



PHARMACY NEWSCAPSULE

DEPARTMENT OF HEALTH SERVICES / DIVISION OF QUALITY ASSURANCE

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IN THIS ISSUE

| | |
|---------------------------|---|
| App for That | 1 |
| Medication Security | 1 |
| Melatonin | 3 |
| Consultant Corner | 3 |

APP FOR THAT



Peak-Brain Games

This is a brain game app with over 30 games developed by neuroscientists to challenge cognitive skills. The games challenge your memory, attention, problem solving ability, and mental agility. Give up your Candy Crush and try something new!

MEDICATION SECURITY

In many facilities regulated by the Division of Quality Assurance there are regulations that address medication security. For example:

Federal Nursing Home Regulation

CFR § 483.60 (e) *Storage of drugs and biologicals (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.*

Federal Hospital Regulation

CFR § 482.25(b)(2)(i) *All drugs and biologicals must be kept in a secure area, and locked when appropriate.*

CFR § 482.25(b)(2)(ii) *Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area.*

(continued)

State Community-Based Residential Facility Regulation (CBRF)

Wis. Admin. Code § DHS 83.37(3)(c) *Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.*

Wis. Admin. Code § DHS 83.37(3) (g) *Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 § USC 812 (c) and Wisconsin's Uniform Controlled Substances Act, Wis. Stat. ch. 961.*

These regulations address all medications and, often, provide additional, more stringent requirements for some controlled substances, illustrating a continued concern for medication diversion.

Unfortunately, in today's environment with the high amount of prescription drug abuse, the security of medications in facilities brings on greater scrutiny. One area where this is evident is the use of medication carts. By design, medication carts are wheeled and mobile, possibly smaller, and occasionally designed to look like furniture. Although these features are desirable, mobile medication carts can be moved out of the facility and may increase the potential for drug diversion. Therefore, there continues to be a need for increased security for medications. Facilities should review the security of their medications, including where locked mobile medication carts are and where they should be stored.

The Centers for Medicare and Medicaid Services (CMS) published the following guidance in the federal register for hospital regulations:

“Due to their mobility, mobile nursing medication carts, anesthesia carts, epidural carts and other medication carts containing drugs or biologicals (hereafter, all referred to as “carts”) must be locked in a secure area when not in use. Hospital policies and procedures are expected to address the security and monitoring of carts, locked or unlocked, containing drugs and biologicals in all patient care areas to ensure their safe storage and to ensure patient safety (71 FR 68689).”

Although this direction from CMS is for hospital guidance, it does reflect a general recognition of securing mobile medication carts.

In some cases, facilities have used chain locks to affix the medication cart to the wall in an effort to secure the cart. However, this idea can lead to other problems if the cart is secured to the wall in an area that is required to be open for fire escape routes. There are other ways, depending on the facility type and pertinent regulations, to secure medication carts. Some examples include placing the cart in a locked room, placing the cart in an area where staff is always present and the cart can be observed, locking wheels on the carts to make them immobile, or the use of alarms on the cart.

Surveyors need to review the medication storage requirements specific to each entity you survey. In those cases where carts are used and left outside of locked rooms or storage areas, you should evaluate if the facility has looked at medication security and the storage of medication carts. Carts will often be locked; however, when not in use, the storage of the cart in an unsecure fashion can lead to citations. Surveyors should focus on carts that are left unlocked, carts that are stored in areas with hidden views, or instances where carts have been broken into or taken outside. Surveyors should collect information on what is in the cart, e.g., which medications are in the cart and any resident-specific information. Collect information on where the cart is located, who may have been around, whether there were any

security breaches, and how the facility has responded to medications that may have been diverted when unsecured.

MELATONIN

Those who survey nursing homes and assisted living facilities may see melatonin used to help people with sleep issues. Due to facility regulations related to psychotropic medications, including those used for sleep, questions have arisen about possible requirements that melatonin be monitored as other psychotropic medications.

First, melatonin is not a psychotropic medication. Wis. Admin. Code ch. DHS 83 for CBRFs states: (41) “Psychotropic medication” means a prescription drug, as given in Wis. Stat. § 450.01(20), that is used to treat or manage a psychiatric symptom or challenging behavior. Melatonin is a dietary supplement and not a prescription medication. For CBRFs, melatonin does not follow the same requirements that other psychotropic medications must follow. In a nursing home, the regulations for “unnecessary medications” apply only to medications (melatonin is not a medication); therefore, if facilities fail to monitor melatonin, a surveyor cannot cite under unnecessary medications.

Second, melatonin is used for sleep issues. If residents are having sleep issues, facilities should be monitoring those sleep issues and implementing interventions. In a nursing home, those interventions may be part of a care plan; in a CBRF, sleep issues may be part of assessments and individual service plans. If melatonin is part of those interventions, it should be monitored as a part of the sleep plan and, if the plan is not working, it should be readdressed. When facilities fail to review, update or revise the service plan in the CBRF or the care plan in a nursing home when needed, these are issues that surveyors should investigate.

CONSULTANT CORNER

by Doug Englebert, R.Ph.



RN Delegation in a Residential Care Apartment Complex (RCAC) or CBRF: Is there a state-approved form to document RN delegation?

No. There is not a form that the Division of Quality Assurance recommends for documenting delegation from an RN to a staff person working in a RCAC or CBRF.

The Nurse Practice Act states:

N6.03(3) SUPERVISION AND DIRECTION OF DELEGATED NURSING ACTS. In the supervision and direction of delegated nursing acts, an R.N. shall:

- (a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised;*
- (b) Provide direction and assistance to those supervised;*
- (c) Observe and monitor the activities of those supervised; and,*
- (d) Evaluate the effectiveness of acts performed under supervision.*

See: http://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

The rule does not state that you need a written form or document; however, the RN and, by default, the RCAC or CBRF need to show that they have provided direction and assistance; have observed, monitored, and evaluated effectiveness; and have delegated the specific act to a RCAC or CBRF staff person.

One way to do that is to have documentation in a personnel file that indicates the RN is delegating the specific staff member to administer certain types of medications. The file should contain evidence that the RN observed and evaluated that staff person administering medications. Policies or time sheets may also be used to show the RN was available to assist or provide direction.

A standardized form can be very helpful but is not required in the Nurse Practice Act or through CBRF or RCAC regulations.



Regarding a PRN order with a range (e.g., Lortab 1-2 tabs every 4 hours, as needed):

If one tab is given at 12 pm and pain is not controlled and a second tab is given at 2 pm, does the 4-hour clock start from the first tab or second tab or will there always be two four-hour clocks running? The same thing comes up with end-of-life morphine (e.g., give 10 to 20 mg every two hours, as needed). The nurses may start with 10 mg and then determine a need to give the other 10 mg before two hours have elapsed, resulting in confusion about when to start the two-hour clock. How do we know what is correct when observing medication pass during a survey?

Range orders need to be addressed by policy or directly by the physician specific to that resident/patient. Facilities should have a written policy and implement that or make sure physician orders are specific for these situations.