



PHARMACY NEWSCAPSULE
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DEPARTMENT OF HEALTH SERVICES / DIVISION OF QUALITY ASSURANCE

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REVIEW OF PHARMACY ISSUES

by Doug Englebert, R. PH.

This spring has been wet and cold. It seems that everyone has been staying inside and getting some spring cleaning done, including me. I’ve been reviewing a lot of different pharmacy issues that have come up on surveys in all different types of facilities and programs. This issue of the newsletter is going to be a review of all of those questions.

- Q1:** I have a couple of questions regarding unlicensed personnel administering medications in a hospital urgent care. Could the prescribing nurse practitioner be considered a registered nurse delegating medication administration to the CMA? In addition, can an unlicensed person (such as a medical assistant) remove from an automated dispensing cabinet, administer, and waste a controlled substance in a hospital setting under an order from a physician or nurse practitioner?
- R1:** For hospitals, the federal regulations and interpretative guidelines in the [State Operations Manual – Appendix A](#) (starting at page 227) provide extensive guidance. To summarize, the task of a medical assistant to administer medications in a hospital would be delegated. The task and the personnel allowed to administer the medications and disposal procedures must be approved by medical staff, nursing staff and, by default, the governing body. In addition, since this involves medications, the pharmacist must also be involved in setting these procedures.
- Q2:** A question regarding non-insulin injections for diabetes in a community-based residential facility (CBRF): The Wisconsin law addresses that a nurse can designate insulin injections. However, what about non-insulin injections for diabetes or for other conditions? Can the nurse also delegate those injections to qualified and trained employees? Or, is a nurse required to administer them since they are not insulin?

R2: This is what the CBRF rule actually says:

Wis. Admin. Code § DHS 83.37(2)(e) Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub.(2)(e) may be delegated to non-licensed employees pursuant to § N 6.03(3).

This rule does not limit injections to insulin. ALL injections must be administered by a nurse (RN or LPN) or must be delegated by an RN. The RN who delegates must follow § N 6.03(3).

Q3: In a nursing home, the nurses have an eMAR for which they chart their medications administered. The pharmacy dispenses medication in strip packaging where the 0800 medications are packaged together in one pouch for administration. What if a medication in a pouch is labeled by the pharmacy to be given at 0800, but has a different eMAR administration time of 0600. If the nurse administers the medication at 0600 as the eMAR requests, but the pharmacy package is saying 0800, does this reach the level of a nursing citation?

R3: The scenario above needs further investigation to determine if there is a citation to consider. For example, is this a situation where an order changed the dose of medication after the supply was received from the pharmacy so that, for the next month, the label indicates to give 20 mg furosemide and the order is now 40 mg of furosemide? In this situation, to avoid waste, the facility is following the eMAR instead of the label and they use warning messages to staff to do so, as noted in their policies and procedures. This would not appear to be an issue that is in violation of any rules.

Is the scenario that all the meds were ordered for 0800 so that the pharmacy supplied a medication pouch labeled 0800, but now the order changed to 0600? Again, to avoid waste, the facility follows the eMAR and not the label and uses warning messages to staff, as part of their policies and procedures, with the expectation that the next supply from the pharmacy will have the updated times on the label. This does not appear to be an issue that is a violation.

Another scenario could be a 0800 pouch with multiple meds where some of the medications ordered are changed to 0600 and the rest are kept at 0800. In this case, the surveyor sees the nurse open the pouch, take out the 0600 meds, and administers those. The nurse then tapes up the pouch to save and give the rest at 0800. In this situation, the nurse did not follow the facility procedures to contact pharmacy to identify by shape, color, and markings the medications that should be given at 0600. The nurse also didn't follow the facility procedures for reclosing the pouches. In this case, it would appear to be a violation of pharmacy services.

Q4: We watched medication pass for a total of 28 opportunities. Upon review of physician orders, three medications were omitted and not given as ordered. There were no other errors. So, we have a total of three errors. Would this be three errors out of 28 opportunities or 31 opportunities?

R4: This would be three errors out of 31 opportunities. You include the missed doses in both the errors and opportunities for calculation of medication error rate.

Q5: I have a resident that has Lorazepam 0.5mg Q2hr PRN and Lorazepam 1.0mg Q2 hr PRN for anxiety. This order was written on 04/04/2017. There is documentation from the physician that, because the resident is on hospice, Lorazepam PRN is to be given indefinitely. Can PRN psychotropic medications be ordered indefinitely while on hospice when the resident is in a nursing home?

R5: The Centers for Medicare & Medicaid Services has provided the following example as guidance.

The regulations state that PRN orders for psychotropic drugs are limited to 14 days; except, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. For instance, if a resident takes Restoril (PRN for sleep), would it be

acceptable for the physician to document a rationale that indicates the duration for the PRN order to be indefinite? Or, is there a max on the duration of time for the PRN order?

There is no maximum duration for PRN orders for psychotropic medications. However, if an attending physician or prescribing practitioner believes it is appropriate to extend a PRN order for a psychotropic medication beyond 14 days, he or she may extend the duration and document the rationale for extending the duration. This requirement was written to address concerns about residents remaining on PRN psychotropic for prolonged periods which may not be appropriate. "Indefinitely" means for an unlimited or unspecified period of time, so, extending a PRN order indefinitely would not meet the intent of this regulation. It is also unlikely that a rationale could be provided to support an indefinite extension of a PRN order for a psychotropic medication.

So, a physician cannot use the term "indefinitely" as their rationale. For someone on hospice, it would be reasonable to indicate a duration of three to six months, since the physician needs to see the patient during that time and will also need to renew or issue new prescriptions for pharmacy purposes.

Q6: [Dillon's Law](#) (2017 Wisconsin Act 133 amending 2015 Wisconsin Act 35), which was enacted in December of 2017, allows any person with proper training to have a prescription for Epinephrine (Epi-Pen). What is considered the proper training?

R6: This law states: An "... employee, agent, or individual shall complete a training program conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment or an organization approved by the department."

Upon review of a Wisconsin Legislative Council Act Memo pertaining to the 2015 Wisconsin Act 35, the Department of Health Services is the relevant department that would approve "other" organizations that provide these training programs. Currently, the American Red Cross is the only organization that DHS has approved to train laypersons on the use of Epinephrine for this purpose.

SURVEYOR PHARMACY TIPS: SCHEDULE I-V MEDICATIONS

In all settings, there are many rules that refer to Schedule II medications and their special requirements, which may include proof-of-use daily audits, separate storage with a separate key, and even storage in permanently affixed storage compartments. For surveyors, the question that comes up is, "What medications are Schedule II?"

Let's begin with, "What is scheduling?" Medications are scheduled I-V in order of those that are most addicting (Schedule I) through those that are least addicting (Schedule V). Schedule I medications are those that are typically illegal with no medical purpose. These include items like heroin. Schedule II medications that are commonly seen by surveyors would be morphine, methadone, and oxycodone. See DQA publication [P-01807, Controlled Substances – Quick Reference for Schedule](#).

Another tip is to simply do an Internet search for the drug name and the words "package insert" (e.g., "oxycodone package insert"). Available options should include the Food and Drug Administration approved package labeling. The package insert will always indicate that the schedule of the drug is on the package insert's first page with the drug name.