PURPOSE:

- To promote the integrity of medication management when patients are receiving care, treatment and/or services from Helms Home Care, LLC.
- To enhance the safety of patients receiving care by ensuring accurate and effective administration of prescribed medications by qualified agency staff.
- To reduce the incidence of actual or potential medication errors within Helms Home Care, LLC.
- To adhere to applicable laws, regulations, and standards of practice.

POLICY:

- Helms Home Care adheres to federal and state laws and regulations governing prescription medications.
- Medication Orders/Prescriptions must contain all the elements of a complete and clear medication order.
    - Any unclear, incomplete, or ambiguous information in medication orders—including illegible entries, “pharmacy to dose” directives, conflicting instructions, or typographical errors—must be clarified with the prescribing provider or pharmacist prior to medication preparation and administration.
- As Needed (PRN) Orders:
    - PRN medication orders must include clear clinical indications for use and parameters for safe administration.
    - For intravenous, intramuscular, and subcutaneous medications, PRN orders must include a defined frequency and/or minimum interval between doses to ensure safe administration and prevent overuse.
    - For oral (PO) PRN medications, frequency may be defined by the prescribing provider or may follow manufacturer-labeled dosing guidelines.
    - When frequency is not explicitly ordered for PO PRN medications, the nurse shall administer or advise the patient to self-administer in accordance with standard dosing

guidelines and manufacturer recommendations, not to exceed the maximum recommended dose within a 24-hour period.

- Any ambiguity in PRN medication orders, including unclear dosing limits or intervals, must be clarified with the prescribing provider prior to administration.

- Range Orders/Titrating Orders:

  - Must include the indications for increases/decreases in dosage along with the maximum dose allowed within a specified period. Any test results pertinent to the order, i.e., blood sugar test results, PT/PTT, INR results are managed by the dispensing specialty pharmacy.

- Taper Orders (i.e., prednisone therapy): must include the specific dosage to be administered at the appropriate period.

- Resumption of Care Orders: when a patient returns home following hospitalization, medication orders should be written in detail or reference the specific order/prescription to resume.

- Transfer/Discharge Orders: When a patient is transferred/discharged to another provider, medications prescribed and any OTC medications, including herbal remedies being administered at the time of transfer/discharge are to be documented with the name of the medication, dosage, and frequency of administration.

- Registered nurses, as permitted by state law and regulations, may accept orders for and administer patient medications.

  - When services are sub-contracted by a Specialty Pharmacy, authorization and medication changes must be approved prior to <u>permanent</u> changes in infusion dose, frequency, or titration.

- All prescribed and OTC medications, including herbal remedies, are to be documented on the patient's Medication Profile.

- Agency Infusion nurses are qualified by education and experience to administer prescribed medications including controlled substances via the following routes: oral, sublingual, intravenous, subcutaneous, and intramuscular.

- All nurses are competency tested on medications during orientation and at least annually thereafter to ensure they are qualified. Competency evaluation may include a written test, along with demonstration of skills in either a simulated or clinical situation.

PROCEDURE:

- Medication orders include the following information:
  - Patient Name
  - Patient DOB (or 2nd unique identifier)
  - Name of the drug
  - Drug dose
  - Route, Frequency & Duration (as appropriate)
  - Diagnosis / indications for use (as appropriate)
  - Date the order is written
  - Name & Authorization of prescriber

- Any medication orders that are questionable, i.e., unclear, incomplete, illegible, whether written by agency staff or by the physician, must be clarified with the physician and/or pharmacy.

- Medication order changes received by the agency should be documented on the patient's medication record and in the visit note as applicable.

- Prior to administering any medication, the nurse verifies the following information based on the medication order and product label:
  - Correct medication & strength
  - Correct dose, route & frequency
  - Expiration date of the medication
  - That the medication is stable, based on visual examination for particulates or discoloration, and that the medication has not expired
  - That all necessary supplies are available to administer the medication completely & safely (flushes, pump/batteries, pre- and post-medications, ANA kit / emergency meds, etc.)
  - That there is no contraindication for administering the medication, based on current knowledge

Reference: PDN Policy 8015

- The nurse adheres to Standard Precautions when administering medications.

- The nurse adheres to applicable laws and regulations and uses safety materials and equipment when preparing hazardous medications, i.e., chemotherapy medications, in the patient's place of residence.

- The nurse instructs the patient/family in an understandable format and language about any clinically significant adverse reaction, potential unanticipated outcomes, or any other concerns about the medication to be administered, along with actions to be taken should any reaction or unanticipated outcomes occur when the nurse is not present.

INFUSION DOCUMENTATION:

- Documentation of IV, SC,& IM medication administration by a Registered Nurse will include:
    - Date, time, name of medication, dose, route of administration
    - Lots number(s) & expiration date(s)
    - Patient response to the medication, including adverse reactions
    - Monitoring of patient vitals, as applicable to drug therapy
    - Instructions provided to the patient/family and their response to/understanding of those instructions. Instructions should include the occurrence of any adverse reactions and/or unanticipated outcomes.
    - Signature of nurse with appropriate professional designation

REDUCING MEDICATION ERRORS

- Agency nurses will utilize best practices, current knowledge, and agency policy to maintain patient safety and accuracy of medication management system.
    - Medication errors can occur at any step of the process, i.e., prescribing, ordering, dispensing, administering, or monitoring the effects of medications.
- Helms Home Care has developed standardized practices for documenting medication orders and for administering medications to patients receiving care, treatment and/or services from Helms Home Care.
- The right drug, right patient, right dose, right time, right route is evaluated prior to administration of the medication.
- Any questionable, incomplete, discrepant, or inconsistent medication orders must be clarified prior to medication administration.
- Agency staff are routinely evaluated for competency in medication administration, monitoring, and documentation.

Reference: PDN Policy 8015