

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION F: MEDICATION POLICIES AND PROCEDURES</p> <p>CHAPTER 23: MEDICATION MANAGEMENT</p> <p>POLICY AND PROCEDURE 23.2 Medication Transcription</p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Registered Nurses and Licensed Practical Nurses</p>

Standard of Practice:

The nurse will ensure that the patient receives correct medications through competent transcription of Physician's orders.

Standard of Care:

The patient can expect to receive medications correctly by the nurse as ordered by the Physician.

A. Medication Administration Record (MAR)

At the top of the MAR, enter the current month, year, patient name and MPI number.

Document any allergies in the red box.

Enter the date ordered or renewed in the "date ordered" block, in ink.

Enter the transcriber's initials in the upper half of the renewal date box.

Enter the name of the medication using the generic format and the dosage, the route, and the frequency in the "medication" block, in ink. Any orders not written using the generic name cannot be transcribed. The physician must be contacted to change the brand name on the order to the generic name BEFORE nursing can transcribe it.

Note the expiration date and time in pencil in the "expiration date" block. (see Automatic Stop Orders).

Indicate the hours of administration, including AM or PM (except for PRN and STAT orders) in the "hour" column. The top box is reserved for AM meds, the middle two boxes for day and early evening meds and the bottom box for night meds.

Enter every medication, including PRN and STAT, in a separate block.

Record scheduled medications in the top portion of the MAR.

Record PRN and STAT medications in the lower portion of the MAR.

Number additional MAR's **at the bottom** of the page. (Page ____ of ____).

Transcribe treatments, which include medication(s), onto the MAR.

Transcribe medication orders with two (2) different doses and/or two (2) different routes of administration in separate boxes. (see Example 1)

EXAMPLE 1

Date Ordered	Initials	DRUGS * DOSE MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8	9	10	11	12
11/5/xx	<i>NN/</i>	Valporic Acid 250mg po 8a-4p	12/5/xx	8a	→											
				4p	→											
		X 30 days														
11/5/xx	<i>NN/</i>	Valporic Acid 500mg po 10p	12/5/xx													
		X 30 days														
				10p m	→											

B. Insulin Orders

Use the top portion of the MAR for standing insulin coverage and the lower portion for sliding scale insulin coverage.

EXAMPLES

Accu-checks at 6 a.m. and 4 p.m. Daily

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	<i>NS</i> <i>MF</i>	Accu-check at 6 a.m and 4 p.m. daily, before breakfast and dinner.	1/30/xx	6a.m.	→			NS	JP	JP	KK	PD
				Results	→			88	104	109	115	111
				4p.m.	→			MF	LW	MF	MF	BF
				Results	→			104	112	100	115	130

Standing Coverage

Glargine Insulin 40 units SC daily x 2 weeks

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	<i>CO</i> <i>LW</i>	Glargine Insulin 40 Units daily at 9 p.m. SC x 2 weeks	1/18/xx	9 p.m.	→			CO	JP	BK	MF	CO
				2 nd Initials	→			LW	LW	LW	LW	LW
				Site	→			LABD	RABD	LLE	RLE	LUE

Sliding Scale Coverage

Do Accu-check every day at 6 a.m., 11 a.m., 4 p.m. and 10 p.m. for three days.

Give regular insulin SC to cover as follows:

Below 180mg/dl. No insulin
 180-200mg/dl, give 2Units
 201-250mg/dl, give 4Units
 251-300mg/dl, give 6Units

Dr. Smith, M.D.

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	<i>EC</i> <i>LW</i>	Do Accu-check Q6a – 11a – 4p – 10 p X 3 days		6am			→	JP	JP	BF	←	
				Results			→	230	210	220	←	
				11am			→	BF	JP	BF	←	
				Results			→	190	185	190	←	
				4pm			→	KK	KK	LW	←	
				Results			→	200	210	205	←	
				10pm			→	LW	NS	NS	←	
				Results			→	180	185	180	←	

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	<i>JP</i> <i>LM</i>	Do Accu-check Q6A-11A-4p-10p x 3 days With regular insulin coverage as follows Below 180mg/dl, give no insulin 180-200mg/dl give 2Units 201-250mg/dl give 4Units 251-300mg/dl give 6Units	1/18/xx	6a			→	JP	JP	BF	←	
				Initials			→	LM	NS	PD	←	
				Site			→	RUE	RABD	LUE	←	
				Units			→	4	4	4	←	
				11am			→	BF	JP	BF	←	
				Initials			→	KK	NS	LW	←	
				Site			→	RLE	LABD	LLE	←	
				Units			→	2	2	2	←	

C. Physician's Order Sheet:

Charts with new orders needing transcription will be flagged using the RED chart tab for STAT orders and the YELLOW chart tab for routine orders. When the nurse completes the transcription she/he will unflag the chart. When all orders have been transcribed from the physicians order sheet, completely underline the order, extending the line up the right-hand side of the orders to insure that the last order is enclosed and that there is clarity about which orders have been transcribed. Sign off these orders with name, credentials, date and time. If the physician writes an order without indicating the time or date, the nurse can not transcribe this. ***Orders without dates/times or unapproved abbreviations are invalid orders.*** The nurse immediately contacts the physician to re-write the order indicating the time/date and clarification of any abbreviation. The start date and time will be dependent upon the pharmacist review for potential medication interactions and a reasonable timeframe for the nurse to verify the transcription with the Pyxis profile.

EXAMPLE

10AM 11/29/xx
Gabapentin 100mg po q8AM
Aspirin 325mg po q8AM
Diphenhydramine 25mg po 8PM Dr. Smith N. Nurse, RN
11am 11/29/xx

In order to assure accuracy of the transcription, all transcriptions must be verified with the review order screen of Pyxis or by printing out a patient profile. If the information on the Pyxis system does not match the nursing MAR, then the following occurs:

- a. The nurse reviews the nursing MAR with the physician order sheet and the Pyxis order.
 1. Any discrepancy is reported as per the Medication Event Reporting OP&P 3.3
 2. If the error is on the MAR, the nurse corrects the MAR. The medication can then be administered as ordered.
 3. If the error is on the Pyxis order, the nurse notifies the pharmacist immediately and explains the error or notifies the pharmacy via voice mail. Once the error is corrected, the medication can be administered as ordered.
 4. If the pharmacy is closed, and the error is on the Pyxis system, then 2 nurses check the physician order sheet with the nursing MAR and verify that the MAR is correct.
 5. Both nurses initial the MAR. The medication can then be administered as ordered.
 6. The nurse paperclips a blue medication card to the order indicating the nature of the error.

If the order is STAT, the medication can be administered one time prior to verification.

All orders written by physicians/PA or APRNs must be reviewed by a pharmacist prior to administration of a medication for the purpose of determining drug-drug or food-drug interactions. The only exception to this are "STAT" medications. STAT medications and emergency medications can be administered without a pharmacist review.

Medication orders written off shift are faxed to the pharmacy for review by a pharmacist. Once the pharmacist reviews the physicians orders, the orders will appear in black on the Pyxis screen and the patient can receive the necessary medications. If the pharmacist identifies a potential medication

interaction, they will notify nursing immediately and request that nursing notify the on-call physician. Following this, the nurse, pharmacist, and physician on-call will need to consult regarding the medication in question.

If the medication is prescribed for patients while the pharmacy is closed, the nurse may administer the medication if, and only if, the physician documents in the progress note that he/she has performed the safety check for the medication(s) prescribed, utilizing the Lexi-Comp Software on the medstation, and there were no safety issues prohibiting the use of the medication.

On the next working day, a pharmacist will review all the new orders and if any contraindications exist, they will notify the nurse and the physician of the respective unit.

- a. In this case, one nurse will transcribe the order onto the MAR and another nurse will check the transcription for accuracy.
- b. Once the orders cross over onto the Pyxis profile, again the order on the nursing MAR must be checked with the Pyxis profile.

Remove Pharmacy copy from the physician's order sheet and forward to the Pharmacy. STAT orders shall be phoned or faxed directly to the Pharmacy. After hours STAT orders shall be faxed to the pharmacy.

When the last Pharmacy copy has been removed, line out any excess space remaining on the bottom of the face sheet (white copy) to insure that no further orders can be written. The white copy of the physician's order sheet is the only copy that permanently remains in the patient's medical record. Insert a new Physician's Order sheet into the medical record and record the patient's name, MPI#, and known allergies.

D. Renewals:

When a medication is renewed exactly as previously ordered, note the renewal date in ink in the next block under the "date ordered" column of the MAR. Adjust the expiration date and time in pencil. Initial the corresponding top half of the renewal date block. Follow the outline in "Physician's Order Sheet".

EXAMPLE

11/29/xx 10 a.m.

Renew Gabapentin 300mg po @10 p.m. J. Smith M.D.

Date Ordered	Initials	DRUGS * DOSE MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
10/5/xx	MM/SE	Gabapentin 300mg po 10pm X 30 days	12/5/xx									
11/5/xx	NN/											
				10p	NN	NN	NN	NN				

E. Expiration/Discontinuation of Orders:

Automatic and/or specified stop dates are indicated on the MAR by placing an "X" in the box next to the last dose, or by outlining (in pencil) the box that will contain the last dose sign-off. This is in

addition to the expiration date and time noted in the expiration date box.

When a medication order expires or is discontinued, a licensed nurse highlights the order on the MAR. Write "D/C" and indicate the date, time, name, and credentials in the sign-off areas of that medication.

F. Changes in Physician Orders:

Changes to orders are written in one of three ways.

For example, a patient is placed on Diphenhydramine 25 mg po at H.S. Several days later, the physician wishes to increase the dose to 50 mg po H.S.

Examples:

1. D/C Diphenhydramine 25 mg HS and give Diphenhydramine 50 mg po HS

2. Change Diphenhydramine 25 mg to 50 mg po HS

Or

Diphenhydramine 25 mg to 50 mg po HS

3. Increase Diphenhydramine from 25 mg to 50 mg po HS

Or

↑ Diphenhydramine from 25 mg to 50 mg po HS

G. Clarification of Orders:

Orders that are not clear are to be clarified before transcription. The unclear/illegible/incomplete order is discontinued and rewritten as a new order by the physician.

H. HOLD Medications

Hold Orders for medications may only be written if the order describes a specific parameter or parameters under which the medication or medications will be held. For example:

Hold clozapine 200 mg po q 8AM if BP is less than 90/50

Hold glipizide 10 mg po q 8AM pending confirmation of today's fasting blood glucose level

Hold valproic acid 1000 mg po q 8AM and 1PM pending completion of today's colonoscopy

Hold Orders which do not specify the parameters for holding a medication, shall not be transcribed by the nurse. The nurse will immediately contact the prescribing physician or (covering MD) to either discontinue the order as written or rewrite the order with the specific parameters referable to the hold.

When a medication is held, the nurse will initial and circle the box on the kardex to indicate that the dose was not given.

I. Antibiotic Form (CVH - 215)

This form must be used for all systemic antibiotics and for all renewals of same.

Remaining blank lines on the regular standing orders are lined out by the transcribing nurse and orders written on the Antibiotic Form. Subsequent non-antibiotic orders will appear on the start of a new physician's order sheet.

The transcribing nurse will transcribe the antibiotic onto the MAR as per usual transcription procedure. For each separate entry on the CVH-215, the transcribing nurse signs off in the last box labeled "Transcribing RN Signature" as per non-antibiotic practice. When all antibiotics are transcribed from this form, the nurse separates the copies, keeping the white original in the record, sending both copies to the pharmacy who forwards the pink copy to Infection Control.

J. Total Parental Nutrition (TPN)

TPN will be documented on the MAR along with any medications added by Registered Nurses. See Nursing TPN Procedure in Chapter 13; NP&P 13.2.7

K. Following a formal 24-hour medication check (NP&P 23.12, the Nurse transcribes all current orders from the Physician's Order Sheet to the new Kardex. The Nurse initiating the new Kardex, initials the first half of the first box of each medication on the Kardex.

On the last day of the month, following the nightly formal 24-hour medication check, the night shift Nurse checks the new Kardex against current Physician Orders and makes any and all changes necessary on the new Kardex. That night Nurse will then initial the second half of the first box of each medication on the Kardex. The second initial is placed on the new Kardex when all current Orders up to the *last shift* of the month has been checked. This will ensure the accuracy of the new month's Kardex.