CHAPTER 14

POLICY AND PROCEDURES
POLICY AND PROCEDURES

- Required for Florida BOP class II institutional permits
- Minimum content depends on specific practice setting
- Reference for P&Ps = State and Federal regulations, Joint Commission Standards and Elements of Performance, Medicare Conditions of Participation, ASHP practice standards
- CHALLENGE: Must be kept current - regulatory and accreditation bodies compare practice with policy
- Available to staff at all times
  - Paper Manual
  - Intranet or other electronic system
- Reviewed at least annually; dated to indicate time last reviewed (FAC 59A-3.2085(2)(p))
- Standardized format and numbering system recommended
- Refer to Florida Records Retention Guidelines
- Archive old policies based on organization’s policy (e.g., 10 years). DO NOT DESTROY.

REQUIRED POLICY AND PROCEDURES

- Policies and procedures to minimize drug errors should include (reference §482.25).
- High-alert medications - dosing limits, administration guidelines, packaging, labeling and storage.
- Availability of up-to-date medication information.
- Availability of pharmacy expertise. Pharmacist available on-call when pharmacy does not operate 24 hours a day.
- Standardization of prescribing and communication practices to include:
  - Avoidance of dangerous abbreviations
  - All elements of the order – dose, strength, units (metric), route, frequency, and rate
  - Alert systems for look-like and sound-alike drug names
  - Use of facility approved pre-printed order sheets whenever possible
  - That orders to “resume previous orders” are prohibited.
- A voluntary, non-punitive, reporting system to monitor and report adverse drug events (including medication errors and adverse drug reactions).
- The preparation, distribution, administration and proper disposal of hazardous medications.
- Drug recalls.
- That patient-specific information is readily accessible to all individuals involved in provision of pharmaceutical care. The patient information must be sufficient to properly order, prepare, dispense, administer and monitor medications as appropriate.
- Identification of when weight-based dosing for pediatric populations is required.
• Requirements for review and revision based on facility-generated reports of adverse drug events and QAPI activities.

• Drug procurement, storage, distribution and control of drugs, radiographic contrast media and blood derivatives to include how inventory is rotated (by oldest stock or by earliest expiration date).

• Disaster procedures to include assessment of medications and determination of usability, how medications will remain secured in event of crisis.

• Drug recalls and withdrawals to include quarantine.

• Outdated Rx drugs are segregated until removed and documentation maintained 2 yrs.

• **Controlled substance storage, distribution, control and destruction.**

• Investigational drug storage, distribution and control.

• Procurement of medications not on the formulary (non-formulary medications).

• **Medical staff approval of automatic expiration of medication orders and mechanism to reinstate the order. TJC does NOT identify specific medications requiring automatic stop.**

• Distribution of drugs to patients at discharge (community permit/labeling requirements, return to pharmacy for pharmacist determination of disposition).

• Procedure for patients bringing medications from home.

• Procedure for obtaining medications when the pharmacy department is closed (single dose removed by charge nurse, pharmacist review process, limited access to medications).

• Sample medications.

• Employee competency and performance evaluation process (TJC HR standards).

• **Technician responsibilities (reference 64B16-27.410 and 64B16-27.420).**

• Medication Administration Record (reference 64B16-28.108; sample policy included).

• Minimum information about the patient available to those involved in medication management (MM 01.01.01).

• Elements of a complete medication order, unacceptable abbreviations, requirements for medication orders (MM 04.01.01).

• Labeling of medications (MM 05.01.09).

• Who may administer medications (MM 06.01.01).

• Self-administration of medications (MM 06.01.03).
POLICY NUMBER: CP02.064
CATEGORY: Patient Care

TITLE: Medication Security

POLICY: All drugs and biologicals must be stored in a Secure Area, and locked when appropriate. Drugs listed in Schedules II, III, IV, and V must be kept locked, and only Authorized Personnel (as specified in Appendix A) may have access to locked areas where the drugs and biologicals are stored. Medications stored at the patient bedside must be secured to prevent access by unauthorized individuals.

PURPOSE: To establish appropriate levels of security and minimum requirements that ensure adequate medication availability/access to meet patient care needs while minimizing the risk of tampering or diversion by:

A. Maintaining the security of medications;

B. Defining personnel who are authorized to access medications, and

C. Developing a mechanism for monitoring unauthorized individuals when they have access to Secured Areas where medications are stored.

DEFINITIONS:

A. Authorized Personnel – As specified in Appendix A.

B. Secure Area – an area where drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals.

1. The operating room suite is considered secure when the suite is staffed and staff are actively providing patient care. If an individual operating room is not in use, non-mobile medication storage cabinets/areas must be locked and mobile carts must be placed in a locked room. When the suite is not in use, it is not considered secure unless the suite is locked to prevent unauthorized access.

2. Areas where staff are actively providing care to patients or preparing to receive patients i.e. setting up for procedures prior to arrival of the patient.

3. Labor and Delivery suites and critical care units are secure if they are staffed and the staff is actively participating in patient care. These areas should also ensure access is limited to appropriate staff, patients and visitors.

4. Mobile nursing carts, anesthesia carts, epidural carts, and other medication carts containing drugs or biologicals must be locked when not in use.

C. Secured – locked or under continuous visual observation or stored in a Secure Area as defined above
PROCEDURE:

I. Minimum security levels and those personnel authorized to access Secured Areas where medications are stored for pharmacy, patient care areas, and ancillary areas are listed in the attached Appendix A.

II. Authorized personnel are allowed to retrieve and deliver medications as specified in Appendix A.

III. Patient Medications Brought Into the Hospital and Patient Self-Administration of Medications, may be stored at the patient’s bedside.

IV. Patient’s own medications that will not be used during the hospitalization will be stored with patient valuables by Security

Medication Security Grid

### Pharmacy Areas

<table>
<thead>
<tr>
<th>Location</th>
<th>Medications</th>
<th>Authorized Personnel</th>
<th>Regular/off-hour access</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pharmacy stores</td>
<td>• Variety of medications in pharmacy controlled areas</td>
<td>• Pharmacy stores personnel</td>
<td>• Environmental services or engineering may have off-hour access only if under the direct supervision of pharmacy stores personnel</td>
</tr>
<tr>
<td>• Central pharmacy</td>
<td></td>
<td>• Pharmacy Personnel</td>
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<tr>
<td>• Satellite pharmacies</td>
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<td></td>
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<tr>
<td>• Pharmacy IV Center</td>
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<tr>
<td>• Investigational Drug Service</td>
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</table>

### Patient Care Areas

<table>
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<th>Medications</th>
<th>Authorized Personnel</th>
<th>Regular/off-hour access</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anesthesia workroom</td>
<td>• Variety of medications in non-pharmacy areas</td>
<td>• Pharmacy technician</td>
<td>• Key access at any time by authorized personnel</td>
</tr>
<tr>
<td>• Radiology</td>
<td>• Selected medications in non-pharmacy areas</td>
<td>• Pharmacy technician</td>
<td></td>
</tr>
<tr>
<td>• Cath lab</td>
<td></td>
<td>• Pharmacist</td>
<td></td>
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<tr>
<td>• Pulmonary lab</td>
<td></td>
<td>• RN/LPN</td>
<td></td>
</tr>
<tr>
<td>• GI lab</td>
<td></td>
<td>• MD</td>
<td></td>
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<tr>
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<td></td>
<td>• Anesthesiologist</td>
<td></td>
</tr>
<tr>
<td>• Routinely assigned</td>
<td></td>
<td>• Key access at any time by authorized personnel</td>
<td></td>
</tr>
<tr>
<td>• Environmental service and</td>
<td></td>
<td>• Key access at any time by authorized personnel</td>
<td></td>
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<tr>
<td>• engineering personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Medications</td>
<td>Authorized Personnel</td>
<td>Regular/off-hour access</td>
</tr>
<tr>
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<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Patient bedside in ICU/IMC setting | • Selected non-controlled, legend and non-prescription medications  
• Examples: Urgently needed medications, selected non-prescription and frequently applied topical medications | • Not restricted  
• Could include: Nursing, medical, pharmacy, respiratory therapy, environmental services personnel and engineering staff and patient’s family members | Open 24 hours per day, 7 days per week                                                  |
| Patient bedside in non-ICU/IMC setting for self-administration by the patient and nurse administration | • Selected non-controlled, legend and non-prescription medications  
• Examples: Selected non-prescription lotions, creams and rewetting eye drop | • Patient  
• RN/LPN                                                                 | Open 24 hours per day, 7 days per week                                                  |
| Patient care areas               | • Transport of a patient’s non-controlled medications with the patient by non-nursing personnel (the transport staff)                                                                                         | • Patient transport personnel  
• Vista/Rehab Couriers                                                                   | Open 24 hours per day, 7 days per week                                                  |
| Patient Care areas               | • Single-dose or small quantity, non-controlled medication delivery, heparin/saline flush devices  
• Examples: STAT/Now medication delivery of meds  
• Medications stored in locked clean medication rooms located on Nursing units, ADC (Omniscell), | • Any patient care provider  
• Support Technicians  
• Unit assistants  
• Patient transport personnel  
• Environmental services personnel  
• Vista/Rehab Couriers  
• CDC personnel                                                   | Open 24 hours per day, 7 days per week                                                  |
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</tr>
</thead>
</table>
| • CDC/Integrated Service Center  | • Variety of medications in Materials Management areas not controlled by pharmacy  
• Examples: crash carts, IV solutions, radio contrast media, and other low risk legend drugs | • CDC/Integrated Service Center personnel | • Locked facility with restricted access |
| pneumumatic tube system          |                                                                              |                                       |                                          |
| • IV fluids in ADC               |                                                                              |                                       |                                          |
TITLE: Patient Medications Brought Into the Hospital and Patient Self-Administration of Medications

PURPOSE: To provide guidelines for the use of a patient’s own medications during hospitalization and patient/family member self-administration of medications.

POLICY: All drugs used for patient care will be issued or verified by the Pharmacy Department. Medications listed in the Formulary must be supplied by the hospital for inpatient care. Patient’s may not use their own supply of any medication designated Non-Formulary and Not Available (NFNA) for safety reasons by the P&T Committee. Independent patient/family member administration of medications requires a medical order.

DEFINITIONS:

A. Non-Formulary: Medication that is not listed in the Formulary; patients may use their own supply if ordered and approved; if patient does not have their own medication and an appropriate alternative cannot be identified, Pharmacy may obtain the medication.

B. Non-Formulary - Not Available: Medication that is not listed in the Formulary; patients may use their own supply if ordered and approved; Pharmacy will not obtain the medication.

C. Non-Formulary - Not Available for Safety Reasons: Formulary; patients may NOT use their own supply due to patient safety concerns; Pharmacy will not obtain the medication.

CORE PROCEDURE:

I. Inpatients

A. When a patient's medication is brought into the hospital, the patient must arrange for the medication to be sent home with a caregiver unless the medication is to be used during their hospitalization, as outlined below. When a patient’s own medication will not be used during hospitalization, and when there are no caregivers with whom to send the medication home, the patient’s own medication will be stored with patient valuables by Security.

B. A patient may use their own Non-Formulary medications or nutritional supplements during their hospitalization provided the following conditions are met:

1. The prescriber enters a complete order including the usual prescribing information (name, dose, route, frequency, etc.).

2. The order states that the patient may take his or her own medication supply or nutritional supplements. If the provider has ordered a non-formulary medication but failed to write for the patient to use their own supply, the pharmacist may write an order for the patient to use their own supply in accordance with P&T Committee authorization.
3. If the pharmacist can positively identify the product and can determine that it is not expired or has not been improperly stored, then he or she will affix a sticker to the container indicating that it has been approved for use. Additional auxiliary labeling will be applied by Pharmacy if defined by policy.

4. The medication must be in its original prescription containers; vials and “pill boxes” containing multiple medications will not be allowed.

5. Nutritional supplements or alternative medications may only be used if they are in an original, sealed container to ensure that the product can be readily identified as the labeled product.

6. If the pharmacist determines that a patient’s own medication or nutritional supplement does not meet the criteria listed above, then he or she shall promptly inform the patient’s physician and nurse.

C. A patient’s own non-FDA approved medication (e.g. medication approved in a foreign country) may be used when no other FDA approved equivalent or adequate therapeutic alternative is available for the intended therapeutic purpose. When an equivalent agent or adequate therapeutic alternative is available, it will be used in preference to the non-FDA approved medication. The non-FDA approved medication must be identifiable and information on potential adverse effects and interactions is retrievable through primary resources.

D. In order to ensure patient safety, certain patient’s own medications or nutritional supplements may not be used while the patient is an inpatient. These conditions are summarized below:

1. Controlled substances: Due to the difficulty of maintaining the security of each individual patient’s supply of controlled substances in Omnicell machines, patient’s own controlled substances may not be used.

2. Injectable Medications: Patient’s own injectable medications cannot be used, except for the following:

   a. Epoprostenol, insulin, treprostinil or similar infusions which are to be administered via a patient’s own infusion device. If the pharmacy is able to obtain the medication and delivery container needed to utilize the patient’s device, the pharmacy will prepare the medication for use.

   b. If the medication is contained in an implantable device (e.g. baclofen pump), the patient’s own supply will be utilized until depleted. Once initial supply is depleted, all subsequent medication refills will be obtained from the Pharmacy supply if available.

   c. Injectable medications needed for inpatient care which are distributed via restricted drug distribution systems and therefore may not be accessible by the UF Health Shands Pharmacy.

   d. Injectable clotting factors used in the treatment of hemophilia, unless the exact branded product is available in the Pharmacy. If the patient supply is depleted, the Pharmacy will substitute its formulary equivalent clotting factor product. The patient’s supply will be sent to the Pharmacy for preparation and dispensing.
3 Oral liquid and topical medications: As a general rule, any medication whose contents or integrity cannot be verified (e.g., opened oral liquids, ointments, creams) cannot be used. However, a patient’s own nonformulary ophthalmic, otic, or metered dose inhaler, which is supplied in the original manufacturer’s administration device and is appropriately labeled by the dispensing pharmacy, may be used after pharmacist identification and approval.

E. Patient’s own medications will not be kept at the patient’s bedside unless the physician specifically orders that the patient is to self-administer the medication.

F. If a patient's own medication or nutritional supplement is approved for use, the nurse will inform the pharmacy at least 24 hours before the patient’s own supply of medication is exhausted in order to allow the pharmacy adequate time to order a supplemental supply to finish the hospital course of therapy. If the nutritional supplement is not available as a product that meets NF standards, the patient’s family will be responsible for obtaining an additional supply of the product.

II. Patient/Family member Self-Administration of Medications

A. Patient/family member self-administration of medications is defined as the administration of medications by the patient or family member without the direct supervision of a licensed practitioner (eg. RN, LPN, RT).

B. Patient/family member medication administration under the direct supervision of a licensed practitioner is not considered to be self-administration.

C. An order stating that a patient/family member may self-administer medications must be present in the medical record. The medication should be ordered with administration instructions stating that medication is to be self-administered.

D. Prior to allowing patient/family self-administration of medications, a licensed practitioner must verify that the patient/family member can verbalize or demonstrate:

1. The medication name, type and reason for use;

2. How to administer the medication, including process, time, frequency, route, and dose;

3. Anticipated actions and potential side effects of the medication administered;

4. Monitoring the effects of the medication

E. Once the licensed practitioner verifies the patient/family is competent to self-administer medications, the competency must be documented in the Patient Education section in the electronic medical record (EMR).
POLICY NUMBER: 09-07
CATEGORY: CLINICAL SERVICES

TITLE: HIGH ALERT MEDICATION

POLICY: The hospital manages high-risk or high-alert medications to minimize the risk for harm due to medication use.

PURPOSE: To identify those medications most commonly associated with harm, and risk reduction strategies for each medication to prevent harm when these medications are used.

SPECIAL INSTRUCTIONS:

A. The hospital, through the Medication Safety Committee, identifies the high-risk or high-alert medications used within the hospital (Appendix A).

B. As appropriate to the services provided, the hospital develops processes for procuring, storing, ordering transcribing, preparing, dispensing, administering, and/or monitoring high-risk or high-alert medication (Appendix A).

C. All High Alert Medications administered via intravenous infusion will be administered with a programmable infusion pump, which contains dose error reduction software.
### High Alert Medication Policy: Appendix A

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Drug Name</th>
<th>Procurement &amp; Storage</th>
<th>Ordering</th>
<th>Dispensing</th>
<th>Administration &amp; Monitoring</th>
<th>Additional References/Note</th>
</tr>
</thead>
</table>
| adrenergic agonists | DOPamine DOBUTamine EPINEPHrine isoproterenol norepinephrine phenylephrine | Use of premixed bags (when available). | • Appropriate default doses in Epic.  
• Default Epic administration instructions include details for appropriate starting doses and titration parameters.  
• Standardized concentrations; for details see Pharmacy Policy 17-06 Adult and Pediatric Standard Concentrations for Intravenously Administered Medications  
• Use of premixed bags (when available) | • Standardized concentrations; for details see Pharmacy Policy 17-06 Adult and Pediatric Standard Concentrations for IV Administered Medications  
• Use of premixed bags (when available) | • Dual Verification of medication and patient care area restrictions. For details see policy MA-005  
• Continuous Infusions given via infusion pump with dose error reduction software.  
• Standardized concentrations; for details see Pharmacy Policy 17-06 Adult and Pediatric Standard Concentrations for Intravenously Administered Medications  
• Default Epic administration instructions include details for appropriate starting doses and titration parameters. |
TITLE: ANTICOAGULATION THERAPY MONITORING

Policy: Each anticoagulant requires specific laboratory monitoring tests to ensure proper use and safety.

Purpose: To provide guidelines for monitoring unfractionated heparin, low molecular weight heparin, warfarin and argatroban. Anticoagulants have been classified as “High Risk” medications that require specific monitoring parameters to maximize therapeutic optimization as well as safety. Through defining standardized laboratory monitoring practices and compliance with the Joint Commission National Patient Safety Goal 03.05.01, best practice can be achieved.

Procedure:

1. Unfractionated heparin (UFH)
   
   a. Baseline Laboratory Monitoring tests
      
      i. Anti-Xa UFH level is the preferred laboratory test used for unfractionated heparin monitoring.
      
      ii. A baseline activated partial thromboplastin time (aPTT), prothrombin time (PT), and CBC with platelet count is recommended prior to initiation of heparin therapy.
   
   b. Routine Laboratory Monitoring tests
      
      i. For individuals greater than or equal to 12 years, an anti-Xa UFH level is recommended every 6 hours after starting or changing the rate of the heparin infusion until two consecutive lab draws are within desired therapeutic range. For individuals less than 12 years, an anti-Xa UFH level is recommended every 4 hours after starting or changing the rate of the heparin infusion until two consecutive lab draws are within desired therapeutic range. For both age groups, once therapeutic, it is recommended that anti-Xa UFH levels be drawn daily.
      
      ii. A CBC with platelet count is recommended every day while receiving a maintenance infusion of heparin.
   
   c. Protocols
      
      i. There are four standardized P&T committee approved Epic order sets for unfractionated heparin in adults: Acute Coronary Syndrome Heparin Protocol, Full Intensity Standard DVT/PE Unfractionated Heparin Protocol, and Low Intensity Heparin Protocol for Patients Considered at High Risk for Bleeding, and Ventricular Assist Device Heparin Protocol. Three protocols are available for pediatric patients: Pediatric Full Intensity for patients less than 12 years of age, Pediatric Full Intensity for those greater than or equal to 12 years of age, and Pediatric Low Intensity.
      
      ii. The Epic order sets for UFH may not be altered.

2. Low Molecular Weight Heparin (LMWH)
   
   a. Baseline Laboratory Monitoring Tests
      
      i. The preferred laboratory test for therapeutic LMWH therapy is an anti-Xa LMWH level. Obtaining anti-Xa LMWH levels are not required except when a physician, in his clinical judgment, deems it necessary to ensure patient safety and efficacy. Examples of conditions where anti-Xa LMWH levels might prove useful include: obesity, low body weight (less than 45kg), and pediatric patients.
      
      ii. A serum creatinine level and CBC with platelet count is recommended prior to initiation of LMWH therapy.
b. Routine Laboratory Monitoring Tests
   i. Routine anti-Xa LMWH levels are not required, however the test is available should the physician deem it appropriate (see Baseline Laboratory Monitoring Tests above for details).
   ii. A CBC with platelet count is recommended daily and serum creatinine level is recommended frequently while receiving therapeutic LMWH therapy.

c. Protocols
   i. Guidelines for the therapeutic use of LMWH therapy are located on the Shands portal. In addition, it is recommended that practitioners refer to the ACCP Heparin and Low Molecular Weight Heparin Guidelines for current evidence-based recommendations.

3. Warfarin Therapy

a. Baseline Laboratory Monitoring Tests
   i. International Normalized Ratio (INR) is the required laboratory test used for warfarin monitoring.
   ii. A baseline PT/INR must be available or ordered on all patients prior to dispensing warfarin. The baseline PT/INR must be collected and reported within the 96 hours of warfarin dispensing.
   iii. If an INR is not available or ordered as indicated above, a pharmacist will order an INR per P&T Committee authorization prior to verifying warfarin order. If the baseline INR is greater than 4, a pharmacist will continue to hold the dose per P&T Committee authorization and contact the provider for further instructions. For pediatrics it is recommended to add an INR to existing morning labs if available.

b. Routine Laboratory Monitoring Tests
   i. The INR is the required laboratory test for routine warfarin monitoring.
   ii. The frequency of INR monitoring must be at least every 3 days for patients on daily warfarin therapy. If an INR is not ordered at least every 3 days, a pharmacist will order an INR per P&T Committee authorization.
   iii. If the INR is greater then 4 during routine monitoring, a pharmacist will hold the next dose per P&T Committee authorization and contact the provider for further instructions.

c. Protocols
   i. Guidelines for the therapeutic use of warfarin are located on the Shands portal. In addition, it is recommended practitioners refer to the ACCP Pharmacology and Management of Vitamin K antagonists Guidelines and INR to guide therapy.
Policy and Procedure Manual
In the Nursing Home

1. **What is a policy and procedure manual?**
   *The P&P manual is a facility specific document that spells out all facility policies and procedures involving the ordering, storage, administration, documentation and distribution of medications in the facility.*

2. **Who is responsible for developing the manual?**
   *The Consultant Pharmacist oversees the policies and procedures in the facility but these policies are reviewed and approved by the facility’s Quality Assessment and Assurance Committee. The vendor Pharmacy is often the party that actually prepares, prints and distributes policies within the facility. Therefore, the Consultant Pharmacist must work closely with the vendor pharmacy and the QAA committee to ensure that policies truly reflect policies in use at the facility.*

3. **Why are they necessary?**
   *The policy and procedure manual establishes standards of practice in the facility and should standardize these procedures for all nursing staff. This manual is an important tool for training new nursing personnel and agency nurses that have questions about procedures within the facility.*

4. **What is the approval process for implementing a new policy?**
   *A new policy (or a change in current policy) should be discussed with the Director of Nursing, the Charge nurses, the vendor pharmacy and possibly the Medical Director before the policy is implemented. Once there is consensus on the policy either the vendor pharmacy or the Consultant will prepare the final document. This new or changed policy is usually presented to the QAA committee for final approval however the facility administration may elect to implement a policy change immediately. Nursing staff should always be notified (either by memo or inservice) of policy changes prior to the implementation date.*

5. **How often should policies be reviewed?**
   *Policies should be reviewed frequently to ensure that they reflect actual practice within the facility. Regulations require that the policy and procedure manual be reviewed at a minimum once each year and further requires that key staff sign off on their review. (See next page for sample of how this is accomplished)*

6. **As a minimum what policies should be included?**
   *See sample index of a nursing home policy and procedure (later in this chapter)
NURSING HOME

SAMPLE POLICY & METHODS

Authority of Policies and Methods

The Quality Assessment & Assurance Committee of SAMPLE Nursing Home is responsible for establishing pharmacy policies in this facility and has reviewed and approved the enclosed policies and methods.

__________________________________________  ______________
Administrator       Date

__________________________________________  __________________
Medical Director

__________________________________________  __________________
Director of Nursing

__________________________________________  __________________
Consultant Pharmacist

__________________________________________  __________________
Vendor Pharmacist

(Note: This sample cover sheet will be signed at least annually by each of the persons listed above. This signature documents that the policies have been reviewed. Most policy and procedure manuals also have a “Review Date” on each page. These review dates should also be updated at least annually even if all policies remain the same.)
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SAMPLE
PROVIDER PHARMACY - REQUIREMENTS

POLICY
Regular and reliable pharmaceutical service is available to provide residents with prescription and non prescription medications and services, and related equipment and supplies. A written agreement with a provider pharmacy stipulates financial arrangements and the terms of the services provided.

PROCEDURES
1) The Facility maintains a written agreement with the provider pharmacy (Appendix 3), signed by the administrator and an authorized representative of the provider pharmacy.

2) The provider pharmacy is responsible for rendering the required service in accordance with local, state and federal laws and regulations, facility policies and procedures and community standards of practice.

3) The provider pharmacy agrees to perform the following pharmaceutical services including, but not limited to:
   - Assisting the facility, as necessary, in determining the appropriate equipment and packaging to meet the medication needs of the residents and the facility.
   - Accurately dispensing prescriptions based on authorized prescriber orders.
   - Providing medications packaged in accordance with the facility’s needs and equipment requirements.
   - Supplying only USP and NF approved medications, biologicals and supplies, other than extemporaneously compounded medications or investigational new drugs.
   - Labeling all medications dispensed in accordance with all applicable laws.
   - Providing routine and timely pharmacy service (7) days per week and emergency pharmacy service 24 hours per day, seven days per week.
   - Maintaining a medication profile on each resident which includes all medications dispensed and facility provided information on the resident’s age, diagnoses, weight, condition, medication allergies, diet and any other pertinent information.
   - Screening each new medication order for an appropriate indication or diagnosis; for drug interactions with other medications ordered for the resident; for duplication of therapy with other drugs in the same therapeutic class ordered for the resident; and for appropriate drug dose, interval and route of administration, based on resident and other pertinent variables. If diagnosis or indication is not available, notifying the nursing staff of the need to obtain the information from the prescriber prior to administering the drug.
Purpose of this Policies and Methods Manual

The purpose of this pharmaceutical services policies and methods manual can be summarized as follows:

1) To standardize safe and effective methods for the use and control of drugs in the facility so everyone does the same thing.

2) To serve as a guide for the training and orientation of new employees.

3) To prevent errors resulting from the oral transmission of a policy from one employee to another.

4) To reduce the need for direct supervision by providing a clearly described procedure for each task performed.

5) To serve as a means of evaluating the quality of drug related services provided to our patients.
The following is a list of emergency telephone numbers to be used in emergency situations such as the need for medications after hours when needed immediately:

Sample Pharmacy ....................... 824-6511
Sample Pharmacy (jim) 829-5315

The following are numbers of the poison control centers in the area:

Florida Poison Information Center/Jax @
University Medical Center, Jacksonville
Telephone: 904/549-4480

Florida Poison Information Center/Tampa @
Tampa General Hospital, Tampa
Telephone: 904/251-7044

Store Hours:

Daily: 8:30 am to 9:00 pm
Sunday: 10:00 am to 9:00 pm
Closed: Christmas
New Years Day
Easter
Fourth of July
SAMPLE POLICY & METHODS

Adverse Drug Reactions

POLICY:

Any unusual or unexpected reaction to a drug shall be called an adverse drug reaction. The reaction shall be immediately reported to the physician.

METHOD:

An incident report shall also be completed and forwarded to the director of nursing. After appropriate investigation as described in the incident procedures, the consulting pharmacist shall be informed.

The consultant pharmacist shall present this adverse drug reaction case for discussion at the next pharmaceutical services committee meeting. If appropriate, the committee may direct the pharmacist to present this information to the FDA adverse drug reporting program.