

# **CBRF Pharmacy**

## **Frequently Asked Questions**

- 1. Q. DHS 83.02 (15) defines chemical restraint. What level of documentation is necessary to verify a medication is being used appropriately and not as a chemical restraint?**

A. A psychotropic medication used for a medical symptom is not a chemical restraint as defined in DHS 83.02(15). Therefore, there must be a specific medical symptom identified for the use of the psychotropic medication. In addition, if the medication is used as needed, documentation should indicate specifically why the medication was being used. Last but not least, the medications will have a purpose so documentation should support that the medication is working, e.g., the specific medical symptom is improving.
- 2. Q. DHS 83.02(29) defines Medication Administration. Can you explain the concept of “assistance with self-administration?” Where do self-administration, assistance with self-administration, and overall medication administration differ?**

A. There are two types of medication administration options:

  - 1) Resident’s medication is self administered.
  - 2) Resident’s medication is administered by staff.

If staff assists the resident at all, that is staff administration of the medication.
- 3. Q. DHS 83.02(41) Psychotropic Medication. What are the drug categories that constitute psychotropic medications --- anti-psychotics, anti- anxiety, sedatives, anti-depressants, others? Will you be providing an updated list?**

A. The definition in the rule specifically defines psychotropic medication as a prescription drug that is used to treat or manage a psychiatric symptom or challenging behavior. See Bureau of Assisted Living (BAL) Medication Management Website:

BAL Medication Management Initiative  
[http://dhs.wisconsin.gov/rl\\_DSL/MedManagement/asstlvgMMI.htm](http://dhs.wisconsin.gov/rl_DSL/MedManagement/asstlvgMMI.htm)

List of psychotropic medications (updated routinely.):  
[http://dhs.wisconsin.gov/rl\\_dsl/MedManagement/psychMeds.pdf](http://dhs.wisconsin.gov/rl_dsl/MedManagement/psychMeds.pdf)
- 4. Q. DHS 83.32(3)(i) related to prompt and adequate treatment. What is the accepted practice when an order is (1) sent to the facility, (2) the order is then faxed to the pharmacy, (3) the insurance does not cover the medication,**

**but will cover another medication, and (4) the pharmacist does not get a response from the MD until 2 days later?**

A. Please see Division of Quality Assurance memos 04-018 and 06-004. If medications that are needed are going to be delayed, a discussion with physician, pharmacist, and appropriate others should occur to determine if the delay is harmful and if alternatives are needed.

**5. Q. DHS 83.32(3)(i) related to prompt and adequate treatment. When a non-life-threatening medication is discontinued (i.e., Crestor) and the medication is in a multi-dose pack, is the pharmacist able to make the determination that the medication can be given until it is removed by the pharmacy from a multi-dose pack?**

A. The physician should be consulted. The pharmacist cannot determine that a medication continue to be given if the physician has discontinued the medication. When medications are discontinued, the physician's order must be clear when that should occur.

**6. Q. DHS 83.37(1)(b). The rules indicate that OTC medications NOT maintained in their original container must be labeled by a pharmacist. If this task is delegated, does that still apply or does a label need to be provided by the pharmacist? Is only the name required on the label of an OTC maintained in original container or must the label also include the directions if different than the package label? Is MAR documentation sufficient for administration? Can you define or give an example of an OTC not maintained in the manufacturer's container labeled by a pharmacist? An OTC only requires the name be on the container. Does this mean the staff should follow the directions on the label? What if the order is different than the directions on the container?**

A. If the resident is using OTC medications, order instructions need to reflect what is on the manufacturer label. If the medication is maintained in the manufacturer container, the label will have everything required except for the resident name. Facility staff can add the resident's name. If, however, the resident will take the OTC medication using directions that are different than those on the manufacturer's label, that OTC medication needs to be labeled by a pharmacist. When OTC medications are transferred to another container, the medication storage requirements in DHS 83.37(3)(a) apply, including the labeling requirement.

**7. Q. DHS 83.37(1)(c). What is the accepted practice and labeling requirement for handling sample medications dispensed at the physician's office --- unit dose, multiple doses in a bottle, Namenda titrated-dose packs, Z-packs, Medrol dose pack?**

- A. Sample medications are addressed in DQA memo 04-029.  
[http://dhs.wisconsin.gov/rl\\_DSL/Publications/04-029.htm](http://dhs.wisconsin.gov/rl_DSL/Publications/04-029.htm)

**8. Q. DHS 83.37(1)(e). What are the requirements for the medication regimen review? If a resident self-administers, is this still required? Is it sufficient to have new prescriptions written by the primary physician for all medications and would that then qualify as an acceptable review by the department? Is there a specific form that should be completed? Is it the facility's responsibility to notify the pharmacist that there has been a significant change in medication? What should the pharmacist use as a reference to determine any irregularities for appropriate action?**

- A. The medication regimen review is required only for residents in situations where the facility staff administers medication. However, as part of the resident assessment, each resident's medications must be assessed per DHS 83.35(1)(c)2. The medication regimen is not required to be on a specific form nor is there a specific guidebook or reference for pharmacists. There should, however, be sufficient documentation to indicate that a review was done. If the review is done by someone other than the prescribing practitioner, the prescribing practitioner must receive a report of any irregularities identified with the resident's medication regimen.

**9. Q. DHS 83.37(1)(e). What is the definition of a med pass observation for the RN or pharmacist --- one medication or the entire pass?**

- A. In addition to the resident medication regimen review, the facility's medication administration and storage systems must be reviewed. The individual conducting this review will determine the extent and methods used to ensure that the systems are adequate and in compliance with DHS 83.

**10. Q. DHS 83.37(1)(f). In regards to the list of medications for multiple providers, since the pharmacy fills the prescription before the medication can even be obtained by the CBRF, isn't this requirement automatically met? If not, please explain. How does this affect prompt and adequate treatment?**

A: Residents may see multiple physicians and utilize multiple pharmacies. As current computer systems are not all interlinked, each pharmacy will not have a complete list of all medications taken by a resident. In addition, OTC medications may not be listed in a pharmacy's computer. So, each CBRF must maintain a complete and current list of all medications taken by a resident. The complete list should be provided to the physician at the time of the resident's visit to ensure that the physician is aware of all the medications taken by the resident. This will assist the physician in treatment decisions.

**11. Q. DHS 83.37(1)(f). If an order is received from a specialist, then forwarded to a primary physician who subsequently discontinues or changes the dose, and**

**the two physicians disagree, what course of action should the facility take?  
Which MD order does the facility follow?**

A: Typically, when physicians disagree, the primary physician's recommendation is followed. This situation should be discussed with the physicians involved as well as the resident or their legal representative. Any decisions should be documented as part of the resident's record.

**12. Q. DHS 83.37(1)(g). What is the accepted expiration date for medications to be destroyed when the original container is not opened or when it is opened?**

A. Prescription medications packaged by a pharmacy usually carry a one year expiration date. However, some medications may carry a lesser expiration date. Examples include insulin, inhalers, and eye drops. The pharmacy can provide guidance on expiration dates.

**13. Q. DHS 83.37(1)(k). Medication error or adverse reaction provisions indicate ALL medication administration errors must be reported to the practitioner, supervising nurse, or pharmacist. But, medication errors have not been defined. In this instance, is it safe to say the state will be looking for our own definition of medication error in individual company policy to assure reporting is being done appropriately in the event of a medication error?**

A: Medication errors are defined on the BAL medication management web site:  
BAL Medication Management Initiative  
[http://dhs.wisconsin.gov/rl\\_DSL/MedManagement/asstlvgMMI.htm](http://dhs.wisconsin.gov/rl_DSL/MedManagement/asstlvgMMI.htm)

**14. Q. DHS 83.37(2)(a). Can an RN change the label from the pharmacy for a scheduled medication if the dose and directions are the same to a PRN and vice versa?**

A. No, an RN cannot change a **pharmacy** label. Until medication labels are changed by the pharmacy, any new directions must be effectively communicated to all staff who administer medications.

**15. Q. DHS 83.37(2)(e). If a task is delegated by an RN, the nurse practice act states there must be a protocol or written or verbal orders. How do we meet that requirement? Delegated tasks must have educational preparation and demonstrated abilities. Is a return demonstration necessary? Is a general demonstration okay or must it be done for each task and each client ( i.e. , suppositories). How often does the RN need to observe and monitor the delegated tasks? How often does the RN need to evaluate the effectiveness of the tasks delegated? What if the delegating RN quits and the resident has a scheduled medication order (i.e., insulin, nebulizer treatment, etc.). Other administration now requires that injectables, nebulizers, stomal and enteral medications, and treatments or preparations delivered vaginally or rectally**

**shall be done by an RN or LPN. It also states that these tasks may be delegated to non-licensed employees pursuant to the Wisconsin Nurse Practice Act. Our perception is that this includes the above when either regularly scheduled or ordered on an “as needed” basis and also that delegation may only be done by an RN, NOT an LPN. Is this correct?**

- A. RN delegation is complex and without many black and white answers when related to the amount of demonstration or supervision. Please see the resources at the BAL Medication Management Initiative website which may help RNs make these decisions:

BAL Medication Management Initiative

[http://dhs.wisconsin.gov/rl\\_DSL/MedManagement/asstlvgMMI.htm](http://dhs.wisconsin.gov/rl_DSL/MedManagement/asstlvgMMI.htm)

If a nurse who has delegated tasks to unlicensed staff terminates employment, the delegation tie no longer exists.

For the medications listed in DHS 83.37(2)(e):

- 1) An RN can administer the medication
- 2) A LPN can administer the medication
- 3) Unlicensed staff can administer the medication, but only under **RN** delegation.

**16. Q: Are physician signature stamps acceptable for quarterly psychotropic med reviews?**

A. Quarterly psychotropic reviews must be completed by a practitioner, pharmacist, or registered nurse and the results must be documented in the resident’s record. The regulation does not specifically address or prohibit signature stamps. The documentation must demonstrate that the review was completed by the practitioner, pharmacist, or registered nurse..