1	Sa 2	Su 3	M 4	T 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	T 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900	RS	RS	RS	RS	CS	CS	RS	RS	RS	RS	RS	
	1300	RS	RS	RS	RS	CS	CS	RS	RS	RS	RS	RS	
	1700	JH	JH	JH	JH	AB	AB	AB	AB	JH	JH	JH	
	2100	JH	JH	JH	JH	AB	AB	AB	AB	AB	LC		
Amoxil 500 mg PO three times daily X 7 days D/C *September 2/18 CRS*	*0600*			LB	LB	LB	LB	JK	JK	JK	Sep	9/ 18	RS
	1300			RS	RS	CS	CS	RS	RS	RS			
	2100		JH	JH	JH	AB	AB	AB	AB	STOP D/C ORDER			

- Transcribe the order as in example **I.** in the "Medication/Strength/Directions" box
- Enter the times the medication is to be given in the "Times" column
- **Block** off the time period the medication has been ordered for
- Once the course is **completed,** place a 'D/C ORDER sticker' where the next administration time would be. In blue/black ink, date and initial above/below the arrow indicating the end of the course.
- Draw a diagonal line through the medication box and write "D/C" for "discontinue".
- **NOTE:** If the RCA is delivering the medication, the Nurse must check the AUD packages to ensure the medication is stopped on the D/C date/time.
- Automatic Stop Orders are listed in Pharmacy Services Web site Automatic Stop Orders

C.   Discontinuing Medication on the MAR

Example: medications delivered by an RCA

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Acetaminophen Caplet 500mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Furosemide 20 mg 20 mg (1 tab) PO daily D/C Order # 68	*0900*												
								STOP D/C ORDER ←					
											Sep	6/18	RS

- ◆ Draw **one** straight line diagonally from the bottom left to the top right corner of the "Medication/ Strength/Directions" box
- ◆ Write D/C in the box – **do not** write over the existing medication order
- ◆ Place a "D/C ORDER" sticker on the MAR where the next initials for administration would be entered
- ◆ Draw an arrow from the far right side of the MAR to the D/C sticker.
- ◆ Enter the date the order is discontinued and your initials either above or below the arrow to the D/C sticker.

NOTE: RN takes back medication administration until AUD packages reflect current orders. (use D/C sticker on AUD strip as flag for oncoming nurses.)

D.   Holding a Medication for a Specified Length of Time

Example 1: "Hold Furosemide for 3 days, then resume at 20 mg daily"

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Furosemide 20 mg 20 mg (1 tab) PO daily *Hold X 3 days, then resume 20 mg PO daily* Order # 68 September 7/18 CRS	0900							X	X	X			

- If the drug is to be resumed at the same dose, place an "**X**" in the corresponding square(s) on the MAR to indicate that the drug is **NOT** to be given on those day(s).
- Write "hold X # days", the date, and your initials in the Medication/Strength/Directions box.
- Remove the medication from the Resident's cupboard (RN removes the medication at the time of administration and gives the rest of the medication).
- Some sites put a D/C order sticker on the AUD package to alert the on-coming RN. The MAR will indicate the specific medication that is being held.

Example2: "Hold Furosemide for 3 days, then decrease dosage to 20 mg every second day"

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12	T 13
Furosemide 20 mg 20 mg (1 tab) PO daily D/C Order # 68	0900							STOP D/C ORDER						
												Sep	7/18	RS
Furosemide 20 mg *20 mg (1 tab) PO every second day* September 7/18 CRS	*0900*											X		X

- [Discontinue]() the Furosemide 20 mg daily order
- Process the order for the changed dosage as a 'new' order
- "**X**" out the dates that the medication will not be given.

Appendix A - 2   Transcriptions by Unit Coordinator + RN verification including MIMOs

A.   Transcribing Medications onto the MAR

Example 1: Order transcribed by a UC, not yet checked by nurse.

Medication/Strength/Directions	Times	F 1	Sa 2	Su 3	M 4	T 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	T 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Amlodipine 5 mg PO daily													

- ◆ Write drug name, dose and frequency in the "Medication /Strengths / Directions "box in blue/black ink.

Example 2: above order, once verified by nurse.

Medication/Strength/Directions	Times	F 1	Sa 2	Su 3	M 4	T 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	T 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Amlodipine 5 mg PO daily	*0900*	→→→											
September 2/18 CRS													

- ◆ In the bottom **left** hand corner of the 'Medication/Strength/Directions' box write the date the order is processed and your initial
- ◆ Enter the exact times the medication is to be given in the "Times" column
- ◆ Draw an arrow to indicate when the first dose is to be given

B.   Transcribing Orders with Specified Short Duration

Example 1: Order transcribed by the UC, NOT yet verified by the nurse

Medication/Strength/Directions	Times	F 1	Sa 2	Su 3	M 4	T 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	T 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Amoxil 500 mg PO TID X 7 days													

◆ Transcribe the order as in example **A.** in the "Medication/Strength/Directions" box

Example 2: above order, once verified by nurse

Medication/Strength/Directions	Times	F 1	Sa 2	Su 3	M 4	T 5	W 6	Th 7	F 8	Sa 9	Su 10	M 11	T 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Amoxil 500 mg PO TID X 7 days *September 2/18 CRS*	*0600*												
	1300												
	2100												

◆ Enter the times the medication is to be given in the "Times" column

◆ **Block** off the time period the medication has been ordered for

◆ In the bottom **left** hand corner of the 'Medication/Strength/Directions' box write the date the order is processed and your initial

NOTE: Once the medication comes in the AUD (Automated Unit Dose) package, the Nurse must decide if the RCA (Resident Care Attendant) can deliver the medication, or whether the Nurse must administer the medication.

C.   Discontinuing Medication on the MAR

Example 1: discontinued medication transcribed by UC
(where RCA has been delivering the medication).

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Furosemide 20 mg 20 mg (1 tab) PO daily D/C Order # 68	0900												

- Draw **one** straight line diagonally from the bottom left to the top right corner of the "Medication/ Strength/Directions" box
- Write D/C in the box in blue/black ink – **do not** write over the existing medication order

Example 2: above order, once verified by nurse.

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Furosemide 20 mg 20 mg (1 tab) PO daily D/C Order # 68	0900								STOP D/C ORDER				
											Sep	7/18	CS

- Place a "D/C ORDER " sticker on the MAR where the next initials for administration would be entered
- Draw an arrow from the far right side of the MAR to the D/C sticker.
- Enter the date the order is discontinued and your initials either above or below the arrow to the D/C sticker.

D.   Holding a Medication for a Specified Length of Time

Example 1: "Hold Furosemide for 3 days, then resume at 20 mg daily" transcribed by UC

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Furosemide 20 mg 20 mg (1 tab) PO daily *Hold X 3 days, then resume 20 mg PO daily.* Order # 68	0900												

- Write "Hold x 3 days, then resume 20 mg. daily in the Medication/Strength/Directions box

Example 2: above order, once verified by nurse.

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Acetaminophen Caplet 500 mg 1000 mg (2 caplet) PO four times daily Order # 32	0900												
	1300												
	1700												
	2100												
Furosemide 20 mg 20 mg (1 tab) PO daily *Hold X 3 days, then resume 20 mg PO daily* Order # 68 *September 6/18 CRS*	0900							X	X	X			

- If the drug is to be resumed at the same dose, place an "**X**" in the corresponding square(s) on the MAR to indicate that the drug is **NOT** to be given on those day(s).
- Write the date and your initials in the Medication/Strength/Directions box.
- Remove all medications from the Resident's cupboard for RN to give during the holding period.

Example 3: "Hold Furosemide for 3 days, then decrease dosage to 20 mg every second day" transcribed by UC

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Furosemide 20 mg 20 mg (1 tab) PO daily D/C Order # 98	0900												
Furosemide 20 mg Hold X 3 days, then decrease to 20 mg (1 tab) PO every second day													

- ◆ <u>Discontinue</u> the Furosemide 20 mg daily order
- ◆ Process the order for the changed dosage as a 'new' order.

Example 4: above order, once verified by nurse.

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12	T 13
Furosemide 20 mg 20 mg (1 tab) PO daily D/C Order # 98	0900							STOP D/C ORDER						
												←		
												Sep	*7/18*	*CRS*
Furosemide 20 mg Hold X 3 days, then decrease to 20 mg (1 tab) PO every second day *September 7/18 CRS*	*0900*											**X**		**X**
			→						→					

- ◆ Discontinue the Furosemide 20 mg daily order
- ◆ Process the order for the changed dosage as a 'new' order
- ◆ D/C sticker

Appendix A – 3   Processing Orders on the Prescriber's Orders Sheet

A.   Processing Orders on the Prescriber's Orders Sheet by Nurse

- Fax order to Residential Pharmacy.
- Affix "Faxed" stamp on the Prescriber's Orders form **after** faxing. Place the "faxed" stamp under the date so that the order is **not** covered.
- Write the date and time in blue/black ink in the box provided. Initial below.
- Transcribe onto **MAR** as per procedure. Mark **MAR** when done.
- **F**lag the new order as per site practice, e.g. on the RN Reminder Sheet or other method, for any medications that the nurse will need to administer from the contingency supply or from baggies sent from Pharmacy. Mark **F** when done.
- Enter medication instructions into Care Organizer. Mark **MI** when done.
- Once the nurse has verified the order, he/she draws a blue/black line underneath the last Prescriber's Orders and enters the date, his/her signature and designation.

B.   Processing Orders on the Prescriber's Orders Sheet by Unit Coordinator

UC Procedure

- UC faxes order to Residential Pharmacy
- Affix "Faxed" stamp on the Prescriber's Orders form **after successful** faxing. Place the "faxed" stamp under the date so that the order is **not** covered.
- Ensure that all faxed transmissions are successful. If unsuccessful, re-fax.
- Write the date and time in **red** ink in the box provided. Initial below.
- Transcribe onto MAR in blue/black ink.
- In **red** ink: - check off the order and enter the accepted abbreviations for where the order has
  - Been transcribed to, and
  - Sign name and designation.
- Notify nurse of the new order and pull the nurse alert flag.

C.   **Processing Orders on the Prescriber's Orders Sheet By Unit Coordinator with Nurse Verification**

- ◆ Verify the transcription against the Prescriber's Orders and place a check mark by each order once transcription is verified as correct. If you can not finish verifying transcription, initial beside what you have checked.

- ◆ Use accepted format as you complete processing the order e.g. **MI, F**.

- ◆ See procedure for entering information on the MAR.

- ◆ Once the nurse verifies and completes processing the whole order, he/she draws a blue line underneath the last Prescriber's Orders and enters the date, his/her signature and designation.

Appendix B: Weekly Unit Coordinator checks for unprocessed orders.

- Indicate on the prescriber order sheet that this chart has been checked for unprocessed orders Stamp below the line drawn at the bottom of the latest order (Use the unit checking stamp: "No new orders" and write in the current date).

- Inform the Nurse/CNL about any unprocessed orders. A PSLS must be completed .At the discretion of the Nurse, if the order is still appropriate, the UC processes the order immediately.

IF YOU RECEIVED THIS FACSIMILE IN ERROR, PLEASE CALL 604-806-8886 IMMEDIATELY		
Providence HEALTH CARE **PRESCRIBER'S ORDERS**	000998877 0000123448383 **Test, Scan Testing**	
DATE AND TIME	**ORDERS** DRUG – DOSE – ROUTE – FREQUENCY – DURATION	PRESCRIBER'S NAME, SIGNATURE AND COLLEGE ID NUMBER
	DO NOT USE Dangerous Abbreviations, Symbols and Dose Designations – see reverse	
Apr 8/14	Furosemide 20 mg po one daily	MAR MI
FAXED Apr 8/14 1000	DR. G. Holly #12345 Dr. A. Holly	F apr 8/14 ☐ Hottie RN
	No new orders APR 0 8 2014	

Appendix C: Opioid Patches

Rescheduling dose times when a narcotic patch comes off before a new patch is due to be applied (e.g. Fentanyl, BuTrans).

Important: Patches release more drug in the first 12 hours of application. Therefore, if a patch comes off before it is due to be changed, the schedule MUST be revised.

- Dispose of old patch by folding patch in half and placing in sharps' container
- Apply new patch
- Re-schedule on MAR (see example below).
- Fax communication form [Residential/Rehab Prescription Communication Form: Form No. PHC-PH187 to Pharmacy with time change.

Medication/Strength/Directions	Times	Th 1	F 2	Sa 3	Su 4	M 5	T 6	W 7	Th 8	F 9	Sa 10	Su 11	M 12
Fentanyl Patch 25 mcg 1 patch applied every 3 days to hairless area of skin Order # 97	0900	X	RS	X	X	JK	X	X		X	X		X
	1300							SJ	X	X		X	X
Fentanyl Patch 25 mcg Removal *Dispose by folding patch in half & placing in sharps' container*	0900	X	RS	X	X	JK	X	X		X	X		X
	1300								X	X		X	X

To re-schedule Patch <u>Application</u> day/time:
- Draw a line from the initials of the last application through all the boxes of the old schedule to the end of the month
- Enter the new application time in the Times column
- Draw an arrow from the "Times" column to the nurse initials for the first new patch application time
- Place 'X' in the appropriate boxes to indicate the new schedule

T**o re-schedule Patch <u>Removal</u> day/time to match new Application day/time**
- Draw a line from the initials of the last removal through all the boxes of the old schedule to the end of the month
- Draw an arrow from the "Times" column to the nurse initials for the first new patch removal time
- Place 'X' in the appropriate boxes to indicate the new schedule

Appendix D: Format for Medication Delivery Instructions

RCA Medication Delivery instructions are written using Care Organizer software: "Med Instr" Questionnaire. This software provides for standardization and customization.

When the medication delivery instructions are printed, they are on a separate page from the rest of the Care Guide. Print two copies of the medication instructions: one for the RCA Assignment Binder and one for the individual Resident's Medication cupboard.

Components

- Drop-down boxes display options. Selecting an option may trigger further drop down options. Only the selected options will print.

- Comment boxes provide opportunity to 'free text' (type in) specific instructions (40 characters in small boxes except liquids are 80 characters. Large comment boxes are 255 characters).

- Some categories allow for more than one option to be chosen, e.g. Pills. To determine whether to choose Crushed or Whole, use the 80-20 rule: if 80% of the medications are given crushed, select 'Pills (Crushed)' and also select 'Other'. In the 'Other' comment box; type in the description of the medications to be given whole.

1. **Special Instructions**

   Categories of Special Instructions include:

   1a   RN to administer all oral meds

   1b   Resident on Tube feed

   1c   Resident on Modified Medication Delivery program (if selected, option 1d displays)

   1d   Modified Medication Delivery program delivered by:

   1e   Special Hydration Instructions (if selected, option 1f displays)

   1f   Special Hydration Instructions Comment:

   1g   Resident on Fluid Restriction (if selected, option 1h displays)

   1h   Fluid Restriction Instructions

   1i   Other (if selected, option 1j displays)

   1j   Other comments:

2. **Time of Medication Delivery**

   Medication delivery times revolve around meal times. (RCAs give residents their medications before they go to the dining room as best/safest practice). Clicking a radial button on the categories below result in a drop down box where a specific time can be selected:

   To keep instructions clear, the time on the Care Guide instructions must match the time on the AUD package and labels for non-AUD packaged medications. Fax a request to Pharmacy to

change the time on the AUD package if it does not match the meal time on form "Residential/Rehab Prescription Communication Form PHC-PH187"

Categories for Time include:

- ON TIME: BEFORE BREAKFAST (time is entered via free text for medications that need to be given on an empty stomach)
- BREAKFAST MEDICATIONS (choices: 0800, 0830, 0900, 0930). Select the time that corresponds to the meal time.
- ON TIME: BEFORE LUNCH
- LUNCH MEDICATIONS (choices: 1200, 1230, 1300, 1330)
- ON TIME: AFTER LUNCH
- ON TIME: BEFORE SUPPER
- SUPPER MEDICATIONS (choices: 1700, 1730, 1800, 1830)
- ON TIME: BEFORE BEDTIME
- BEDTIME MEDICATIONS (choices: 2000, 2100, 2200

Note: Don't choose 2200 as an RCA medication delivery time. All medications for the day must be given before the nurse places the strip containing medications RCAs deliver the next day. RNs start placing strips around 2100. If a resident needs a medication after 2100, the RN must administer it.

3. **Type of Medication**

- Click on appropriate type(s) – pills, liquid medication, patch, eye drops, skin products

4. **How the Medication is Given**

- Click appropriate "radial button/tick box" to indicate how the medication is to be given (See Components above)

    E.g. *give meds crushed in applesauce*

- If a medication needs to be dissolved or cut (example 1), type in a description of the medication.

- Instructions that are typed in 'Other' will appear below 'Pills' on the Medication Delivery Instructions Report (see example 2 below)

- Instructions that are typed in 'Comments' will appear at the end of the delivery instructions for that specific time (see example 2 below)

- If a medication has to be given at a specific time, select 'on time' and enter the time in the box. Choice of medication is either 'pill' or 'liquid'.

- **NOTE:** for **crushed** medications, it is understood that **capsules** must be opened so do **not** state 'open capsules' in the instructions.

- Liquid medication: type in the amount in 'mL' in the box provided.   Do **NOT** include name of the medication

SAMPLE MEDICATION INSTRUCTIONS

Example 1:   **Whole Medication** (with Special Instructions)

Medication Delivery Instructions	
Special Instructions	
Other Comments:	Give one cup of warm water after medications
BREAKFAST	0830
Pills (Dissolve):	Pink oval pill - mix with fruitlax
Pills (Cut):	Big green pill in half
Pills (Whole):	Give meds whole in jam
Liquid Medication:	15 mL
Eye drops:	2
Which eye?	Both
ON TIME: BEFORE LUNCH	1100
Pills (Whole):	Give meds whole in applesauce
BEDTIME	2100
Pills (Whole):	Give meds whole in ice cream

Example 2:   **Crushed Medication** (No Special Instructions)

Medication Delivery Instructions	
BREAKFAST	0830
Pills (Crushed):	Give meds crushed in jam
Other:	Give small round blue pill whole
Patch:	Apply patch
Skin Product Directions:	Apply treatment cream to rash on right thigh
Comments:	Keep resident upright for 30 minutes after breakfast meds.
BEDTIME	2100
Pills (Crushed):	Give meds crushed in applesauce
Patch:	Remove patch
Skin Product Directions:	Apply treatment cream to rash on right thigh

Points to Remember

- If the nurse is administering all the oral medication, RCA Medication Delivery Instructions must state "Nurse to administer all oral meds" (includes the first 48 to 72 hours for new residents).

- Up-date the Nurse Reminder Sheet.

- Collaborate with RCAs to ensure instructions make sense.

- Use simple, specific, action words in "other" or "comments" section.

- Consolidate medication delivery times. See B-00-13-10189 - Appendix E: Simplifying medication times.

  E.g. If one AUD package is scheduled for 0800 and the second package for 0900, check with Pharmacy to see if medications from both packages can be given at the same time.

- RCAs cannot give range doses: e.g. order **for Oxazepam 15 to 30 mg PO daily.** Pharmacy enters the orders so that 15 mg will appear in the AUD package and the second 15 mg is provided as a PRN.(to be administered by the Nurse)

- It takes about 2 days for orders to appear in the AUD strip packages. Until then, the Nurse administers the medication in the 'baggie' from Pharmacy, or from the contingency supply. Enter the directions for the new medication in the Care Guide **when the order is processed.** Print 2 copies of the new instructions. Only put them out when the NEW time appears in the AUD packages.

- When a medication is discontinued, the Nurse removes the AUD package(s) containing the medication from the resident's cupboard *at the time the order is processed*. Because the AUD package will be altered, the Nurse must give all of the medications from those packages. Safe practice requires that discontinued medications are removed from the AUD package *at the time* of administration.

  NOTE: Pale blue tape is only used by a Nurse to re-seal a package that has been accidentally torn and the contents have not been altered. I.e. the contents must match the descriptors on the outside of the package.

- Discuss concerns/issues with colleagues.   If needed, use the Safety Huddles as a forum for discussion and problem solving.

- Include a Patch chart (Form PHC-EL038) in the RCA assignment binder and inside the door of the resident's medication cupboard for *each* resident requiring a nitroglycerin patch that an RCA will be applying.

Appendix E: Daily Pharmacy Reports

I.   BFH BF3 Orders – Prescribed Yesterday

Wednesday, August 22, 2018

BFH BF3   Room: 339-1

005644907	LAST Name, FIRST Name	Start Date	Stop Date	
Order #:35	**HYDROmorphone TAB 1 mg** 0.5-1mg (0.5-1 tab) every hour as needed	8/22/2018	8/22/2019	New

BFH BF3   Room: 339-1

005644907	LAST Name, FIRST Name	Start Date	Stop Date	
Order #:36	**HYDROmorphone Inj 2mg/mL (1mL)** 8/22/2018 0.25-0.5 mg (0.125-0.25 mL) sc every hour as needed for pain or dyspnea		8/22/2019	New

II. BFH BF3 Orders – Discontinued Yesterday

Wednesday, August 22, 2018

BFH BF3   Room: 314-1

036859757	LAST Name, FIRST Name	Start Date	Stop Date	
Order #:162	**Vitamin D Tab 1000 units**	8/15/2018	8/22/2018	STOPPED

BFH BF3   Room: 326-3

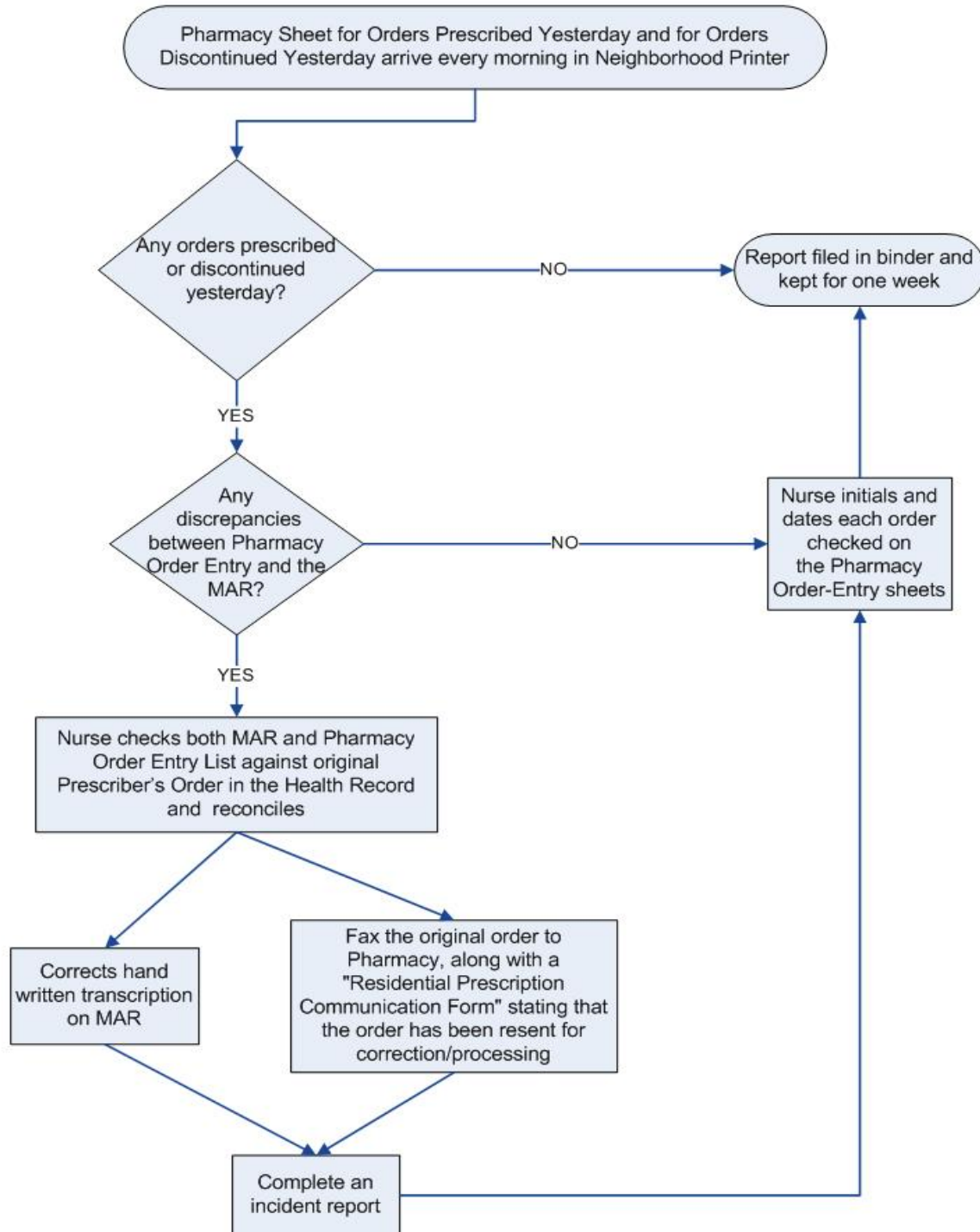| 004644907	LAST NAME, FIRST NAME	Start Date	Stop Date	
Order #:87	**Acetaminophen Tab 325 mg** 325mg (1 tab) every four hours as needed for fever (Max: 4000 mg/day of all acetaminophen containing dosage forms)	8/18/2018	8/22/2018	STOPPED

Appendix F: Checking the Pharmacy Reports of New / Modified / Discontinued Orders

1. Pharmacy remote prints the **two** daily reports each morning to the individual neighborhood printers. If there are no discontinued or new orders, blank sheets will still be printed for the day with the title on top and the date on the bottom.

2. The reports are placed in a centralized location for access by the nurses.

3. The day shift nurse may start the procedure of checking the Pharmacy Order-Entered medications (listed on the report) against the MAR (medication processed by Nurse).

4. The evening nurse must complete the process **before** placing medication in the individual Resident medication cupboards.

5. Checking the Daily Pharmacy Report against the new handwritten order on the MAR includes ensuring that:

   o The drug, dosage and directions correctly match

   o Any stop date(s) have been correctly entered/modified by Pharmacy

5. If there is a discrepancy, the Nurse checks both the MAR and the Daily Pharmacy Report with the Prescriber's Orders in the Health Record. The nurse completes a PSLS report and either

   o Corrects the MAR and/or

   o Circles the incorrect order on the Daily Report, then **faxes** the original order and the Report to Pharmacy

   o If an order appears on the "Discontinued" report that should not have been discontinued, indicate this on the report and **fax** it to Pharmacy for review/correction

6. After checking, the nurse initials and dates the order on the Daily Pharmacy report.

7. Orders faxed to Pharmacy after 1730 hours may not be processed by pharmacy in time to appear on the next day's 0700 report. The nurse ensures on-coming nurses are reminded to check these orders and ensure they appear on the following day.

8. The Unit Coordinator will ensure the Daily lists are kept for a minimum of time to align with MAR printing (usually at least two weeks), and then shredded.

   Note: For easy retrieval, both the "Prescribed" and "Discontinued" reports should be filed together by date.
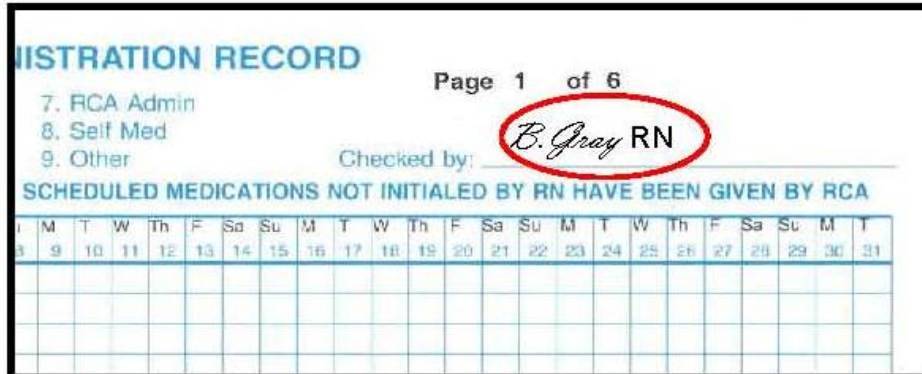
Process For Checking Daily Pharmacy Sheets

Pharmacy Sheet for Orders Prescribed Yesterday and for Orders Discontinued Yesterday arrive every morning in Neighborhood Printer

Any orders prescribed or discontinued yesterday?

NO → Report filed in binder and kept for one week

YES

Any discrepancies between Pharmacy Order Entry and the MAR?

NO → Nurse initials and dates each order checked on the Pharmacy Order-Entry sheets

YES

Nurse checks both MAR and Pharmacy Order Entry List against original Prescriber's Order in the Health Record and reconciles

Corrects hand written transcription on MAR

Fax the original order to Pharmacy, along with a "Residential Prescription Communication Form" stating that the order has been resent for correction/processing

Complete an incident report

September 2018

End of Month Verification of MAR Accuracy

- On the last day of each month, ALL new MARs must be verified to be correct and complete. Verify accuracy by comparing the previous month's MAR to the new MAR to ensure new orders and discontinued medications are accounted for. Initial each the MAR page after checking it. New MARs arrive about noon. This task is spread amongst the Nurses on duty on the last day of the month but must be completed by the evening Nurse.

NOTE: when Pharmacy packages medications for resident passes greater than 24 hours:

- It will look like all their regularly scheduled orders have been discontinued and there is a 'new' set of orders
- The order numbers will have the prefix "LO", followed by longer order numbers (this will differentiate these orders from the regular orders)
- The entries on the "Orders Prescribed Yesterday" report will include **"PASS MED"** at the end of the directions for each medication
- All orders with the prefix "LO" do **NOT** need to be reviewed.

Appendix G   Medication Reconciliation (MedRec) at Hand off Points

MOVING – IN		TRANSFER OUT
MIMO: Moving-in Medication Orders (PHC facility) **TMO**: Transfer-in Medication Orders (VCH facility e.g. Richmond, UBC, Lions Gate)	Moving In Medication Reconciliation **Manual MIMO** (sites other than a VCH or PHC facility e.g. Royal Columbian, Burnaby, home)	**Residential Transfer MedRec.** (non-PHC Residential Sites)

1. Unit Coordinator sends email to Pharmacy notifying them of the resident's name, PHN, facility they are coming from, bed they are being admitted to and date of admission.	1. Unit Coordinator prints the blank "Moving In Medication Reconciliation Orders (Residential Care/Rehab Medicine) Form No. PHC-PH250", from SCM Chartscan/Softmed	1. To send a Medication Profile out of SCM:
		
		• Log into SCM.
		   ▪ Select Resident in SCM, then click the "Med Profile" icon. The Med Profile Viewer will open in a separate window.
		   ▪ Click the Resident's Name within the Med Profile Viewer.
		   ▪ Click "Patient Reports".
		   ▪ Select desired report; i.e. #5 SCM Transfer Meds (Residential).

2. If there is no UC or it is an unexpected re-admission, the nurse can phone Pharmacy to ask for the MIMO	2. Nurse transcribes the medication information from the transfer records and/or from medication bottles (from home). Pharmacist will consult PharmaNet.	▪ Click "Print". Report will open in a separate window. ▪ Open ONLY as PDF. Report will open in a separate PDF window.
3. Pharmacy sends the MIMO/TMO to the unit printer for that resident.	3. Nurse verifies the transcribed medication information.	▪ Click the Printer icon. Default printer will be selected. ▪ Click Print.
4. Nurse retrieves MIMO/TMO and compares it to a previous MAR (if available) or to any other information available about the resident's medications, e.g. from Resident/family	4. Nurse writes in the unit and his/her cell phone number on the top of the form, then faxes the Manual MIMO to the admitting physician	▪ IMPORTANT: Close all Med Profile windows.

5. Nurse adds any "overlooked" or "missing" medications to the list under "Additional Medications" and makes any other changes they are aware of for the resident	5. Nurse calls the physician's office after approx. 30 minutes and gives a brief summary of the new resident, including Diagnoses. Then reviews the list of medications with the MD. The nurse transcribes the orders ("continue", "discontinue", "hold" or "change") and signs the bottom of the form as a <u>telephone</u> order from the MD.	2. Nurse then checks and writes in the date and encircles the time of the last dose of every medication was given. If any medication was intermittently accepted, make a note on this report.
6. Nurse writes in the unit and his/her cell phone number on the top of the form, then faxes the revised MIMO/TMO to the admitting physician	6. Completed Manual MIMO is faxed to Pharmacy. Original is placed in the Prescribers' Orders section of the resident's chart.	3. This transfer document is sent INSTEAD of the MAR.
7. Nurse calls the physician's office after approx. 30 minutes, gives a brief summary of the new resident/or changes in returning resident, including Diagnoses so both can review the list of medications. The nurse transcribes the orders ("continue", "discontinue", or "change") and signs the bottom of the form as a <u>telephone</u> order from the MD.	7. MAR arrives from Pharmacy at the next delivery time.	4. A copy of the Transfer/Discharge Medications for Reconciliation (Form No. PHC-PH345) is placed in the "Prescriber's Orders" section of the Resident's chart.
8. Completed MIMO/TMO is faxed to Pharmacy. Original is placed in the Prescribers' Orders section of the resident's chart.	8. Nurse compares the MAR and Manual MIMO orders. Reconciles any discrepancies.	
9. MAR arrives from Pharmacy at the next delivery time.		
10. Nurse compares the MAR and MIMO/TMO orders. Reconciles any discrepancies.		

How to Print a Manual MIMO from SCM Chartscan

Follow the steps below if the "Moving In Medication Reconciliation Orders (Residential/Rehab Medicine)", Form No. PHC-PH250 is not in the Moving-In package printed by the UC.

- Log into SCM:
- Highlight the Resident's Name

- Click on the E-form icon
- On the top of screen select 'Document Types'
- On left side of screen in "Enter or select a document" field, enter **Moving** then search
- Click to highlight "Moving In Medication Reconcili…" , form PHC-PH250.
- Once it displays, click Print Documents

NOTE: if you select "Moving In Medication Reconcili…" form GPHCPH250, there will be no information in the addressograph section. You will need to add a label from the chart.