

WHITING FORENSIC HOSPITAL
Nursing Policy and Procedure Manual

SECTION F: MEDICATION POLICIES & PROCEDURES

CHAPTER 23: MEDICATION MANAGEMENT

POLICY & PROCEDURE 23.2: MEDICATION TRANSCRIPTION

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, MPI number, and date of birth.

Document any allergies in the red box.

Enter the date ordered or renewed in the "ORIGINAL DATE ORDERED" column block, in ink.

In the "RENEWAL DATE" column first draw a diagonal line from the top right corner to the bottom left corner. Enter the transcriber's initials in the left upper half. The initials of the verifying nurse will be placed in the lower right half.

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

Original Date Ordered	Renewal Date	DRUGS *DOSE*MODE * INTERVAL	EXPIRATION DATE	HR	1	2	3	4	5	6	7	8	9	10	11	12
11/5/x x	N.N/			8a												

		Valproic Acid 250mg po	12/5/xx														
		8a-4p		4p													
		X 30 days															
11/5/x x	<i>NS</i>	Valproic Acid	12/5/xx														
		500mg po															
		10p															
		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

Fingersticks daily at 6 am and 4 pm X 30 days

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>	Fingersticks daily at 6am and 4 pm X 30 days	2/3/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

Example of Standing Insulin Order

Glargine Insulin 40 units subcutaneous at 9pm X 2 weeks

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

Sliding Scale Coverage

Perform Fingersticks every day at 6 am, 11 am, 4 pm and 10 pm for three days.

Give regular insulin subcutaneously to cover fingersticks as follows:

less than or equal to 180mg/dl. No insulin

181-200mg/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>	Perform Fingersticks every day at 6 am, 11 am, 4 pm and 10 pm for three days	1/6/xx	6am	→			JP	JP	BF	←	
	<i>lw</i>			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>						→				←	
		Give regular insulin subcutaneously to cover Fingersticks at 6 am, 11 am, 4 pm and 10 pm as follows:	1/6/xx	6a			→	JP	JP	BF	←	
				Initials			→	LM	NS	PD	←	
				Site			→				←	
							→	RUE	RABD	LUE	←	
				Units			→	4	4	4	←	
		less than or equal to 180mg/dl No insulin 181-200mg/dl ,give 2Units 201-250mg/dl, give 4Units 251-300mg/dl, give 6Units	1/6/xx				→				←	
				11am			→	BF	JP	BF	←	
				Initials			→	KK	NS	LW	←	
				Site			→				←	
							→	RLE	LABD	LLE	←	
				Units			→				←	
							→	2	2	2	←	

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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 cannot 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 exceptions 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 physician's 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 (Whiting Unit will use ink). Initial the corresponding top half of the renewal date block. Follow the outline in "Physician's Order Sheet".

EXAMPLE

11/5/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	NN/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 (WFH – 8b)

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 WFH-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.