FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS
Case # 11-090-9028
St. Mary's Hospital

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at St. Mary's Hospital. Complaints alleged the following:

1. Inadequate care, including no food, water or medication for 6 hours after surgery, no physician orders for food water or medication, no discharge plan, staff being rude to patient, and staff not responding to call lights,.
2. Inadequate explanation regarding condition and treatment with patient
3. Communication violation, no phone in the room or access to phone for a patient to use.

If found substantiated, the allegations would violate the Medical Patient Rights Act (410 ILCS 50/3), Illinois Hospital Regulations (77 Il Admin Code 250), and the Hospital Licensing Act (77 Il Admin Code 250).

St. Mary's Hospital conducts 13 to 14 surgeries per day and has an average of 35 patients at the hospital per day. The hospital's primary service area is LaSalle County, and the secondary area is Bureau, Putnam, Marshall, and Woodford counties. There are 99 available beds in the hospital on Medicare dependent status and the hospital employs approximately 550 staff members including students and PRNs.

The patient named in this complaint receives mental health services and has a prescription for Wellbutrin among other medications for mental health treatment.

COMPLAINT STATEMENT

The complaint states that a patient at St. Mary's Hospital had inadequate care including, no food, water or medication for 6 hours after surgery, no physician orders for food water or medication, no discharge plan, staff being rude to the patient, and staff was not responding to call lights. The complaint states that the patient had outpatient surgery, but due to complications with anesthesia, the patient was admitted to the hospital. The complaint states that the patient was admitted to the 5th floor where the nursing staff treated her poorly. After being admitted, the patient reportedly requested water, food and medication (Wellbutrin) and was denied for 6 hours without adequate explanation. The patient became increasingly anxious and staff refused to respond to her call lights. The patient received mixed information for not receiving the requests.

Nursing staff indicated that there were no orders for the food, water and medication and that the patient's physician was in surgery and could not be interrupted for orders. There was also no other physician who could make these orders. The patient eventually received a food tray after a visitor who was also a nurse approached other nurses on the floor. The patient still did not receive her medication. The patient decided to pursue discharge and was discharged around 8pm. The complaint alleges the nursing staff became abrupt and the patient was discharged without a discharge plan and without assistance in arranging for transportation to her home. The complaint states that the patient did not even have a phone in her room (although there was a phone jack) and no one offered to make calls for her. Eventually, a nursing student and instructor who entered her room provided her a phone for her to call someone for a ride home.

FINDINGS

Interview with staff (7/8/2011)

The HRA began the investigation by interviewing St. Mary's Hospital staff regarding the complaints. The staff explained that the patient was admitted to the hospital for minor toe surgery on an in-patient (same day) basis. The staff said that after surgery, the patient met all in-patient discharge criteria. When the patient was discharged, the nurse decided that she needed crutch training. While receiving crutch training, the patient became dizzy. The patient was taken back to same day surgery. The staff stated that there is minimal documentation regarding this part of the story. The physician admitted the patient back to the 5th floor, where she had been discharged from previously. The patient was admitted at 1:30pm and the physician arrived at the floor at 5:30 to write the patient orders. The staff was unsure of other nurses being at the room, but they did state that the patient did have a phone in the room. The patient had transportation after her initial discharge but the individual providing the transportation left when she was readmitted. The patient was finally discharged completely from the hospital at 10:10pm and she had transportation when she was discharged. The staff explained the patient did receive food, water, and post-operation medication. The patient did not receive Welbutrin because she was not scheduled for that medication.

The St. Mary's staff explained that the nurse who worked with the patient was not the best performer or patient advocate. At the time the nurse was on a performance improvement plan. The nurse is no longer with the hospital. The staff said that the patient could have felt that she received poor treatment because of the nurse. The staff did state that the patient used the call light 3 times and the light was answered each time.

The staff explained that they have a software program for the incident processes and a policy for the process. The patient called the Risk and Quality department the next day and made a complaint. The complaint was reviewed on the 17th (she left on the 16th) and then another complaint was made on the 21st with additional allegations. The staff explained that the patient stated in the complaint that she felt as though she was not treated as a human. St. Mary's sent a letter to the patient on the 22nd which stated that appropriate staff was spoken to and counseled. The letter asked the patient to call with further questions, which the patient did. The staff explained that they followed the grievance procedure.

The St. Mary's staff explained that it was physical therapy that took the patient back to day surgery. Staff said that the physical therapy staff are actually trained to take people to the emergency department. Procedure is to call the hospitals Rapid Response team but it was not done in this case. The staff admitted to the physical therapy staff not following procedure in this case. The staff said that the patient could not have food or water because they were unsure as to what tests the physician may order and they did not want to ruin the testing process if they gave her food. The staff was not sure if this was explained to the patient as it was occurring. They said that they would like to think that it was explained but the nurse who would have discussed this with the patient is no longer with them. They did state that they explained why the patient could not receive food or water after the fact when she called the hospital with her grievance. On the day of the incident staff did try to contact the physician to see the patient but he was in surgery. The staff said that the nurse made a judgment that the situation was not an emergency. The staff explained that the patient was not in distress and her vitals were fine. If it was an emergency, they would have called an emergency room doctor. The staff also explained that the physician who was in surgery does not have a back-up and there is no hospitalist.

The staff said that there is no documentation regarding patient receiving ice chips. According to the documentation, the staff said that she ate at 5:20pm. The staff explained that the patient also ate lunch after surgery, then the incident occurred and she was readmitted and then had dinner at 5:20 when she ate a quarter of her meal. The staff said that they recognize that they had a system issue with the case. They said that it was a judgment error but they do feel that they treated the patient correctly and humanely.

Regarding the patient not having access to a telephone, the staff said that all rooms have phones and the patient also had a cell phone. They stated that there was a phone in the patient's room. They also said that a phone book was brought to the patient and they think that she may have been using both the cell phone and the room phone but they were unsure.

The staff explained that surgical patients are to have transportation home after surgery and that is hospital procedure. The patient's original ride left because she was readmitted and that person also could not see to drive at night. The staff said they attempted to find her transportation at 5pm according to the records for the second discharge and someone did pick her up from the hospital. The hospital said that they work aggressively to find transportation for people because they do not have public transportation in the area. They also explained that they usually would not talk about transportation until they know exactly what is occurring with the patient.

The staff stated that according to the documentation, the physician wrote orders at 4:53pm for the patient so he had examined her around that time. The staff said that the doctor thought if she ate and everything checked out, then she could leave, but this is not documented. There was not a medical doctor available, only the surgeon, so the staff did not think to order the anti-anxiety medication. The staff explained that this was a case where the patient was admitted by a surgeon unexpectedly and he was in surgery. The physician actually admitted the patient from surgery for observation. The staff reiterated that if it had been an emergency, they would have contacted a physician from the emergency room. Also, the staff explained that the plan was for the patient to eat and then they would discharge her so she could return home. They could

not call the patient's physician because he did not have privileges at the hospital. The patient was actually discharged at 9:45pm but she had eaten and was prepared to go at 5:30pm. She had to stay later because her discharge was contingent on finding a ride home.

The staff stated that they have not changed any policy because of the situation but they did have some educational opportunities because of what happened. They said that their policies are sound but they were just not followed in this instance. They said that physical therapy has been good in the past about following the policy; they just felt in this instance that it was the correct action to take. The hospital did have an in-service with physical therapy about following the policy. The staff said they did not actually know what was wrong with the patient as far as her dizziness. There was no further documentation stating that she was no longer dizzy when she was discharged.

The staff stated that they have no documentation in the notes as to why she could not have food or water, just that they could not give her food without doctor's orders. They feel like she was aware of the reason why she could not receive food but was not excepting the reason. They said that they possibly failed in sitting with her and explaining the whole situation while trying to help calm her. They feel as though the nurse who was working with her could have been saying "we have to wait for doctor's orders" but not fully explaining the situation. The staff felt as though the nurse was a poor performer that was not grasping the nursing process as a whole and that may have led to water not being offered and some of the other problems for the patient. The staff explained that they feel like they have taken the steps to resolve the problem.

TOUR OF FACILITY

The HRA toured the 5th floor of the facility to view the rooms and see if telephones were available. The first room that the HRA viewed did not have a telephone in the room. The room was a specialty room for larger patients. The room had a telephone jack but no phone. The HRA viewed 4 more rooms which did have telephones, making the ratio 4 out of the 5 rooms had a phone available.

Record Review

The HRA reviewed records that were relevant to the complaints alleged in this case. The HRA began the review by reading the patient's record. According to the patient's "Attestation Report" the patient was admitted on 2/16/2011 at 5:39am and discharged at 9:45pm. There is also a discharge instructions sheet that is signed by an individual at 12:05pm. This discharge document concerns topics such as anesthesia and orthopedic surgery. There is a second discharge instruction sheet that is signed by the patient at 9:45pm on 2/16/11 which concerns fainting, deep venous thrombosis, and pain management. The documents indicate that the patient was finally discharged at 9:45pm. The nursing admission profile has admission data starting on 2/16/11 at 1:30pm. There is also a General Medical Admission document which indicates that the patient's surgeon admitted the patient for observation at 12:55pm on 2/16/11. Under diagnosis, it is written "Syncope post status" and "Right metatarsal." A physician progress record, written at 2:52pm on that day, "OBS for lightheadedness." According to the

documentation, the patient was admitted for surgery in the morning, discharged, and then readmitted in the afternoon and was discharged again at 9:45pm.

The History and Physical document for the patient, dated 2/16/11 appears to have the time of 7:01am written underneath the date. There are also dates of 2/14/2011 and 2/15/2011 typed in the document. The document states the patient takes Wellbutrin 2/75 three times a day. The patient's other medication is also listed on this form. There is a also a Physician's Order Patient's Home Medication List, dated 2/16/11 at 1:30pm, that is signed by a registered nurse which lists the patient's medication. On that list, it states Welbutrin 275 milligrams. The nurse's notes from the patient's readmittance reads, at 7:25pm "[Doctor] notified -- of pt's Wellbutrin Dose being a total of 140mg not 275mg. No orders received."

In the patient's post-operation assessment, it states that a light meal was given at 10:05am and at 10:35am it indicates that the patient consumed toast and cola (the amount is indistinguishable because of the handwriting). In the nursing notes, within the Nursing Admission Profile, it reads at 3:15pm that the "Patient is -- starting to become tearful and angry while waiting for orders. Pt. was told that we need orders such as diet in order to initiate." At 3:45pm it is written that "Patient is agitated and depressed -- at this time stating that is is [sic] angry that orders have not been initiated. Pt was told that [Doctor] will be in to write orders and possibly see the pt, pt was still not -- satisfiyed [sic] at this time." At 4:50pm the nurse's notes read that the physician is there to write orders. At 5:00pm the nurses notes read "Patient is angry and uncooperative -- at this time. Pt is talking to friend on phone but is yelling which was able to be heard in the hallways. Even though orders were written pt would still like to leave but is -- trying to find a ride [sic]." At 6:00pm it is written "Resting in bed watching TV and appears comfortable. No C/O's voices and call bell W/In reach. -- Dinner tray brought in at this time." It is also written in the patient's notes, between 5:00pm and 5:05pm notations, that the patient ate ¼ of dinner. At 6:05pm the nurse's notes read "Logicare teaching done at this time which are to follow same day surgery's discharge orders. Pt. signed Logicare papers and is trying to find ride." At 6:40pm the notes state "Pt is still irate at this time and continues to call friends and family for rides but is yelling to them about her care." At 9:45pm it states that the patient's ride is there. The Nursing Admission Profile also indicates that "upon discharge pt has discharge instructions logicare instructions prescription" and "Patient verbalizes discharge instructions and follow up care." Another notation in the Nursing Admission Profile indicates that the patient wanted to wait until she eats to take her PRN medication. Also, regarding the complaint that there is no phone in the patient's room, there are statements above indicating that the patient was talking on a telephone, but they are not specific to if the phone is a cellular phone or in the room.

The HRA reviewed a detailed room activity document (which was explained as a response time form for call lights) for the patient's room. On the form, the call light was pressed on 3 different occasions, and all occasions received responses. The first response was completed within 2 minutes and 10 seconds, the second response was completed in 25 seconds, and the third response was completed in 5 minutes and 53 seconds.

There is no indication that the reasoning for not receiving the patient food without physician orders was explained nor is there any indication that ice chips, water or any type of food was offered to the patient. There is also no indication that staff was rude to the patient.

The HRA reviewed a documented policy on the hospital's Rapid Response Team. The policy introduction states that the Rapid Response Team ". . . is in place at St. Mary's Hospital to aid in the assessment and care of any patient with a change in their condition . . . A Family Rapid Response call is in place to aid in the facilitation of emergent care/assessment when a family member or patient feels that they or the patient is having a change in condition and has alerted the patient's nurse multiple times without satisfaction." The policy documents criteria as a guideline (and guideline is emphasized in the document by making the word entirely capitalized) and the criteria are staff being concerned about a subtle change, an acute change in several different physical situations that are listed, new and prolonged seizures, failure to respond to treatment, and then there is a reference for pediatric patients on a separate list. The policy documents a similar list for family members to call a separate document for pediatrics. In a document titled "Family Rapid Response Call" which indicates that it is a description of the service for family members, it reads "If you've notified your nurse and you still feel you need further assistance, you may call a Family Rapid Response call." It is not directly mentioned in the policy to call the Rapid Response if a patient has been discharged and is showing symptoms or if a non-patient needs medical assistance in the hospital although it does say to call if a patient's condition deteriorates. In accordance with the nursing admission assessment, the patient was educated on the process for family rapid response.

In reviewing the patient's rights and responsibilities, which are located in each room, it reads that patients have the right to participate in care decisions and "Receive complete information about your care, treatment, and services; to be involved in decisions about your care including discharge instructions and referrals."

Although there are mentions of communication within the patient rights policy, the HRA saw no specific telephone or communication policy.

Mandates

The HRA reviewed mandates and regulations pertaining to the complaints in this case. The Medical Patient Rights Act reads "(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law" (410 ILCS 50/3).

The Hospital Licensing Act reads "(a) No administrator, agent, or employee of a hospital or a member of its medical staff may abuse a patient in the hospital" (210 ILCS 85/9.6). The Hospital Licensing Requirements mirror this verbiage (77 Ill. Admin. Code 250.260).

The Hospital Licensing Requirements read " a) No medication, treatment or diagnostic test shall be administered to a patient except on the written order of a member of the medical staff, a house staff member under the supervision of a member of the medical staff, or allied health personnel with clinical privileges recommended by the hospital medical staff and granted by the hospital governing board, with the exception of influenza and pneumococcal

polysaccharide vaccines, which may be administered per medical staff-approved hospital policy that includes an assessment for contraindications" (77 Il Admin Code 250.330). The Hospital Licensing Requirements also state "1) The hospital shall develop a discharge plan of care for all patients who present themselves to the hospital for care. 2) The discharge plan shall be based on an assessment of the patient's needs by various disciplines responsible for the patient's care" (77 Il Admin Code 250.240) and that "b) The hospital shall provide basic and effective care to each patient. Insofar as possible the hospital shall assign patients to such accommodations as will provide for adequate segregation with regard to sex, age, and medical management. See Section 250.240(b)(2)" (77 Il Admin Code 250.1070).

The HRA found no evidence or regulation that a telephone is needed in each patient's general hospital room. The HRA also spoke to the Joint Commission and was explained that they have no standard that a telephone is required in each patient's room.

FINDINGS

Complaint #1 - Inadequate care, including no food, water or medication for 6 hours after surgery, no physician orders for food water or medication, no discharge plan, staff being rude to patient, and staff not responding to call lights.

The complaint states that a patient received inadequate care, no food, water or medication for 6 hours after surgery. Also, no physician's orders for food, water or medication, and no discharge plan was provided. The complaint also states that the staff were rude and did not respond to call lights. The staff explained that the patient did receive food and post-operation medication but did not receive Welbutrin because she was not scheduled for the medication. The staff explained that the surgeon admitted the patient from surgery and the staff did not want to give the patient food or water because they did not want to interfere with any possible tests. Also staff did not have physician orders. The staff also said that call lights were answered. The staff did admit that the nurse who worked with the patient was on a performance improvement plan and is not longer with the hospital. The staff said the patient could have felt as though she received poor treatment because of the nurse. The staff also admitted that the physical therapy staff did not follow hospital procedure and call the Rapid Response team regarding the patient feeling dizzy. In reviewing the documentation, the HRA discovered that the patient was given food after surgery and was given food later during her readmittance. The patient was given toast and cola at 10:35am and then given dinner sometime between the hours of 5pm and 6pm that evening after the surgeon wrote orders, which would equal more than 6 hours later. The HRA saw that the patient was ordered Welbutrin while at St. Mary's but at the wrong dosage, and there was no indication that the Welbutrin was prescribed at the accurate dosage. The HRA did review two discharge instruction sheets relating to the health situations of the patient. The HRA also reviewed documentation indicating that the facility responded to call lights. The HRA saw no indication in the documentation that the staff was rude to the patient although it was insinuated by the staff that the nurse working with the patient was not the best patient advocate. Even with many allegations having evidence leading them to be unsubstantiated, the HRA finds that the patient not receiving Welbutrin and, after receiving orders for Welbutrin, receiving the inadequate dosage violates that Medical Patient Act which ensures the right to sound practices (410 ILCS 50/3). Hospital licensing requirements state that all persons admitted to the hospital

shall be under the professional care of a member of the medical staff. No medication, treatment or diagnostics shall be administered except on written order of a member of the medical staff (77 Ill. Admin. Code 250.320, 330). Because of the lack of the appropriate medication dosage for the patient upon a physician's order, the HRA **substantiates** the complaint but only on that allegation due to evidence that the rest of the allegations are unsubstantiated. The HRA offers the following **recommendation:**

- **Follow medication orders unless contraindicated by a medical professional.**

The HRA offers the following **suggestions:**

- Although the circumstances of the events that occurred in this situation are unusual, the HRA believes the facility should create a policy/procedure for providing a patient with their prescribed/home medication at the accurate time should an instance as this one, or a similar instance, occur again.
- After reviewing the Rapid Response Team policy/procedure, the HRA feels as though this would have been an excellent opportunity for them to intervene in the situation. The HRA suggests that should a situation such as this occur again where a patient is uncomfortable and needs care above and beyond the nursing staff, and there is no doctor available, that the nursing staff should be encouraged to contact the Rapid Response Team to work with them on the situation. The HRA also feels as though this situation could have been avoided had the Rapid Response team been contacted even after the patient was readmitted.

Comment:

Although the complaint did not include the issue of physical therapy staff not following protocol for involving the Rapid Response Team, the HRA believes this oversight may have led to the complaints in this report. The HRA recognizes that the facility has taken full responsibility for not following their own procedure and feels as though the hospital has gone through the corrective process by educating its staff on policy. The HRA does not have any further suggestions on correcting the issue.

Complaint #2 - Inadequate explanation regarding condition and treatment with patient

The complaint alleges that a patient received an inadequate explanation regarding condition and treatment. The patient received mixed information about the reason for not receiving water, food and medication. The staff explained that they could not give the patient food and water because they did not want to affect possible tests and the patient's physician was in surgery and could not write the orders. The staff also stated that they were unsure as to whether the nurse explained this to the patient. The staff also expressed that the nurse was not the best employee or patient advocate and, although they would like to think that she explained treatment to the patient, there is a chance that she did not. In reviewing the documentation, the patient was told that they did not have physician orders for food, water, and medicine, but there is no documentation that the staff member explained that the staff did not want to ruin the opportunity for tests if needed.

Due to the fact that there is no conclusive evidence that this was not explained to the patient, the HRA finds this complaint **unsubstantiated** but offers the following **suggestion:**

- The HRA recognizes that the facility had put the nurse involved on a performance improvement plan prior to the incident, but the HRA is still very concerned that the nurse could have possibly not described all treatment details to the patient. The HRA suggests that staff be trained on educating patients regarding their care. This will ensure that staff is accountable for what is expected of them as far as job performance and care of patients. The HRA feels staff should document as to whether the patient was explained the situation accurately in this case and suggests the hospital emphasizes this to the staff in the future.

Complaint #3 - Communication violation, no phone in the room or access to phone for a patient to use.

The complaint alleges that there was no phone in the room or access to a phone for patient use. The staff stated that all the rooms have phones and the patient also had a cell phone. The staff also explained that the patient was brought a phone book to assist her and the patient may have been using both the cell phone and the room phone. The HRA did see evidence in the nursing notes that the patient was using the telephone but it did not state whether it was a cell phone or a telephone in the room. When the HRA toured the facility, they did see that one room did not have a telephone but the other rooms did have telephones. Also, the HRA found no regulations that mandate that telephones are required to be in patient's rooms or that the facility is responsible for the patient being able to communicate via phone. Due to the fact that the HRA has no evidence that the there was not a phone in the room the day that the patient was there and because there is no regulatory requirement regarding room phones, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- If it is the facility practice to have a phone in each patient's room, the HRA suggests that the facility create a quality assurance procedure to assure that there is a phone in each occupied room and notate that there is a phone in the room before the patients occupy the room. If there is no phone in the room, ensure that the patient has access to a phone if needed.
- The HRA did not review a phone policy and it was indicated that there was no facility policy dealing directly with phone use. The HRA suggests that, if the facility is going to make phones available to patients, then the facility should create policy regarding phones and outside communications. Although this is not governed by any regulations, it is felt that it may be best practice for the facility.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

St. Mary's
HOSPITAL
STREATOR, ILLINOIS

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An Affiliate of Hospital Sisters Health System

December 13, 2011

VIA FEDEX

Meri Tucker, Chairperson
Regional Human Rights Authority
Guardianship & Advocacy Commission
401 Main Street
Suite 620
Peoria, IL 61602

RE: Plan for Improvement - HRA. No. 11-090-9028

Recommendation: Follow medication orders unless contraindicated by a medical professional.

The [redacted] record was reviewed in depth concerning her medication of Wellbutrin. Per the patient and documented on the home medication reconciliation sheet, her dose was 2 tabs of 75 mg three times a day. She took her first dose prior to coming in for the outpatient surgery. Upon unexpected admission to Observation status that afternoon, the dosage of 275 mg of Wellbutrin was written incorrectly as the physician's order. As that dose strength was not clear, the nurse caring for the patient made attempts to clarify the dose with the surgeon. No clarifying orders were received. The patient was discharged to home that evening and took her second dose for the day. She missed one dose; the afternoon dose of Wellbutrin. According to Wellbutrin guidelines from the Manufacturer (Attachment A – Page 1, 31 and 33), if a dose is missed, an extra dose should not be given (Attachment A – Page 31). Manufacturer guidelines were followed.

Nurses would not give a dose of any medication that is not clarified by the physician, as that would be considered acting beyond their scope of practice. Only the physician is capable of ordering the medication and dose. The nurse made unsuccessful attempts to clarify and upon receiving no clarification, the medication was not dispensed. This practice is consistent with our Medication Administration Policy 5000.32 (Attachment B).

While the circumstances of the [redacted] were unfortunate, it is believed that St. Mary's Hospital did indeed act in the best interest of the patient in its attempts to "do no harm" by not delivering a medication whose dose was not clarified.

Please let me know if you need any additional information.

Sincerely,

Sharon D Timmons

Sharon D. Timmons
Interim President/CEO

cc: Mark Dabbs, SMS Chief Nursing Officer
Carrie Lijewski, SMS Director of Quality/Safety

Attachments

PRESCRIBING INFORMATION

WELLBUTRIN®
(bupropion hydrochloride)
Tablets

WARNING
Suicidality and Antidepressant Drugs

Use in Treating Psychiatric Disorders: Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of WELLBUTRIN or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. WELLBUTRIN is not approved for use in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk in Treating Psychiatric Disorders, PRECAUTIONS: Information for Patients, and PRECAUTIONS: Pediatric Use.)

Use in Smoking Cessation Treatment: WELLBUTRIN®, WELLBUTRIN SR®, and WELLBUTRIN XL® are not approved for smoking cessation treatment, but bupropion under the name ZYBAN® is approved for this use. Serious neuropsychiatric events, including but not limited to depression, suicidal ideation, suicide attempt, and completed suicide have been reported in patients taking bupropion for smoking cessation. Some cases may have been complicated by the symptoms of nicotine withdrawal in patients who stopped smoking. Depressed mood may be a symptom of nicotine withdrawal. Depression, rarely including suicidal ideation, has been reported in smokers undergoing a smoking cessation attempt without medication. However, some of these symptoms have occurred in patients taking bupropion who continued to smoke.

All patients being treated with bupropion for smoking cessation treatment should be observed for neuropsychiatric symptoms including changes in behavior, hostility, agitation, depressed mood, and suicide-related events, including ideation, behavior, and attempted suicide. These symptoms, as well as worsening of pre-existing psychiatric illness and completed suicide have been reported in some patients attempting to quit smoking while taking ZYBAN in the postmarketing experience. When symptoms were reported, most were during treatment with ZYBAN, but some were following discontinuation of treatment with ZYBAN. These events have occurred in patients with and without pre-existing psychiatric disease; some have experienced

What should I tell my doctor before using WELLBUTRIN?

Tell your doctor if you have ever had depression, suicidal thoughts or actions, or other mental health problems. See "Antidepressant Medicines, Depression and Other Serious Mental Illnesses, and Suicidal Thoughts or Actions."

- **Tell your doctor about your other medical conditions including if you:**
  - **are pregnant or plan to become pregnant.** It is not known if WELLBUTRIN can harm your unborn baby.
  - **are breastfeeding**. WELLBUTRIN passes through your milk. It is not known if WELLBUTRIN can harm your baby.
  - **have liver problems**, especially cirrhosis of the liver.
  - have kidney problems.
  - have an eating disorder, such as anorexia nervosa or bulimia.
  - have had a head injury.
  - have had a seizure (convulsion, fit).
  - have a tumor in your nervous system (brain or spine).
  - have had a heart attack, heart problems, or high blood pressure.
  - are a diabetic taking insulin or other medicines to control your blood sugar.
  - drink a lot of alcohol.
  - abuse prescription medicines or street drugs.
- **Tell your doctor about all the medicines you take**, including prescription and non-prescription medicines, vitamins, and herbal supplements. Many medicines increase your chances of having seizures or other serious side effects if you take them while you are using WELLBUTRIN.

How should I take WELLBUTRIN?

- Take WELLBUTRIN exactly as prescribed by your doctor.
- Take WELLBUTRIN at the same time each day.
- Take your doses of WELLBUTRIN at least 6 hours apart.
- You may take WELLBUTRIN with or without food.
- If you miss a dose, do not take an extra tablet to make up for the dose you forgot. Wait and take your next tablet at the regular time. **This is very important.** Too much WELLBUTRIN can increase your chance of having a seizure.
- If you take too much WELLBUTRIN, or overdose, call your local emergency room or poison control center right away.
- **Do not take any other medicines while using WELLBUTRIN unless your doctor has told you it is okay.**

If you take a urine drug screening test, WELLBUTRIN may make the test result positive for amphetamines. If you tell the person giving you the drug screening test that you are taking WELLBUTRIN, they can do a more specific drug screening test that should not have this problem.

This Medication Guide summarizes important information about WELLBUTRIN. For more information, talk to your doctor. You can ask your doctor or pharmacist for information about WELLBUTRIN that is written for health professionals.

What are the ingredients in WELLBUTRIN?
Active ingredient: bupropion hydrochloride.

Inactive ingredients: 75-mg tablet – D&C Yellow No. 10 Lake, FD&C Yellow No. 6 Lake, hydroxypropyl cellulose, hypromellose, microcrystalline cellulose, polyethylene glycol, talc, and titanium dioxide; 100-mg tablet – FD&C Red No. 40 Lake, FD&C Yellow No. 6 Lake, hydroxypropyl cellulose, hypromellose, microcrystalline cellulose, polyethylene glycol, talc, and titanium dioxide.

This Medication Guide has been approved by the U.S. Food and Drug Administration.

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August 2011
WLT:7MG

ST. MARY'S HOSPITAL
STREATOR, ILLINOIS

DEPARTMENT:	Patient Care Services
SUBJECT:	Medication Administration
NUMBER:	5000.32
DATE:	08-85

POLICY:

Medications are administered according to a Unit Dose System by licensed personnel, in accordance with the Medical and Nurse Practice Acts of this state.

The five Rights of Medication Administration will be followed by all personnel: the right patient, medicine, dose, time, and route.

PURPOSE:

To establish clinical guidelines to safely administer medications while caring for the patients.

SPECIAL INSTRUCTIONS:

1. Only licensed nursing personnel and respiratory care practioners administer medications as ordered by the physician. Competency of the nurse and therapists to administer medication is assessed during orientation and annually there after.

2. LPN's may perform saline flushes and subsequent doses of IVPB antibiotics with peripheral lines upon validation of competency.

3. Medications may be administered by nursing students in a clinical setting under the direct supervision of a clinical instructor. An agreement between the hospital and the school must be placed on file in People Services.

4. All medications are documented as they are taken by the patient.

5. Scheduling of Medications - Time selections as defined are in the information system. Schedules for medications are determined by Pharmacy and Nursing taking into account the need for around the clock dosages, drug-drug, and drug-food interactions.

6. An apical pulse is taken prior to administration of any drug from the digitalis group and the drug withheld if the pulse is less than 60/minute. Notification of the patient's physician is required documentation in the patient record.

7. A Medication Reconciliation "T" Report (along with Orders Reconciliation Report) will be printed by the nurse/unit secretary and placed on front of patient's chart. All medications and IV orders are stopped by the Pharmacy according to physician order for NPO, medication on hold, unless otherwise ordered. Orders must be renewed/rewritten on Medication Reconciliation Report, if they are to be continued postoperatively. The physician must reorder the appropriate medications prior to the patient returning to the unit. This form will be a permanent part of the patient's medical record and will need to be faxed to the Pharmacy.

8. If there are any questions about the compatibility of medications with the IV fluid and/or other medications, the following resources must be utilized:
   a. Registered Pharmacist
   b. Compatibility charts
   c. Textbooks or drug references
   d. Micromedix – on-line

SPECIAL INSTRUCTIONS CON'T:

9. Dosage verification/accuracy check, with another licensed nurse is required on the following medications:
   a. Insulin
   b. Heparin (when dose is prepared by the nurse) and Heparin pump settings
   c. Insulin pump settings
   d. PCA pump settings
   e. Epidural pump settings
   f. Femoral nerve catheter settings
   g. Chemotherapeutic agents
   h. Any medication requiring calculation – including neonate and pediatric doses
   i. Any time a medication is removed and stored from the original container. (Refer to General Policy #1000.30 for Labeling of Medications, Solutions in Perioperative/Procedural Settings.)

10. Nursing staff are alerted to Look Alike, Sound Alike Medications –Refer to Attachment B with Risk Reduction Strategies.

11. When our pharmacy is closed, orders will be faxed, utilizing the same process to St. Mary's Decatur. The Pharmacist will enter IV fluids, STAT medications, antibiotics.

12. Registered Nurses are qualified to review medications as being patient appropriate in the following ways:
   a. By education and the completion of a college level Pharmacology class.
   b. By passing a medication competency exam in Patient Care orientation.
   c. By completing a departmental based orientation and being verified by another RN on medication safety and knowledge of medications.
   d. By being proficient in the use of medication resources to assist in checking the safety of the medication (e.g., Micromedix, clinical consult, Pharmacist on-call usage, etc.)

   A High Risk Medication List and a Respiratory Medication Interaction list have been composed by Pharmacy (see Attachment C & D). This list provides a list the House Supervisor consults the Pharmacist on call for new or changed orders.
   The Supervisor documents all calls to the Pharmacist on-call on the green order sheet. The documentation must include – date, time, name of Pharmacist, reason for review, direction provided, and Supervisors signature.

13. Nursing staff always questions and clarifies any unclear medication dosage and/or route and obtain approval from the Pharmacist and/or Physician.

14. Patients receiving therapy with vesicant or long-term antibiotic medications must be recommended for insertion of Central Venous access device.

Delivery of Medication

1. Nursing staff will remove medications from Pyxis. Medications are premeasured and labeled. All partial doses of any vials/tablets are clearly labeled so nursing staff knows to not use full amount of medication.

2. Medications will be sent from the Pharmacy to each unit via the dumbwaiter as they are ordered. STAT medications will be filled within 60 minutes from the time they are ordered. All doses sent via the dumbwaiter are tamper-tape sealed.

3. Pharmacy hours are posted on the units. The stock from the medication dispensing system should be used when the pharmacy is closed.

SPECIAL INSTRUCTIONS CON'T:

Preparation and Administration of Medications

1. Check physician's orders and patient's medication profile and the eMAR for drug name, dose/strength, route of administration and time intervals.

2. Identify any unfamiliar drugs.

3. Research any unfamiliar drugs using appropriate reference (drug books, pharmacist and Micromedex).
   a. Generic and trade name
   b. Drug classification and major uses.
   c. Pharmacologic actions.
   d. Safe dosage, route and time of administration.
   e. Side effects: adverse reactions
   f. Nursing implications.
   g. Complete patient teaching as needed.

4. Review patient's record for allergies, lab data, any factor (e.g. NPO status, planned procedures) that contraindicates administration of ordered medications.

5. Identify any new medications, discontinued medications, or altered dosages before continuing with medication preparation.

6. When obtaining medications from an automatic dispensing unit: obtain only one patient's medication at a time, with removal verified against physician order, and then administer medication to patient according to outlined steps 7-19.

7. Wash your hands.

8. Take medication cart to the automatic dispensing unit. "Pull" the patient's scheduled medications by "profiled" medications for specific time and any PRN medications as needed.

9. Open medication cart; take out patient's medication drawer.

10. Starting at top of medication list in the eMAR check each medication against the medication packages as taken from each drawer.

11. Compare drug label with eMAR for medication dose and route. **Rationale:** This is a safety check to ensure the right medication is given.

12. Retrieve medication to be given and inspect label to assure that medication is indicated for ordered route of administration.

13. Determine if any calculation is necessary to prepare the correct dosage.

14. Medications requiring dosage calculation will be double-checked with another nurse for accuracy before administration. **Clinical Alert!** Medications requiring clinical assessments, have assessments attached to eMAR entry and assessments are documented at time of administration.

SPECIAL INSTRUCTIONS CON'T:

15. Prepare medication as indicated for nonparental or parental route, checking drug label before, during, and after preparation. Refer to flush procedures in policy #5000.28 – Infusion Therapy.
Clinical Alert! Check medication label three times: When retrieving medication from storage area, when preparing the medication and prior to administration.

16. **Before administering any IV medication, visually inspect for discoloration, deterioration, or particles. Check expiration date and check for contraindications.**

17. Check **"The Five Rights"** with each medication administration: **Right patient** using two identifiers – patient name and wristband Medical Record number, **Right medication**, **Right dose**, **Right method or route** of administration, and **Right time.**

18. Take medication cart to the patient's bedside. Prepare and dispense medications at the patient's bedside, leaving all medications in original packaging until administered. Verify against eMAR and administer via use of the BMV function, scanning the patient and scanning the medication competing assessments and re-assessments as necessary.

19. In the event of a medication error, the physician must be notified immediately so the potential danger to the patient is minimized.

20. In the event that a medication is drawn up and not given immediately, label the syringe with the name of medication, dosage, initials, and time drawn up.

21. Pharmacy will label medication/solutions requiring in-line filter. (Refer to Attachment F on in-line filters.) Filters are on the Central Supply carts.

22. Before giving a patient any new medication, education is given about the medication to the patient and/or significant other.

Documentation

1. Record all medications administered via BMV function and include injection sites. If the patient refuses or is unable to take a medication, chart non-admin and include the reason and notify the Physician, if appropriate.

2. When charting PRN medications, include the reason for giving the medication by completing the assessments attached to the eMAR order. Complete reassessments as appropriate.

Medication Storage

1. All medications, including unit stock medications are stored in accordance with the manufacturer's guidelines. Unit stock medications are locked/secured.

2. Refrigerated medications are stored in a dedicated medication refrigerator. These are secured/locked. Temperature of refrigerators is recorded daily.

3. Drug boxes/crash carts are locked and replenished by Pharmacy each time the lock is opened. The date of the most recent medication to expire will be posted on the outside of the crash cart. The integrity of the lock and the lock number is recorded daily. If crash cart used when pharmacy is unavailable, House Supervisor will replace medication tray.

SPECIAL INSTRUCTIONS CON'T:

4. All multi-dose vials must be labeled with date/time when opened.
   a. All preservative-free vials are discarded 24 hours after opening.
   b. All preservative added vials are discarded 28 days after opening, unless a different time period is recommended by the manufacturer, such as detemir insulin is good for 42 days..

5. Mobile nursing medication carts, anesthesia carts and respiratory carts are locked when not in use.

Patient Profile

1. The Nursing staff will obtain a new patient profile each shift and check the medication list for accuracy.

Medication Orders

1. The Pharmacy will enter all medication orders into the computer system. The order must include patient name, drug, dose, route and frequency, and indication for prn medication. Orders with "Do Not Use Abbreviations" (See Attachment A) or lack of indication for PRN medications require clarification before entry of order.

2. All orders will be faxed to Pharmacy. Medications will be sent to the unit after Pharmacy receives the fax, verifies the order, and enters the order into the computer system.

3. The RN assumes responsibility for accurate order entry. The written order is compared with the computer entry for accuracy. Orders with "Do Not Use Abbreviations" (See Attachment A) require clarification. Orders are acknowledged prior to administration. Pharmacy must be notified of any "rejected" orders, and order clarified prior to administration of medication.

4. Orders for PRN medications will include indications for use. The prescriber must specify one dose, one frequency, and include severity indication when necessary.
   a. When more than one drug is ordered for the same indication (e.g.; pain), the dose, frequency, and indication severity must be included, e.g.; Tylenol po 1 tab q 4 hrs prn for mild pain, Vicodin po 2 tabs q 6hrs prn for moderate pain, Morphine 1 mg IVP q 4hrs. prn for severe pain.
   b. When one drug is ordered with more than one indication and a second drug is added for the same indication, rules listed above apply. (e.g.; Tylenol po 2 tabs q 4 hrs prn pain or Tylenol po 2 tabs q 4 hrs for fever, adding Vicodin for pain causes need to clarify pain severity indications on both medications used prn for pain.
   c. Range orders such as 1 or 2 tabs and every 4 – 6 hrs. must be separated with each having severity indication when to use 1 tab or 2 and when to give every 4 hrs or every 6hrs.
   d. When more than one prn pain medication is ordered, patient may request pain medication ordered for lesser severity of pain, but may not receive pain medication for greater severity of pain.
      Example: Vicodin is ordered for pain rated 1-5 and Morphine is ordered for pain rated 6-10. Patient rates pain as 6, but requests Vicodin. The patient may receive the Vicodin per patient request. If the patient rate pain at 4 and requests Morphine, the patient may not receive Morphine.
   e. Order may not contain more than one dose, one schedule, or one level of severity.

5. The Nurse will update the patient profile with the new order or print a new profile.

SPECIAL INSTRUCTIONS CON'T:

Home Medications

1. The Admitting RN, Emergency Department RN, and Same Day Surgery RN will attempt to obtain a complete home medication list as part of the medication reconciliation process. The list may be obtained in any of the following ways:
   a. Obtain list from patient or nursing home.
   b. Copy medications and dosages from pill bottles/containers brought in by patient or family.
   c. Call patient's pharmacy for current medications
   d. Call patient's primary physician's office for current medications
   e. If unable to get medication list from any of the above, document the list is unavailable and notify the physician.
   f. The RN will review the list and complete the Medication Reconciliation in the computer system and will include indication for use as stated by the patient, and enter into the "Comment" field for each medication. If the patient is not knowledgeable of reason for medication, education is required.

2. Medication Reconciliation "A" is printed out and placed in the patient chart by the unit secretary/tech or Nurse and will be completed by the physician. When the physician is not present at admission, and physician notification for further orders is necessary, contact the Physician to review medication orders and complete the Medication Reconciliation documenting the selections resume or stop as ordered by the physician. This must be done within 24 hours of admission.

3. All patient medications brought into the hospital and not returned to the patient's family/caregiver, will be labeled with the patient's name and sent to the Pharmacy. Home medications not returned to the patient family/caregiver will remain in Pharmacy until discharge. Pharmacy will return them to the unit and the Nurse will return them to the patient upon discharge. Any medications left at the hospital after discharge will be sent to Pharmacy and handled by Pharmacy according to existing Pharmacy policy.

4. For Optimum patients, any medication brought to the hospital by the patient, which is in an original sealed container, that medication may be administered to that patient by an Optimum nurse. Medications in original sealed labeled containers do not need to be identified by pharmacy.

5. For patients who have expired, the medications will be disposed of by the Pharmacy according to Federal law prohibiting the transfer of medications to one other than to whom they were prescribed. A Pharmacist's note shall be entered into the medical record documenting such disposal.

6. Same Day Surgery will complete the Medication Reconciliation.

7. When the patient is received from a nursing home, the RN will:
   a. Review medications on transfer sheet and identify known allergies.
   b. Compare written medication orders with transfer medication orders and identify any dose changes.
   c. Complete the Medication Reconciliation Record.
   d. Contact physician to clarify and confirm medication orders.

Controlled Substances

1. Controlled substances are obtained using the medication dispensing system. (Refer to Policy #1000.84)

SPECIAL INSTRUCTIONS CON'T:

2. Pharmacy will hand deliver the controlled substances to the units.

3. Medication wasting is done using the medication dispensing system with a witness (second licensed professional).

4. When using a bulk controlled substance (i.e., narcotic infusion), enter waste in the medication dispensing unit.

5. Narcotic discrepancies in the dispensing system are reconciled immediately by notifying pharmacy, or nursing supervisor.

Self Medication

1. Only hospital provided medications will be used for patient administration. There may be exceptions with investigational or non-formulary drugs or if the physician specifies by order that the patient may use their own home supply of medications. In all cases, a Pharmacist has verified the supply/vials.

2. Patients that self-administer medications will be trained and supervised for proper administration of medications and appropriate documentation is done. The patient and/or significant other is trained on medication name, type, and reason for use, how to administer, time, frequency, route and dose, anticipated action, and potential side effects and how to monitor effects of the medication. The RN determines if the patient is competent to administer their own medications. If the patient is determined incapable, the RN will notify the physician and the licensed staff will administer the medication. Appropriate documentation is done in the computer system.

3. The following medication has been approved to be left at the bedside: Oral Contraceptives (in original container).

Patient Controlled Analgesia (PCA)

See Policy #5000.49 – Infusions for Pain Management

Intravenous Oxytocin (Pitocin)

1. Pitocin may be used in the following situations without the physician present in the hospital:
   a. Incomplete abortion
   b. Missed abortion
   c. Septic abortion

   Reference: (From the Rules and Procedures of WH-Gyn)

Adverse Drug Reactions

1. Notify the Physician immediately of any adverse drug reaction.

2. Document the reaction in the computer system under nurses' notes. Note symptoms, treatment and the patient response.

3. Notify the Director, Clinical Supervisor, or House Supervisor.

4. If a potential adverse drug reaction is recognized, fill out the pink Quality Improvement form and send to Pharmacy.

SPECIAL INSTRUCTIONS CON'T:

Medication Errors

1. Report medication errors immediately to patient's physician. Report the following errors: Wrong medication, wrong route, wrong dose, wrong date/time, wrong patient, error in transcribing, omitted medication and delayed medication.

2. Notify the Manager or House Supervisor and complete the Peminic report.

3. The Manager will investigate and initiate the Medication Education Plan or Follow-up Report.

4. If a potential medication error is recognized, you may report it using Peminic system.

Discharge

1. The RN will ensure each patient has their prescriptions before the patient leaves the hospital.

2. In the case where the physician has written orders for prescription medication upon discharge and did not write a prescription, the nurse will notify the physician to telephone or fax the order in to the pharmacy for the patient. The nurse cannot call the "prescription" to the Pharmacy.

3. Reconciled medications prescribed at discharge are listed on the electronic discharge instructions, which are reviewed with the patient and/or family prior to discharge.
   a. The complete list of reconciled medications is provided to the patient or the patient's known primary care provider.
   b. Written information on all prescribed medications will be reviewed with and provided to the patient.
   c. The importance of keeping all medication information up to date and provided to all health care providers is stressed.
   d. Medication Reconciliation "D" will be printed by unit secretary/tech or nurse and completed by physician as discharge orders. The nurse will complete the Medication Reconciliation including times of last dose and a c copy of the Medication Reconciliation "I" will be given to the patient/caregiver and a copy to each care provider.

Special Care Medication Use in General Care Areas

1. Registered Nurses in Medical/Surgical or General Care Areas may administer medications following the approved guidelines. If these medications are administered IV drip or IVPB, an infusion pump must be used. "IV push with Physician present" does not mean the Physician has to give the medication, it means the Physician must be present when the medication is given. These guidelines do not apply to a situation where ACLS is in progress.
   a. **Adenosine (Adenocard):** IV push, under the presence and supervision of the Physician and patient is on a cardiac monitor.
   b. **Atropine:** IV push for arrhythmia as per ICU arrhythmia policy, patient must be on a cardiac monitor.
   c. **Diltiazem (Cardizem):** IV push with Physician present and patient is on a cardiac monitor. IV continuous infusion must be infused in ICU.
   d. **DOBUTamine:** IV infusion per infusion pump at no more than 5 mcg/kg/minute for renal perfusion in CHF patients only as long as there is no titration.
   e. **DOPamine:** IV infusion per infusion pump at no more than 5 mcg/kg/minute for renal perfusion in CHF patients only as long as there is no titration.

SPECIAL INSTRUCTIONS CON'T:

f. **Enaliprilate (Vasotec):** IV push under the presence and supervision of the Physician, IVPB without Physician.
g. **Insulin:** IV push insulin may be given by Registered Nurse as ordered by a physician (must be double checked with another Registered Nurse and only Regular insulin if to be given IV route)
h. **Propranolol (Inderal):** IV push with Physician present and patient on cardiac monitor. IVPB without Physician if:
   1) Patient has cardiac monitor.
   2) Patient on oral Inderal prior to current NPO status.
   3) RN carefully monitors vital signs through first infusion and notifies Physician of any variations.
   4) Cannot give concurrently WITH ANY DEXTROSE SOLUTION.
   5) Vital signs prior to and immediately after each infusion.
i. **Labetalol (Trandate, Normodyne):** IV push with Physician present. IV drip must be infused in ICU.
j. **Lidocaine:** IV push only for arrhythmia under supervision by Physician or ICU Nurse as per ICU arrhythmia policies. Patient has to have cardiac monitoring.
k. **Metoprolol (Lopressor):** IV push with Physician present and patient on cardiac monitor.
l. **Verapamil (Calan, Isoptin):** IV push with Physician present and patient on cardiac monitor.

2. If the patient is in ICU, the following medications may be administered by the ICU RN, as directed by the Physician, without him/her present: Adenosine (Adenocard), Atropine, Diltiazem (Cardizem), DOBUTamine, Enaliprilate (Vasotec), Propranolol (Inderal), Labetalol (Trandate, Normodyne), Amiodarone (Cordarone), Lopressor (Metoprolol), Calan (Verapamil), and Procainamide (Pronestyl).

3. Specific intravenous drugs will not be administered to patients in non-intensive care beds, except in emergency situations. These drugs can be started while arrangements are being made to transfer the patient.
   a. **Nitroglycerine** IV infusion
   b. **DOPamine** greater than 5 mcg/kg/minute with titration
   c. **DOBUTamine** greater than 5 mcg/kg/minute with titration

4. Some medications are not approved in Medical/Surgical or General Care Areas.
   a. Thrombolytic agents, administered in ICU or ER only under the presence or supervision of the Physician.
      1) **Alteplase (Activase, "tPA")** (exception: Activase/Cathflo for occluded central venous line clearing)
      2) **Reteplase (Retavase)**
      3) **Streptokinase**
   b. **Amiodarone (Cordarone):** IV infusion, in ICU or ER
   c. Any anesthetic agent. Never given on general care floor. Some anesthetic agents are: **Atracurium**, **Midazolam**, **Versed**, **Mivacurium**, **Pancuronium**, **Tubocurarine**, **Vecuronium**, **4% Lidocaine**, **Pentothal**, **Succinylcholine**.
   d. **Ibutilide (Corvert):** in ICU or ER only with Physician present.
   e. **Isoproterenol (Isuprel)**
   f. **Norepinephrine (Levophed)**
   g. **Nitroglycerine:** IV infusion
   h. **Nitroprusside (Nipride)**
   i. **Procainamide**: IV push, IV infusion
   j. **Tirofiban (Aggrastat):** IV infusion

SPECIAL INSTRUCTIONS CON'T:

k. **Insulin:** IV insulin drips
l. **Xigris (Drotrecogin Alfa):** treatment of sepsis. Patient must meet criteria.

5. Handling of potentially hazardous medications:
   a. Pharmacy will send a notice to the nursing unit with drugs that should be handled as hazardous.
   b. All potentially hazardous medications will be prepared only by a Pharmacist. Refer to Attachment E.

PREPARED BY:

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REFERENCES:

- Medical Staff Bylaws Section 8.5.3
- Medical Staff Rules and Procedures, General Section 12.3, 16.1 through 16.7
- Women's Health/GYN/PEDS Department Rules and Procedures, Page 7
- Clinical Nursing Skills: Smith, Duell, and Martin 2004 Pages 521-522
- General Policy #1000.84 - Medication Management and Administration
- Joint Commission Guidelines

NOTES:

- Reviewed & Approved by Medicine Department, July 14, 2000; May 11, 2001; July 9, 2004
- January, 2002 – Patient Care Services Policy #5000.85 – Deleted and Incorporated into this policy.

Revised: January, 1992; January, 1996; May, 1997; June, 1998; May, 2000; April, 2001; January, 2002; September, 2003; February, 2004; June, 2004; November, 2004; January, 2005; October 2005; March, 2007; June, 2007; February, 2008; May, 2008; September, 2009; December, 2009; November, 2011
Reviewed: August 1994

St. Mary's Hospital
Streator, Illinois

DO NOT USE ABBREVIATIONS

IU for international unit

MgSO4

MS

MSO4

QD, Q.D., q.d., qd

QOD, Q.O.D., q.o.d., qod

Trailing Zero (X.0 mg)

Lack of leading zero (.X mg); includes IV fluids (Example: must state 0.9 saline)

U or u for unit

NOTE: **The abbreviations of SC, SQ, D/C and cc are highly recommended to not be used or written in the medical record.**

New: January 2008
Revised: July 2008; March 2009; January 2010

High Risk Look Alike Sound Alike Medications

January 2011

Individual Agents	Risk Reducing Strategy
Epidurals Ropivicaine 0.1% (plain) Ropivicaine 0.1% Fentanyl 2mcg/ml Ropivicaine 0.1% Fentanyl 4mcg/ml	Colored bags for each strength Red Green Blue
clonidine/klonopin Effexor/Effexor XR ephedrine/epinephrine glyburide/glipizide hydroxyzine/hydralazine lorazepam/alprazolam meloxican/moexipril metformin/metronidazole metoprolol tartrate/metoprolol succinate tramadol/trazodone tramadol/Toradol Zantac/Zyrtec	**On nursing units** Stop sign stickers in pyxis Pink line on all medication in patient drawers TALL MAN/small man lettering in pyxis and electronic records when possible **In pharmacy** Stop sign stickers on bins Red bins

High Risk Medications Requiring Phone Call to Pharmacist on call when pharmacy is closed.

Any medication that is not familiar should be researched on Micromedex (or other appropriate source) prior to administration!

Every phone call must be documented on the green order sheet to include nature of the call, pharmacist contacted, and his/her response. Include time and date of call.

Individual Agents	Caution	Guidelines	Supervisor to call Pharmacist
Any medication requiring use of more than 4 tablets to make 1 dose	Verify dose not excessive		Required
Any injectable medication requiring more than 2 vials to make 1 dose	Verify dose not excessive		Required
All pediatric and neonatal medications	Verify dose based on patient age, weight and diagnosis		Required
Concentrated electrolytes	Not to be administered undiluted	Only stocked in pharmacy	
eplase (Activase) (except when used for occluded catheter)	Risk of bleeding	Physician present – follow protocol	
Aminophylline	Narrow therapeutic index.	Must infuse slowly. Must be mixed in D5W. Verify dose based on age, weight, diagnosis. Dose adjusted for serum levels, cardiac disease, or liver dysfunction. Monitor for toxicity – tachycardia, agitation, seizure, coma	
Amiodarone drip	May cause serious pulmonary toxicities	Must dilute in D5W. 150mg in 100ml 900mg in 500ml glass bottle For critical care areas only.	
Diltiazem (Cardizem)	Hypotension may occur	In critical care areas only unless physician present	
Enalaprilate (Vasotec)	Hypotension may occur	In critical care areas only unless physician present Do not use in second or third trimester due to risk of fetal death.	
Esmolol (Brevibloc)	Hypotension may occur	Must dilute to at least 10mg/ml Verify dose of 250-500 mcg/Kg over 1 min followed by 50-250 mcg/Kg/min. Verify dose based on patient weight. Monitor blood pressure, heart rate	
Heparin (excluding maintenance)	Narrow therapeutic index	Protocol sheet completed, checked, and followed. Labs ordered.	
Hypertonic saline (3% NS)		Verify correct compounding of solution, rate of fluid administration. Order limited to one bottle only.	

High Risk Medications Requiring Phone Call to Pharmacist on call when pharmacy is closed

nsulin drip	Potential for hypoglycemia	Proper lab work ordered. Accuchecks performed frequently Insulin order sheet preferred. Continuous infusion in ICU only	
Labetalol (Trandate)	Hypotension may occur	Verify dose to be given as slow injection over 2 minutes every 10 minutes. Usual pediatric dose = 0.2-1mg/kg up to 40mg/dose Usual adult dose = 20-80 mg based on supine blood pressure. Monitor blood pressure, heart rate IV push with physician present. IV drip in critical care areas only	
Metoprolol (Lopressor)	Hypotension may occur	Verify dose of 2.5-5mg every 2-5 minutes up to a max of 15 mg in 15 min. Monitor for heart rate, blood pressure, ECG and respiration In critical care area only unless physician present	
Naloxone (Narcan)	Other resuscitative measures should be readily available.	Verify dose of 0.1mg/Kg for children less than 5 years or less than 20 Kg 2mg for all others Monitor respiration and blood pressure. Never given subcut or IM in pediatric patients	
Nitroprusside	Severe hypotension may occur.	Verify dose not to exceed 10mcg/Kg/min for more than 10 minutes. Usual dose 3mcg/Kg/min. Monitor blood pressure, heart rate	
Norepinephrine evophed)	May cause local tissue necrosis if extravasation	Dilute in D5W only. Limited to critical care areas only	
Phenytoin (Dilantin)	Monitor for cardiovascular collapse, CNS depression and hypotension	Verify any dose larger than 100mg Give immediately after mixing due to risk of precipitation. Never given IM. Avoid extravasation.	Required for IV dose greater than 100mg
Propofol drip	Hypotension may occur	For ventilator patients only Limited to critical care areas only	
Protamine sulfate	Only for severe heparin overdose or bleeding	Verify dose based on recent heparin dose 1mg neutralizes 100 units heparin. Give slowly and monitor blood pressure and heart rate. Do not exceed rate of 50mg over 10 minutes. Verify proper coagulation tests are ordered.	
Reteplase (Retavase)	Risk of bleeding	Physician present – protocol followed Not compatible with heparin	
Tirofiban (Aggrastat)	Risk of bleeding	Initial rate of 0.4mcg/kg/min for 30 min then 0.1mcg/kg/min. Reduce dose by half in crcl <30 ml/min Compatible with heparin Physician present – protocol followed	

St. Mary's Hospital Respiratory Medication Interaction List:

Respiratory Med	Interacts With:	Cautions:	Stop Action When:
Albuterol	1. Beta Blocker 2. Patient Sensitivity 3. MAOI 4. Atomoxetine (Strattera)	1 Decreased effect of Beta Blocker-potential hypertension 2. Tachycardia 3. Agitation 4. Increased B/P	1. Contact physician with increase in BP of 20 over baseline. 2. Increased HR of 20 over baseline.
Ipratroprium	1. Patient Sensitivity to Atropine	1. Tachycardia. 2. Palpitations 3. Eye pain 4. Bronchitis, dyspnea, bronchospasms.	1. Increased HR of 20 over baseline. 2. Increased bronchospasms. 3. Severe eye pain, severe headache.
Xopenex (Levalbuterol)	1. Beta Blocker 2. Patient Sensitivity.	1. Decreased effect of Beta Blocker-potential hypertension. 2. Increased Heart Rate.	1. Contact physician with increase in BP of 20 over baseline. 2. Increased HR of 20 over baseline.
Budesonide and Flunisolide	Bupropion (Wellbutrin)	1. Decreases threshold for seizure activity.	1. Check with Doctor.
Salmeterol, Formeterol	1. Tricyclic antidepressants	1. Increased cardiovascular excitation	1. Increased HR of 20 over baseline.
Salmeterol	Erythromycin	1. Increased salmeterol concentration with tachycardia, tremor, headache	1. Increased HR of 20 over baseline
Pulmocort (Budesonide)		1. Use separate nebulizer 2. Have patient rinse mouth after tx.	
Racepinephrine	MAOI	1. Nervousness, tremors, nausea. 2. Increased Heart Rate	1. If asthma is not the diagnosis. 2. Increased HR of 20 over baseline. 3. Symptoms become worse.

Betablockers include: acebutolol (Sectral) , atenolol (Tenormin), betaxolol (Kerlone), bisoprolol (Zebeta), carteolol (Cartrol), esmolol (Brevibloc), metoprolol (Lopressor, Toprol XL), nadolol (Corgard), penbutolol (Levatol), pindolol (Visken), propranolol (Inderal), sotalol (Betapace), timolol (Blocadren)

Monoamine oxidase inhibitors (MAOI) include: phenelzine (Nardil), tranylcypromine (Parnate), isocarboxide (Marplan)

Tricyclic antidepressants include: amitriptyline (Elavil), clomipramine (Anafranil), doxepin (Sinequan) , imipramine (Tofranil), desipramine (Norpramin), nortriptyline (Pamelor, Aventyl), protriptyline (Vivactil)

Potentially Hazardous Medications

Generic (Trade)	Route IJ = inject PO = oral TOP=topical	Require caution labeling	Caution sign for infusion	Require hazardous disposal	On formulary	On NIOSH list
Anastrozole (Arimidex)	PO	No	N/A	No	Yes	Yes
Azathioprine (Imuran)	PO	No	N/A	No	Yes	Yes
Bicalutamide (Casodex)	PO	Yes	N/A	No	Yes	Yes
Chlorambucil (Leukeran)	PO	Yes	N/A	Yes	Yes	Yes
Chloramphenicol	IJ	Yes	Yes	Yes	Yes	Yes
Dinoprostone (Cervidil)	TOP	No	N/A	No	Yes	Yes
Dutasteride (Avodart)	PO	Yes	N/A	No	Yes	Yes
Estradiol	PO	No	N/A	No	Yes	Yes
Estrogen conj. (Premarin)	PO	No	N/A	No	Yes	Yes
Exemestane (Aromasin)	PO	No	N/A	No	Yes	Yes
Finasteride (Proscar)	PO	Yes	N/A	No	Yes	Yes
Hydroxyurea	PO	Yes	N/A	No	Yes	Yes
Infliximab (Remicade)	IJ	Yes	Yes	Yes	No	Yes
Letrozole (Femara)	PO	No	N/A	No	Yes	Yes
Medroxyprogesterone	IJ, PO	No	No	No	Yes	Yes
Megestrol (Megace)	PO	No	N/A	No	Yes	Yes
Methotrexate	IJ, PO	Yes	Yes	Yes (INJ only)	Yes (PO only)	Yes
Oxytocin (Pitocin)	IJ	No	No	No	Yes	Yes
Raloxifene (Evista)	PO	No	N/A	No	Yes	Yes
Tacrolimus (Prograf)	PO	No	N/A	No	Yes	Yes
Tamoxifen (Nolvadex)	PO	Yes	N/A	No	Yes	Yes
Zidovudine (Retrovir)	PO	No	N/A	No	No	Yes

IV medications that require an in-line filter

Drug	Size filter	Reason	Recommendations
Albumin			Use supplied tubing with filter in it
Amphotericin B	Do not use filter during administration		Only compatible with D5W – flush line before and after with D5W
Amphotericin B Lipid Complex (Abelcet)	Do not use a filter during administration		Only compatible with D5W – flush line before and after with D5W
Amiodarone (Cordarone)		May precipitate at high concentrations	Filter not needed at 900mg/500ml. If any other concentration – use 0.22 micron
Etoposide	0.22 micron filter	May precipitate at concentration more than 0.4mg/ml	
Infliximab (Remicade)	1.2 micron filter		
Lipids	1.2 micron filter		
Mannitol	0.22 micron filter	Incidence of crystallization at concentration more than 20%	Do not need to filter premade bags of 5%, 10% or 20%
Paclitaxel (Taxol)	0.22 micron filter	Small fibers may be present in product	Use NON-DEHP IV tubing with 0.22micron filter – supplied by manufacturer
Pentobarbital	0.22 micron filter	May precipitate if diluted	
Phenobarbital	0.22 micron filter	May precipitate if diluted	
Phenytoin (Dilantin)	0.22 micron filter	May precipitate due to low solubility	Preferably administered by direct IV injection. It is not required to be filtered if IVP. Use a 0.22 micron filter if diluted.
TPN	0.22 micron filter		If more than 3 additives

References: AHFS Drugs 2007
Package inserts
Trissel, L., Handbook on Injectable Drugs eighth edition