



ExpressCare Pharmacy

POLICY AND PROCEDURES MANUAL

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Objectives

A. Community/Residence Objectives

The community's efforts and goals centralize around providing; maintaining and coordinating quality care to residents in a professional and efficient manner and the proper administration of medications provided by the community's pharmacy services vendor.

B. Pharmacy Objectives

Consultants and vendor pharmacy are to be responsible for coordinating and supervising all policies and procedures directly or indirectly affecting pharmaceutical services at the community.

Consultants and vendor pharmacy efforts and goals centralize around providing accurate dispensing and distribution of medications and nutritional supplements for effective therapeutic outcomes.

C. Policy and Procedures Manual Objectives

This manual is a written guide for the community's personnel. Its purpose is to provide specific information relating to pharmaceutical policies and principles and on approved methods and systems for implementation. These policies and procedures carry the approval of the Pharmacy Services Team.

Administrative Policies and Procedures

A. Responsibility of the Pharmacy Vendor

1. To furnish drugs with sufficient dispatch to ensure that resident care will not be hindered. To implement this policy the pharmacy shall:
 - a. Stock adequate inventory
 - b. Provide a delivery system for transport of medications to the community that meet ordering time requirements set forth in the manual.
 - c. Provide a back-up pharmacy vendor ("satellite") for emergencies, weekends and medications ordered after cut-off time.
2. Supervise compliance with Pharmacy Laws
 - a. Label medications for legibility and legality, including appropriate accessory and cautionary instructions as well as expiration dates when applicable.
 - b. Monitor drug distribution procedures to assure adequate patient safety.
 - c. Audit record-keeping procedures, periodically, in all areas of drug usage, as well as distribution and administration of pharmaceuticals.
 - d. Monitor security of dangerous drugs.
 - e. Provide State Board of Pharmacy with required licensure information as required.
3. Maintain current profiles via computer on all residents.
4. Employ a legally qualified and registered pharmacist in charge of pharmacy operations.

B. Pharmacy Services Team

The Pharmacy Services Team consists of at least three persons including:

1. Executive Director/Administration
2. Resident Care Director/Supervisor-In-Charge/Med Tech(s)
3. Consultant/Vendor Pharmacist
4. Other parties as designated by the Pharmacy Services Team.

This team shall oversee the community's Pharmacy Services, make recommendations for improvement and monitor all drug-related services to assure accuracy.

Objectives

The Pharmacy Services Team shall be responsible for:

1. Developing written policies and procedures for the safe procurement, storage, distribution, use and disposal of drugs and biologicals.
2. Establishing written procedures for the receipt and distribution of all drugs, particularly Schedule II and other controlled drugs.
3. Written determination of which personnel are authorized to have access to keys to drug storage areas.
4. Developing a list of abbreviations and chemical symbols that are approved for use in ordering medications.
5. Determining pharmaceutical reference materials that should be available at each resident care area.
6. Assuring that ongoing drug utilization review is being conducted.

C. Consultant Pharmacist

1. Duties:
 - a. Responsible for spending a sufficient number of hours to carry out functions of a consultant, according to requirements of law and regulations.
 - b. Review at least every quarter (in N.C.), & every 6 months (in Virginia) the drug regimen of each resident.
 - c. Submit a written report at least quarterly to the designated residence staff.
 - d. Assist in conducting pharmacy in-services for the community utilizing pharmaceutical sales representatives for such services when needed.
2. Responsibility to Administration
 - a. Pharmacy shall advise administration on drug policies and procedures.
 - b. Advise on changes in drug laws and methods of compliance.
 - c. Report to administration evaluations of employees on drug ordering, drug administration record keeping and stock levels.
 - d. Ensure proper communication between the community and vendor pharmacy.
3. Establishment of Policies:
 - a. The Pharmacy Consultant shall advise in the formulation of the drug policies within guidelines of State and Federal Laws.
 - b. The Pharmacy Consultant shall consider pharmacy regulations foremost in formulating policy and procedural recommendations.

Operation Policies and Procedures

A. Physicians Orders

1. All medications administered to residents of the community are ordered, in writing, by the resident's attending physician. Such orders are then faxed to the pharmacy.
2. All medication orders shall be written in the resident's chart on the physician's order form. If the order is telephoned, only the person(s) qualified should take the Verbal Order (V.O.) which is to be counter signed by the physician within 15 days. The person receiving the order shall record it on the physician's order (P.O.) sheet followed by the name of the physician, his/her signature and date. The order should be read back to the physician for confirmation. After the qualified person has transcribed the orders on the P.O. sheet, he or she must "note" the order with their signature, date, and time, indicating the

order has been completed. A Telephone Order (T.O.) or Verbal Order (V.O.) shall be placed beside all orders as they are transcribed by the qualified person.

3. Medication orders are to be legibly written and include:
 - a. Name of medication
 - b. Dosage to be administered, expressed in the metric system, except in instances where dosage is commonly expressed otherwise.
 - c. Specific directions for use, including frequency of administration, and/or Hours of Administration (HOA).
 - d. Route of administration.
 - e. Date.
 - f. PRN or "as needed" orders must also clearly state the reason for administration.
 - g. Physician's signature.(NOTE: Abbreviations and chemicals in the writing of medications are discouraged).
4. All Controlled Drugs must be ordered as indicated in this procedure manual. Any Schedule II narcotic order must be accompanied with a prescription signed by the resident's physician before dispensing.
5. Telephone Orders taken by the residence must have original order date, be signed by the resident's physician within 15 days, and filed in the resident's chart.
6. When a new order changes dosage or times of doses on a current medication, the previous order shall be discontinued (D/C'd) on the Physician Order Sheet and the new order should be transcribed to a new space on the Medication Administration Record (MAR). The Physician Order should be faxed to the vendor pharmacy.
7. PRN (as needed) medication orders shall show an indicated use for ordered medication in the "sig" (directions of the order). On-going need for certain PRN medications (Tylenol, laxatives, etc.) and treatments may be provided by standing orders predetermined by the community.
8. Each chart should be organized or divided as to indicate where documents are located in the chart as determined by each residence.

B. Medication Orders

1. Physician medications orders may be ordered from the pharmacy by any person designated by the community. It is advisable that the pharmacy be notified by administration as to the name of such designated personnel.
2. Persons ordering medication shall identify themselves to the pharmacy as well as identify the community's location.
3. New orders shall include:
 - a. Resident's name.
 - b. Physician's name.
 - c. Name of drug.
 - d. Strength of the drug and amount.
 - e. Route of administration.
 - f. Form required, e.g. liquid or capsule.
 - g. Time of dose limit if specified by physician. (i.e. Stop Order).
 - h. Date and time as indicated by the facsimile.
 - i. Any ancillary orders; Treatments, diets, etc.
 - j. Pay status of resident and Billing Information (on admittance to the community, the FL-2 form/Admission orders and/or Responsible Party Information Sheet where applicable should be complete).
3. All orders shall be faxed to the vendor pharmacy. All C-II controlled substance medication orders must have a "hard-copy" prescription, signed and sent to the vendor pharmacy by way of the courier delivering medications or mailed in by the physician's office.
4. Individual residents may obtain their medications, with the community's permission, from other than the designated vendor pharmacy. The consultant pharmacist must monitor these medications and records as well as the records from the vendor pharmacy. Alternate vendor(s) should be required to conform to the established drug distribution system of the residence.

6. OTC (non-prescription medications), for use as stock, can be ordered by the community staff as needed through the Pharmacy Vendor. The community should maintain at least a week's supply on hand at all times.
7. "New Admissions" Orders must be accompanied with:
 - a. A copy of the resident's FL-2 Sheet and/or Responsible Party Information Sheet for billing purposes .
 - b. Physician medication orders.
 - c. Signed Purchase Agreement.
8. Whenever a resident changes "pay status" or "3rd Party" status, the community must immediately inform the vendor pharmacy the same day, as well as for residents who have been "discharged" or are "deceased". "Room number" changes must be sent to vendor pharmacy as well.
9. The community staff is responsible for:
 - a. Making changes/corrections of physician order forms and updating MAR's prior to placing forms on chart.
 - b. Removing the corrected yellow copy and forwarding to the pharmacy vendor as soon as possible to allow reprinting.
10. Re-orders of PRN and non-unit bulk medications should be done on a pharmacy communication sheet and faxed to pharmacy vendor no later than 3:00 p.m.
11. Discontinued orders or altered orders (i.e. strength change) should be faxed to the pharmacy no later than 4:00 p.m. in order to receive changes that day. It will be the responsibility of the community staff to pull all discontinued medications from the medication cart and place in the pharmacy tote, with Return to Pharmacy Form, for return to vendor pharmacy.
12. Emergency Orders:

Under a bonafide emergency need, or when an ordered medication is not available under reasonable circumstances or within a reasonable time period, the possibility must be considered to send this resident to the local hospital for treatment.
13. If the medication is urgently needed between regularly scheduled delivery/pickup (night, weekends or holidays), the person qualified page the pharmacist-on-call to arrange filling and delivering the order in question.
14. The community's staff is responsible for ensuring that insulin and stock medications (over-the-counter or OTC's) are checked every week to insure a continuous supply over a weekend or holiday. Approximately a one week supply of OTC's should be maintained in the community at all times.
15. When ordering any medication for Medicaid residents, the residence should check with the vendor pharmacy to ascertain if the drug is covered by Medicaid. If the drug is not covered, check with the physician to determine if an alternate drug can be ordered utilizing the pharmacy vendor for any drug information needed.
16. If the physician determines a particular drug is needed for a resident which is not on the state formulary, the physician shall indicate on the prescription order by writing the words "medically necessary" above his signature.
18. "Readmissions" must be accompanied with:
 - a. A copy of the resident's new FL-2 Sheet
 - b. Physician medication orders

This information shall be faxed immediately to vendor pharmacy for review/comparison of medication orders.
19. "STAT" Orders:

STAT orders shall be faxed immediately to vendor pharmacy along with a telephone call to notify vendor pharmacy of incoming order(s). If this occurs after hours the qualified person shall page the vendor so backup pharmacy can be notified by the vendor within one hour. The backup pharmacy shall provide sufficient doses until vendor pharmacy can provide doses through normal delivery system.
20. All new orders shall begin administration at the first appropriate hour of administration after the next scheduled drug delivery.

C. Labeling and Packaging

1. All packages shall conform to current Federal and State packaging and safety laws.

2. All labels should be typed or machine printed.
3. All labels shall be firmly affixed to package, shall conform to Federal and State regulations and shall contain:
 - a. Name, address and telephone number of pharmacy.
 - b. Resident's name.
 - c. Physician's name.
 - d. Quantity, name and strength of drug.
 - e. Directions for use.
 - f. Any auxiliary labels or caution statements.
 - g. Expiration dates if applicable.
 - h. Date the order is filled.
 - i. Dispensing Pharmacist's name or initials.
4. Route of administration (ROA) shall be indicated on labels of all medications.
5. Drugs in forms intended for dilution or reconstitution should carry directions for so doing. Whenever possible, dilutions and labeling should be done in the pharmacy.
6. Containers (ophthalmic ointment, or ophthalmic drops, suppositories, etc.) should be labeled with the same information as required in #3 above and should be placed on the box or bag that holds the container itself where size permits. If container is too small, the container itself should be labeled with no less than the name of the patient and should be placed in a larger container/plastic bag bearing a label with the necessary information.
6. Medication containers having soiled, damaged, incomplete, illegible or makeshift labels are to be returned to the pharmacy vendor for relabeling. Containers having no labels are to be disposed of according to Federal and State Laws.
7. Medications for which changes in frequency or times of administration have been ordered should be returned to the pharmacy for relabeling to assure proper labeling.
9. OTC (stock) medications can have only the original manufacturer's label or labeled by vendor pharmacy.
9. If an OTC medication is ordered for a specific resident, a prescription label is necessary for the container. However, a prescription label cannot cover any essential information on a manufacturer's container (i.e. expiration date & lot number).

D. Receiving and Storing of Drugs

1. When medication is received from the pharmacy, the SIC/Med Tech or their designee shall sign the delivery driver's logbook confirming receipt of the package containing medications. Then confirm the receipt of all items listed on the enclosed delivery sheet and report, if any, discrepancies to the vendor pharmacy.
2. Community shall notify pharmacy vendor via fax of all discontinued (D/C'd) medications immediately.

The following procedure should be followed:

- a. A D/C's drug record shall be maintained by the community with the following information:
 1. Resident's name.
 2. Rx number.
 3. Name and strength of medication.
 4. Vendor pharmacy name.
 5. Quantity returned to pharmacy vendor.
 6. Qualified persons signature returning medications.
3. Medication rooms and/or carts shall be functional and provide:
 - a. Adequate space so that medication can be placed and arranged without crowding.
 - b. Adequate lighting and accessibility so that labels can be plainly read.
 - c. Locked rooms and/or carts for security of all controlled drugs with appropriate accountability records.
 - d. Refrigeration.

- e. Separate storage facilities for “External Use” drugs.
 - f. Poison Control telephone number.
4. Medications for patients are kept and stored in their original container. Transferring between containers is not permitted.
 5. Only drugs and equipment for administering drugs should be stored in medicine cabinets.
 6. Multi-dose vials or other drugs reconstituted on the resident care unit shall carry a label with the following:
 - a. Date opened.
 - b. SIC/Med Tech or qualified persons name or initials.
 7. Opened multiple-dose vials, containers and topical irrigation solutions are to be handled as follows:
 - a. General Rule
 - All must be initialed and dated when opened.
 - All Multi-Dose Vials (MDV) shall be considered out-of-date (expired) and should be removed from use and placed in a designated area for disposal after 30 days from the date opened or as specified in the community’s policies or manufacturers recommendations.
 - All Topical Irrigation Solutions will be disposed of within 72 hours after initial opening.
 - b. Exception:

Due to the package size and cost containment, some medications are exempt from the general rule. i.e. (immunizations, vitamin B12, and insulin). These drugs are to be disposed of within the time period specified by the manufacturer.
 - c. Refer to Drug Reference(s) or contact vendor pharmacy when unclear of drug disposal dates.
 8. Drug carts and/or medications rooms should be examined at least weekly by the SIC or their designee. Drugs which appear to have deteriorated or exceed their expiration date shall be returned to pharmacy vendor according to the community’s policy and procedures. Consultants should examine all drug storage areas upon each visit.
 9. The community’s personnel shall not alter, in any way, tamper with or deface any labeled medication card or container label. Qualified person(s) (i.e. Med Techs/SIS’s, etc) may make notations on a sticker beside the label.
 10. A medication container with an incomplete or illegible label shall be returned to the pharmacy for re-labeling and the vendor pharmacy notified as soon as the problem is noted. No pharmacy label may cover any essential or vital information on a manufacturer’s label, (i.e. expiration date, lot number or directions).
 11. Medications requiring refrigeration shall be stored in the refrigerator.
 - A. An approved thermometer should be located in the refrigerator.
 - B. A temperature chart should be located on the refrigerator door with daily/weekly documentation indicating the reading of the thermometer. The temperature should range between 36 and 44 degrees F.
 - C. No food or drinks shall be stored in the refrigerator, other than a vehicle containing medication for administration, (i.e. applesauce, pudding, fruit juices, etc).
 12. External medications shall be maintained in a separate location from oral medications (for internal use).
 13. Controlled drugs shall be stored under the protection of two (2) separate locks. If a controlled drug requires refrigeration, the drug shall be in a locked box within the refrigerator and the refrigerator must be lockable.
 14. The medication room and drug carts are to be locked at all times. Drug carts may be unlocked but must be in a locked med room.
 15. No drug shall be transferred from one container to another by anyone except by the vendor or consultant pharmacist.
 16. Keys for medicine carts, medication room and controlled drugs are to be kept with the person in charge of the cart (i.e.SIC/Med Tech, etc) at all times, during the time which they are scheduled to work. These keys shall be passed to the “on-coming person in charge” at shift change. Controlled substances controls should be counted and signed for by persons in charge of the medications for each shift at the time of shift change.

17. Controlled substances shall be stored in a locked medication room or medication cart at all times except for those designated “for bedside use” by the resident’s physician.
18. Only designated personnel shall have access to a key for the medication room/cart.
19. Unit dosed medications for deceased or discharged residents as well as those, which have expired, deteriorated or been discontinued shall be placed in the pharmacy tote for return to the vendor pharmacy. A record of drugs returned should be maintained in the community and the pharmacy. Controlled substances destroyed on-site (as in the case of refusal) at the community shall be recorded and disposition made by a minimum of 2 qualified persons. Discontinued controlled substances should be inventoried and returned to the vendor pharmacy for destruction.
20. External medications shall be stored separate from “internal” or “oral” medications.
20. Stock medications, including intravenous and irrigation solutions, shall be stored separate from individual resident medications.
22. Disinfectants and cleansing agents shall be stored separate from all medications.
23. Alcoholic beverages shall be stored in accordance with the community’s policy and controlled in same manner as drugs.
24. First Aid Supplies shall be stored in accordance with the community’s policy away from patient access in a secure location, eg. Med room.

E. “In-Residence” Delivery System

1. Type of System - 30 DAY PUNCHCARD - an exchange system whereby solid oral dosage forms (i.e. tablets and capsules) are sealed in 6” by 9” disposable cards containing 31, 62, or 90 doses of medication in plastic bubbles with foil backing.
 - A. The punch cards will contain 31, 62, or 90 dosage units depending upon the size of the tablet or capsule and the total number of doses required for a month’s supply of medication.
 - B. The number of cards required to furnish a month’s supply of medication will be so noted on the prescription label on each card, in the bottom right hand corner of the label.
EXAMPLE:
 - If 1 card is required, there will not be any notation on the card.
 - If 2 cards are required, the notation will be 1 of 2 on the first card and 2 of 2 on the second card.
 - If 3 cards are required, the notation will be 1 of 3 on the first card, 2 of 3 on the second card, and 3 of 3 on the third card.
 - C. The cards must be kept in sequence, using the lowest number first and going to the highest number in the sequence.
 - D. Give medications from the cards by punching the dose directly into a soufflé cup, beginning with the highest numbered dose and giving in descending order to the lowest numbered dose. Re-order when the specifically marked dose is punched out. If more than one card is required to furnish a month’s supply of medication, the re-order point shall be observed on the last card.
(i.e. 2 of 2)
 - E. When the last dose is punched from a card, do not put the empty card back into the patient’s medication storage area/slot. Place the empty card in the trash container on the medication cart or in the medication room and pull a new card from backup storage (drawer or bin). If through error, there is not a card in backup storage, re-order the medication by either peeling the label from the empty card or writing the re-order on the re-order form, being sure to circle the re-order as a reminder to phone the re-order to the pharmacy for delivery on the next drug delivery.
 - F. Arrange medications in the drug cart in some type of organized sequence (i.e. alphabetical, room number etc). Cards of medications are best if arranged in the order they are given according to the medication administration record (MAR). If the residence stores extra cards in a backup storage area, they should also be arranged in a similar organized sequence as mentioned above.
2. The speed and accuracy of the information transmitted by the community’s staff and received by the pharmacy staff is vital to a smooth operation. Type of information needed:
 - a. New medication ordered by the physician.

- b. Medication discontinued.
- c. Changes in dosage strength.
- d. Discharged or expired residents.
- e. New admissions.
- f. Room changes.
- g. Resident pay-status changes.
- h. D/C'd medications.

3. Personnel

- a. It shall be the responsibility of the Executive Director, Resident Care Director, Manager, SIC or their designee and the Pharmacy Consultant to insure that all resident care personnel are trained in proper handling, storage and administration of medications.
- b. The residence, according to State Rules & Laws shall designate only those personnel demonstrating complete competence in this area to handle and administer medications.

F. Administration of Medications

1. General Rules:

- a. Medications should be given within 1 hour on either side of the specified times.
- b. The resident for whom the medication is intended shall be positively identified.
- c. No resident shall be left alone while taking medication. The community's staff will ensure that medication is taken properly and in the quantities prescribed.
- d. The community's staff shall never permit medications to remain in a resident's room (unless designated "for bedside use") if for some reason the resident does not consume all the medications.
- e. Resident care personnel shall carefully observe residents after administration of medication in order to be on alert for adverse reactions.
- f. Only community approved designated personnel are permitted to prepare and administer medications.
- g. Residents shall not be allowed to self-administer their own medication(s) without a written order by the attending physician, or a community approved program or procedure.
- h. A Medication Error (ME) occurs if the wrong dose or wrong drug is administered to the resident, or, if a medication is administered at the wrong time. Medication Errors (ME) shall be reported immediately by telephone or in person to administration, vendor pharmacy, and the resident's physician. Continued follow up requires filling out an Incident Report (IR) directed to administration, vendor pharmacy, and the resident's physician. Proper form(s) will be completed by personnel incurring the error, with explanation. The resident's physician should make an evaluation of the resident and incident, make a concluding comment pertaining to the prognosis on the form and sign in the appropriate space. All signatures should be obtained within a reasonable time period, with appropriate comments from each.
- i. Adverse Drug Reactions (ADR) shall be reported in same manner as medication errors. The adverse drug reactions shall also be documented on the outside cover of the resident's chart.
- j. Medication Errors (ME) and Adverse Drug Reactions (ADR) shall be presented to the consultant pharmacists for evaluation and comments upon each visit to the community.
- k. The community shall ensure availability of current medication information reference books or texts, as determined by the Pharmacy Services Team, at each resident care station, concerning prescription and non-prescription medications, their indications, actions, adverse reactions, interactions, contraindications, administration, precautions, and dosages.
- l. Medication error or other incident reports should be reported to the attending physician immediately, in person or by phone. If contact is by phone, the qualified person acting on the incident should make a notation on the incident form of the date, time, and name of physician contacted, comments, orders and prognosis by the physician. The responsible/qualified person in charge should then sign and date their section of the form.
- m. All controlled drugs (Schedules II, III, IV & V) should be counted by two designated staff members at change of shifts daily. Documentation of the count shall be noted on Controlled Drug Usage Forms or form designated by the residence. One staff member should be from a previous shift and the second member shall be from the next shift.
- n. The staff person administering medication is responsible for charting the drug immediately after administration on the resident's MAR.
 - 1. Doses will be recorded in accordance with instructions for completing the Medication Administration Record (MAR).
 - 2. PRN medications administered shall be recorded on the face of the MAR, and on the reverse side, indicating: time given, reason or indication and follow-up for results. Results should be recorded in 2-hour periods after administering PRN until the next dose or need is due. It is best resident's physician should be contacted if PRN medications fail to produce the desired results (i.e. drop in temperature or result in bowel movements, etc) after the second dose.
 - 3. Doses not given shall be noted as circled at the appropriate time slot on the MAR with an explanation given on the

- back of the AR of why the dose was omitted.
4. Medication shall not be borrowed from one resident's medications and given to another resident, unless in the event of an emergency, which should be approved by the vendor pharmacy/manager/administration/nurse/etc. New admissions, transfers, re-admissions, re-ordering schedules, etc., should be anticipated for the proper amount of medication to be on hand for each resident.
 5. Once a dosage has been removed from the sealed unit-of-use pack, it shall not be retained for future use. The MAR should be noted that a dose has been wasted, along with a reason.
 6. Discontinued orders should be indicated by writing "D/C" on MAR or "yellow-out" with the date and persons initials, making the change.
- o. PRN medications administered shall have an indication in the "sig" or "directions of use" and the effectiveness shall be determined and recorded on the back of the MAR. Such follow-up on effectiveness or results shall be documented within a two (2) hour period following administration, whether within the same shift or across shifts.
 - p. Attending physician shall be notified after three (3) doses of "refused meds". Additionally, the refusals shall be documented by external notes or in the nursing notes" section of resident's chart. Medications can be "withheld" only by physician order. "Withheld" medications must be documented on the resident's MAR by a circle around the initials of the person documenting, or doses and/or days blocked out for drug holidays with an explanation on the back of the MAR. Nursing notes should document "withheld" medications, reasons and results.
 - q. Residents leaving the grounds for visits requiring medication must give pharmacy vendor a 24-hour notice. Medications shall not leave the community unless properly labeled and written on a "leave of absence" form with responsible party's/resident signature, and in full compliance with the State and Federal Pharmacy Laws.
- r. CRUSHING OF MEDICATIONS
1. Medications shall be crushed only upon the physician's written order.
 2. When ordering a new medication, the supplying pharmacist is to be informed if the medication must be crushed to be administered. This prior notice may result in two positive aspects:
 - a. Prevention of possible adverse effects from crushing medications that should not be crushed.
 - b. Possible change to an alternate dosage form or drug. If an alternate drug is suggested, the physician must be consulted and document his approval.
 3. An extensive list of drugs that should not be crushed will be posted in the Med Room. Also, do not crush drugs are identified by auxiliary labeling on the medication card and in directions of administration on the MARs. When a nurse incurs a situation in which nurse is uncertain about the safety of crushing a medication, and the information is not contained in the reference literature available, either the Pharmacy Consultant or the supplying pharmacist should be contacted before the medication is crushed and administered.

METHOD OF CRUSHING MEDICATIONS

There are a number of available methods for crushing medications. Any of these methods are acceptable provided that contamination of the dose is avoided. This can be accomplished primarily by double cupping in the pill crusher.

RATIONALE FOR NOT CRUSHING MEDICATIONS

1. Enteric Coated:
Designed to pass through the stomach without dissolving (i.e., the whole intact tablet) and then dissolves in the intestines. Reasons for this type of formulation include (a) to prevent the destruction of the drug by stomach acid; (b) to prevent irritation to the stomach; (c) to achieve prolonged action.
2. Time Release Capsules:
Designed to release medication over a period of 8-12 hours. The beads within the capsules are designed to dissolve at different times. It should not hurt the medication to open the capsule and administer the contents, but DO NOT crush or chew the contents.
3. Time Release Tablets:
Designed to give medication release over a period 8-12 hours. Some formulations are designed to reduce gastric irritation. Specific types are (a) slow release core-outer coating may dissolve to give initial dose of medication followed by the slow dissolving of the core to give a prolonged release of medication, (b) mixed release granules - formulated with regular and slow release granules to give immediate and also prolonged medication release, (c) multiplayer tablets - usually 2 or 3 layers with one

layer designed to dissolve at a fast rate to give a loading dose of the medication and the remaining layers dissolve at a slow rate to maintain constant blood levels of the medication, (d) porous inert carriers - a small plastic pellet with thousands of small passages filled with the medication. Medication is slowly released into the gastric fluids, and (e) soluble matrix - a wax matrix that allows a slow release of a drug into the gastric fluid. Prevents a large concentration of a drug in a local area, thus preventing gastric upset.

4. Sublingual and buccal tablets:

Designed to dissolve in the oral fluids and be readily absorbed in the mouth. Swallowing, chewing or crushing may prevent the drugs from reaching the blood stream and thus making it ineffective. Some medications are formulated differently. If the doctor orders a sublingual tablet, it should be administered in that way.

PSYCHOTHERAPEUTIC Drugs

Psychotherapeutic drugs should be supported by a suitable diagnosis and prescribed with care because of the many possible adverse side effects.

- A. ANTIPSYCHOTICS - should not be ordered for a period less than 3 days and should not be prescribed in excess of the maximum daily dosages. No more than 2 of these drugs should be ordered at the same time. Nurses or other qualified personnel are to monitor for any untoward side effects and notify the physician of the same.

Examples:

Chlorpromazine	Serentil	Risperdal
Haldol	Stelazine	Zyprexa
Loxitane	Taractan	Abilify
Mellaril	Thioridazine	Vesprin
Moban, Lidone	Thorazine	Seroquel
Navane	Tindal	
Prolixin	Trilafon	

- B. HYPNOTICS - should not be used continuously on a routine basis because of adverse side effects and a loss of therapeutic effectiveness in a relatively short time span. These drugs should not be administered in doses exceeding the usual maximum daily doses. Nurses or other qualified personnel shall monitor for excessive drowsiness or lethargy and report the same to the physician.

Examples:

Ambien	Nembutal	Dalmane
Amytal	Noctec (Chloral Hydrate)	Butisol
Placidyl	Restoril	Doriden
Chloral Hydrate	Seconal	

- C. ANXIOLYTICS - should not be administered in doses exceeding the maximum dosage ranges. Nurses or other qualified personnel should observe for adverse side effects (lethargy, drowsiness, loss of interest, loss of appetite) and report same to physician.

Examples:

Ativan	Meprobamate	Diazepam
Buspar	Miltown	Tranxene
Centrax	Serax	Equanil
Chlordiazepoxide	Valium	Xanax
Librium		

- D. ANTIDEPRESSANTS - should not be administered for less than 3 days and there should be no more than 2 changes of antidepressants within 7 days. Dosage range should not exceed suggested maximum ranges. Nurses or other qualified personnel should monitor adverse side effects (drowsiness, agitation, hypotension, extra-pyramidal symptoms) and report same to physician.

Examples:

Adapin	Imipramine	Doxepin
Amitriptyline	Ludiomal	Tofranil
Asendin	Norpramin	Elavil
Aventyl	Pamelor	Vivactil

s. MEDICATION ADMINISTRATION:

1. FOR SOLID ORAL DOSAGE FORMS:

- A. Using the MAR, check the directions, medication and strength of each package of medication, one at a time, against the label.
- B. If no discrepancy exists, empty the unit dose that contains the correct dose of medication into the soufflé cup. (If a discrepancy does exist, proper procedures for verifying the order and medication must be followed.)
- C. Empty the unit dose directly into the soufflé cup; do not touch the medication itself.
- D. After the dose is removed, if it does not need to be reordered from the pharmacy, place it on the opposite side on the top of the med cart.
- E. If it does need to be reordered, immediately pull the label and place it DIRECTLY onto the reorder sheet. Then place the package in the stack with the others.
- F. If the last dosage unit is removed, place the package in a separate area as a reminder to replace it with a new package from the back-up bin at the end of the med pass.
- G. Follow the above procedures for all solid oral dosage units needed on the med pass.
- H. Check the Mar and the labels one more time to be sure all needed meds have been placed into the cup.
- I. The packages must be replaced in the proper sequence in the cart immediately after removing medications out of the cards.

2. For Liquid Medications

- A. The above procedure should be followed in regard to the Mar and labels.
- B. The liquid dose is to be prepared immediately before administration to the patient; it is to be measured using a medicine cup, oral syringe, or other approved device for measuring oral liquids.
- C. When using the medicine cup, the liquid is to be measured at eye level using the bottom of the meniscus as the measurement guide.
- D. If the liquid is to be poured from the medicine cup into another larger volume of liquid, it is good practice to pour the medicine into the larger volume, then rinse the medicine cup with an additional small amount of diluent and again pour it into the larger volume to insure all of the dose is administered to the patient and does not remain as droplets along the sides and bottom of the medicine cup.
- E. In diluting liquids, be sure that no incompatibility exists between the medication and the diluent.

3. For preparing other dosage forms of medications (suppositories, topical agents, injections) for administration, follow standard nursing procedure.

- A. Hands should be washed thoroughly with soap and water before administering eye drops or eye ointments. Drops should be placed in lower outer corner of eye. Do not drop onto sensitive eye area, and do not touch eye with bottle or dropper.
In administering more than one ophthalmic solution to the same patient on the same med pass, be sure that at least 5 minutes elapse between administrations of the two or more solutions. This will insure optimal absorption and effectiveness of the drug and will lessen the chance for incompatibility between the two solutions once in the eye. At least 15 minutes should elapse between the administrations of more than one ophthalmic ointment.

At least 3-5 minutes should elapse between eye drops, then and eye ointment. After administering either, have patient close eyes slowly, not squeezing tightly, in order to prevent losing the medication.

In order to allow the proper time lapse, it is permissible to administer one of the ointments or solutions when the oral/injectable medications are administered, finish the med pass, then come back and administer the second solution or ointment. Be sure to mark the MAR in the binder, though, as a reminder to return to the patient at the end of the med pass.

- B. In administering insulin, it is advisable to let the insulin warm up to room temperature before the injection. It is permissible to take the insulin out of the refrigerator about 1 hour prior to the injection. It is also permissible to leave the insulin on the cart and not refrigerate. Remember, never shake the insulin; always rotate it gently between the palms for sufficient mixing. Always prepare the injection immediately prior to administration, drawing up the insulin for one patient at a time. The insulin should be injected subcutaneously, rotating sites of injection with each administration. All available sites should be injected before repeating a particular site, unless patient has undergone amputation (four sites: left arm, left leg, right arm, right leg). Sites should be documented on MAR in provided space

4. For administration of oral medications through a Nasogastric Tube or Gastrostomy Tube.

- A. After washing hands, dispense all crushable tablets into soufflé cup. Place another soufflé cup on top of pills (i.e. double cupping). Crush tablets thoroughly with pill crusher, and then mix the crushed tablets with diluting liquid.
 - B. Open all capsules that can be opened and mix their contents with diluting liquid.
 - C. Pour liquids to desired quantity into plastic, calibrated cups. Add to diluting liquid.
 - D. Assure proper placement of NG tube by placing stethoscope on patient's abdomen and gently pushing air into the tube with a syringe. Listen for gastric noise created when the air enters the stomach. Once determined, flush tube with approximately 30 ml of water.
 - E. Assure proper placement of G-tube by installing approximately 30 ml of water. Water should flow easily into tube.
 - F. Pour diluted medication into syringe barrel, elevating the tube slightly to increase flow rate.
 - G. After all medications have been given, flush again with 30ml and reclamp tube.
5. For administration of oral inhalants.
- A. Shake inhaler well and remove cap from mouthpiece.
 - B. Have resident breathe out to clear air from lungs.
 - C. Insert mouthpiece into patient's mouth with lips closed around it, and have them breathe deeply.
 - D. Depress medication canister with index finger, releasing when patient begins to exhale.
 - E. Allow 1 minute between inhalations if more than one is required.
 - F. Clean inhaler frequently.
6. For administration of nasal inhalants.
- A. Have patient gently blow now to clear the nostrils.
 - B. Shake medication well and remove cap.
 - C. Carefully insert nozzle into one nostril and close the other nostril with one finger.
 - D. Have patient tilt head back and breathe in while pressing medication canister.
 - E. Instruct patient to hold breath, then breath out through the mouth.
 - F. Repeat inhalations as ordered.
 - G. Clean inhaler frequently.
7. For administration of eye drops.
- A. Wash hands with soap and water.
 - B. Pull lower eyelid down with tissue. While patient tilts head back and looks up, place drops into lower outer corner of the eye.
 - C. Have resident close eyelids slowly to spread drops over the surface of the eye.
 - D. Wait at least 5 minutes between two or more different eye medications.
 - E. Eye drops should precede eye ointments by at least 5 minutes.
8. For administration of eye ointments.
- A. Wash hands with soap and water.
 - B. While patient looks up, pull lower eyelid down and apply about 1/8 inch of ointment into lower, outer corner of the eye.
 - C. Have patient close eye slowly to spread ointment over eye.
 - D. Eye ointments should follow eye drops by at least 5 minutes.
9. For administration of eardrops.
- A. Have patient tilt the affected ear up, while either lying down or sitting up.
 - B. Roll medication in hands for a few minutes to warm, then shake well.
 - C. Place drops into ear and have patient keep head tilted for about 2 minutes (DO NOT touch ear with dropper).
10. For administration of rectal suppositories.
- A. Wash hands with soap and water.
 - B. After explaining procedure to patient, place on disposable gloves.
 - C. Lubricate first finger and suppository.
 - D. Insert suppository into rectum beyond the first sphincter muscle, applying pressure for a brief period until desire to expel the suppository has passed.
 - E. Remove gloves and place them and tissues in paper towel wrap, to be placed in a container for disposable contaminated articles.
 - F. Place patient in comfortable position.
 - G. Wash hands with soap and water.

11. Subcutaneous Medications

- A. Confirm order, assemble equipment, identify patient, explain procedure, wash hands, provide privacy. Prepare medication and glove per policy.
- B. Select a site on the outer upper arm, anterior thigh, abdomen or upper buttocks without excessive pigment, nodules, lesions or hair. Select a site that has not recently been used.
- C. Cleanse area with an alcohol swab, wiping with firm pressure from injection site outward in a circular motion. Allow skin to dry.
- D. Hold needle in the dominant hand like a dart or pencil.
- E. Pull cover straight off the needle with non-dominant hand. Use the thumb and forefinger of the same hand to grab and bunch the area surrounding the injection site.
- F. With dominant hand, inject the needle quickly at a 45-90 degree angle depending on the amount of fatty tissue and its turgor and length of the needle. A dart-like motion is least uncomfortable.
- G. After needle is inserted, release skin with non-dominant hand. Place hand at end of the barrel to steady it. Slide dominant hand to barrel.
- H. If your policy indicates, pull back on the plunger to aspirate for blood. If present, remove needle and discard. Repeat procedure to this point.
- I. Inject medication slowly.
- J. Withdraw needle quickly at the same angle in which it was inserted.
- K. Massage area gently with alcohol swab if indicated. (Do not massage heparin or insulin injection site.)
- L. Discard needle in sharps container without recapping.
- M. Remove gloves, wash hands.
- N. Document procedure and patient response to medication.

Tips:

1. Medications given by the SQ method include epinephrine, growth hormone, insulin, erythropoietin and some vaccines.
2. Always choose an abdominal site for heparin injections.
3. Do not give a SQ injection into the side of the abdomen that has an implanted peritoneal dialysis catheter.

12. Enemas

An adult patient should lie on the left side (to facilitate movement in the sigmoid and lower descending colon) with knees bent or kneel on the bed with the head and chest lowered and forward until the left side of the face is resting on the surface of the bed. The patient or person administering the enema should then:

1. Insert the lubricated enema nozzle into the rectum with steady pressure, with the nozzle pointed toward the navel.
2. Insert the nozzle until it seems that it will go no further.
3. Squeeze the container until the entire dose is expelled.

13. Topical Cream/Ointment

Apply a thin layer to entire affected areas after washing and drying. Use as directed by physician. Avoid contact with eyes and mucus membranes.

14. Sublingual

Tablet should be dissolved under the tongue.

15. Nebulizer

1. Add the proper amount of drug/dosage into the nebulizer reservoir.
2. Connect the nebulizer reservoir to the mouthpiece or facemask.
3. Connect the nebulizer to the compressor.
4. Have the patient sit in a comfortable position. Place the mouthpiece in the patient's mouth (or place the mask on) and turn on the compressor.
5. Have the patient breath as calmly, deeply, and evenly as possible until no more mist is formed in the nebulizer reservoir (about 5 to 15 minutes, depending on dose). At this point the treatment is finished.
6. Clean or dispose of equipment per residence requirement.

16. Transdermal Patch

1. Clean and dry area where the patch is to be applied.
 2. Be sure the patch is applied to a clean, dry, and unbroken skin.
 3. Open package following manufacturers directions.
 4. Apply patch as directed will holding to patient with firm pressure for 10 seconds making sure no air bubbles are under it.
 5. Do not apply lotion or powder to area unless directed to.
- Important note: be sure to rotate site or transdermal patch application.

- r. Preparation of medications for administration must be given full and undivided attention.
1. All drug containers must be completely and properly labeled with a prescription label. Under no circumstances should a prescription drug be administered from an unlabeled container or one with a mutilated or defaced label.
 - a. Labeling shall be in accordance with Federal and State laws and Standards of Pharmacy Practice. Auxiliary labels shall be utilized as needed and necessary.
 - b. Medications requiring dilution or reconstitution at the time of administration shall have instructions, provided by vendor pharmacist, included with the medications.
 - c. No label is to be imposed over pre-existing labels (Double labels).
 2. In preparing to administer a medication, the label shall be checked three (3) times:
 - a. Before removing container from drawer.
 - b. Before removing med dose from package.
 - c. Upon returning container to drawer. It is important to remember that the medication administration person is the final check on the accuracy of the medications given to residents. It is therefore essential that the three above “checks” be regularly systematically and consistently performed.
 3. Different classes of medications will be administered (via Med passes), monitored and documented in accordance with regulations and standards of practice.
 4. Frequency and times of administration.

All areas: as indicated on MAR

“sig”	Frequency	Sample Times	Residence Specific Times
qd	(once a day)	9 am or 8 pm	_____
bid	(twice a day)	8 am & 8 pm	_____
tid	(three times a day)	8 am, 2 pm & 8 pm	_____
qid	(four times a day)	8 am, 12 pm, 4 pm & 8 pm	_____
qod	(every other day)	9 am or 8 pm	_____
q4h	(every four hours)	8 am, 12 pm, 4 pm, etc.	_____
q6h	(every six hours)	6 am, 12 pm, 6 pm, etc.	_____
q12h	(every twelve hours)	8 am, 8 pm, etc.	_____
ac	(before meals)	30 min. before meals	_____
pc	(after meals)	30 min, after meals	_____

5. Deviation from established medication hour routines shall be permitted in the community according to resident needs and requirements, category of medication, groups of medications, number of medications to be given at one time, types of medications which should not be mixed or given concurrently and to coincide within parameters of medication pass time.
6. All administered medications shall be noted on the resident’s MAR by recording the name of the drug given, dosage, hour of administration, and initials of person administering dose. Any dose not given should be circled at the appropriate time slot on the front of the MAR with reason for omission recorded on the reverse side of the MAR.
7. Consultant Pharmacist will conduct a “med pass” review periodically to ensure that medication administration personnel made aware of the principles, practices, requirements and problems associated with administration of medications. Four methods are used and acceptable.
 - a. Direct med pass observation as a staff member performs a med pass (30 minutes to 1 hour)
 - b. Resident care station discussions and tests on med pass facts are discussed.
 - c. Organized “in-services” where all aspects of med passes are discussed.

- d. "Mock" survey type "med pass" observations will be conducted as determined necessary by the consultant pharmacist.

Standing Order Policy

1. The community's Standing Orders (SO) for medications, laboratory tests and certain treatments (TX) shall be used in lieu of leaving PRN conditions on each resident's Medications Administration Record (MAR). Standing orders will prevail except if otherwise ordered.
2. Each residence may customize their own standing orders as long as they are approved and signed by the primary physician upon initiation and every 6 months.

"Bedside Medication

1. Bedside medications are not permitted, except when specifically ordered by the resident's physician.

Medications Brought in by Residents

1. Any new resident may finish home medications before ordering new meds from vendor pharmacy.
2. Vendor pharmacy cannot assume responsibility or liability for dispensing errors or concurrent drug interaction monitoring when any resident chooses to use an outside source for obtaining medications. The Consultant Pharmacist will however be responsible for reviewing any resident's MAR and chart who choose to use an outside pharmacy vendor on their regularly scheduled visits.

Labeling

1. Label change
 - a. Immediately fax information to pharmacy.
 - b. Note Medication change on MAR.
 - c. Apply auxiliary label to containers if allowed by facility (ex. Order changes refer to MAR).
 - d. Pharmacy will not legally be able to provide a label to the facility to "fix" the directions
 - e. If appropriate, the pharmacy will make efforts to re-label medication for the facility.

Discontinued Drugs (i.e. discharged or deceased patient)

1. Immediately fax information to pharmacy.
Remove "discontinued" med(s) from drawer and place in designated pharmacy tote with completed Return-to-Pharmacy form, to await return to the pharmacy for disposal/destruction or credit if applicable.

Medication Administration for Residents on Leave of Absence (LOA)

1. Medications may be released to residents on LOA.
2. Every effort should be made to contact vendor pharmacy or backup pharmacy (after hours, weekends, and holidays) for preparation and dispensing of LOA medications in a conventional prescription vial system with appropriate labeling.
3. An approved release form provided by the community should be signed by the resident or the responsible party.
4. The physician may order a drug holiday while resident is on LOA.
5. Individual unit-dose medications should not be released to a resident unless dispensed by a registered nurse or pharmacist with written instructions. Non-unit dose medications may not be released to the resident without a registered pharmacist's preparation and labeling.
6. No unused unit-dose medication can be returned to the community.

Sample Medications:

1. The residence should assure that the patient has an order for the medication.

2. Labeling should be clear and visible and include normal labeling protocol. The practitioner providing the sample is responsible for labeling.
3. Administration and documentation should be performed as indicated for purchased medications.
4. Storage should be appropriate for the dosage form as indicated for purchased medications.
5. Disposal should be performed as purchased medications according to residence's policy.
6. Record keeping should be performed to include a medication acquisition log.

Recommended procedure:

1. The community's staff should call or fax vendor pharmacy to prepare sufficient medication to cover the period of time out of the residence. If possible, pharmacy may deliver meds to the community before resident departs or resident's family or guardian may pickup medication at pharmacy.
2. If 24 hours notice is not possible or if time does not permit pharmacy to deliver meds, pharmacy vendor will have back up prepare medications and instruct family of resident to pick-up at back-up pharmacy designated by pharmacy vendor. All meds will be billed to resident by pharmacy vendor (there will be no cash transfer from back-up pharmacy).

M. Emergency Kits

1. "Emergency Kits" are prohibited from being maintained or utilized within the community unless authorized by the state in which the community resides (i.e. NC – no and VA – yes, as long as there is a registered nurse on site to manage the kit).

N. Alcoholic Beverages

1. Recognizing that alcohol can in fact act as a medication, alcohol consumption should be under a physician's order and if so, shall be recorded the same as any and all medications.
2. Since alcoholic beverages are usually obtained from a source other than the pharmacy, the pharmacy shall be notified so that they may be alerted for any possible incompatibilities with medications.

O. Controlled Drugs (Controlled Substances, Narcotics, etc.)

1. All controlled drugs (CII, III, IV, V) require a written prescription order from the resident's physician. The written prescription must first be faxed and later sent to the vendor pharmacy with the designated delivery driver. For internal control the community should follow these guidelines.
 - a. Individual controlled drug records shall be maintained for each resident; one medication per record with the following information:
 1. Name of resident.
 2. Name of medication.
 3. Dosage administered.
 4. Date of administration.
 5. Initial and ending count.
 - b. All controlled drugs shall be counted once each shift by two (2) persons (not from the same shift one from the preceding shift and one from the incoming shift).
 - c. Documentation of count shall be maintained on individual controlled drug sheets, on the active MAR (Med Book), one medication per sheet, signed by two (2) persons, as in a. above.
 - d. It shall be the medication person's responsibility to complete individual controlled drug records for each medication administered.
 - e. If all drugs are not accounted for, the Resident Care Director, Executive Director and vendor pharmacy must be notified.

- f. If a controlled drug requires refrigeration, the drug shall be in a locked box within the refrigerator or the refrigerator must be lockable.
- g. All controlled drugs will be dispensed in suitable packaging so that quantity can always be determined.
- h. Delivery by driver requires the SIC's signature on the itemized general delivery acceptance sheet.
- i. Return of controlled substances from the community to vendor pharmacy requires documentation of such drugs on the Return to Pharmacy Form and placed in a sealed tote for return to vendor via the delivery driver. The vendor pharmacy will confirm the returned medications and return the confirmed receipt to the community.
- j. Periodic spot counts shall be taken of these drugs by the Pharmacy Consultant and/or a person designated by administration. Results of this count should be compared with patient medication records and discrepancies reported to pharmacy vendor/consultant and administration.

P. Disposal Policy and Procedures

1. It is the responsibility of the Pharmacist and the Supervisor-In-Charge, or designee to inventory and document all discontinued, outdated, adulterated, deteriorated and deceased resident's medications in the community, on a regularly scheduled basis. No medications are to be disposed of in trash, wastebaskets or garbage cans.
2. Disposal procedure shall be documented in writing using the "Medication Destruction" form, recording the following information:
 - a. Name of resident for whom drug was prescribed.
 - b. Prescription number.
 - c. Name of pharmacy.
 - d. Name and strength of drug.
 - e. Amount of drug destroyed.
 - f. Reason for destruction.
 - g. Destruction records shall be signed by both Pharmacist and SIC.
3. These medication records shall be maintained by the community for a period of at least three (3) years.
4. Any medication brought to the community by a resident shall be inventoried and treated in the same controlled manner as controlled substances obtained from the vendor pharmacy.
5. Needles and syringes are to be deposited in an approved disposable container, (i.e. Sharps container). When full, the container should be picked up by a medical waste management service or their designee.

Q. Access to Services

"The community will have access to medication and consultation 24 hours a day 7 days a week" by:

- a. Direct deliveries or pick-up from vendor pharmacy, during normal hours, or
 - b. Local pharmacies (i.e. back-up pharmacy), or
 - c. Local hospitals, in this order.
1. Daily Deliveries
 - a. Vendor pharmacy will deliver once a day Monday through Friday for new admissions, new orders and changes in meds.
 - b. Vendor pharmacy is open Monday through Friday from 9:00 am to 6:00 pm. Back-up pharmacies will have longer and more varied hours. Facility will be notified of closing on holidays at least 3 days prior to holiday.
 - c. The community's staff shall fax orders no later than 3:00 pm to vendor pharmacy for normal daily delivery. After 3:00 pm, fax orders should still be sent to vendor pharmacy; however, the "back-up" pharmacy may fill the order and deliver as soon as possible if requested by vendor pharmacy. Vendor pharmacy may rely on "back-up" pharmacy and not process orders after 3p.m. until closing if possible to complete and send out with that night's courier.

R. Medicaid/Medicare Part D Drug Program

Medicaid has the following program coverage for providing medications to recipients:

1. Legend drugs
 - a. Drugs must be on formulary and meet the limitations of the plan under present regulations.
2. Non-Legend Drugs (OTC's)
 - a. Vendor pharmacy will bill each resident or responsible party for all non-legend and non-covered drugs ordered for that resident by their physician.
 - b. Vendor pharmacy recommends that in order to minimize non-legend drugs processed as prescriptions (not stocked by the community) and excessive inventories, a non-legend formulary designated "Community Stock" should be developed and strictly enforced if residence desires and agrees.
3. Medicare Part D will be billed for all medications covered by the individual plans.

S. Library

1. The community shall have available drug information such as the Physician's Desk Reference or Mosby's Nursing Drug Handbook and any other volumes deemed necessary by the Consultant Pharmacist.
2. The pharmacy shall maintain a library as required by the Board of Pharmacy including but not limited to:
 - a. Fact and Comparisons
 - b. PDR - Physician's Desk Reference
 - c. Remington's Practice of Pharmacy
 - d. Medical Dictionary
 - e. Any other volume deemed necessary

T. Poison Control Information

1. The community should have a poison control chart or telephone number conspicuously posted.
2. Each resident care area shall have posted the telephone number of the appropriate poison control center.

U. Drug Product Selection Authorization

Vendor pharmacy dispenses the equivalent brand name drug or a generic brand drug as set forth in the Substitution laws of the State of North Carolina unless the prescribing physician specifies otherwise (by writing Brand Medically Necessary) in his/her own handwriting.

V. Reviewing and Monitoring

1. Drug Regimen Review (DRR) forms shall be maintained as a part of the medical record of each resident, located as the last sheet under the Physicians Orders section of each chart. Other areas may be designated in medical record (chart/folder) determined on a per residence choice. A DRR shall be documented at least quarterly by the consultant pharmacist. An appropriate amount of time shall be allocated, as determined by the consultant pharmacist, to perform quarterly DRR's. Any irregularities shall be reported, in writing, to the attending physician (where applicable), the SIC (where applicable) and the Executive Director (if policy and applicable).
2. A report or system shall be designed to allow the physician to respond to irregularities applicable to his or her area of responsibility and expertise, the SIC, or designee, to respond to irregularities applicable to his or her area of responsibility and expertise. Such records should contain signatures of the consulting pharmacist and the Supervisor-In-Charge (SIC), Resident Care Director (RCD), or other designee, and made available to the Executive Director for review and/or comment.
3. Drug Room Inspection Report (DRI), or Resident Care Station Inspection (RCSI) will be completed quarterly by the

consultant pharmacist. Irregularities will be discussed with the SIC or a designee for corrective action. Such records shall be maintained by the community for a period of two (2) years.

4. Quarterly, DRR and DRI or RCSI reports, will be included in the Consultant Pharmacists' Report, with responses and comments of corrective action taken or resolutions made and will be submitted to the community Administration for review. Such reports shall be maintained by the community
5. Irregularities to be assessed during the quarterly DRR and DRI are enumerated on the forms of the same title.
6. The DRR form lists items of law, regulations and standards of practice (SOP) by which all charts are evaluated. Ultimately, all efforts in reviews of charts are designed to eliminate all "unnecessary" drugs. "Unnecessary" drugs are those without an indication, excessive dosing, excessive periods, and adequate monitoring and undue adverse consequences.
7. Drug Holidays can be attempted for any medication including maintenance drugs and psychotherapeutic agents. This allows a resident to be without certain medications for a day at a time to determine if he or she can do "without". The resident is monitored for adverse side effects while drug free. If a resident's condition can be maintained without the medications, it should be discontinued as an unnecessary drug. If the resident demonstrates adverse effects due to the absence of the medications, the physician shall be notified for any further orders.
8. Consultant Pharmacist may use technicians, computers and other resources to accomplish consulting responsibilities in the most efficient way.

W. Pharmaceutical Reports On-File

1. All reports pertaining to pharmaceutical services shall be kept on file at the facility and may contain:
 - a. Med Room & Cart Audit
 - b. Medication Destruction Reports (MDR)
 - c. Quarterly Drug Regimen Review (DRR)
 - d. Medication Errors Reports (MER)
 - e. Adverse Drug Reaction Reports (ADR)
 - f. In-service Records (ANI)

X. Forms and Lists

1. Telephone List
2. Procedure for 24-hour pharmacy service (backup policy)
3. FL-2 Form and Responsible Third Party Form
4. Pharmacy Fax Order Form
5. Delivery Sheet and Check List
6. Controlled Substance Count Record
7. Physician Orders Form
8. Medication Administration Record (MAR)
9. Medication Cart & Room Inspection
10. Medication Error Report Form (MER)
11. Drug Regimen Review Form
12. Control Drug Destruction Form
13. Metric-Apothecary Conversion Chart
14. Poison Control Telephone Number
15. Do Not Crush Medication Listing
16. Standard Medical Abbreviations

Z. General Abbreviations

SIC	Supervisor-In-Charge
LTC	Long Term Care
LTCS	Long Term Care Services
LTCF	Long Term Care Facility
LOA	Leave of Absence

DEA	Drug Enforcement Agency
MDI	Multi-Dose Injections
MDV	Multi-Dose Vial
UD	Unit Dose
ROA	Route of Administration
PA	Prior Approval
DOB	Birth Date
DX	Diagnosis
IX	Indication
PRN	As Needed
HOA	House of Administration
TO	Telephone Order
VO	Verbal Order
MAR	Medication Administration Record
TAR	Treatment Administration Record
PO	Physician Order
TX	Treatment
IAW	In Accordance With
P&P	Policies & Procedures

Natural Disaster Plan

Express Care Pharmacy has instituted provisions to continue providing sufficient Pharmaceutical Services during and following any natural disasters, including but not limited to hurricanes, tornadoes, fires, floods.

The following are items included in those provisions:

A Registered Pharmacist is on-call 24hrs/day, & 7 days each week

A list of all pharmacist with their personal phone numbers is included in this procedure manual.

A pharmacist will be prepared to appear in person at the facility, and assist the facility with any emergency needs, including the relocation of residents.

Express Care Pharmacy will continue all pharmaceutical services at another location, in the event residents are relocated.

In the provisions of the Pharmacy Laws of NC, should the Governor of NC declare a disaster or a “state of emergency”, Express Care is permitted to provide drugs, devices, and professional services to the public.

Express Care Pharmacy also has agreements with other pharmacies to help with dispensing of medications locally.

There is also taxi and/or cab service contracts in place that will be utilized to accommodate delivery of medications from the local pharmacy to the facility.

During any natural disaster, Express Care will be in contact with state and local officials for advice and means to take care of the residents within the facility.

TELEPHONE LIST & HOURS OF OPERATION

Address:

**Express Care Pharmacy
915 West 13th Street
Washington, North Carolina 27889**

Hours of Operation: Monday – Friday 8:30am – 5:30pm

Pharmacy Phone#: 866-946-2425 or 252-946-2425

Pharmacy Fax #: 866-946-2421 or 252-946-2095

Emergency (After Hours #): 866-946-2425 or 252-946-2425

Pharmacists:	Greg Poythress, R.Ph.	Office:	866-946-2425
		Mobile:	252-717-1932
		Fax:	866-946-2421

	John Boyd, R.Ph.	Office:	866-946-2425
		Mobile:	252-902-6790
		Fax:	866-946-2421

	John Dombach, RPh	Office:	866-946-2425
		Mobile:	252-367-2215

	Kennedy Blount, RPh	Office:	866-946-2425
		Mobile:	252-714-6686