SUBJECT: Personnel Identification Verification (PIV) Card Policy

1. **PURPOSE:** To establish policy for the Minneapolis VA Health Care System (MVAHCS) regarding the use of identification badges, including the Personnel Identification Verification Card (PIV card), for employees, volunteers, vendors, contractors, and others who either work at or conduct business on Department of Veterans Affairs (VA), its Community Based Outpatient Clinics (CBOCs), and other off-site property (e.g., Adult Day Health Care, Community Resource and Referral Center/homeless program). For purposes of this policy, VA and CBOC properties refer to all non-residential buildings on MVAHCS campuses and grounds (parking lots, recreational/therapeutic courts, picnic areas, etc.), and other leased or program areas such as the Adult Day Health Care and the Community Resource and Referral Center.

2. **POLICY**: The ability to identify any person at the MVAHCS is important for maintaining overall safety and security. Appropriate PIV cards will be issued to all MVAHCS temporary/permanent employees, volunteers, students, and others as defined in this policy in accordance with VA Handbook 0735. The PIV card process will enhance the security, increase MVAHCS efficiency, reduce identity fraud, and will protect personal privacy by establishing a standard for secure and reliable forms of identification. Secure and reliable forms of identification for purposes of this policy means identification issued, and based on sound criteria for verifying an individual's identity that is strongly resistant to identity fraud, tampering, counterfeiting, and terrorist exploitation, and which can be rapidly authenticated. Any person who is issued a PIV card must wear such in a manner where it is displayed on an outer garment or lanyard above the waist, while on duty, on official business or conducting business at any MVAHCS Facility or VA leased space. PIV cards will be worn in addition to any other program badge if so issued.

3. **RESPONSIBILITIES:**

A. Primarily with the PIV card, the critical roles associated with the sponsorship, registration, and issuance are:

1) Applicant—The individual to whom a PIV card needs to be issued to.

2) PIV Sponsor—The Service Line Chief/Manager/Supervisor or designated official who substantiates the need for a PIV card to be issued to the applicant and provides sponsorship to the applicant. The PIV sponsor requests the issuance of a PIV card to the applicant.

3) PIV Registrar—The entity or person responsible for identity proofing of the applicant and who provides the level of background investigation needed and applicable dates. The PIV registrar provides the final approval for the issuance of a PIV card to the applicant.

4) PIV Issuer—The entity or person that performs final identity authorization, personalization operations, and issues the PIV card to the applicant after all identity proofing, background checks, and related approvals have been completed. The PIV issuer is also responsible for maintaining records and controls for PIV credential stock to ensure that this stock is only used to issue valid PIV cards.

5) PIV Card Issue (PCI) Manager—Responsible for the overall operation of the issuance of PIV cards at the MVAHCS. The PCI manager is responsible for ensuring that the PCI conforms to the requirements of Homeland Security Presidential Directive 12 (HSPD-12) and Federal Information Process Standard 201 (FIPS 201). The Chief of Police is designated as Minneapolis VAHCS PCI Manager.

6) Facility Privacy Official—Oversees privacy issues at the facility within the identification process.

B. Service chiefs are responsible to ensure all employees obtain new PIV cards, and for supervising the wearing of such by all employees, vendors, trainees and affiliates. The Chief of Volunteer Services is responsible for ensuring all volunteers obtain a PIV card and the wearing of such. The ACOS for Education is responsible for ensuring all trainees and affiliates wear a picture ID. The Chief of Contracting is responsible for ensuring that all appropriate contracting personnel wear a badge, PIV card or vendor identification.

C. The PIV registrar is responsible for verifying the information provided by the sponsor, serving as approval for the issuance of a badge. Registrars are responsible for identity proofing the applicant and verifying that the appropriate level of the applicant's background information is complete. Registrars have the responsibility to collect the applicant's biometric information such as fingerprints and facial image.

D. The PIV issuer is responsible for verifying the applicant's information and the signature of the sponsor and registrar, printing badges and PIV cards, and completing post issuance steps with the card applicant. Issuer must perform card lifecycle management processes that include, but not limited to: PIV card termination, PIV card re-issuance and Personal Identification Number (PIN) reset. Issuer must maintain a smart card inventory log and provide the required reports to the PIV Program Office.

E. All MVAHCS employees are responsible for the care of any PIV card issued, the wearing of such, and advising appropriate persons when such are lost, damaged or stolen.

F. Police Service is responsible for enforcing all aspects of this policy, to include the printing and issuance of PIV cards and badges, and for collecting all forms of VA identification from employees when they terminate employment. Police Service will ensure that all employees, vendors, volunteers, contactors and others comply with the intent of this policy.

4. **PROCEDURES**:

A. Who Must Wear VA PIV Badges. The following personnel must wear a VA PIV badge:
- All Salaried Employees—Permanent, temporary/term, full-time, part-time, intermittent, consultant, and fee basis personnel.
- Without Compensation (WOC) Employees—Including staff, researchers and research assistants, trainees and students.
- Residents and Fellows.
- Medical Students and Nursing Affiliates.

- Contract Personnel.
- Long Term Visitors--Any visitor of the MVAHCS who is here on official business and will be here for one week or more (e.g., audit and inspection teams, vendors). These will be PIV flash badges with photos on them.

Note: VA volunteers are addressed in Voluntary Service procedures.

B. PIV Card: An Applicant applies for a PIV card by completing electronic VA Form 0711 via the HSPD-12 PIV Portal, which contains the following sections:
   1) SECTION I - Applicant Information-Completed by applicant with the assistance of the sponsor.
   2) SECTION II - Sponsor Verification-Completed by sponsor.
   3) SECTION III - Applicant Identity Verification-Completed by registrar.
   4) SECTION IV - PIV Card Acceptance – Completed by applicant and issuer.
   5) SECTION V – Issuer – Completed by issuer.

C. PIV Cards (Badge): Employees of Minneapolis VAHCS will be required to wear a means of photo identification while in a duty status. Photo identification will be in the form of a PIV card and must be prominently displayed. Vendor and contracting pass badges without an affixed photo are not considered a means of photo identification.

   1) PIV cards will be issued by the Minneapolis PIV Office located in 4N-101, Building 70.

   2) Employees will display PIV cards on their clothing with their name and photo clearly visible. In accordance with VA Handbook 0735, names on PIV cards will be displayed in one of the following forms:
      a) Legal name as it appears on the employee's accepted identity source document, (Appendix B-Identity Documentation Criteria);
      b) Full last name, first name, middle initial

   3) The badge will not be decorated with pins, stickers, etc. which obscure the name and/or information of the employee. It is prohibited that the PIV card be decorated with any item.

   4) The PIV card may be removed due to safety concerns when the employee is engaged in "close work" or dangerous situations.

   5) Employees, volunteers, vendors, contractors, trainees and affiliates are responsible for immediately reporting lost or stolen PIV cards to Police Service and their supervisor, or service line designee. Replacement PIV cards will be provided free of charge to employees, volunteers, trainees, affiliates and vendors in the event of a name change or destruction of the PIV card through no fault of the employee, volunteer, vendor, trainee or affiliate. Replacements will be obtained at an authorized VA Facility capable of reproducing such.

6) Temporary badges or passes for official vendors will be issued by appropriate service chiefs under the guidance of Police Service and in compliance with established MVAHCS Policy #MA-08.

7) All badges, PIV cards are, and remain, the property of the Department of Veterans Affairs.

   a) PIV cards will be surrendered to Minneapolis PIV Office upon separation, and as part of the exit process. For employees of Community Based Outpatient Clinics (CBOCs), PIV cards will be surrendered to the designated official of that CBOC. Such designated official will immediately mail, utilizing a tracking mail type system, those PIV cards to the Minneapolis PIV Office. Upon appropriate approval, employees may be allowed to retain their PIV card if transferring to another VA facility or to another VA function.

   b) Residential program PIV cards will be surrendered to the Minneapolis PIV Office upon completion of program participation at the MVAHCS. Residential program participants who have not yet completed the full residential program and are expected to return to the MVAHCS on their next rotation will surrender their PIV card to their responsible residential program PIV sponsor. Subsequently the responsible residential program PIV sponsor will come to the PIV office with a memorandum from their MVAHCS residential program manager requesting temporary retention and securing of the PIV card in a specified secure temporary storage safe within the PIV office. The PIV card will be returned to the resident upon arrival of their next rotation by the responsible Residential Program PIV Sponsor. Security of surrendered PIV cards will be in compliance with standards established by the PCI manager

   c) Volunteer badges and PIV cards will be surrendered to the Voluntary Service Office upon termination of volunteer status. Voluntary Service will immediately return all badges and PIV cards to Police Service.

   d) Trainees and affiliate PIV cards will be surrendered to the ACOS for Education or service line designee (e.g., manager in Mental Health, Primary Care, Pharmacy, etc.) upon completion of their rotation. The respective VA staff will immediately return all PIV cards to the MVAHCS PIV office.

   e) The finding of unattended PIV cards (cards left in computers, left in common areas, etc. with no one around) should be immediately reported to an immediate supervisor. Said supervisor will immediately secure the PIV card and conduct an inquiry into the matter.

8) Contracting PIV cards will be surrendered to the appropriate service chief upon the completion of their visit. These PIV cards will be returned by the appropriate service or returned to the MVAHCS PIV office.

D. Requesting and Obtaining a PIV Card. Personnel in the above categories will obtain a PIV card during their first week of duty. A safety breakaway neck strap is available upon

request. Personnel should report to the PIV Office room 4N-101 on Monday through Friday between 7:30 a.m. and 4:30 p.m.

E. Format For PIV Cards. All PIV cards will be in compliance with HSPD-12 and VA Handbook 0735. The first and last name, or first name and middle initial will be on the photo (front) side of the badge.

F. Wearing PIV Cards. PIV cards must be worn above the waist with the picture side facing out. Exceptions (e.g., operating room personnel) must have their PIV card easily accessible. Personnel are responsible for keeping their PIV card in good condition**. PIV cards may not be defaced**, including with pins or stickers. However, PIV cards may be carried in a clear protective sleeve and in the event there exist a security need to limit the first or last name but not both, opaque tape may be placed on the protective sleeve, not the PIV card. In this way when a security need arises to see the person's name, they can remove the card from its sleeve since there would be nothing attached to the card itself.

G. Reporting Lost, Stolen, Damaged, or Found PIV Cards. Lost or stolen PIV cards will be immediately reported to the VA Police Service. Found PIV cards will be turned over to the MVAHCS PIV Office.

H. Replacing PIV Cards. PIV cards damaged through normal wear will be replaced without charge. To replace lost badges, notify the employee's supervisor that the badge has been lost and then follow the same process in section 4B. *Note:* If the PIV card has been stolen, a copy of the local police report or report number (indicating the stolen PIV card has been reported to the local authorities) should accompany the application for a replacement PIV card.

I. Surrendering A PIV Card. Personnel will return or surrender their PIV card to the MVAHCS PIV office when they clear or out-process the station, or on demand. The PIV card will then be de-activated. *Note:* Research investigators are responsible for ensuring that WOC researchers and research assistants return their PIV card to the MVAHCS PIV office for de-activation. If a vendor or contractor does not return their PIV card at the completion of their work, the responsible department must notify the contract officer immediately, who will then contact the VA Police Service to file a police report for the lost/stolen PIV card and notify the MVAHCS PIV office.

J. Access To The MVAHCS. A PIV card authorizes entry to the *MVAHCS* daily. It also permits access into the Medical Library at all times.[1] Access to specially designated controlled areas will be determined by the area PSL/department director. A listing of approved personnel will be maintained and submitted by each PSL/department in electronic format to the MVAHCS PIV office. Personnel will present their PIV card at the time of entry, or upon request by VA Police. PIV cards shall be worn at all times while at the VA MVAHCS.

[1]If an employee is found to have abused after hours library privileges, their PIV card will be recoded to prohibit after hours library use.

5. **RESPONSBILITIES**: All personnel listed in section 4A are required to comply with this policy. Failure to do so may result in disciplinary action.

6. **REFERENCES**: VA Directive 0735, Homeland Security Presidential Directive 12 (HSPD-12) Program.

7. **RESCISSION:** Policy # EC-14C, Identification Badge System, dated March 6, 2009.

8. **FOLLOW-UP RESPONSIBILITY**: Chief, VA Police Service

/S/
Patrick J. Kelly, FACHE
Director, Minneapolis VA Health Care System

SUBJECT: Dress Code/Professional Appearance for Minneapolis VA Health Care System Employees

1. **PURPOSE:** To outline Minneapolis VA Health Care System (MVAHCS) policy guiding proper attire for employees. *Note:* This policy applies to all salaried employees,[*] without compensation employees, residents and fellows, and contract health care personnel.

2. **POLICY:** Employees must abide by the attire guidelines set forth in this policy. It is the responsibility of immediate supervisors and managers to interpret these guidelines for their employees.

A. Uniforms and Special Footwear. For services that require uniforms and/or special footwear, it is the responsibility of the individual service/patient service line (PSL) to recommend to the MVAHCS director for approval the type and appropriateness of uniforms

B. General Attire and Appearance.

(1) *Identification*--ID badges must be worn above the waist with the picture side facing out. Exceptions (e.g., operating room personnel) must have their ID badge easily accessible. ID badges may not be defaced, including with pins or stickers.

(2) *Cleanliness and Appearance*--Clothes must be clean, neat, presentable and properly fitted. Hair will be neat, clean, of safe length and/or netted if required, and appropriate to the workplace.

(3) *Undergarments*--Appropriate undergarments must be worn.

(4) *Suggestive Clothing*--No suggestive, revealing, or see-through clothing is allowed.

(5) *Footwear*--Shoes must be in good repair, clean and intact, allow for ease of movement, and be appropriate to the work environment, as determined by the supervisor. Thong footwear is considered inappropriate for safety reasons. If portions of feet or toes are exposed, appropriate hygiene must be maintained. Occupational Safety & Health Administration (OSHA) standards will apply to the wearing of footwear. Based on job hazard, specialized PPE may be required. This could include but is not limited to: head coverings (nets, Caps), gowns, proper foot protections (e.g. closed toes, closed heel shoes, steel toed shoes, electrical safety boots, non-slip soled shoes). Each department will maintain information on PPE that is specifically required based on a job hazard analysis.

(6) Jewelry--Jewelry, body piercing and tattoos should not interfere with the performance of duty and should be appropriate for the workplace.

(7) *Perfume or Cologne*--Perfume/cologne, if permitted in the working area, should be worn in moderation.

[*] This includes permanent, temporary/term, full-time, part-time, intermittent, consultant, and fee basis personnel.

C. For Employees Who Wear Street Clothes.

(1) Women:

- Dresses, blouses, skirts may be worn.
- Culottes, skorts, and slacks may be worn.
- No halters, low scooping tops, sundresses open to the waist in back, strapless tops, or bare midriffs.
- Sweatshirts and T-shirts must be in good repair without holes or tears.
- At the discretion of the PSL director/service chief, employees working in certain areas or in certain categories may wear colored jeans, provided they are in good repair, without holes or tears, and not faded.

(2) Men:

- Dress or casual slacks may be worn.
- Dress or casual shirts including sweater and turtlenecks may be worn.
- No underwear tee shirts or sleeveless muscle shirts.
- Sweatshirts and T-shirts must be in good repair without holes or tears.
- Ties are optional.
- Men should be clean-shaven, or mustache/beard must be neatly groomed.
- At the discretion of the PSL director/service chief, employees working in certain areas or in certain categories may wear colored jeans, provided they are in good repair, without holes or tears, and not faded.

D. Lab Coats. The MVAHCS director will approve which clinical staff are approved to wear lab coats.
E. Hygiene. It is expected that all employees practice appropriate personal hygiene.

3. RESPONSIBILITY: PSL directors, managers/supervisors and Human Resources are responsible for enforcement of this policy.

4. **RESCISSION**: Policy HR-22C, dated April 3, 2009.

5. **FOLLOW-UP RESPONSIBILITY**: Director, Human Resources

/S/
KENT CROSSLEY, MD
Acting Director, Minneapolis VA Health Care System

SUBJECT: Infection Precautions Policy

1. **PURPOSE:** To minimize risk of transmission of infectious agents to patients and employees.

2. **POLICY:** Because it is often not possible to know when an individual may be infected with an infectious agent, consistent use of a barrier to reduce the chances of direct contact with potentially infected blood and body substances is the best way to avoid accidental exposure to infection. Accordingly, Standard Precautions have been recommended by the Centers for Disease Control and Prevention and the Occupational Safety and Health Administration for all Health Care Workers (HCWs) whose functions could bring them into contact with blood and body substances. Therefore, "Standard Precautions" (SP) are practiced at the Minneapolis VA Health Care System (MVAHCS). Additional Transmission-based Precautions (Airborne, Droplet, Contact and Neutropenic) will be superimposed on SP when indicated.

3. **PROCEDURES:**

A. Standard Precautions. The effectiveness of Standard Precautions (SP) depends on vigilant compliance by each individual staff member. Standard Precautions rely on the individual to take responsibility for his or her own potential exposure.
   1. Hand-Hygiene. Hand hygiene following the care of any patient is the most effective method of preventing transmission of infectious agents. (Please refer to IC-14 Hand Hygiene Policy)
   2. Gloves. Gloves will be worn by HCWs for all procedures that entail contact with mucous membranes, non-intact skin, or any body substance. Body substances include blood, cerebral spinal fluid, feces, urine, sputum, pus, saliva and tears. Gloves will be worn for all vascular access procedures. Any HCW with non-intact skin will wear gloves for all patient contact. Any HCW with exudative lesions or weeping dermatitis should be evaluated by Occupational Health prior to any patient care. Gloves will be available at each patient's bedside (except as distinctly contraindicated by the patient's mental status) and in each exam or procedure room.
   3. Gowns & Aprons. Gowns or aprons will be worn when extensive contact with body substances is likely, to prevent soiling of HCW clothing.
   4. Masks. Masks will be worn when the HCW anticipates possible splashing of body substances, to prevent contact with nasal or oral mucosa. Infection Prevention Practices for special lumbar puncture procedures are as follows: Face masks will be worn by the healthcare provider placing a catheter or injecting material into the spinal or epidural space to prevent droplet spread of oral flora during spinal procedures.
   5. Eyewear. Protective eyewear will be worn by HCW in all situations in which splashing of blood or other body substances to the eyes or mucous membranes is anticipated, including all operative and invasive procedures. In the Operating Room, loops that have shields are considered protective eyewear.
   6. Mouth to Mouth Resuscitation. Mouth to mouth resuscitation is not recommended. A one-way valve mask with or without an ambu bag should be used. Masks will be available in each patient room (except as distinctly contraindicated by the patient's mental status) and each exam or procedure area. A mask and an ambu bag will be on every emergency cart.
   7. Soiled Clothing. Soiled non-disposable clothing must be changed as soon as possible (including scrub suits, uniforms, gowns, etc.). Disposable items will be disposed of promptly when soiled or after use.
   8. Carts. Carts will be available outside patient rooms for patients requiring a high volume of personal protective equipment supplies (referred to as isolation carts).

9. Needles & Sharps. All needles and other sharp items will be disposed of in an appropriate needle disposal container immediately after use. Needle disposal containers will be easily accessible at every patient bedside (except as distinctly contraindicated by the patient's mental status) and in every exam and procedure room. Needles will not be recapped or broken before disposal.
10. Soiled Linen. All soiled linen will be placed in regular cloth laundry bags. Plastic heavy-duty (non-red) bags will be used for heavily soiled or moist laundry if leakage is anticipated.
11. Soiled Reusable Medical Equipment (RME). See MVAHCS policy IC 19 – Medical Device Reprocessing.
12. Lab Specimens. Laboratory specimens from all patients are handled with equal care. Specimens must be collected in containers that will remain leak-proof in the transport system. The outside of the specimen containers will be clean. Specimens will be placed in plastic zip lock biohazard bag prior to transport.
13. Cleaning Up Body Substances. Body substances will be cleaned up promptly by gloved personnel using the hospital-approved disinfectant. Contact Environmental Management Service for large spills.
14. Prohibitions On Labeling. Institution of SP policies will obviate the need for labeling of patient charts, specimens, rooms, or addressograph plates. Diagnoses such as HIV, hepatitis B virus, hepatitis C virus and other infectious agents will be treated like all other diagnoses. They will be recorded in the medical record and nursing in the usual manner.
15. Trash Collection. All trash will be collected in heavy-duty plastic bags. Biohazard trash collection from all areas within the MVAHCS will be collected and placed into a secondary covered container (properly labeled as Biohazard) and transported to the hazardous waste storage room for disposal by contracted services. Reusable sharps containers are exchanged by the responsible contracting company. All remaining trash will go to the compactor. Disposal of trash from Research Service is addressed in XXXIV Infection Control Research Manual.
16. Deceased Patients. All deceased patients will be placed in a plastic zippered body bag prior to transfer to the morgue to prevent HCW contact with any potential leakage of blood or body fluids.
17. Employee Education. All employees will be educated about the reasons for SP and specifics that pertain to their jobs before beginning work. This will include students and volunteers. A description of SP will be included in orientation materials.
18. Needlesticks & Exposure To Body Substances. If a HCW sustains a needlestick or significant mucous membrane exposure to body substances, the HCW will report to their immediate supervisor and then Occupational Health as soon as possible. If the exposure source is known, the patient will be requested (with informed consent) to submit blood for bloodborne pathogen testing.
19. Respiratory Hygiene/Cough Etiquette. Measures to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings including covering the mouth and nose during coughing and sneezing, using tissues to contain respiratory secretions with prompt disposal, offering a surgical mask to persons who are coughing to decrease contamination of the surrounding environment and turning the head away from others and maintaining spatial separation when coughing. These measures are targeted to all patients with symptoms of respiratory infection and their accompanying family members/friends beginning at the point of initial encounter with the healthcare setting.
20. Safe Injection Practices. Adherence to basic principles of aseptic technique for the preparation and administration of parenteral medications including use of a sterile, single-use,

disposable needle and syringe for each injection given and prevention of contamination of injection equipment and medication. Use of single-dose vials whenever possible is preferred.

B. Additional Precautions. Additional precautions will be necessary for some patients. These include patients with known or suspected airborne transmissible disease, those requiring Contact Precautions, and patients requiring Neutropenic Precautions (as defined in the Infection Prevention and Control Manual). These additional precautions will be identified on a color-coded "Infection Precautions" sign. Procedures for discontinuing Transmission-based Precautions may be obtained from the IPs.

C. Other Precautions. Creutzfeldt-Jacob Disease (CJD), other spongiform encephalopathies (TSE), and some emerging pathogens may require additional precautions for management. Infection Prevention (ext 4449) or after hours the Infectious Disease on call staff, should be contacted for suspected or confirmed CJD, TSE, or emerging pathogens. Infection Prevention RNs will have access to up-to-date information on these agents.

D. Private Rooms. Infection Control recommendations will take precedence over other considerations for a private room. A private room will be assigned whenever possible for the following patients (in no order or priority):
   1. Patients with poor hygiene (i.e., patients who are likely to soil the environment with body substances).
   2. Patients with draining infected wounds on surgery stations.
   3. Patients with secretions or excretions that cannot be contained.
   4. Patients who are colonized or infected with multiple resistant organisms (as determined by the Surveillance, Prevention and Control of Infection Committee).
   5. Patients with absolute granulocyte counts (neutrophils and bands) less than $500/mm^3$.
   6. Patients with airborne transmissible diseases that will pose significant dangers to others (Airborne or Droplet.)

   Note: Recommendations for cohorting of patients in the above groups or exceptions to the above recommendations will be made after consultation with Infection Prevention and Control personnel.

4. **REFERENCES:** American Hospital Association Report of AIDS/HIV Infection Policy: Ensuring a Safe Hospital Environment, Report and Recommendations of the Special Committee on AIDS/HIV Infection Policy, November 1987; Recommendations for Prevention of HIV Transmission in Health Care Settings, MMWR 1987, 36(2S):1S-17S; Recommendations for Preventing Transmission of Infection with Human L-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus During Invasive Procedures, MMWR 1986, 35:221-223; Recommended Infection Control Practices for Dentistry, MMWR, December 19, 2003, 52(RR17),1-61; AIDS Syndrome, Occupational Health, Bureau of National Affairs, Inc., 1986, No. 100; Infection Control Manual, Section V, Employee Health and Section VI, Infection Precautions; Occupational Exposure to Bloodborne Pathogens, Final Rule, Department of Labor, OSHA, 29 CFR Part 1910.1030, December 6, 1991; Garner JS, Hospital Infection Control Practices Advisory Committee, CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007; Isolation Precautions in Hospitals, Infect Control Hosp Epidemiol 1996, 17:53-80; Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post-Exposure Prophylaxis - 2005, September 30, 2005, 54(RR09): 1-17; Management of Occupational Exposures to Hepatitis B, Hepatitis C, and HIV and

Recommendations for Postexposure Prophylaxis-Updated 2001 June 29, 2001/Vol. 50/No. RR-11; Guideline for Hand Hygiene in Health-Care Settings Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force October 25, 2002/51(RR16).1-44; Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006, HICPAC;

5. **RESCISSIONS:** Policy #IC–01E, Infection Precautions Policy, dated April 3, 2009.

6. **FOLLOW-UP RESPONSIBILITY:** Surveillance, Prevention and Control of Infection Committee (111F1).

/S/
Judith L. Johnson-Mekota, FACHE
Acting Director, Minneapolis VA Health Care System

SUBJECT: Medical Records

1. **PURPOSE:** The requirements for documentation of inpatient, outpatient, home and community living center care records are defined by this policy and are based, when appropriate, on standards published by VA, Joint Commission, CARF, the Center for Medicare and Medicaid Services, and other regulatory bodies.

2. **POLICY:** Documentation in patient records will be complete, concise, legible and accurate. To enhance access to patient data by health care providers and support personnel, electronic entry and storage of medical information will be used to the fullest extent possible. Manual or paper medical records will only be used if data cannot be entered electronically.

3. **PROCEDURES**:

A. Unique Identifiers. Each patient will be assigned a unique identifier (social security number) when first presenting for health care. The identifier is unique in the national VA system and is verified by submission to the national patient index.

B. Components of Medical Record. Every client receiving health care will have a medical record. All information stored in an electronic medium is considered part of the computerized medical record (except for Outlook and VistA e-mails, which are not part of the medical record). Paper forms will be part of the medical record if approved by the Medical Record Committee. In addition:
   - ***Collateral Records***—Non-veterans will have a separate medical record if they are seen for humanitarian reasons, as an adjunct to patient therapy, or when collateral is seen or interviewed separately from a veteran patient.
   - ***Occupational Health Records***—Medical information will be entered and stored electronically in the Computerized Patient Record System (CPRS) for all employees. Access to this information is restricted to Occupational Health providers.
   - ***Administrative Medical Record Folders***—Original copies of correspondence, eligibility, fee basis and other documentation will be filed in the paper medical record or scanned into CPRS. Original documents will be destroyed after scanning.

C. Scanning of External Source Documents (Outside Records) into CPRS. To enhance access to pertinent clinical documentation provided by non-VA health care providers without compromising patient safety or liability, scanning of external source/outside documents into CPRS will be limited as follows:
   - The File Room will *automatically scan* the following external source/outside documents: all discharge summaries; operative reports; histories and physicals; pathology reports; CT, mammogram and MRI reports; and procedural reports for endoscopies, echos and cardiac caths. All other documents will be returned to the *appropriate provider*.
   - The *appropriate provider* will review any other documents that were not automatically scanned (per above) according to the following algorithm:
     1. Pertinent clinical external source/outside documents will be summarized in a progress note by the provider and shredded.
     2. Pertinent clinical external source/outside documents that are identified as critical to be placed in the electronic record must be signed by the provider and returned to Scanning via the 'Scanning' box located in the clinic area.
     3. External source/outside documents returned to Scanning unsigned by the *appropriate provider* will be returned to the provider for shredding.

- A request to amend an external source document must be referred back to the original source.

D. Entry of Information into the CPRS.

1. Shadow Records. Shadow records (an original document maintained outside the medical record) are not allowed except in the following instances:
   - ***Psychology***—will keep original test results and place a report detailing the results in the medical record.
   - ***Radiation Oncology***—will keep originals of their physiologic measurements and include a summary in the medical record.
   - ***Dialysis and Hematology/Oncology***—will keep original records of procedures until treatment is complete and then incorporate into CPRS.

2. Authorization to Enter. Staff must be authorized to enter clinical information into CPRS. Scope of practice statements and credentials specify an individual practitioner's authority to enter information and write orders. All entries will be in English. Transcription by appropriately trained staff is an acceptable method of entry into CPRS.
   - ***Clerical Staff***—are authorized to enter patient postings. They may also write, "No Show," "Appointment canceled," and "Patient Contact" entries, but these must be verified by the appropriate clinical staff.
   - ***Scribes***—Scribes may not be used at this facility. Medical Students cannot be used as scribes. See the Medical Student Documentation – Attachment C.
   - ***Residents, Fellows and Medical Students***—Policy # MS-02 specifies entries that residents, fellows and medical students may make and which entries must be co-signed. Also see Attachment A.
   - ***Advance Practice RNs and Physician Assistants***—Policies #HR-14 and #HR-16 specify documentation requirements for APRNs and PAs, respectively. Also see Attachment A.
   - ***Students in Authorized Teaching Affiliations—***may make entries into the medical record, but the entry must be co-signed by a staff provider.
   - ***Patients:*** Patient written documentation may not be entered into the medical record. Provider entry will summarize and assess the information appropriate to the encounter.

3. Making Corrections. If a note or imaging error is made in CPRS, the author must immediately write an addendum indicating the note has been entered in error. The author should then send a VistA email to the "g.error" mail group. This mail group will make the note non-viewable. All handwritten entries in the paper record must be made in indelible ink (no pencil). Errors will be corrected by drawing a line through the incorrect entry and initialing and dating the correction. Whiteout or blocking-out data in the paper medical record is prohibited. *Note:* The Privacy Act of 1974 contains provisions for the amendment or correction of a medical record. In CPRS, the HIM manager or designee is provided a security key to access the computer-based record for amending or correcting the record.

4. Historical Notes. Progress notes used to enter patient flag or critical information will be made historical when the information is updated. For example, the original advance directive note will be made historical when a patient changes or updates their advance directive information. CPRS users must send a VISTA email to the g.error mail group to remove the posting or advance directive by changing the title to historical.

5. Abbreviations. Abbreviations used in the medical record must be in the latest edition of Stedman's ABBREV: Abbreviations, Acronyms and Symbols or on a list approved by the

Medical Record Committee. Abbreviations are not acceptable in the final diagnoses on the discharge summary. The following abbreviations are also prohibited—in any form—upper or lower case, with or without periods. For clarity, instead write what is outlined below.

Prohibited Abbreviation	**For Clarity Write**
Lack of zero before decimal (such as .5mg)	Add a zero before the decimal (such as 0.5 mg)
Trailing zero after decimal (such as 1.0 mg)	Whole numbers without a decimal and 0 (such as 1 mg)
IU	International units
MS, MSO_4, $MgSO_4$	Morphine sulfate or magnesium sulfate
Q.D., QD, q.d., qd	Daily or q day
Q.O.D., QOD, q.o.d., qod	Every other day or q other day
U or u	Units

D. Viewing Entries Prior to Authentication. Health information directly entered into CPRS will not be viewable by anyone but the author until the entry has been authenticated. The only exception to this is discharge summaries, which may be viewed by clinical providers prior to authentication; however, they must be authenticated before being released outside the Minneapolis VA Health Care System.

E. Authentication of Entries. Every entry into the medical record (including progress notes and orders) must be authenticated by either direct or electronic signature. Authentication consists of date, time (if required), and the name, credential and title of the person making the entry. If initials are used on individual entries, a signature sheet showing initials and signature of the person doing the entry must be documented in the chart for each episode of care (i.e. admission, length of specified treatment or individual encounter). *Note:* For co-signature requirements for residents, see policy #MS-02. For co-signature requirements for APNs and PAs, see policies #HR-14 and #HR-16, respectively. In the event the author of a progress note or other paper or electronic entry is not able to sign the documentation, the service chief or section chief may sign the order or note. Otherwise, the documentation may be reviewed by the Medical Record Committee to determine if the entries should be filed as incomplete.

F. Signatures. There are three types of signatures in the electronic health record: (1) Signer–this is the author of a document; (2) Co-Signer–this is the attending, staff or supervising clinician; and (3) Identified Signer or Additional Signer–signature -only indicates the signer has received the information contained in the note (signature does not constitute responsibility for content).

G. Timeliness of Entries and Authentication and Delinquent Records. Attachment A details timeliness requirements for most components of the medical record. Entries should be made as soon as possible after or during the encounter. Required entries and authentication must be complete within 30 days after a discharge/encounter or the medical record will be considered delinquent.

H. Quality of Documentation. Individual providers are responsible for the quality, completeness, clinical pertinence and timeliness of their entries into the medical record. The Medical Record Committee, or designee, conducts ongoing monitoring of entries into the medical record. Review results are reported to Patient Service Line (PSL) leadership. PSL directors are responsible for submitting action plans to the Medical Record Committee that address identified documentation issues and implementing plans to achieve needed corrections. The Medical Record Committee chairperson reports quarterly results to the Executive Committee of the Medical Staff. Entries should not contain facetious, libelous or other-wise inappropriate or subjective remarks. Personal opinions or non-medical judgments shall not be expressed in the medical record, except as they pertain to the direct medical care of the patient.

I. Templates/Forms/Titles. The Medical Records Committee's Forms Subcommittee or designee must approve all forms, templates, titles or other entry methodologies. Titles must conform to VISN and/or nationally published standards. Proliferation of note titles makes retrieval difficult and cumbersome. Contact HIMS for assistance at extension 2378 or 3373.

J. Accessibility of Patient Care Records.
- Paper medical records are available upon request by clinicians. Paper records can be requested by calling the file room.
- Inactive records stored in Federal Record Centers will be retrieved at the request of the clinician.
- A patient, their attorney, or other representative can personally review an original patient record, provided their access is properly authorized. To prevent tampering or alteration of the original record, HIMS staff will observe the patient or representative during possession of any original medical record whether in paper, electronic or other medium.

K. Contingency Plan for Computer Downtime. PSLs have contingency plans detailing procedures to follow during computer failures. There is also a Minneapolis VA Health Care System contingency plan filed in the Emergency Incident Management Plan notebook located in each service/section/clinic/ward. For contingency plans regarding the Bar Coded Medication Administration system (BCMA), see policy #TX-19, BCMA.

L. Retention of Records. Medical information will be kept in an archival medium for 75 years after the last date seen or as specified in VA regulation. Retention and disposition requirements are listed in the VHA Records Control Schedule (RCS) 10-1.

M. Ensuring Confidentiality. Every employee with access to patient records is responsible for proper protocol in handling records—whether in paper or electronic form—and for safeguarding patient confidentiality and privacy. See the Minneapolis VA Health Care System's privacy policy, IM-07 for more details.

N. Security of the Medical Record.

1. Releases. Medical records are the property of the Minneapolis VA Health Care System and cannot be released unless VA release of information requirements are met. Contact ROI for assistance and/or see policy IM-02, Release of Information, Specimens and Materials. Medical records also cannot be transported, accessed, downloaded or printed off-site unless an official exception has been granted. See policy IM-07, Privacy Policy and/or contact the Privacy Officer for assistance.
2. File Room. All patient-specific medical information will be kept in a dry secure area. The Medical Record File Room will remain locked and only file room staff, HIMS-designated and other employees approved by the Director, HIMS are allowed access.
3. Clinical Areas. Medical records stored in clinic areas, inpatient units or other clinical areas will be safeguarded by the continuous presence of staff or be stored in a secure area. When accessing patient information electronically, computer screens must be secured from unauthorized personnel. Paper records will be transported by VA staff or secured in envelopes, mailbags, or secured carts. All users must discontinue access to VistA before leaving a computer.
4. Employee/Volunteer Records. Paper employee or volunteer records written prior to the implementation of CPRS will be kept in locked file cabinets in the File Room.
5. Release of Original Records. The medical record is the property of the Minneapolis VA Health Care System and will not leave the premises except in accordance with federal law, or a

subpoena or court order from a United States Court. Unlawful removal or destruction of medical records will cause penalties to be enforced as provided by law (18 U. S. C. 234-235).

6. Employee Access. Access to patient-specific medical information will be limited to staff members with a legitimate "need to know" to perform official duties. Staff with access to confidential medical information will receive training in maintenance, confidentiality and security of information on initial employment and annually. The same training, guidelines and penalties apply to all staff and students in the Minneapolis VA Health Care System, community based outpatient clinics, contract facilities and research areas.
7. Electronic Signature Codes. Electronic signatures will be used in computer-based records and the signature will be secured by encryption. The computer system will not provide an electronic signature to anyone including IRM staff. All VA staff authorized to use VistA are responsible for safeguarding electronic signature codes and paper or computer-generated documents to prevent unauthorized use. Electronic signature codes will be set up by every user and changed as needed. PSLs are responsible to ensure access to VistA is secure (for those employees who require VistA) and that employees protect the security and integrity of electronic signatures and computer-generated documents. PSLs are also responsible for defining an appropriate user class for each employee and updating user class status as needed (user class defines the entry and co-signature requirements for each individual).
8. Inactive Medical Records. Inactive medical records will be stored in federal record centers subject to laws governing confidential medical information, or with local storage companies that meet contract specifications for safeguarding the physical security and confidentiality of medical information. Transport will be done by companies meeting security guidelines specified in the National Archives and Records Administration directives.

O. Documentation Guidelines for Components of the Medical Record. Every test, procedure or treatment must be ordered and interpreted by a clinician and documented in the medical record. See Attachment A for a detailed list of documentation requirements for these components of the medical record:

Advance Directives	Hand Offs When Non-Primary Care Providers Identify Clinical Issues Requiring Follow Up by Another Provider
Against Medical Advice (AMA)	History and Physicals
Allergy and Adverse Reaction	Informed Consent
Anesthesia Evaluations & Notes	Medication Reconciliation
Assessment (Initial) & Treatment Plans	Nursing Database
Assessment: Local Anesthesia	Operative Progress Notes & Reports
Assessment: Pre-Sedation--Deep Sedation	Orders
Assessment: Pre-Sedation--Moderate Sedation	Patient Education
Attending Notes	Problem Lists
Clinical Reminders	Progress Notes
Consultations	Time Outs
Discharge Summaries	Verbal Orders (Other than for Medications)
DNR/DNI Orders and Code Status Progress Notes	

P. Special Conditions for Surgery. Except in extreme emergencies, surgery will only be performed after the following has been completed: informed consent; appropriate history, physical examination;[1]

[1] An appropriate assessment for a focused H&P is required for any surgery or procedure that requires general, spinal, or other major regional anesthesia, or IV conscious sedation. These procedures may be performed by practitioners who are

indicated laboratory and x-ray examinations; and an entry of the preoperative working diagnosis into the medical record. If a history and physical and/or nursing assessment has been obtained within 30 days prior to surgery, this report may be used in the patient's medical record—provided any changes that have occurred in the interim period are documented at the time of the invasive procedure. Immediately after surgery, the following will be entered into the medical record: postoperative diagnosis; description of findings, technical procedures used, and specimens removed; and the name of the primary surgeon and any assistants. Operative reports must be authenticated by the surgeon.

Q. Rules for Copying and Pasting and/or Importing Text. All clinical medical record entries should provide an accurate depiction of evaluation and treatment at a particular patient-provider encounter. Therefore, use of copying and pasting functions should only be done to include historical information that is pertinent to the encounter and is used in the evaluation and treatment of the patient. When copying and pasting is used, the source from which the information was taken must be appropriately attributed. The following rules for importing and/or copying text must be adhered to:

1. Never copy the signature block into another note.
2. Never copy data or information that identifies a health care provider as being involved in care that the health care provider is not involved in.
3. Do not copy entire laboratory findings, radiology reports, and other information in the record verbatim into a note when it is not specifically addressed or clearly pertinent to the care provided.
4. Do not re-enter previously recorded data, unless specifically required for the assessment of a specific patient problem.
5. Use the functionality of importing data objects into progress notes and other documents judiciously. Any imported object, dialog, etc. must be reviewed and must be pertinent to the patient assessment.

The authors are liable for the content of copied items within the notes they authenticate. Where violations of the above rules for importing or copying information occur, findings must be reported to the author's supervisor for review and education as appropriate. Egregious and/or repeated misuse of copy and paste should be reported to the author's PSL director for review and action and—if deemed necessary—referral to the Minneapolis VA Health Care System's Compliance Officer for disciplinary or other adverse action. Failure to comply with these standards may be deemed a violation of the Privacy Act requirement (5 U.S.C. Section 552a(e)(5) or Standards of Ethical Conduct for Employees of the Executive Branch (5 CFR Part 2635). Disciplinary action may be taken if violations of these standards are validated per VA Directive 5021. Criminal charges may be filed when in violation of Federal law.

R. Limitations on Use of Passes. Passes are not permitted for patients on Medicine and Surgical wards (exceptions may be granted in rare and extenuating circumstances, provided approval has been obtained in advance from both the attending physician and the PSL director). Passes allowing inpatients to leave the facility are only allowed for:

- ***CLC patients***—Passes for CLC patients are covered in CLC policy. See the CLC pass policy for further details.
- ***Rehabilitation patients***—who have a clinically-justifiable rehabilitation need for a pass (e.g., to test cognitive or physical skills outside the rehabilitation setting). Passes for rehabilitation must be documented by nursing and approved by the attending MD. The length of time for the pass will be determined by the interdisciplinary treatment team.

privileged to perform operative procedures and residents who meet the requirements outlined in policy #MS-02, Supervision of Residents.

- ***Mental health patients***—who have a clinically-justifiable need for a pass (e.g., to visit a group home.) Passes for 1K patients may be for no longer than 8 hours and may not be overnight. If such a pass is granted, it must be documented by nursing and approved by the attending physician. A one hour on grounds pass may also be granted if the patient was admitted voluntarily (i.e., was not committed) and will be accompanied by another responsible adult.

4. **REFERENCES:** IM-07, Privacy & IM-02, Release of Information, Specimens and Materials.

5. RESCISSIONS: Policy #IM-01 J, Medical Records, dated November 29, 2010.

6. **FOLLOW-UP RESPONSIBILITY**: Chair, Medical Records Committee.

/S/
KENT CROSSLEY, MD
Acting Director, Minneapolis VA Health Care System

Attachments:
A. Documentation Guidelines for Components of the Medical Record (Updated September 19, 2012)
B. File Room Security, Including Protection of Integrity Of Medical Records From Water Damage And Moisture
C. Medical Student Documentation

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Require-ments	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Advance Directives	See Minneapolis VA Health Care System policy #RI-04. A CPRS patient posting will be placed in the electronic record by a social worker to alert staff of the advance directive.				
AMA Against Medical Advice	Within 24 hours of discharge or departure.	Physician, Dentist, or Staff authorized to do so.	Final Progress Note must contain: • Date and time of release • Reason for leaving • Notification to patient of risks involved in refusing treatment • Any special disposition arrangements • Last observed condition of the patient.	----------	Prescriptions are not normally provided but may be dispensed at the discretion of the provider.
Allergy & Adverse Reactions	----------	Physician, Dentist, Podiatrist, RN, LPN, Pharmacist	• Name of reactant • Historic or observed signs and symptoms • Signs and symptoms of reaction	----------	Data must be entered in into the "Allergy" package by entering pertinent information from the cover sheet of CPRS or "generic allergy orders" on the orders tab.
Anesthesia Evaluations & Notes *For assessment requirements for sedation see below.*	----------	*Pre-Anesthesia Evaluation:* An anesthesiologist or a CRNA will complete pre-anesthesia evaluations. *Post-Anesthesia Evaluation:* An anesthesiologist or designee will write post anesthesia notes.	*Pre-Anesthesia Evaluation:* • choice of anesthesia; • ASA rating; • surgical procedure anticipated; • previous drug and anesthesia history; and • any potential anesthetic problems. *Post-Anesthesia Note:* Document the name of the anesthesiologist responsible for the patient's release from the recovery room (or clearly document discharge criteria used to determine release). The anesthesiologist's signature is required to release the patient from the PACU.	Pre-anesthesia evaluation done by CRNAs must be co-signed by an anesthesiologist.	Reassessment must occur immediately prior to sedation being given. Update significant findings or document no change immediately prior to induction/procedure and document in the medical record. There shall be at least one post-anesthesia visit, after leaving the recovery room. This should describe the presence or absence of anesthesia-related complications.
Assessment (Initial) & Treatment Plans	Initiated within 24 hours of admission to acute care or 72 hours of CLC admission.	----------	• Reassessments will reflect any changes to the treatment plan during hospitalization. • Psychiatry and CLC will formulate comprehensive assessments and treatment plans that indicate a multidisciplinary approach to the patient's care.	----------	The plans may be documented in paper or electronic medium.

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Require-ments	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Assessment: Local Anesthesia	Before starting procedure	Attending physician, resident, APN, or PA.	• The indication for the procedure and a physical exam of the planned operative/invasive site.	-----	-----
Assessment: Pre-Sedation--Deep Sedation	Before beginning sedation	Physician credentialed in sedation	• Plan for sedation • Notation of previous adverse experience with analgesia, sedation or anesthesia • Complete H&P within 30 days of procedure including relevant system and cardiopulmonary exams • Airway assessment • ASA score	-----	Re-evaluation must occur immediately before giving sedation. Update significant findings or no change immediately prior to induction/procedure and document in the medical record.
Assessment: Pre-sedation – Moderate Sedation	Before beginning sedation	Physician credentialed in sedation	• Plan for sedation • Notation of previous adverse experience with analgesia, sedation or anesthesia • Focused exam of heart, and lungs unless a valid H&P has been performed within 30 days. • Airway assessment • Results of diagnostic/laboratory tests pertinent to the procedure being performed • Current medication and allergy profile • Baseline level of consciousness, blood pressure, heart rate, respiratory rate and oximetry • Time of last oral intake • ASA score	---	A focused H&P must be completed or updated within the last 30 days. This H&P must address the elements listed to the left. Re-evaluation must occur immediately prior to sedation being given. Update significant findings or document no change immediately prior to induction/procedure and document in the medical record.
Attending Notes	First note within 24 hours of admission. Frequency of subsequent notes shall be determined by the patient's condition, likelihood of treatment plan changes, complexity of care, and the experience of the resident.	Attending physician.	• Attending's findings; • Concurrence with the resident's work-up, initial diagnosis, and treatment plan. *Any modifications must be noted.* • The note must be dated and timed.	None.	Documentation may be an independent progress note or an addendum to the resident note. See policy MS-02, Supervision of Physician Residents, for details. Documentation must be entered by the end of the calendar day following admission.

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Clinical Reminders	CPRS automatically generates clinical reminders to providers on clinical topics (e.g., diabetic screening). It is each clinician's responsibility to address these reminders and enter information to resolve them.				
Consultations	*Inpatient Consults—* unless specified otherwise by the requestor, inpatient consults will be answered (resulted) within 24 hours of request. *Outpatient Consults—* For routine consults, outpatients must be scheduled for an appointment or placed on an Electronic Wait List within 7 days. Non-routine consults will be answered in a timely manner in accordance with patient need.	*Requests and Responses:* Will be entered electronically by the service requesting the consultation. *Note:* For consults that are needed on weekends and holidays, the requesting service must telephone the on-call provider of the service that is being consulted (to alert them a consult is needed). Registered nurses may send consults "per policy" to: Bioethics Committee Chaplain ET Nursing Nutrition Occupational Therapy Physical Therapy Social Work Speech VIST Coordinator	*Requests:* • brief description of the patient's condition; • reason for the consultation; • other pertinent information (such as medications which may affect the condition being evaluated); and • electronic signature of the requesting physician. *Responses:* • electronically entered opinion by the consultant; • date of the response; and • signature of author. *Note:* If a consultant or their designee decides to deny a consult and/or change a consult plan, the reasons for doing this must be documented on the consult or in subsequent provider notes. (Per Network Policy V23-CMO-031.) Leadership of the consultant service is responsible for ensuring all consult requests are appropriately managed. An alert is automatically generated to the ordering provider when a consult is resolved (completed).	Appropriate documentation of supervision must be documented in the medical record. See Resident Supervision Policy MS 02.	Consults are needed when a provider treating a patient requests additional expertise and/or needs services for which the requesting provider lacks privileges. PSLs will conduct clinical reviews of all back-logged consults to determine appropriate disposition and clinical follow-up by the receiving service. See Network Policy V23-CMO-031 for more specifics on responding to consults, including definitions of types of consults.

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Death Certificates **and** **Pronouncement of Death** *(for inpatients)*	Both death certificates and pronouncement of death must occur soon after death.	*Certificates*—Chief resident or attending physician or designee. *Pronouncement*—Both APRNs and MDs may pronounce death for patients followed by the hospice and palliative care program. In all other areas, only MDs may perform this function. See comments to the right on what to do if a treating surgeon is not immediately available.**	**Guidelines for Completion of Death Certificates/Worksheets** Based on Guidance Received from the State Registrar (referred by MDH), the following questions on the death certificate may be completed as follows: ➢ *Did the physician view the body?* This refers to the physician completing the death certificate/worksheet. ➢ *What dates did the physician care for the patient?* Simply record the time frame for the patient's inpatient stay. **When Families Want a Specific Cause of Death Listed for VA Benefit Purposes**—Physicians must only list what they consider to be the true clinical cause of death based on their clinical judgment. Should the family be unhappy about this, the physician should contact the Chief of Staff for support and guidance.	None	***Pronouncement if a Treating Surgeon Is Not Available*—If the treating physician is a surgeon or surgical chief resident—and the surgeon and/or surgical chief resident is in the OR at the time of death—then the MOD may be paged to pronounce a patient as dead. If the surgeon/resident will be tied up for a significant delay, the MOD will call the family to inform them of the death and tell them the surgeon/surgery resident will call them as soon as they are out of the OR to share more details. If it were a critically ill patient or an arrest, the surgery resident would scrub out and attend to the patient.
Discharge Summaries	If the patient is being discharged to an outside nursing home or the CLC, the summary must be dictated PRIOR to discharge. All other summaries must be dictated within 48 hours of discharge and signed 48 hours after transcription. See "other comments" for guidance re: discharge summaries by APRNs.⇒	Resident, attending staff, nurse practitioner, or other staff authorized to do so. See "other comments" for guidance re: discharge summaries by APRNs.⇒ *Note:* To expedite transcription of a discharge summary, the physician should press the number 6 anytime during his/her dictation to mark this summary as a priority. It will then be the next piece of work that a transcriptionist receives to transcribe.	• Reason for hospitalization; • Significant findings; • Procedures performed and treatment rendered; • Patient's condition at discharge; • Instructions to the patient and family; and • Final diagnosis. The final diagnosis shall include the principal diagnosis (the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care). *Note:* Additional diagnoses should include all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.	The attending must co-sign the discharge summary within 48 hours of transcription. See "other comments" for guidance re: discharge summaries by APRNs.⇒	If the summary is dictated more than 48 hours before discharge, then an addendum must be dictated. This must reflect the hospital course and final diagnosis after the last discharge note was done. Discharge summaries completed by APRNs do not require co-signature. However, the: (1) the APRN must identify a staff physician as an "additional signer"; and (2) the staff physician must review and sign as an "additional signer" within 24 hours.

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
DNR/DNI Orders and Code Status Progress Notes	Attendings must document concurrence with the code status within one working day. See co-signature requirements.	May be written by staff physicians and resident physicians. Advance practice nurses (excluding CRNAs) may also write these orders, provided their practice agreement has authorized them to write such orders.	*Initial DNR/DNI Order sand Code Status Progress Notes:* An accompanying notation will be made in the progress note. This notation may include any of the following, as appropriate to the situation: • rationale for the order, • diagnosis and prognosis, and • names of those involved in the discussion. *Subsequent Admissions:* The physician or APRN must review the DNR/DNI order with the patient to ensure that it remains appropriate. The physician or advance practice nurse must discuss the order with the attending physician and rewrite the order. Use of the Code Status Progress note template in CPRS is mandatory.	The attending must document concurrence with the code status by co-signing the resident's or APRN's note or by indicating concurrence in the attending's own progress note. This must be done within one working day.	Residents and advance practice nurses must discuss a DNR or DNI order with the attending physician at the time the order is written. The code status progress note creates a patient posting for quick retrieval of information. *Note:* The DNR/DNI order will not be considered valid until the resident or APRN has documented the attending's concurrence in a progress note.
Hand Offs When Non-Primary Care Providers Identify Clinical Issues Requiring Follow Up by Another Provider (for example, if a PM&R realized a patient had a lung nodule that required action by another provider)	Immediate Contact	VA physicians, residents, dentists, podiatrists, and advance practice nurses/physician assistants who are authorized to do so.	Urgent Issue Identified: The provider who identifies the urgent clinical issue should make *direct contact* with the appropriate provider (i.e., speak with the other provider in person or by phone, NOT voice mail, or email or CPRS). Hand off of this information should then be documented in a CPRS progress note with the appropriate provider listed as an additional signer.	Appropriate documentation of supervision must be documented in the medical record. See Resident Supervision Policy MS 02.	----------
	Timely manner in accordance with patient need	VA physicians, residents, dentists, podiatrists, and advance practice nurses/physician assistants who are authorized to do so.	Non-Urgent Issue Identified: If follow-up is needed on a non-urgent issue, the provider should write a progress note and list the appropriate provider as an additional signer. If appropriate, the provider may also order a consult in CPRS or schedule a follow up appointment.	None	----------
	Timely manner in accordance with patient need	VA physicians, residents, dentists, podiatrists, and advance practice nurses/physician assistants who are authorized to do so.	Information Only: Other types of information that do not merit a direct contact "hand off" can be done via a progress note in CPRS, which lists the appropriate provider provider as an additional signer.	None	----------

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
History and Physicals	Must be in the CPRS within 24 hours of admission to acute bed, or within 72 hours if admitted to CLC. See "other comments" for guidance on H&Ps by APRNs.⇒	• Physicians with appropriate privileges. • Oral surgeons with appropriate privileges (for the part of the patient's H&P pertaining to dentistry). • Podiatrists with appropriate privileges (for the part of the patient's H&P pertaining to podiatry). • Advance practice nurses (excluding CRNAs), provided their practice agreement has authorized them to do so. See "other comments" for more guidance on H&Ps by APRNs.⇒ *Note:* H&Ps will be accepted from physicians, oral surgeons and podiatrists (as noted above) at other VA facilities, including contract and VA-staffed CBOCs.	• Medical history, including: the chief complaint; details of present illness; relevant past, social and family histories; and an inventory by body system. • Relevant system and cardiopulmonary exam • Impressions/diagnosis • Treatment plan and goals *See assessment/pre-sedation for elements required prior to a patient undergoing an invasive procedure.*	H&Ps byPAs or other authorized staff must have co-signature or a note documenting concurrence. This must be done by an attending physician within 24 hours of admission and be dated and signed. See "other comments" for guidance on H&Ps by APRNs.⇒	See policy PE-01, Assessment of Patients, for minimum assessment/H&P requirements for inpatients and outpatients. An H&P may be completed by an APRN if designated in her/her scope of practice. The H&P must be documented as a "history and physical" in CPRS. In addition: (1) the APRN must identify a staff physician as an "additional signer"; and (2) the staff physician must review and write an addendum indicating concurrence within 24 hours (72 hours for CLC) -- or prior to performing any procedure that will require an H&P. *Note:* The same requirements also apply when an APRN performs an H&P or focused review prior to a procedure (e.g., pre-operative or pre-sedation H&P).
H&P Updates	Prior to surgery	Same as above.	Update the patient's condition prior to the start of surgery if the history and physical was done within 30 days of surgery. *Note:* This update must explicitly address the relevant system and cardiopulmonary exam	Same as above.	The pre-anesthesia assessment and the update to the H&P can be combined.

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Informed Consent	The informed consent progress note and patient consent will be entered in CPRS. See Hospital Policy #TX-02, Informed Consent, for documentation guidelines.				
Medication Reconciliation	Within 24 hours of admission	Clinician responsible for admitting H&P.	A complete list of all medications and patient compliance.	-----	-----
Nursing Database	The nursing admission database must be completed within 24 hours of admission. Other requirements for nursing documentation are located in the Office of Nursing Professional Services, Policy #39.				
Operative Progress Note: A note in CPRS before the patient leaves the operating suite.	*Operative Progress Note:* Must be placed in the medical record before a patient is transferred to the next level of care.	*Operative Progress Note:* A physician or dentist who is authorized to do so.	*Operative Progress Note:* • name of the primary surgeon and assistants; • description of degree of involvement by attending surgeon; • findings; • procedures; • specimens removed; • estimated blood loss; • postoperative diagnosis; • time and date.	None	*Operative Reports* For procedures aborted after the induction of anesthesia, the report must be dictated describing the situation and detailing the reason(s) for cancellation
Operative Report: A dictated report completed after surgery.	*Operative Report:* Must be dictated immediately after surgery.	*Operative Report:* A physician or dentist who is authorized to do so.	*Operative Report—If Performed in an OR Suite:* • name of the primary surgeon and assistants; • description of degree of involvement by attending surgeon; • findings; • procedures; • specimens removed; • estimated blood loss; • postoperative diagnosis; • time and date. *Operative Report—If <u>Not</u> Performed in an OR Suite:* Detailed reports of diagnostic and therapeutic procedures <u>not</u> performed in the operating room will be documented in a progress note and will contain: name of procedure, person performing procedure, details of procedure, major findings and conclusions, tissue removed, any complications, signature, title, time, and date.	Operative reports must be co-signed by a staff physician if completed by a resident.	

Attachment A, Documentation Guidelines for Components of the Medical Record

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Orders	----------	VA physicians, residents, dentists, podiatrists, and advance practice nurses/physician assistants who are authorized to do so.	----------	Medical or dental students and sub-interns will have orders co-signed by a supervising physician prior to initiating the order.	All orders need to be signed by the responsible clinician.
Patient Education	See Minneapolis VA Health Care System policy #PF-01.				
Problem List	----------	Clinicians or staff authorized to do so.	In the electronic record, the problem list will be developed by the third visit and contain a list of active medical problems, pertinent procedures, and pertinent past medical problems. Providers must designate problems inactive when no longer pertinent.	----------	Inpatient and outpatient problems and significant procedures must be documented.
Progress Notes	Inpatient progress notes must be documented at least daily, and more often as patient condition warrants. *Note:* Daily notes are not mandated on the CLC and Polytrauma Transitional Unit. Attending notes must be done within 24 hours of admission. Outpatient progress notes must be completed within 48 hours (or sooner if clinically indicated). All Emergency Department progress notes must be completed by the end of each shift (prior to departure).	Physicians and house staff, nurses, pharmacists, rehabilitation therapists, dietitians, social workers, psychologists and other qualified members of the health care team.	The notes must be titled, dated and identify the name and profession of the author.	Student and resident notes must either be co-signed or appropriate documentation of supervision must be documented in the medical record.	A progress note will be documented for every encounter in the outpatient setting. See the Resident Supervision Policy, #MS-02, for documentation requirements for resident supervision.
Time Outs	See policy TX 22, Correct Site Surgery/Invasive Procedures.				

Attachment A, Documentation Guidelines for Components of the Medical Record (Updated September 19, 2012)

What	Time Requirements	May Be Dictated or Written By	Must Contain These Elements	Co-Signature Requirements	Other Comments
Verbal Orders—Other Than for Medications *For verbal orders pertaining to medications, see policy, TX-04, Medication Use.*	**All** verbal orders must have prescribing provider's signature/date within one working day	Authorized VA physicians, residents, dentists, podiatrists, and advance practice nurses/physician assistants. *Note:* CRNAs may only give verbal orders during codes.	----------	Attending co-signatures are not required on verbal orders. Speech therapists may record orders but they must be cosigned by a physician.	*For verbal orders pertaining to medications, see policy, TX-04, Medication Use. The information below applies to all other verbal orders:* Staff may accept a telephone or verbal order by individuals with prescriptive authority in emergency situations or when the provider is unable to enter the order electronically. The staff member must: (1) Document the complete order including the date/time, name and title of the prescriber as well as their own name and title. (2) Then give a verbal read back of the patient's full name, social security number or date of birth, and drug name, dosage, route, frequency and duration.

Attachment B, File Room Security, Including Protection Of Medical Records From Water Damage, Moisture And Fire

File Room Security, Including Protection Of Medical Records From Water Damage, Moisture And Fire

The Minneapolis VA Health Care System will maintain patient-specific medical information including the paper record in a secure area free from water damage or moisture. Paper or electronic mediums may be used to store confidential medical information. Environmental services will be responsible for testing for excess humidity or moisture that could damage paper or electronic records. Medical information will be stored in an area unlikely to flood or be subject to excessive moisture or water.

If sufficient notice is received that there is a likelihood of damage to medical records due to water or flooding, all efforts will be made to safeguard medical information without risking human life. If possible, records will be moved to a dry secure location.

If records/electronic medium are damaged by water or flooding, every effort will be made to restore the medical information. Records may be shipped to a professional water damage restoration company to restore the medical information to a useable condition. If only a few records are water damaged, staff may separate and dry the records page-by-page in a secure area. To minimize the risk of water damage, all possible efforts to minimize damage to medical records will be implemented. Records will not be stored on the floor or on top of filing cabinets

The Medical File Room is protected by firewalls enclosing the entire space and automatic sprinklers. Employees have been trained to respond to fire danger by:

R. Rescue anyone from the area.
A. Alarm, announce FIRE, activate pull station, dial 1-911.
C. Contain, close doors.
E. Extinguish, if possible, or Evacuate.

Employees receive annual training on fire safety and emergency procedures. A notification system, consisting of a series of bells, informs employees of the location of any fire. Five chimes or bells will ring if a fire is located in the basement. Fire doors automatically close for each section of the hospital. If a fire occurs in the Medical File Room, automatic sprinklers will put out the fire but may cause water damage.

If employees can remove medical records from the immediate fire source without harming themselves, storage carts are always available for chart removal. Carts with medical records should be moved to the nearest secured storage space – Medical Records Processing Unit or Transcription.

Attachment C, **Medical Student Documentation**

Medical students may document services in CPRS but their entries must be co-signed by an attending/ teaching physician. The co-signature indicates the note is accurate and may be entered into CPRS. Residents or teaching physicians must enter a note reflecting the services they themselves delivered at the visit.

History and Physicals or Consults
Medical students cannot act as scribes for entering history and physicals or consultations The teaching physician or resident must enter their own note indicating history, exam, assessment and plan. The teaching physician may refer to the medical student note for vital signs, review of systems and/or past family/social history.

Inpatient Progress Notes
Medical student progress notes cannot be used to document the patient's exam, assessment or plan. Inpatient progress notes must be written by the resident or attending as appropriate to patient's condition.

Outpatient Progress Notes
Outpatient progress notes written by medical students can be entered into CPRS if co-signed. The teaching physician may refer only to the medical students note for vital signs, review of systems and/or past family/social history in writing their own note. Residents or teaching physicians must enter a note reflecting the services they themselves delivered at the visit.

SUBJECT: Information Security Policy/Procedures

1. **PURPOSE**: To establish policy, responsibilities, and procedures for the security of Minneapolis VA Health Care System (MVAHCS) information systems to include, but not limited to, access, disclosure, modification, destruction, or misuse. This policy also applies to the security of all information that is collected, transmitted, used, processed, stored, or disposed of, by or under the direction of this operating unit or its contractors.

2. **POLICY:**

A. Minneapolis VAHCS will develop, implement, maintain, and enforce a structured program to safeguard all information technology assets to assure integrity, availability, confidentiality, and authenticity of data and information; to protect our assets from theft, misuse, and unauthorized use; and develop a continuing awareness of the need for, and the importance of, IT security.

B. All Minneapolis VAHCS employees are responsible for complying with this security policy. Violations of security policy or procedures will be brought to the attention of the appropriate Minneapolis VAHCS facility management for appropriate disciplinary action and reported in accordance with national and Minneapolis VAHCS Incident Reporting policy.

C. All policies, procedures, and any actions/activities taken as a result of these policies must be documented and retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

D. All documentation related to the information security program will be reviewed annually and updated as needed in response to environmental or operational changes affecting the security of the sensitive data.

E. Facilities can append site-specific clarifications or site-specific procedures to the Procedure section of a control as long it does not alter the content of the original procedure or lessen the authority of the control.

3. **RESPONSIBILITIES:**

A. **Executive Management (Director, Associate Director**) are responsible for:

- Providing the necessary resources to support the Information Security Program and ensuring that Minneapolis VAHCS facilities meet all the information security requirements mandated by Executive and VA policy and other federal legislation.
- Ensuring there is adequate private office space for the ISO at the facility. The facility ISO will report through the Field Security Service (FSS) Network ISO Team Lead with additional oversight and performance input provided by the MVAHCS Director or Associate Director.
- Ensuring ISOs are fully involved in all new projects concerning the development or acquisition of systems, equipment, or services including risk analysis, security plans, requests for proposal (RFPs), and other procurement documents that require the ISO's participation.

B. **Facility ISO (FISO)** is responsible for implementation of an Information Security program consistent with VA directives, security policies, federal laws and regulations, and guidelines at the facility. Activities include, but are not limited to:
   - Coordinating, establishing, facilitating, and updating any additional information security policies and procedures.
   - Auditing the media sanitization process in accordance with VA guidelines.
   - Establishing effective working relationships with facility Privacy Officer, Freedom of Information Act (FOIA) Officer, Contracting Officer, and Human Resources personnel to assure IT security and HIPAA/FOIA/Privacy Act/FISMA policies complement and support each other.
   - Monitoring the facility Information Security Program to ensure that appropriate and timely action is taken to protect assets from damage, destruction, alteration and misappropriation.
   - Recommending appropriate alternate ISO coverage to the facility Director and the NISO.
   - Maintaining documentation of incidents related to information security and their resolutions; reporting these incidents to VANSOC and management, as appropriate, and ensuring risk management processes are in place at the facility.
   - Ensuring mechanisms are established to document requests for access to sensitive automated information systems and providing user awareness training and orientation of information security to all employees.
   - Reviewing and evaluating the impact of proposed facility changes to the information security program and performing information security program assessments by monitoring systems and user activity regularly and maintaining logs of reviews.
   - Ensuring all appropriate IT business continuity plans and disaster recovery plans are developed, tested, and maintained.
   - Ensuring procedures are established for identifying actual or suspected computer security incidents and for investigating, mitigating, and reporting such incidents.
   - Participating in Federal Information Security Management Act (FISMA) activities to include timely updating of Security Management and Reporting Tool (SMART) database; coordinate remediation of identified deficiencies with local and Minneapolis VAHCS staff.
   - Ensuring the Certification and Accreditation (C&A) of information systems and Health Insurance Portability and Accountability Act (HIPAA) security requirements are implemented.
   - Coordinating the vulnerability scans for all IT systems within the area of responsibility and ensuring remediation actions are taken as a result of these scans or VANSOC alerts.
   - Coordinating and documenting all remote access requests within their facility and disabling remote access accounts when no longer required or the result of inactivity.
   - Enforcing all policies and procedures pertaining to transportation, transmission, remote access and use of VA IT equipment.

C. **Facility Chief Information Officer (FCIO)** or designee is responsible for:
   - Working closely with ISO to provide technical advice and other assistance dealing with implementation of IT security policy.
   - Assuring all IT staff receives security training appropriate to their job functions.

- Identifying each locally maintained computer system that contains sensitive information, and providing technical input into various mandated documents/reports (i.e., FISMA, HIPAA).
- Identifying all assets and implementing security measures, which meet established security standards and policies, in order to protect said assets on all systems under their management control.
- Assuring all high security areas meet acceptable levels of physical security. High security areas include, but not limited to, computer room(s), telephone switch (PBX) room(s), and main telecommunications demarcation point if not located in the PBX or computer room, data/telecommunications closets, IT work areas and IT storage areas.
- Enforcing policy and procedure that restricts access of personnel to all computer room environments. Assuring, in coordination with ISO and supervisors, the termination of IT access of users who no longer have a need.
- Authorizes and monitors the use of guest and/or anonymous and/or accounts deemed to be 'generic' (not tied to a specific user) used on any IT system within their area of responsibility.
- Ensures all user accounts are reviewed every 90 days and any unneeded accounts are terminated and/or removed.
- Ensuring critical system files are backed up on a regular basis and are housed in a secure location far enough away from the system to not be affected by the same catastrophic event.
- Implementing media control policy and procedure, assuring software security controls are implemented, enforcing established policy for the use of non-VA hardware and software; implementing configuration management and change controls; and assuring adherence to current VA network security policies, directives, and standards.

D. **Facility Privacy Officer** and/or designee is responsible for:
- Coordinating with the NISO and/or FISO for the assurance of reasonable safeguards as required by the HIPAA Privacy Rule or other federal privacy statutes.
- Working with the NISO and/or FISO to assure IT security and HIPAA/FOIA/PA/FISMA policies complement and support each other.

E. **Facility Chief, Human Resource Management Service** and/or designee is responsible for:
- Submitting requests for obtaining background investigations on all appropriate workforces.
- Providing guidance to supervisors and managers regarding personnel actions, sanctions, or other actions to be taken when employees have violated information security practices, laws, regulations, policies, and rules of behavior; and providing feedback on information security performance standards and position descriptions for employees authorized to access IT systems.
- Managing in coordination with the Facility Chief of Police, the PIV card security and badge system.

F. **Facility Contracting Officer/Contracting Officer Technical Representative (COTR)** is responsible for:
- Including a specific set of IT security responsibilities in all contracts and abide by regulations stated in those contracts.

- Ensuring all computer equipment has been sanitized in accordance with OI&T FSO mandates before final disposition.
- Assuring background investigations of contractors in accordance with VA policy are conducted. Contracts should stipulate that the contractor is responsible for the cost of background investigations. Security requirements and specifications for hardware and software maintenance personnel contracted from commercial sources shall be defined and approved prior to the signing of contractual agreements.
- Ensuring that business associate agreements are enacted for all contracts in which the contractor meets the definition of a business associate.
- Procurement officials shall ensure negotiated contracts pertaining to IT services include a separate section dealing with information security issues specifying the level of trust required and contractor responsibility in complying with established VA requirements.
- Procurement officials shall ensure that all Request for Proposals (RFPs) and purchase agreements pertaining to IT hardware and software are reviewed for security implications. Such officials are responsible for the inclusion of a separate section in the contract dealing with information security issues, where appropriate.
- The Contracting Officer's Technical Representative (COTR) for the contract must measure contract performance and terminate the contract if security requirements are not being met.
- The Contracting Officer's Technical Representative (COTR) will ensure the proper personnel are informed to remove computer accounts when a contract employee terminates or when a contract expires.

G. **Facility Chief of Police**, and/or designees, are responsible for:

- Overseeing the physical security and physical access to the facility by users or the public and conducts annual physical security assessments to include IT assets.
- Managing in coordination with the Facility Chief of Human Resources, the PIV card security and badge system.

H. **Local Managers, Supervisors**, and designees (e.g. ADPACs) are responsible for:

- Identifying and protecting all assets within their assigned areas of management control.
- Protecting and ensuring sensitive information generated or used by their staff from disclosure to, and/or modification by, unauthorized individuals and worksites are secured when unattended.
- Ensuring sensitive information crucial to the service/program is adequately backed up noting variances from established IT security policies or procedural practices, initiating corrective actions, and notifying the ISO of all reportable incidents.
- Participating with the ISO and Human Resources Management Officer to determine the appropriate sensitivity level designation for positions under their control and briefing new personnel on rules for protecting sensitive data.
- Ensuring that supervised personnel have only the minimum necessary access to the sensitive information required to carry out their authorized functions or assigned duties and that access privileges of terminating or transferring staff are rescinded and periodically reviewing access privileges for each staff member.

- Ensuring each employee completes formal IT security training and it is documented; ensuring each employee signs the Rules of Behavior.
- Ensuring that service/clinical center/service line has written business contingency plans to assure continuation of operations when a computer system(s) is down.
- Ensuring that media with sensitive data is disposed of via approved means. Data that is not destroyed at the site of production, such as areas where shredding is contracted, must be secured in locked containers or in locked areas until its removal for destruction.
- Perform reviews of VistA menu access and security key allocation as required under VA Directive 6500.

I. **Facility Director of Education** is responsible for facilitating and supporting New Employee Orientation, yearly security awareness training and documentation of training.

J. **All individuals** who have access to sensitive information or locations are responsible for:
- Signing the Rules of Behavior prior to gaining access to a VA Systems and maintaining confidentiality of sensitive data or information; accessing the minimum necessary data for which they have authorized privileges; and maintaining confidentiality of sensitive data or information.
- Protecting their assigned user IDs, passwords, electronic signatures, and other access keys from disclosure; appropriately securing sensitive printed information; and practicing good housekeeping with equipment and work areas.
- Logging off systems before leaving a terminal or computer unattended; refraining from illegal reproduction or unlawful use of licensed computer software; and reporting any violation of IT security to their supervisor and/or ISO.
- Attending IT security orientation training and completing annual refresher training as required by policy.
- Using only government furnished equipment (GFE) and VA approved Remote Access processes to remotely logon and access any VA computer system and information.
- Ensuring any GFE, information and/or software is adequately secured as defined in VA Directive 6500. Obtaining supervisors and/or management authorization before taking any GFE, information and/or software off-site as outlined in VA Directive 6500.

4. **PROCEDURES**: As outlined in references.

5. **REFERENCES:** VA Directive 6500; Network 23 Information Security Procedures Handbook; Network Policy V23-CIO-005

6. **RESCISSION**: IM-06C, dated November 10, 2009.

7. **FOLLOW-UP RESPONSIBILITY**: Information Security Officer.

/S/
Judith L. Johnson-Mekota, FACHE
Acting Director, Minneapolis VA Health Care System

SUBJECT: Assessment of Patients

1. **PURPOSE:** To explain how patient needs are assessed and reassessed by the interdisciplinary team during the delivery of health care services.

2. **POLICY AND PROCEDURES:**

Note: See Attachment A for an overview of assessment and reassessment requirements. This chart summarizes, by discipline, the criteria and required timeframes for assessing and reassessing patients.

A. Assessing Patient Needs. When a patient comes to the Minneapolis VA Health Care System for care, his/her needs will be assessed prior to the delivery of services (unless it is an emergency). This assessment will address health care, comfort, psychological, and social needs. The extent of the assessment will depend on the patient's diagnosis, response to previous treatment, consent, and the setting in which care is being delivered. Care decisions will be based on identified needs and care priorities. The assessment will be accomplished through a variety of mechanisms, including (but not limited to) the following:

- ***For Inpatients***--Both the nursing assessment and the history and physical exam will be completed within 24 hours of admission. *Note:* If a history and physical examination, and/or nursing assessment was obtained within 30 days prior to admission, it is not necessary to complete a comprehensive assessment. In those instances, review previous database—enter a CPRS note including significant changes in the patient's condition; updated screening for risks: falls, nutrition, skin integrity, delirium, and functional status; and reference date of previous database. For patients in Observation status, a shortened nursing assessment and risk screening will be completed.
- ***For Outpatients***--The provider will review the current health summary[1] and other data sources and complete a physical/assessment within 24 hours of the outpatient appointment (unless additional testing/assessment is required). A preventive/chronic health survey/assessment may be conducted to assess and plan for future health needs.

Note: Patient needs vary across service lines. Therefore, individual service lines will utilize a variety of assessment and reassessment guidelines or forms appropriate to their discipline (see references).

B. When Patient Needs Should be Reassessed. The purpose of reassessment is to periodically review a patient's status in order to determine if care decisions remain appropriate and effective. This review process is ongoing throughout the patient's contact with the organization. Individual patients will be reassessed at regular intervals in the course of care:

- to determine the patient's response to treatment;
- when a significant change occurs in the patient's condition or diagnosis;
- upon discharge; and
- during follow-up appointments.

C. Determining When Intensive Assessments are Needed. Nursing will apply screening criteria to determine when a patient needs a more intensive assessment of psychosocial, comfort, nutritional, and/or functional status (and initiate consults as appropriate).

[1] The following comprises the health summary: medical diagnosis and conditions (problem list); current medications; allergic/adverse reactions; height/weight; and surgical/procedural history.

D. Emergency Situations. A full assessment is not needed in emergency situations (only the life threatening condition needs to be assessed). An "emergency situation" exists when delaying treatment (in order to conduct an assessment) will place the patient at greater risk than proceeding with treatment based on a limited assessment.

E. Special Conditions For Surgery Patients. Surgeries will be performed only after:

- a history and physical examination is completed;
- a preoperative diagnosis is identified;
- the diagnosis and indicated diagnostic tests and results have been entered in the patient's medical record;
- informed consent is documented; and
- a pre-anesthesia assessment has determined that the patient is an appropriate candidate for planned anesthesia (this will also be verified immediately prior to the induction of anesthesia).

The postoperative status of the patient will be further assessed when s/he is admitted and discharged from the Post Anesthesia Care Unit (PACU).

3. **REFERENCES:** Joint Commission Comprehensive Accreditation Manual for Hospitals; Medical Center Policies: #RI-06, "End of Life Care for the Dying Patient"; #RI-08, "Management of Suspected Abuse, Assault and Neglect Cases"; #RI-12, "Management of Pain"; #TX-03, "Physical Restraint and Seclusion"; #TX-04 "Medication Use"; #TX-06, "Discharge Planning"; #TX-12 "Lodging"; #PF-01, "Medical Center Education Program"; #LD-03, "Referral of Patients to Non-VA Providers (at VA Expense)"; Mental Health Patient Service Line (PSL) guidelines for special assessment of chemically dependent patients; PSL-specific scope of assessment statements; and a variety of protocols and pathways which delineate assessment functions.

4. **RESCISSIONS:** Policy #PE-01F, "Assessment of Patients," dated November 29, 2010.

5. **FOLLOW-UP RESPONSIBILITY**: Director, Continuous Improvement (00D)

/S/
Patrick J. Kelly, FACHE
Director, Minneapolis VA Health Care System

Attachments:
A. Summary of Interdisciplinary Assessment and Reassessment Requirements

Attachment A, Summary of Interdisciplinary Assessment/Reassessment Requirements

Area	ASSESSMENT		REASSESSMENT	
	Time Frame	Criteria	Time Frame	Criteria
NURSING				
SPECIAL CARE UNITS	• Initial focused assessment within 10 min of admission	• Initial focused based on presenting complaint and biophysical parameters	Every 4 hrs and as appropriate to patient's condition, but at least every 4 hours; when patient's condition or diagnosis changes significantly; at transfer out/discharge from unit; change in physician orders, response to treatment/nursing interventions. Focused assessments may be as frequent as every 5-15 min, depending on patient condition, i.e. neuro checks, etc.	• Disease specific systems • Patient response to treatment • Pain Assessment • Pertinent areas based on patient's individual needs • Significant change in patient condition
EMERGENCY DEPARTMENT (ED) & URGENT CARE	• Within 10 minutes of presentation to ED • Initial focused assessment within 10 minutes (initial triage) of presentation to Urgent Care	• Identification of Patient's needs • Biophysical parameters	• ED: as indicated by patient condition, but at least every 30 minutes • UC: As indicated by patient's condition and length of stay, with a determination of stability and needs met at least every 2 hours	Pertinent areas based on patient's individual needs, diagnosis, significant change in condition or diagnosis, change in physician orders, and to determine response to treatment/nursing intervention
MONITORED NON–ICU UNITS	• High Risk Step down: Within 10 min of admission • Moderate/Low risk Telemetry: Within 30 min of admission	High Risk • Requires titrated IV drip drugs • Continuous oximetry Moderate/Low Risk • Continuous cardiac monitoring	• At least every 8hrs • Patient response post intervention	Cardiovascular and respiratory status parameters
ACUTE CARE	• Initial/immediate assessment with documentation of at least biophysical parameters within 30 minutes of admission • Complete General Admission Assessment within 24 hours of admission	• General Admission Assessment • Systems review • Education needs/barriers • Pain Assessment • Skin Assessment • Fall Risk Assessment • Dysphagia Risk Assessment Pending • Assess discharge planning need • Screening for ancillary referrals	• Every shift • Change in clinical status, diagnosis, significant change in physician orders or change in level of care • Daily Skin Assessment	• Physical, psychological and social status are reviewed • Pain interventions/ effectiveness
BEHAVIORAL HEALTH	High Risk: 1K 30 Minutes Consultations: 24 hours unless staff request includes need for immediate assessment (4 Hrs)	• All patients admitted • Immediate assessment may be indicated for cases of delirium, suicidal or homicidal patients	• Full database within 24 hrs of admission • Reassessment every 8 hours • When services provided in consultative role, ongoing assessment is dependent on the nature of patient's needs and response to intervention	• Progress toward identified goals in the Interdisciplinary Treatment Plan
COMMUNITY LIVING CENTER (CLC)/ EXTENDED CARE UNITS	• Initial/immediate assessment with documentation of at least biophysical parameters within 1 hour of admission • Complete General Admission Assessment within 24 hours of admission	• General Admission Assessment • Systems review • Education needs/barriers • Pain Assessment • Skin Assessment • Fall Risk Assessment • Assess discharge planning need • MDS	• Every 7 days • Change in condition, diagnosis, significant change in physician orders	• Patient response to treatment • Pain Assessment • Pertinent areas based on patient's individual needs
PRE-OP, SHORT STAY & PROCEDURE INTERVENTION	Nursing assessment upon entry to OPS, Clinic or Short Stay Ward	• Vital Signs (which may include O_2 sats), NPO status, current medications • Pain	• Pre-op • During and after sedation • Prior to discharge from OR • Prior to discharge home	• O2 Saturation • Vital signs (BP, P, R) • Short Stay Discharge Criteria • Aldrete score, except for Short Stay patients
SURGERY (OR)	Interviewing patient in the Pre-Op Holding and/or prior to start of surgical procedure	• Peri-Operative Assessment tool • Education needs/barriers • Psychosocial, pain assessment • Presence of family support system	Continuous monitoring	Performs reassessment based on priorities of patient's needs as warranted by patient's condition and response to previous treatment

Attachment A, Summary of Interdisciplinary Assessment/Reassessment Requirements

Area	ASSESSMENT		REASSESSMENT	
	Time Frame	Criteria	Time Frame	Criteria
NURSING (*continued*)				
PACU PHASE I	Continuous monitoring Documentation Q 15-30 minutes until Aldrete Score ≥8	• Peri-Operative Assessment tool • Education needs/barriers • Psychosocial, pain assessment • Presence of family support system • Spiritual needs	Continuous monitoring	• Discharge assessment • Must meet discharge criteria-standardized procedure as approved by Anesthesia
PACU PHASE II	Initial set of vital signs upon admission to Phase II from PACU	• Ambulatory Assessment Tool • Respiratory status, temperature on admission, repeat if < 95 ° F	Continuous until discharge or transfer	Must meet discharge per criteria approved by Anesthesia.
ET NURSING	• Preoperative stoma marking • Consults: within 2 business days	• Comprehensive skin assessment for patients at risk for pressure ulcers per Braden assessment. • Assessment of learning needs for patients with ostomies • Assessment and recommendations for treatment of pressure ulcers and complex wounds	Related to plan of care, response to plan of care and staff request	Based on plan of care, duration of treatment interventions, and staff request
Transitional Care Unit	Acute care admission database within 24 hours • Initial/immediate assessments with documentation of biophysical parameters within one hour of admission. • Short term/long term goals (ITP interim care plan)	• Educational needs • Pain • Falls • Chemical screen • Skin • Systems review • memory	Change in condition, diagnosis, significant change in physician's orders. Evaluate progress toward goals every two weeks	Self medication program/1-2 times per week depending on level System review PRN Pain/every shift Braden weekly
HOME BASED PRIMARY CARE	Screening: 72 hrs Comprehensive Assessment: 14 days	• See database	Every 90 days or sooner if indicated	• Change in diagnosis • Hospitalization • Death or change in status of caregiver
NURSING: CLINICS	• On intake to Nurse Run Clinics • According to clinic guidelines	According to established protocols or clinic guidelines	Post treatment/procedure As indicated by condition	• Response to treatment/nursing intervention • At time of follow-up appointment
Temporary Bed Location This section addresses what to do when a pt is to be admitted from a clinic but there is no bed available	*Admission to a **monitored** bed:* Patients who need to be admitted to a monitored bed will be moved to the ED immediately if no monitored bed is available. *Admission to a **non-monitored** bed:* When the provider makes the decision to admit from a clinic to a non-monitored bed, if a bed is not immediately available, an RN will assess the patient to determine whether s/he should be transferred to the ED immediately or wait in the clinic for up to two hours. If an RN is not available for assessment, the RN Clinic Director will be notified.	• Identification of patient's needs • Vital signs (which may include O_2 sats) • Pain *Note:* Documentation of vital signs and a pain rating will be completed in a CPRS note for clinic patients and ED will follow ED documentation guidelines.	• The patient will be transferred to the inpatient unit as soon as possible, with hourly RN assessments conducted in the clinic until transferred.	Ensure the patient receives needed care based on the patient's individual needs, diagnosis/reason for admission, significant change in condition or diagnosis, change in physician orders, and to determine response to treatment/nursing intervention. In the clinic the provider who is admitting the patient is responsible for the patient (in the ED it is the ED physician). Decisions re: when to transfer a patient to another hospital are based on the patient's needs and when the bed will be available.

Area	ASSESSMENT		REASSESSMENT	
	Time Frame	Criteria	Time Frame	Criteria
OTHER CLINICAL				
MEDICAL STAFF	• Within 24 hours of admission (or assignment to a temporary bed location)	• Medical history, including the chief complaint; details of present illness; relevant past, social and family histories; and an inventory by body system. • Relevant physical examinations • Impressions/diagnosis • Treatment plan and goals	Resident Physician or Provider Minimum of daily[2] and as indicated by patient need. (If seen by a resident, then resident supervision requirements must be met per MS-01)	• Determine the patient's response to treatment • Significant change in the patient's condition or diagnosis • Upon discharge • During follow-up appointments
PROCEDURE: Provider Responsibilities	• H&P within 30 days with an update immediately prior to procedure • Staff surgeon assessment, plan, and procedure planned may be addendum to resident note (documented prior to procedure)	• Pre-procedure H&P includes at a minimum: medical history, exam/ assessment of cardiac and respiratory status, and review of the system relevant to planned procedure(s), with diagnosis and treatment plan/goals • Plan for sedation and airway assessment (Anesthesia in the OR, Anesthesia or provider for moderate sedation in clinics) • Current list of medications & allergies	Post-procedure/ Post-op note must be done immediately post procedure	• Provider is responsible for supervising administration of moderate sedation and for discharging patients by order or by use of approved release criteria • See Medical Center policy for additional information
NUTRITION SERVICES	Within 24 hours of receipt of consult	Patients in the facility for >48 hours who have an Albumin <2.8, BMI<18.5, NPO or Clear liquid diet ≥ 3days, on Tube Feeding or TPN	Level of Nutritional Compromise **Acute Care** Severe: 5 days; Moderate: 5 days; Mild: 7 days; Normal: 14 days **CLC** According to MPAF requirements for 1st 90days; after 90 days = Severe: 7 days;, Moderate: 14 days; Normal & Mild: 30days	Based on patient's needs, response to care and significant change in patient's condition, diagnosis or physician's orders, but is no less than the level of nutritional compromise assigned.
PHARMACY	Upon admission except in emergencies	Medication orders are verified by Pharmacy **before** medication is administered. Exceptions: Urgent/Emergent situations	• At time new orders written • At discharge	• All medication orders received by the Pharmacy initially assessed for appropriateness, dose, route, interactions, indications, and in some cases duration, and patient response. • Provider Request
SOCIAL WORK SERVICES	Available 24/7 (access through nursing supervisor after regular business hours)	• Suspected abuse/neglect • Family/caregiver concerns • Community resource/referral (placement) • Homelessness • End of Life Issues/Advance Directive • Legal issues • Counseling- behavioral issues	Reassessment is determined by patient's condition, previous treatment, or significant change in diagnosis or discharge plan.	As appropriate to condition of patient/family
SPIRITUAL SERVICES	Within 2 hours of patient/family request Within 24 hours of request or consult by patient/family/staff, prior to major surgery, patient seriously ill (Call 2027 during week, or nursing supervisor off tours)	Services available: • Interview patient, family • Collaboration with team • Visitation • Sacraments • Family conference • Spiritual support / direction / prayer • Worship, Reflection, Discernment • Referrals to appropriate resources	Spiritual care is an ongoing process based on patient's requests or needs.	Spiritual care is an ongoing process based on patient's requests or needs.
FUNCTIONAL				
PM&R (PT, OT and Speech)	Within 72 hours	• Unmet needs for adaptive mobility (PT) or ADL (OT) devices • Needs independent living skills evaluation (OT) • Intensive assessment by PM&R staff to evaluate function and/or cognitive status	• Ongoing by interdisciplinary team. • Discipline progress note weekly. • Treatment summary at conclusion of service	Based on patient's progress toward identified goals, change in patient status, ITP, and patient/family input
RECREATIONAL THERAPY	5 days to address consult 5 days for completion of comprehensive leisure assessment	• CLC Patients • TBI/Polytrauma/TRU • Stable inpatient psychiatry • One time service request	Ongoing based on progress toward identified treatment goals	Ongoing based on progress toward identified treatment goals

** *Note*: Programs, services, and PSLs have additional assessment policies specific to the population served and/or the focus of care treatment and services provided.

[2] Daily notes are not mandated on the CLC and Polytrauma Transitional Unit.

SUBJECT: Medication Use

1. **PURPOSE:** To delineate functions of medication processes at the Minneapolis VA Health Care System.

2. **POLICY:** Medications are an essential component of the care provided to most patients. They are potent agents for curing illness and for moderating symptoms. Medication use involves multiple services and service lines and therefore significant linkages must occur among those responsible for each process. Personnel involved with medication management have the following information available to them:
   - Age
   - Sex
   - Allergies/sensitivities
   - Current medications
   - Diagnoses, co-morbidities, conditions
   - Relevant laboratory values
   - Appropriate physiologic parameters (e.g., height, weight, lactation/pregnancy status)

3. **PROCEDURES:** To achieve optimal outcome of medication management, the following five processes will be performed as outlined below:

A. Prescribing or Ordering. A national formulary (http://www.pbm.va.gov/PBM/natform.htm), based on a systematic review process, lists medications available for prescribing. Individuals who prescribe or order medications are authorized to do so.

B. Preparing and Dispensing.
   - Preparation and dispensing are consistent with law and regulations.
   - Records of dispensed medications are maintained as required by applicable law to ensure adequate control and accountability.
   - Medications are dispensed safely and accurately to patients for whom they are prescribed/ordered.
   - Pharmacy Service maintains a medication profile for each patient.
   - Pharmacy services are available 24 hours/day, seven days/week.
   - In patient care areas, IV admixture by RNs is allowed in emergencies or when a delay in therapy might adversely affect a patient. As allowed by USP 797.
   - A stock of emergency drugs is available in Pharmacy and in designated patient care areas as determined by the CPR Committee.
   - There is a system for recalling medications including provider notification.

C. Administration. Medications are administered safely and accurately

D. Monitoring**.** Each patient's medication is monitored for effectiveness and actual or potential adverse effects or toxicity. Monitoring activities are conducted to track, trend and analyze adverse medication events which can be minimized or eliminated through process/procedure changes.

E. High Risk Medications**.** These are drugs which have a propensity for patient harm when they are used in error or have potential for abuse. Safeguards are in place for investigational drugs, controlled

substances (narcotic renewal program) and chemotherapy agents. Additional medications for which controls have been put in place are further defined in Attachment F.

4. **RESPONSIBILITIES:** The Minneapolis VA Health Care System Director, Chief of Staff, Chief of Pharmacy and Nurse Executive are responsible for assuring safe medication systems are in place. The Pharmacy and Therapeutics Committee is responsible for providing system oversight and making recommendations to improve processes. Disciplines responsible for performing each process are responsible for developing, maintaining, and enforcing written policies and procedures regarding medication selection, procurement, distribution and administration.

5. **REFERENCES:** JCAHO Manual; VA Manual M-2, Part V, Chapter 3; VA Manual M-2, Part VII; P&T Committee Policy #PI-04, Attachment L; Policy #HR-14, Advanced Practice Nurses; Policy #HR-15, Clinical Pharmacy Specialists; Policy # HR-16, Physician Assistants; Policy #IM-01, Medical Records; Policy #PI-01, Continuous Improvement Plan: An Approach for Excellence; Policy TX-19, BCMA; Policy TX-01, Verifying Patient Identities; Policy TX-13, Protocols and Practice Guidelines; Policy TX-34, Moderate Sedation; Institute for Safe Medication Practices; Clozapine Patient Management Protocol VHA Handbook 1160.2 (December 2008); Drug Abuse Treatment Act of 2000 (specifically VHA Pharmacy Benefits Management Criteria for Non-Formulary Use); Investigational Drugs and Supplies VHA Handbook 1108.04 (October, 2005); Controlled Substance Handbook, 1108.01 (November 2010), 1108.02 (April 2010), 1108.05 (May, 2006) and 1108.06 (June, 2006), National Pharmacy Benefits Management, VISN 23 Formulary Committee; discipline-specific policies and procedures; and other references as cited on attachments to this policy.

6. **RESCISSIONS:** Medication Use Policy, #TX-04G, dated August 14, 2009 and all related attachments.

7. **FOLLOW-UP RESPONSIBILITY:** Pharmacy and Therapeutics Committee and Chief, Pharmacy Service.

/S/
Judith L. Johnson-Mekota, FACHE

Acting Director, Minneapolis VA Health Care System

Attachment A: **Prescribing/Ordering Function,** Updated December 24, 2012
Attachment B: **Preparing and Dispensing Function**, Updated February 10, 2013
Attachment C: **Administration Function,** Updated December 24, 2012
Attachment D: **Monitoring Of Medication Effects Function**
Attachment E: **Regulatory Management of Controlled Substances and Alcohol**
Attachment F: **High Risk Medication Index,** Updated February 10, 2013
Attachment G: **Polytrauma Transitional Unit Self-Medication Program (SMP)**
Attachment H: **Medication Administration Matrix**
Attachment I: **Anticoagulation Therapy Management**
Attachment J: **IV MedicationParameters Guidelines** Updated July 2, 2012
Attachment K: **Continuous Subcutaneous Medication Infusion Guidelines**
Attachment L: **Anti Neoplastic Temporary Reassignment of Duties**
Attachment M: **Inpatient Self Management of Subcutaneous Insulin Pumps** (New July 2, 2012)

- **M-1, Continuous Subcutaneous Insulin Pump Therapy Patient Contract** (New July 2, 2012)
- **M-2, Patient Bedside Insulin Pump Record Form,** (New July 2, 2012)

Attachment A, Prescribing/Ordering Function, Updated December 24, 2012

1. ***DISCIPLINES* THAT MAY PRESCRIBE OR ORDER:**

A. Individuals with Prescriptive Authority. VA physicians, dentists, optometrists and podiatrists have prescriptive authority. The following disciplines also may prescribe, provided they have scopes of practice and/or written individual practice agreements in place to do so: clinical nurse specialists (CNS), nurse practitioners (NPs), clinical pharmacy specialists (CPS), and physician assistants (PAs). Enterostomal nurses (ET) and Respiratory therapists (RTs) may also prescribe via written individual practice agreements/scopes of practice. To prescribe controlled substances, the individual practitioner's state of licensure or registration must specify this authority. Eligibility/authority review procedures are outlined within PSLs and Pharmacy Service.

B. Orders By Medical Students and Sub-Interns. Medication orders written by medical students or sub-interns are co-signed by a supervising physician prior to therapy initiation.

C. Consultant-Ordered Inpatient Medications. Inpatient medications recommended by consultants become effective after approval by the physician responsible for the patient's care or someone acting on their behalf (e.g., on-call). If a consultant believes the medication needs to be initiated without delay, they will apprise the primary physician of this need. *Exception:* Enterostomal (ET) nurses providing consultation for wound or ostomy care may enter prescriptions for topicals, medicated dressings and supplies as verbal orders of the admitting/responsible physician.

D. Non-VA Medications. To avoid interruption of therapy, inpatient medications not provided by the VA may be utilized IF they are identified, examined for integrity, and ordered by a physician.

E. Verbal Orders—Conditions of Acceptance. When action is initiated at the request of an RN, R.T., or registered pharmacist (RPh), a telephone or verbal order may be accepted. All other telephone/verbal orders are limited to emergency patient care situations or when a provider is unable to enter the order electronically. Orders accepted from individuals with prescriptive authority must include documentation of the following:
   - Date/time, name and title of the prescriber
   - Receiving person's name and title
   - Patient's full name and social security number or date of birth
   - Drug name, dosage, route, frequency, duration if applicable, and indications for PRN medications.

   Once written, the procedure includes a verbal read back of the above components to the prescriber. The prescriber's signature is required within one working day.

F. Formulary Supply Items. RNs and RPhs may write orders for formulary supply items. Registered dietitians may write orders for commercially prepared nutritional supplements and diabetic supplies.

2. ***WHAT* MAY BE PRESCRIBED/ORDERED:**

A. Formulary/Non-Formulary. Drugs approved for general use are identified in the National VA Formulary. The P&T Committee Policy addresses non-formulary medication prescribing. Only FDA-approved medications are ordered for use (for exceptions, see Attachment F, Investigational Drugs).

B. Complete Medication Orders. Medication orders are considered complete when they include the following:
   - Patient full name and full social security number or full name and date of birth
   - Ward or clinic area

- Date
- Generic medication name
- Dosage
- Frequency
- Route
- Signature and DEA number when required
- Rate of IV fluid/medication infusion or when applicable, titration endpoints

C. Indications for Use. These are reflected in the patient's medical record and are encouraged to be included with medication orders.

D. Allergy and Adverse Reaction Information (Including Food). This is available in CPRS. Inpatients and outpatients who are here for a procedure will wear an ID band (plus an allergy armband if needed, as an additional precaution).

3. ***HOW* ORDERING/PRESCRIBING SHOULD OCCUR:**

A. Medication Orders. These may be entered via VA prescription forms, CPRS order entry, ECMS-approved protocols, or on doctors' order forms (this is only allowed if CPRS is down). Drugs regulated under the Controlled Substances Act will include the prescriber's DEA number.
B. Illegible, Incomplete, or Improperly Written Orders. These will not be initiated until clarified by the RN or RPh. "Renew," "Repeat," "PRN," "Resume," and "Continue" are unacceptable orders unless the drug, dosage and frequency are specified. Indications are required on all PRN medications.
C. Hold Orders for Inpatients. These equate to discontinuation unless a specific timeframe is indicated.
D. Dosing Range and Intervals. Some orders may be written to include a range of dose and dosing intervals. Double range orders are not allowed.
E. Titration of Medications IV infusions that are titrated to achieve specific patient parameters will have provider orders that include: concentration, dosage, target parameters, and when to call the provider.
F. Taper Orders. These include both dose and schedule.
G. Medication Related Devices for Outpatients. These are available via a Prosthetics consultation.
H. Herbals and/or Nutraceuticals. These may not be dispensed or purchased by the VA.
I. Telephone Orders for Outpatient Narcotic Prescriptions. These are limited to Home and Community Care and are followed with receipt of a hard copy of a Schedule II prescription order to Pharmacy within 72 hours.

4. ***TIMEFRAMES* FOR REVIEW AND DISCONTINUATION:**

A. Medication orders will be reviewed for appropriateness:
- When initially ordered
- Upon transfer from one clinical service to another
- Upon returning from major surgery
- Upon resumption following automatic stop dates

B. Discontinuation of Inpatient Medications by Registered Nurses and Pharmacists. Nurses or pharmacists are authorized to discontinue medications that are not permitted to be administered on the ward. This will be accomplished by entering a physician order that requires co-signature. When patients' do not have IV access, RN may discontinue scheduled Normal Saline flushes using 'Obsolete Order' option.

Attachment B, Preparing and Dispensing Function (Updated February 10, 2013)

Preparing/Dispensing Function:

1. **PHARMACY SERVICE RESPONSIBILITIES:** Pharmacy Service and its personnel will:
   - Adhere to departmental policies for the procurement, storage, preparation, segregation, and inventory control of medications and also adhere to sanitation guidelines.
   - Prior to administration, review each medication order for clinical appropriateness, possible drug/food interactions, incompatibilities, duplications, appropriate dosage, frequency, route, and allergies/sensitivities (function of pharmacist) when feasible.
   - Fill and deliver medications to requesting areas.
   - Fill prescriptions written at the MVAHCS and affiliated CBOCs or utilize the Consolidated Mail Out Pharmacy (CMOP).
   - Implement prescription conversions that involve a change in the administration frequency or dosage (without adversely affecting the therapeutic outcome) following P&T Committee.
   - Communicate changes affecting prescriptions to prescribing physicians, nursing (inpatient) or patients (outpatients).
   - Provide consultation in parenteral product prescribing.
   - Manage drug distribution systems for patients (specific policies are available in both the PSLs and Pharmacy).

2. **RESPONSIBILITIES OF NURSES:** Nurses will prepare IV admixtures only in emergencies or when preparation by Pharmacy is not feasible. Nurses will also adhere to sterile parenteral preparation and labeling. If during a regularly scheduled check a refrigerator has deviated from a recommended temperature range for medication storage, nursing personnel will alert Engineering and Pharmacy, and return the medication to Pharmacy for destruction.

3. **MEDICATION LABELING RESPONSIBILITIES:** Minimal labeling requirements for medication include:
   - Drug name, strength, amount
   - Name/concentration of additives
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours
   - Date prepared
   - Patient name
   - Identity of preparer
   - Every IV bag must be labeled, including stock medications. IVs with no additives will have a label indicating the date and initials of the staff who hung the IV only
   - Medications that are administered by a syringe must be labeled unless they will be **immediately** administered by the person preparing the medication.

4. **BEDSIDE MEDICATIONS:** Personal inhalers, eye/ear drops, lotions, ointments, and creams may be dispensed from Pharmacy or ward stock, labeled with the patient's name, and stored at the patient's bedside (for comfort and expediency) unless a concern for patient safety/abuse is identified. Labeling will not obscure the drug name.

5. **MEDICATION DISPOSITION UPON ADMIT**: Nursing addresses this component when completing the nursing admission database. Medications brought in by patients, whenever possible, are returned to family members or mailed to the patient's residence or other address by nursing staff. Mail envelopes will be kept in stock in the Medication Room on each unit. Nursing staff will put medications in the envelope, address and seal the envelope and place the envelope in the "pharmacy pick-up" box in the Medication Room. If the patient refuses to turn over his/her medications

or is unable to provide an address, the nursing staff will notify their Nurse Manager or Nursing Supervisor to handle the issue. If there is no mailing address, the Nurse Manager or designee will inform the patient that medications will be destroyed.

6. SCRIP TALK PROCEDURES: In order to assist veterans in independent and safe management of prescriptive medications, staff may refer veterans for audible prescription reading devices (APRDs). APRDs are designed to assist severely visually impaired or illiterate veterans in managing their medications. The following procedure outlines responsibilities for making and managing these referrals.

A. Assessment. In order to assess if a veteran is appropriate for an APRD, staff who wish to refer a veteran should review the following: veteran can independently manage multiple medications; veteran can open and close medication bottles; veteran has no major hearing problems; veteran has no obvious cognitive impairment. If the initial screening indicates the veteran is appropriate for a device, the team will initiate a Scrip Talk assessment consult. The consult should be routed to the VIST Coordinator who will schedule an appointment. *Note:* Instruct the veteran to bring all medication bottles to their Scrip Talk appointment. If the veteran uses a pill organizer s/he should bring it to the appointment.

B. Evaluation by the VIST Coordinator. The VIST Coordinator will review to determine if the veteran has received VIST services, is appropriate for VIST Program enrollment based on blindness or level of visual impairment, is motivated and has a goal to use Scrip Talk to improve medication compliance, and has been evaluated for other optical aids to read medication labels.

The VIST Coordinator will also assess the veteran's inability to read medication labels/directions and determine if s/he is able to hear the Scrip Talk device. The VIST Coordinator will then complete the Scrip Talk assessment consult. If the patient is appropriate for Scrip Talk, the VIST Coordinator will coordinate a CPRS prosthetics consult for Scrip Talk with the primary care provider (include ICD-9 diagnostic code and equipment serial number), and escort the veteran to the Pharmacy along with a Scrip Talk device.

C. Referral/Patient Education/Software Registration. After the VIST Coordinator determines a patient is a candidate for Scrip Talk, Pharmacy Service will conduct education on the Scrip Talk device, medication education, patient education, software registration and documentation. Specifically, the pharmacist will: (1) enter the patient into the Scrip Talk program software; (2) process prescriptions and coordinate filling medications with the Scrip Talk microchip labels; (3) check the microchip label for accuracy using the Scrip Talk reader device (done on each fill/refill); (4) train the patient on the use of the Scrip Talk device (for first time use); (5) assess the veteran's ability to operate the device independently by having the veteran demonstrate use of the device (if unable to do so, the VIST Coordinator will be contacted for further follow-up); (6) counsel and provide necessary education to the veteran regarding medications; document education in a Scrip Talk software-generated CPRS progress note; (7) ensure the patient has a Pharmacy staff "key contact" name and phone number; and (8) confirm a back-up plan is in place to take medications in the event of a Scrip Talk failure.

D. Repair and Prosthetics Issues. Prosthetics will act on prosthetic consults, provide a small stock of Scrip Talk APRDs to the VIST Coordinator, and be responsible for repair or replacement of Scrip Talk APRDs.

7. **MULTI-DOSE PENS**: In order to ensure safe administration of medications using multi-dose pens, the following procedure outlines responsibilities for use:

A. Multi-dose pen injectors shall be stored in the Pharmacy and dispensed with an individual patient label. Multi-dose pen injectors shall not be ward stocked.

B. Multi-dose pen injectors are to be used by a single patient only and should never be shared with other patients, even when the needle is changed.

C. Disposable safety needles with shield guards must be used to ensure OSHA compliance on patient care units. The needles should be promptly and properly discarded after each injection and a new safety needle attached prior to each additional injection.

D. Education on facility policy and safe use of pen injectors must be provided to new RNs, and be a part of their annual competency assessment.

Attachment C, Administration Function, Updated December 24, 2012

Administration Function:

1. **TRANSCRIPTION/VERIFICATION:**

A. Medical Support Staff will notify pharmacy of all patient movements throughout the day.

B. Pharmacy will receive either written or electronic orders.

C. Both the RN and RPh will verify all inpatient orders. Medications cannot be administered unless they have been verified in BCMA, except when given as telephone orders, when given as verbal orders by a provider who is present in the department, and/or in emergency/acute situations when a delay may cause harm to the patient then the BCMA Medication Order function may be used.

D. Throughout tour on all wards/units (including CLC and ICUs) and/or at the time of patient transfer, all new medication and treatment orders written will be verified by the accountable RN.

E. Outpatient setting only: All new medication and treatment orders written will be verified by appropriate staff (including RN, LPN, RPh).

F. Chart checks are completed once every twenty-four hours on general wards (including CLC) and **at the beginning of every shift** in the intensive care units and/or at the time of patient transfer, all new medication and treatment orders written will be verified by the RN.

G. At the beginning of each shift, the on-coming nurse will validate the accuracy of each IV infusion by:
- Following the tubing from IV bag to the infusion pump and to patient IV access site
- Checking the IV bag label and IV pump settings against the CPRS/BCMA order (3K/ICUs also double check entries in CIS) to assure correct drug, correct dosage and correct rate (e.g., mcg/min vs. mg/min).
- 3K/ICUs only: For titrated IV infusions, two nurses double check IV pump and CIS charting to ensure right medication, right dosage, right rate are infusing.
- Telemetry Units 2LS and 3LS: Cardiac medication infusions require a two RN double check of correct drug, dose, and rate (mcg/min vs. mg/min) at change of shift, change in level of care (transfer to a different tele unit or to the ICU), and or anytime there is a physician order to change the dose or rate of the infusion.

2. **ADMINISTRATION TIMES:** The following administration times are in effect for all inpatients (except Mental Health) unless specified differently in the orders. RPhs may modify medication administration times based on clinical judgment and pharmacokinetic properties of the drug.

A. Administration Times for Oral and I.V. Medications.

Standard Scheduled	Administration Times			
Every Day	0900			
Twice Daily q. 12 hours	0900	2100		
Three Times Daily	0900	1300	1700	
Four Times Daily	0900	1300	1700	2100

Pharmacy's unit dose computer system prompts these standard administration times when standard schedules are entered in the computer.

B. Administration Times for Medications Needing to be Given with **Food**.*

Standard Scheduled		Administration Times			
Every Day		0900			
Twice Daily	q. 12 hours	0900	1800		
Three Times Daily	q. 8 hours	0900	1300	1800	
Four Times Daily	q. 6 hours	0900	1300	1800	2300

* This refers to the following drugs: erythromycin, macrodantin, metformin, NSAIDS (Ibuprofen, Indomethacin, Piroxicam, Naproxen), salicylates, oral steroids, verapamil SR, and any drug ordered to be taken with food

Pharmacy and Nursing will collaborate to assure necessary modifications occur (e.g. patient home medication regime).

C. Medications Requiring Special Administration Times.

Medication	Schedule	Administration Times		
Alendronate	Give 30" before first meal of day with H_20			
H_2 Receptor Antagonists/PPIs	Once daily	2100		
Insulin, NPH	Twice daily	0700	2100	
Insulin, Regular	Twice daily	0700	1700	
Insulin, Aspart	Immediately before meals			
Insulin 70/30	Twice daily	0700	1700	
Insulin Glargine	Daily @ bedtime	2100		
Oral Hypoglycemics	Once daily	0700		
Oral Hypoglycemics	Twice daily	0700	1700	
Isosorbide	Three times daily	0500	1100	1700
Furosemide	Twice daily	0900	1700	
Furosemide	Three times daily	0900	1300	1700
Sotolol	Once daily	0700		
Warfarin	Once daily	1700		
HMG-CoA reductase inhibitors (such as simvastatin)	Once daily	2100		

- Insulin should be administered between 30-45 minutes **prior** to meal tray delivery except Aspart.
- Aspart has an immediate onset of action, and should be administered immediately **before** meals. Administration times should be adjusted accordingly.

Attachment C, Administration Function, Updated December 24, 2012 (continued)

D. Medication Administration Times in Mental Health. To accommodate patient needs, separate administration times are permitted to minimize sleep disruption, facilitate therapy attendance and to assist patients in developing a routine which can be complied with post-discharge.

Schedule	Administration Times			
Every day	0700			
Twice Daily	0700	1700		
Three times daily	0700	1200	1700	
Four times daily	0700	1200	1700	2200
Q. 6 hours	0600	1200	1800	2400
Q. 8 hours	0600	1400	2200	
Q. 12 hours	0600	1800		
At bedtime	2200			

3. Pain Medication- Administration is dependent on staff assessment of the acuity and stability of the patient, including physiological parameters (as appropriate). The appropriate starting dosage within the range order is based on factors such as pain score, patient age, patient body mass, and history of opiod use. The size and frequency of subsequent doses are incrementally adjusted based on:
   - Severity of patient pain score
   - Patient response to previous dose

4. **STOP DATES:**
   - Oral inpatient medications have a stop date of 99 days.
   - Schedule II controlled substances have a stop date of 7 days. If a physician or advance practice nurse or PA with prescriptive authority specifies in the order, it can be extended to 30 days.
   - Meperidine is limited to 72 hours (see Attachment F).
   - Inpatient IV medication has a stop date of thirty days.
   - Inpatient clindamycin (oral and IV) has a stop date of fourteen days.
   - Vancomycin has a stop date of 3 days unless approved by Infectious Disease Service.
   - Medications cannot be administered beyond the stop dates unless a new order is received.

5. **ADMINISTRATION AND DOCUMENTATION:**

A. Outside Medications. Medication provided by an outpatient's healthcare facility (e.g. nursing home) or caregiver may be administered by ambulatory care personnel provided:
   - the medication is labeled with patient and drug name, dosage, administration time--and title/name of preparer/caregiver and a copy of prescriber's order is also present; or
   - the medication is listed on current medication profile; or
   - the medication is verified by telephone with facility nursing personnel.

   Administration of the medication must be documented in a CPRS progress note and include the drug name, dose, route and time of administration. A copy of this documentation will be returned to the healthcare facility/caregiver.

B. Competencies. Personnel authorized to administer prescribed medications have demonstrated competence in safe medication administration including:
   - Verification of patient identification using two unique identifiers (e.g. full name, full social security number, and/or birth date)

- Correct medication, dose, time, and route
- Knowledge of the medication being given
- Intended purpose for specific patient
- General knowledge of contraindications, side-effects and drug interactions and/or resources to access this information.
- Dosage calculations
- BCMA (Bar Code Medication Administration) for inpatients and observation status

C. Patient Education and Monitoring. Health care providers are responsible for advising patients or families of indication of medication, potential clinically significant adverse drug reactions, and for monitoring individual patient response to medications administered.

D. Special Circumstances.
- Oral liquids are administered via graduated measuring cup (large volume) or oral syringes (small volume). IV syringes **will not** be used for measuring or administering oral liquids.
- All single use vials are to be discarded appropriately after the first dose is drawn.
- Multi-use vials can be used according to the manufacturer's recommendation or 28 days, whichever is less, as long as no evidence of contamination (e.g. clouding) is noted. All Multi-use vials will be labeled with date opened and expiration date of vial.

E. Intravenous Medications.
1. An infusion pump is required with:
    - Continuous medication infusions.
    - TPN and lipids.
    - Intermittent medication infusions that require an infusion time of greater than twenty minutes.
    - Maintenance IVs with ≥ 20 mEq KCL or other additives.

2. Infusion pumps are considered the primary tool of infusion calculations and the infusion pump software must be used when infusing any medicated IV. Use of the CIS flow sheet calculator remains a part of the unit flow sheet and serves as double verification of calculation.
3. Pharmacy is responsible for placing a "filter" sticker on appropriate IV medications.
4. IV solutions are prepared by Pharmacy, Anesthesia staff, or in an emergency, the RN administering the solution.
5. LPN5-6 with demonstrated competency may hang maintenance and intermittent IVs and discontinue peripheral IV catheters.
6. Registered Nurses administer IV medications that require continuous monitoring (cardiac, hemodynamic, oximetry, blood-sugars, etc.) according to the IV Medication Parameters guidelines (Attachment J). Exceptions are made for stable non-monitored patients receiving maintenance IV doses of medication such as digoxin, phenytoin, fosphenytoin, or metoprolol, and for end-of-life care where the provider and nurse manager or designee agree that administering a specific IV medication is in the best interest of the patient. This decision will be documented in a progress note in CPRS and placed on the Kardex.

F. Refusal to Administer Medications. Administering personnel have the right and/or responsibility to refuse to administer any medication that he/she feels uncomfortable giving, or for which he/she has received inadequate information/education to assure safe administration of the medication. In cases of refusal, the accountable RN must delegate this responsibility to another RN on his/her unit who is knowledgeable about the medication, notify the charge nurse and refer the situation to the nurse manager/nursing supervisor. The nurse manager/nursing supervisor will contact the prescriber to resolve any administration problems.
   - After contacting the prescriber, any omitted medications are noted in BCMA with appropriate explanation.
   - If medication is administered by provider it must be documented in CPRS by the provider. The nurse will document a comment in BCMA under the drug order that the med was given by the provider

G. Non-VA Infusion Devices. Inpatients with infusion devices not managed by the MVAHCS are evaluated on an individual basis through referral to the Chief of Staff Office. These medications will be entered by the patient's provider as an inpatient medication and upon discharge, into the patient's non-VA medication profile.

H. Administering Medications and Other Items Per Protocol. Upon approval by the ECMS and verification of appropriate competencies, staff may be approved to administer medications and/or other items per protocol (e.g., ophthalmic technicians and assistants and a clinic photographer may administer eye drops in Eye Clinic). See policy TX-13, Protocols and Practice Guidelines.

Monitoring of Medication Effects Function

1. **PURPOSE:** Medication monitoring requires assessment and evaluation of both individual patients as well as groups of patients with certain diagnoses or certain classifications of medications. Monitoring the effects of medications:
   - assures medication therapy is appropriate;
   - minimizes the occurrence of adverse events;
   - assures appropriate results of intended medication use;
   - utilizes information from the patient's medical record, relevant laboratory results, clinical response and medication profile;
   - obtains patient perception regarding side effects and when appropriate, perceived efficacy;
   - identifies opportunities for improving processes related to medication functions (these particular improvement activities are demonstrated through the monitoring of medication errors, adverse drug reactions, and results of studies/analyses by the DUE Subcommittee or other clinical services);
   - permits post-marketing drug surveillance; and
   - identifies problems related to drug manufacturing.

2. **INDIVIDUAL PATIENT MONITORING:** This is required to determine medication effectiveness and actual or potential adverse effects.

A. Collaborative Assessments. These are conducted at the time of clinic appointment, Urgent Care presentation, transfer, admission, and when reconciling the patient's medication profile for:
   - Accuracy.
   - Appropriateness of medication use including indications, dose, frequency, route, patient-specific contraindications, compliance, and therapeutic response of the medication regimen.
   - Changes are determined by interviewing the patient, reviewing their written list of medications, and updating the medication profile. These practices are consistently encouraged.
   - Pharmacy collaborates with the provider by identifying potential drug/drug and/or food/drug interactions, as well as potential adverse effects due to such items as dosage, route, frequency, drug classification, etc.
   - Nursing staff monitor patients' responses to medication through ongoing observation and special monitoring procedures for a period of time appropriate to the medications given. This includes regular evaluation of PRN medication effectiveness and initial doses of new medications.

B. Examples of Monitoring Processes.
   - Periodic laboratory monitoring to determine therapeutic endpoints
   - Point of care glucose testing
   - Routine monitoring of patients receiving antipsychotic medications for signs and symptoms of tardive dyskinesia
   - Vital sign monitoring
   - Cardiac Monitoring
   - Pulse oximetry
   - Culture and sensitivity results
   - Pharmacokinetic monitoring
   - PRN medication effectiveness

- Standardized medication protocols/order sets/guidelines (e.g. heparin, TPN, MINDs, enoxaparin, argatroban)
- Supratherapeutic INR monitoring program
- Daily serum creatinine monitoring
- Pharmacy Therapy Monitoring Program
- CLC monthly drug regimen review

3. **ADVERSE DRUG EVENT MONITORING:** Adverse drug event monitoring is the responsibility of all personnel associated with medication use processes. Events may include medication errors, untoward side-effects and adverse drug reactions.

A. **Adverse Drug Event (ADE).** An ADE is an untoward outcome or injury resulting from the use of a drug. The event associated with the drug may result from exaggerated pharmacological effects, adverse drug reactions, drug-drug interactions, product quality problems or drug overdoses (whether accidental or intentional). Severity levels are:
   1. Mild ADE. A mild ADE is an event that requires no intervention or minimal therapeutic intervention such as discontinuation of drug(s).
   2. Moderate ADE. A moderate ADE is an event that requires active treatment of adverse reaction, or further testing or evaluation to assess extent of non-serious outcome.
   3. Serious ADE. An ADE is serious when the patient outcome is: death, life-threatening, hospitalization-initial or prolonged, disability or permanent damage, congenital anomaly or birth defect, required intervention to prevent permanent impairment or damage, other serious important medical events.

B. **Medication Errors**. A medication error is a mishap that occurs during prescribing, transcribing, dispensing, administering, adherence, or monitoring a drug. Medication errors are preventable events that may cause or lead to inappropriate medication use and potential or actual patient harm, while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing; ordering; communication; product labeling, packaging and nomenclature; equipment malfunction; compounding; dispensing; distribution; administration; education; monitoring; and use. ***NOTE:*** *Not all prescribing errors lead to adverse outcomes.* When a medication error occurs:
   - Report the incident to the responsible provider, who will initiate action to minimize adverse effects or to prevent problems.
   - In the event of a negative outcome to the patient, document the error in the patient's medical record.
   - Initiate an incident report and forward promptly to the Patient Safety Manager (OOD).
   - In cases of a major injury or death, staff will notify their supervisor who will notify the Chief of Staff or Nurse Executive in the Director's Office immediately.

   Each report will be reviewed, a safety assessment code (SAC) will be assigned and reports will be generated to identify trends or patterns. Potential or actual serious medication errors may result in focus reviews, root cause analyses, or Boards of Investigation. (See Policy PI-01, Continuous Improvement Plan.)

Attachment D, Monitoring of Medication Effects Function, Continued

C. **Adverse Drug Reaction (ADR).** An ADR is a response to a drug which is noxious and unintended and which occurs at doses normally used for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function. ***NOTE:*** *There should be a causal or suspected link between a drug and adverse reaction. However, a causality assessment or association of the drug to the adverse reaction does not have to be established in order to report an adverse drug reaction or adverse drug event.*
   1) Allergy. An allergy is an ADR mediated by an immune response (e.g., rash, hives).
   2) Side Effect. A side effect is an expected and known effect of a drug that is not the intended therapeutic outcome. Since the term "side effect" tends to nominalize the concept of injury from drug, it is recommended that this term be avoided and be reported and monitored as an ADR.

D. **ADE Classification.**
   1) Historical ADE. A historical ADR is a past event (i.e., more than 3 months old) or an event that reportedly occurred in the past at another healthcare setting. It is defined in the CPRS system as "reported by the patient as occurring in the past; no longer requires intervention."
   2) Observed ADE. An observed ADR is defined in the Computerized Patient Record System (CPRS) as a reaction that is "directly observed or occurring while the patient was on the suspected causative agent." ***NOTE:*** *Observed refers to a newly noted adverse outcome, typically within the past 3 months. Although the term implies that the provider of record made the diagnosis, the fact that a provider may not have visually "observed" an adverse drug reaction does not preclude reporting as "Observed."*

E. **Reporting Adverse Drug Events.** All actual or possible ADEs should be reported using any of the following methods:
   1) Completion of an incident report.
   2) Contact of decentralized /clinic pharmacist.
   3) Direct entry into the VISTA (hospital) computer via the Adverse Reaction Tracking (ART) option or through the CPRS medical record by a health care provider or support staff under the direction of a health care provider.
   4) The use of the answering machine dedicated to reporting drug events (extension 5520) or voice-mail to the DUE Coordinator (extension 4468) by the reporting health care professional.
   5) The use of Continuous Improvement reports.
   6) Review of "Remote Data" in CPRS.
   7) The completion of the FDA MedWatch form by the reporting health care professional.
   8) Electronic-mail notification to G.Drug Reaction mailbox or DUE Coordinator.
   9) Contact of decentralized/clinic pharmacist.

   All observed adverse drug events will be recorded in the VA Central Office program, by the DUE Coordinator/VA ADERS pharmacist, with appropriate reactions forwarded to the FDA using an electronic MedWatch Form (accessed through VA ADERS). Patient profile entries are to be made through the ART program or CPRS when appropriate. Historical events should be entered through ART or CPRS.

Attachment D, Monitoring Of Medication Effects Function, Continued

4. **DRUG USAGE EVALUATION (DUE):** DUE systematically measures medication use processes applying an interdisciplinary approach to improve such processes. They may be done either concurrently or retrospectively applying the following guidelines.

A. Basis of Selection Process.
   1. Affects a large number of patients
   2. Potentially places patients at serious risk when processes fail
   3. Problem prone
   4. Determine adherence to prescribing criteria/guidelines/algorhithms/protocols.

B. Predetermined Criteria.
   1. Developed prospectively by appropriate services
   2. May include both quantitative and qualitative data
   3. May incorporate screening processes and intensive assessment

C. Reporting Mechanisms for DUE.
   1. Studies conducted external to the DUE or P&T Committee are reflected in departmental meeting minutes.
   2. Studies through DUE are presented to the P&T Committee and Executive Committee of the Medical Staff who provide guidance and recommendations for corrective action.
   3. The DUE pharmacist prepares an annual evaluation of all DUEs performed at the VISN level, including outcomes, conclusions and action taken.

D. Continuous Improvement Activities. These may include system re-design to eliminate or minimize risk, using evidence-based best practices to develop and implement medication management processes, provider education, modification of drug availability, equipment standardization, and/or modifying computer entry nomenclature.

Attachment E, Regulatory Management of Controlled Substances and Alcohol

1. **PURPOSE:** To ensure the safety and accountability of controlled substances during ordering, storage and administration; maintain systems to minimize the potential for diversion; and provide guidance for reporting incidents of suspicious loss or theft of controlled substances.

2. **ORDERING/DISPENSING OF SCHEDULE II AND III CONTROLLED SUBSTANCES AND ALCOHOL:**

A. Acceptance of Deliveries. All orders for controlled substances received from the vendor are delivered directly to Pharmacy in unopened shipping cartons. Two designated employees (one from Pharmacy and one from the warehouse) annotate receipt on opening of the cartons.
B. Inventories. Non-Pyxis area drug inventory is received from the Inpatient Pharmacy upon receipt of an order on VistA via the controlled substance package. Handwritten orders may be accepted in rare instances on a one-time basis (e.g., computer down times). Pyxis area drug inventories are maintained by authorized pharmacy personnel.
C. Anesthesia Requests. Anesthesia requests controlled substance boxes from the Inpatient Pharmacy by either a certified registered nurse anesthetist (CRNA) or anesthesiologist. Anesthesia lock boxes are stored in the narcotic cabinet of the Anesthesia Work Room.
D. Research Controlled Substances. These are ordered through Pharmacy and issued on request only to personnel authorized by the MVAHCS Director on the advice of either the Chief of Staff or the ACOS for Research.

3. **ACCOUNTABILITY AND STORAGE:**

A. Non-Pyxis Areas.
   1. To verify receipt of controlled substances (after product inspection), the RN or authorized employee in Research signs the "Controlled Substance Order Form" and an entry is made and signed on VAF 506-10-179. Entries are made when controlled drugs are administered, used or wasted. VAFs 506-10-179 are returned to Pharmacy daily to weekly from research areas and clinics. Completed forms from Anesthesia are turned in with the used controlled substance lock boxes.
   2. All areas with controlled substances conduct "narcotic counts" at the change of each shift or working day to verify the inventory is correct. These counts are conducted by two licensed staff persons, one of which is an RN.
B. Pyxis Areas. Pyxis drug accountability is maintained by perpetual inventory counts and discrepancy reports.
C. Alcohol. This requires a written order by a physician and is issued on the Controlled Substance Order Form. Available types of alcohol are wine, whiskey/brandy, and various pure alcohols.
D. Storage. Storage of controlled substances is via Pyxis medication stations, double locked secured areas, or vaults.
E. Inventories. For areas using Pyxis, the Nurse Manager will assure that weekly inventories are completed.

4. **TURN-IN IN NON-PYXIS AREAS:** VAF 10-2321 is initiated in duplicate for each controlled drug turned in. The "Turn-In-Slip" includes the nursing unit/clinic, date, drug name and quantity, and the signature of an RN. The pharmacy narcotic technician is notified and both individuals sign on each form (VAF 10-2321 and VAF 506-10-179) to document the transfer.

5. **SPECIAL CIRCUMSTANCES:**

A. Wasting/Disposal. Wasting/disposal of complete or partial doses of controlled substances (including IV solutions and patches) will be performed by two licensed personnel, one of which is an RN. The wasting will be documented by electronic signatures through Pyxis and/or by 'Add Comment' on BCMA by both individuals or written for non Pyxis areas. Unused partial doses will be appropriately disposed of with a licensed witness and the person who signed out the narcotic. Oral, IV and patch narcotics are disposed of by flushing down a toilet. See specific Fentanyl Patch and PCA waste policy for procedure.

Controlled substances, including IV solutions and patches, should be withdrawn based on assessment of the patient's need. Should a nurse remove and not use a controlled substance, s/he will return the drug or dispose of the drug following the criteria for wasting in "A" above.

Controlled substances, including IV solutions and patches, will be withdrawn by the licensed staff administering the drug to the patient. The ONLY exceptions to this would be urgent/emergent patient needs where the clinician cannot leave the patient and for use of controlled substances in procedure areas and the OR.

B. Accidental Loss, Breakage, or Destruction. These situations require written explanation on the controlled substance dispensing form or Pyxis waste option by the responsible individual. For breakage/loss/destruction of a *one* dose unit, the substance must be wasted in the presence of a licensed witness and the witness must document this via the Pyxis waste option. If the incident involves *more than* a one-dose unit, the incident will be brought to the immediate attention of the nurse manager/nursing supervisor. If the explanation is not satisfactory, the nurse manager/nursing supervisor will alert Pharmacy, who will report the incident to the Controlled Substance Coordinator and VA Police.

6. **INSPECTIONS:** Inspections are the responsibility of the Controlled Substance Coordinator. They are conducted unannounced on a monthly basis, include all controlled substance/alcohol storage areas, and are conducted by reconciling records with the actual stock of drugs. The same inspector does not conduct consecutive inspections in the same area. See VA Handbook 1108.2 for additional information about controlled substance inspections and inspector responsibilities.

7. **DISCREPANCIES:** A discrepancy report will be run at each shift by the nurse manager/charge nurse (for more details see Nursing Procedure 2.2). When discrepancies (including losses) are identified that cannot be expediently resolved:
   - The nurse manager or designee contacts VA Police, Nursing Supervisor (off-tours, weekends, and holidays) and Pharmacy (in non-Pyxis areas only). On off tours, the charge nurse will notify the nursing supervisor, who will in turn notify Pharmacy and Police.
   - The Nursing Supervisor or VA Police will notify the Controlled Substance Coordinator (CSC).
   - A VistA email is generated by the CSC to the Controlled Substance Notification group. This message outlines the details of the discrepancy.
   - In collaboration with Controlled Substance Notification group, and/or the VA Police, the CSC determines if further review is necessary.

- Further review may not be necessary if the loss is attributed to manufacturer shortage or mathematical error. These losses are logged and tracked on the Monthly Adjustment Report completed by Pharmacy Service.
- In instances of potential theft or suspicious loss of controlled substance the VA OIG is notified by VA Police, CSC or the MVAHCS Director's designee.
- In such cases, following OIG review, either a focused review or board of investigation may be appointed as determined by the MVAHCS Director. Results of the review are communicated to executive leadership.
- VA Police will provide information to the CS Coordinator including the Uniform Officer's Report number, name of medication, section (Ward/Clinic), quantify and if reported to OIG.
- Pharmacy will notify the DEA of reportable events through DEA form 106 "Report of Controlled Substance or High Value Drug Loss." A copy of this form is forwarded to the Controlled Substance Coordinator.

8. **RESPONSIBILITIES:**
   - *MVAHCS Director*—establishes a system for inspections and receives reviews and acts on reports/findings.
   - *Nurse Executive*—ensures all requirements for handling, storage and security of controlled substances under the control of nursing are followed. In addition, provides access and support for all assigned inspections in areas that are under the control of nursing.
   - *Controlled Substance Coordinator*—administers the inspection program, provides necessary training, and maintains a register of both inspections and report findings.
   - *Chief, Pharmacy*—establishes and maintains a register of controlled substances and alcohol received from vendors and communicates with the DEA as appropriate.
   - *Patient Service Line Staff*—assist with narcotic checks and assist in the resolution of discrepancies found during inventory of records.
   - *VA Police*—execute responsibilities as outlined above.

Attachment F, High Risk Medication Index, Updated February 10, 2013

High Risk Medication Index

1. **PURPOSE:** Certain medications or procedures associated with medication use require special consideration due to medication toxicity, risk or potential for adverse effects or errors. Others require active patient participation, compliance and accountability. Guidance on the medications listed below appear in the pages that follow:

Topic
1. Antineoplastic Agent Safety (parenteral)
2. Automatic Conversions
3. Buprenorphrine SL tablets
4. Clozapine Use
5. Cyclophosphamide (Cytoxan)
6. Fentanyl Transdermal Patch
7. Haloperidol (IV)
8. Heparin Infusion Therapy
9. Home and Community IV Therapy
10. Insulin Administration
11. U-500 Insulin
12. Intravenous Medication Administration
13. Investigational (including Cooperative Studies) and FDA Approved Research Drugs
14. Meperidine (Limited Use)
15. Methadone Dispensing Program
16. Methylene Blue
17. Midazolam Use Outside of ICUs
18. Nitroprusside
19. Patient Controlled Analgesia Pumps (PCA)
20. Pharmacokinetic Monitoring
21. Placebo Use
22. Potassium Chloride for Injection Concentrate/Cardioplegic Solutions
23. Prochlorperazine (Compazine)
24. Propofol
25. Self-Medication Programs
26. Thalidomide
27. Therapeutic Interchanges
28. Total Parenteral Nutrition (TPN)
29. Urgent Care/Emergency Department Prescriptions
30. Warfarin

Attachment F, High Risk Medication Index, Updated February 10, 2013

1. **Antineoplastic Agent Safety (Parenteral):**

A. All employees handling antineoplastic agents follow appropriate policies and procedures for preparation, handling, disposition, administration, disposal and emergency management. References include standard substance precautions, material safety data sheets, biohazard material guidelines, and PSL policies/procedures including management of spills and agent extravasation.

B. Employees are fully informed of potential reproductive hazards. Staff members who are pregnant or breastfeeding may request to be temporarily assigned other duties. With documentation from their provider and a written request from the employee to their supervisor, males/females actively trying to conceive a child may request to be assigned other duties for a period of one year. Request for extensions up to one year will be granted with appropriate documentation. Staff may make requests for an additional one year extension which will be considered on a case by case basis with documentation from a provider to the service chief that the employee is having difficulties conceiving. Employees trying to conceive and requesting temporary duty assignments because of this will also receive a form, (see Attachment L), with written information regarding the essential functions of their position, the process for requesting temporary duties, the maximum time allowed for temporary duty assignments for conception and suggestions regarding considering other career opportunities. This form will be signed by the employee acknowledging they have received the information.

C. Annual testing of employees involved with antineoplastic agents is available by Occupational Health.

2. **Automatic Conversions:** Such conversions are approved by the P&T Committee.

3. **Buprenorphrine and Buprenorphrine/Naloxone Combination SL Tablets:** These are Schedule III partial opioid agonists approved for the treatment of opioid dependence under the Drug Abuse Treatment Act of 2000. According to Pharmacy Benefits Management the following criteria for providers and patients are required.

A. Qualified physicians may treat no more than 30 patients at any one time during the first year after receiving the original waiver and agree to treat no more than 100 patients at any one time thereafter. In addition, the provider must meet all requirements for the Opioid Treatment Waiver Program, and, either:
   - have experience in addiction medicine or addiction psychiatry; or
   - if inexperienced in addiction medicine treat patients in consultation with a provider in the Physician Clinical Support System (PCSS) mentoring program.

B. Criteria for Patients. Patients must meet one or more of the following three criteria:
   1) They are a new patient and on Opioid Agonist Therapy (OAT) and: (1) do not have timely access to a VA-supported OAT center, or (2) do not meet federal regulatory criteria for treatment in a methadone program, or (3) will have difficulty adhering to scheduled visits at a VA supported OAT center because of limited clinic hours or geographic access.
   2) They are a stable methadone patient who has demonstrated inconsistent compliance with scheduled OAT visits or does not require close supervision.

   3) They are an existing patient with a documented severe, uncontrollable adverse effect or true hypersensitivity to methadone.

4. **Clozapine Use:** Clozapine ordering, dispensing, administration and monitoring is under the jurisdiction of the Clozapine Patient Management Protocol (CPMP) as defined in VHA Handbook 1160.02

Attachment F, High Risk Medication Index, Updated February 10, 2013

5. **Cyclophosphamide (Cytoxan):**

A. Non-Neoplastic Indications for Use. These include various forms of Lupus Erythematosus, Systemic Necrotizing Vasculitis, myositis, and chronic inflammatory neuropathy and neuronopathy.
   1. Dosage Guidelines:
      - Range: Usual dose is 0.5 – 1 gram/m^2 in a single dose.
      - Single dose is not to exceed 2,500 mg. Exceptions must be verified by a staff M.D.
   2. Infusion Guidelines:
      - IV Cyclophosphamide (2,500 mg or less) may be given through peripheral line access.
      - Adequate hydration is required for no less than 24 hours. Unless contraindicated, the patient is advised to continue adequate hydration for several days.
   3. Personnel Responsibilities:
      - A staff M.D must sign all IV peripheral line Cyclophosphamide orders.
      - Cyclophosphamide can be administered by RN nursing personnel through a peripheral line on all medicine wards and in the Observation Unit.

B. Neoplastic Indications for Use:
   1. Dosage Guidelines:
      - May be given in doses up to 1.5 gm/m^2.
      - Single dose should not exceed 3,450 mg. Exceptions must be staff-MD verified.
      - Peripheral line doses should be administered over one hour.
      - Frequency/duration of therapy varies depending on clinical indication for use.
   2. Infusion Guidelines:
      - IV Cyclophosphamide (3,450 mg or less) may be given through a peripheral line.
      - Adequate hydration is required for no less than 24 hours. Unless contraindicated, adequate oral hydration should continue for several days.
   3. Personnel Responsibilities. These are identical to those listed above.

6. **Fentanyl Transdermal Patch:**

A. General Information. This long acting dosage form requires caution in both prescribing and administration due to the potential for over-sedation. Its use is restricted to authorized prescribers for patients who meet these criteria:
   1. Patients unable to tolerate sustained release morphine or sustained release oxycodone despite concomitant use of anti-emetics, laxatives, or other medications used to treat side effects.
   2. Patients unable to take oral medications.
   3. Patients who have failed an adequate trial of short-acting analgesics **and also** meet either the first or second criteria listed above.
   4. Fentanyl is inappropriate to use in an acute pain setting (e.g. immediately post-op).
   5. Transdermal fentanyl may be prescribed by staff providers if they have completed the Long Acting Opioid Consult found in CPRS > Pharmacy Drug Approval Consults > Pharmacy DUE Requests>Long Acting Opiod.

B. Dosing. Opioid naïve patients should not receive doses exceeding 25 mcg/hour. Fentanyl is not considered a first-line agent; it is considered a third-line agent by the World Health Organization pain management recommendations. Analgesia will not begin for 6-8 hours following application; therefore, patients should have short acting analgesics prescribed for breakthrough pain until the efficacy of the transdermal system is attained. Three days or 72 hours should elapse prior to increasing the fentanyl patch dose. Further dosage adjustments to the transdermal fentanyl dose should not be made for 6 days so that equilibrium on the new dose can be reached.)

C. Application. When applying the patch, indicate the date and time of application directly on the patch, along with your initials so other staff are aware when it is due to be replaced. This information also assists in determining peak concentration levels and provides valuable information should an adverse drug event occur. It is suggested the patch be secured. If a patient admitted to the hospital does not know when his/her patch was applied and admission orders include fentanyl patch, the old patch should be removed and a new patch placed the day of admission. If the dose of fentanyl is increased or decreased during a hospital stay, all of the patches are to be removed and the newly ordered dose applied on the day the order is written. The presence/absence of the patch will be verified every shift.

D. Disposal. Active drug remains in the reservoir even after 72 hours of use. Patch disposal requires the patch to be folded so that the adhesive side adheres to itself and then it should be flushed down the toilet. Patch change/disposal requires both witnesses' signatures in BCMA prior to disposal. In the case of death, transdermal fentanyl systems should be removed, witnessed and properly disposed of prior to the disposition of the body. Patches should not be cut prior to disposal as medication (in a gel form) may leak from the reservoir. If the gel from the reservoir comes in contact with the skin, wash the area thoroughly.

E. Drug Interactions. Effects of fentanyl may be potentiated by other CNS depressants (e.g. alcohol, barbituates, benzodiazepines, general anesthetics, and other opioids). Concomitant use of other long acting opioids (e.g., MS Contin, Oxycontin) is contraindicated.

F. Monitor for Side Effects. The most serious side effect is hypoventilation or respiratory depression. Constipation and nausea can occur as with other opioids. Antiemetics and/or bowel hygiene should be initiated. Urinary retention and skin reactions may also occur. Additionally, skeletal-muscular reactions such as myoclonus have also been reported with transdermal fentanyl.

G. Reversal of Transdermal Fentanyl Procedures.
   1. Remove the patch.
   2. Administer naloxone (Narcan). Administer 0.4 mg IV every 2-3 minutes as needed. If no response is observed after a total of 10 mg, question the diagnosis.
   3. Report an adverse drug reaction.
   4. Monitor the patient in an inpatient setting at least 24 hours (since the half life of fentanyl is approximately 17 hours compared to naloxone, which is one hour).

H. Patient Education. Provide patients and their families with the medication brochure on fentanyl patches. Emphasize the following points:
   - The patch will take one day for the effect to start.
   - Short acting pain medications should be taken as prescribed.
   - Apply the patch to the chest or back where there is no hair. Hair may be clipped but not shaved. Place a new patch on a different site each time.
   - Press the patch in place for at least 30 seconds to make sure it sticks.
   - Keep a record of the date and time patches are applied.

- Direct sources of heat such as heating pads, hot showers, or fever, may increase the effect of the patch. If the patient develops a fever greater than 102°, his/her physician should be contacted immediately.
- When the patch is removed, fold the adhesive side together and flush the patch down the toilet.

I. Resources. Refer to the following medical center resources for additional information: Pharmacy Service (#2040) Educational Primer; CPRS Consult tab > Pharmacy Drug Approval Consults > Pharmacy DUE Requests > Long Acting Opioids; Pharmacologic Principles of Pain Management (available in Pharmacy); and Patient Education Brochure.

7. **Haloperidol (IV):** May be administered by RNs in managing acute psychoses/delirium. Maximum rate of administration is 5 mg/minute. Blood pressure must be monitored every 5 minutes and 15 minutes after each administration by either the physician or nurse. A saline flush must be used before and after administration of IV Haloperidol to prevent precipitation.

8. **Heparin Infusion Therapy:** To achieve adequate anticoagulation during the first 24 hours of therapy, Pharmacy-managed heparin protocols are available for use through CPRS quick order sets. The protocols describe baseline and ongoing laboratory testing, initial heparin dosing, continuous infusion rates, and bolus doses dependent on heparin APTT results.

9. **Home and Community IV Therapy:** Includes medication and total parenteral nutrition (TPN) delivered by infusion. Candidates for home IV therapy require advance approval of the Home IV Therapy Coordinator. Program Oversight and Evaluation is provided by the Coordinator with other clinical staff as indicated/The Coordinator and the Director of Home and Community Care serve as the Contracting Officer's Technical Representatives (COTR) for contracted Home IV services.

A. VA Patient Criteria. The criteria are as follows: current VA patient; designated primary care provider or staff physician; outpatient IV therapy is medically appropriate; veteran is capable and willing to receive such therapy; outpatient IV therapy is the most cost effective way for the veteran to receive required therapy.

B. Processing Home IV Therapy Patients.
   1) Consult is submitted to the Home IV Therapy Coordinator at least 24-48 hours in advance of projected discharge to permit adequate time for evaluation and patient education. Telephone contact (located under "Home IV Therapy" in VistA 411 option) will expedite communication as well.
   2) The Coordinator collaborates with Nursing, Nutrition and Food Service, Social Work, Physicians and others as appropriate in developing a home IV care plan which is safe and timely, assuring continued therapy and follow-up.
   3) Prior to discharge, the Coordinator verifies all components are arranged by respective services including home health agency referral. Explicit checklist procedures are available in Home and Community Care.
   4) VA prescribers write orders for agency staff.
   5) Agency staff administer home IV therapy.
   6) VA coordinates payment.
   7) The Coordinator authorizes services until discontinuation of IV therapy.

High Risk Medication Index, Updated February 10, 2013 (cont)

10. **Insulin Administration:** All subcutaneous doses of insulin are double checked by a second nurse before administration. Double check requires the vial from which the insulin was removed, the current BCMA order and the syringe containing insulin. Multi-dose insulin pen injectors are dispensed and labeled for single patient use.
11. **U-500 Insulin:** All U-500 insulin doses will be prepared by pharmacy for specific patients. This medication will not be stocked on wards.
12. **Intravenous Medication Administration:**

A. Administration by RNs. RNs are authorized to administer intravenous preparations except: antitoxins or similar materials containing animal serum such as tetanus; radioactive compounds; and radiographic compounds.
B. Administration by LPN5-6s. LPNs are authorized to administer premixed intravenous preparations except for the drugs limited to RNs (listed above) and benzodiazepines, morphine, fentanyl, hydromorphone, chemotherapy, heparin, TPN, lipids, and investigational drugs or IV push drugs.
C. Delivery. The following IV fluids and medications are administered using an infusion pump: all continuous medication infusions; all TPN and lipids; intermittent medication infusions that require an infusion time of greater than twenty minutes; and maintenance IVs with ≥ 20 mEq KCL or other additives (i.e., $Na+HCO_3$).

13. **Investigational (including Cooperative Studies) and FDA-Approved Research Drugs:**

A. Approval Processes/Study Supervision. These drugs are under the direction of the Human Studies Subcommittee and the Research and Development Committee. The Principal Investigator (PI) receives approval from the above committees and files an Investigational Drug Information Record (1090-12) with Research.
B. Procurement/Prescribing. The PI is responsible for procuring drugs and delivering them to the Chief, Pharmacy Service for dispensing. Pharmacy is provided with: a copy of the protocol; the patient information document; the original 1090-12, signed by the PI; adequate pharmacological information for medical center staff involved in preparing, administering and monitoring use of the research drug; a copy of the signed patient consent form for each subject; and a memorandum specifying which practitioners are authorized to order the drugs. *Note:* Physicians are authorized to continue Minneapolis-initiated investigational drugs on admission.
C. Preparation/Dispensing/Administration.
    1. Pharmacy Service is responsible for the custody and dispensing of all investigational drugs used in human research studies. Prior to dispensing the drugs, Pharmacy verifies that informed consent has been obtained.
    2. Any patient admitted to the medical center who is receiving an investigational/research drug from sources external to MVAHCS, may continue to receive the drug provided the physician managing his or her care: contacts the Chief of Staff requesting and justifying that the administration of the investigational drug be continued; documents approval by the Chief of Staff in a progress note in CPRS; contacts the study's principle investigator (PI) and obtains a copy of the signed informed consent, information on the protocol and all drug-related information prior to reissuing for patient use; delivers the drug to Pharmacy for identification and re-labeling; and provides adequate pharmacological information to Pharmacy and Nursing to allow the drug to be safely handled, administered, and to monitor for possible toxicity, side effects or adverse reactions.
    3. Orders such as "patient may take own medication" or "patient may self-medicate" cannot be used to circumvent the above requirements.

4. It is prohibited to "borrow or bring" investigational drugs from another facility to the MVAHCS without having completed the required review and approval procedures.
5. LPNs are not authorized to administer investigational drugs.

D. Humanitarian Use. In the late stages of drug investigation, investigational drugs may be obtained for patient use as a humanitarian (compassionate) act outside of the regular protocol in the presence of an emergency life-threatening situation for which there is no comparable alternative drug or therapy. Such approval can be obtained from the Chief of Staff or Chairperson of the Human Studies Subcommittee. Additionally, informed consent must be obtained as well as notification of the Investigative Research Board within five working days.

E. Monitoring Procedures. Research records may be audited by FDA investigators to assure compliance with FDA regulations for the conduct and reporting of investigational studies. Records must be retained a minimum of 3 (VHA regulations) years after completion or termination studies. Any unexpected complication, injury, or death associated with use of investigational or FDA-approved research drugs must be reported to the Human Studies Subcommittee within 5 working days.

14. **Meperidine (Limited Use):** Use of Meperidine for the management of pain is not recommended. It is recommended to be used only for treating rigors, shivering, reactions to blood and reactions to other medications, i.e. amphotericin B, rituximab, etc. . It is an opioid analgesic with rapid onset of action/peak and of short duration. Its active metabolite, normeperidine, can produce untoward side effects including central nervous system excitation and seizures. It is eliminated by the kidneys, and therefore has a greater potential for adverse impact with use in an older patient population. It should not be used for chronic pain: in doses greater than 600 mg/24 hours or for more than 48 hours in any patient; in patients with impaired renal function; in elderly patients; in patients receiving monoamine oxidase (MAO) inhibitors; in patients with untreated hyperthyroidism, Addison's disease, benign prostatic hypertrophy, or urethral stricture; in patients with pre-existing convulsive disorders; in patients with atrial flutter or other supraventricular tachycardias; and in patients with sickle cell disease. Orders for meperidine will have a stop date of 48 hours.

15. **Methadone Dispensing Program:** Methadone is used for detoxification and treatment according to FDA and DEA regulations. Outpatient methadone for treatment program patients can only be provided by the Addictive Disorders Section (ADS). Program control procedures and policies are delineated in Addictive Disorders Clinic and Pharmacy Service.

A. Inpatient Methadone Treatment Program. Patients receive their medications from inpatient hospital supplies and the provider notifies the Pharmacotherapy Clinic when a program patient is admitted.

B. Drug Prescribing/Dispensing/Administration.
   1. Prescribing is limited to authorized providers from ADS.
   2. Preparation and dispensing is performed by ADS/Pharmacy staff using a computerized dispensing and record control system.
   3. ADS maintains the following dispensing information: patient name, address and social security number; name of substance, strength, dosage form; date dispensed; amount consumed or taken home; dispenser's initials; signature of prescribing provider; and total number of doses and amount dispensed.

C. Drug Accountability.
   1. Pharmacy verifies new orders and provides ongoing inventory review and control.
   2. Unused doses are destroyed in accordance with DEA requirements.
   3. If a loss is discovered, local DEA officials are notified by Pharmacy Service.

Attachment F, High Risk Medication Index February 10, 2013 (cont)

16. **Methylene Blue:** This cannot be used in conjunction with tube feedings. If a question of aspiration is present the patient should be evaluated.

17. **Midazolam (versed) IV use *outside* ICUs:** This may be administered by RNs without continuous monitoring as adjunctive management of pain and anxiety in dying patients. This is usually given in a low dose continuous drip, or by Anesthesia in patients being managed with a PCA pump (usually given as intermittent low dose boluses). In these circumstances, the prescribing physician is responsible for determining the type and extent of patient monitoring required. Other intravenous benzodiazepines may be given in emergency situations (seizures) while awaiting transfer to a monitored bed setting**.**

18. **Nitroprusside:** Sodium Thiosulfate will be added to all nitroprusside infusions in a 1:10 Nitroprusside:Sodium Thiosulfate ratio to prevent cyanide toxicity.

19. **Patient Controlled Analgesia Pumps (PCA):** These pumps are used to optimize pain control with minimal side effects and toxicity. *Intravenous* PCAs are managed by RNs and *epidural* PCAs are managed by Anesthesia. For information on management of PCA pumps, see Lippincott Nursing Procedure '*Patient Controlled Analgesia and Continuous Narcotic Infusions'*.

A. RN Management of Intravenous PCA Pumps.
   1. This is an extremely high risk-low frequency procedure in many hospital areas and requires verification by two registered nurses. All RNs are expected to complete a yearly competency validation. Each unit's nurse manager is responsible for ensuring RN competency.
   2. The provider is responsible for ordering the PCA and regulating the dosage of narcotics delivered using a pre-established CPRS order set. Orders will be programmed into the pump using the Standard, High Dose, or Non-Standard options of the PCA pump program. Manual programming of non-standard drug concentrations will be used only in rare, extreme opiate tolerant patients. This requires a special code which is entered by Bio-med staff (with NM authorization) on days, or entered by the Nursing Supervisor during off-shifts**.-**
   3. The accountable RN is responsible for assessment and documenting on the PCA flow sheet.

B. For Hospice/Comfort Care patients-
   1. For Palliative Care patients- Assess VS, LOC, RR, pain score every 4 hours or more frequently if warranted. Dose range will be included in provider order set and changes made according to patient condition.
   2. For Hospice/Comfort Care patients (end of life care) - Assess VS, LOC, RR, pain score as needed per provider order.. Dose range will be included in provider order set and changes made according to patient condition. Minimally, assess pain every 2 hours.

C. Epidural PCA Administration
   1. Preparation and labeling is performed by Pharmacy Service. Pharmacy will label epidural infusions with a high alert label.
   2. Responsibility for the management of the pump and pain control is designated to anesthesiology, using a pre-established order set in CPRS.
   3. Patient education is provided by Anesthesia and reinforced by nurses in the patient care areas.
   4. Documentation of medication administration, effectiveness, tubing change, patient education, and pump discontinuation is the responsibility of Anesthesia. Staff RNs are responsible for frequent assessments and documentation on patients with Epidural PCA as outlined in PCA Procedure. (See Lippincott Custom procedure '*Patient Controlled Analgesia and Continuous Narcotic Infusions')*

D. PCA Narcotic Procurement and Wastage
   1. IV narcotic bags will be obtained from pharmacy using the reorder card method.
   2. Narcotic infusion bags will be stored in either the Pyxis machine or the locked narcotic box in areas without a Pyxis.
   3. PCA pump/lockbox keys must be locked in pyxis machine and returned after use. If key is missing, follow the pyxis discrepancy procedure. If unresolved, notify Nurse Manager.
   4. PCA bags/pumps while in use will be locked in the PCA lock box at all times.
   5. When a PCA is discontinued, the residual narcotic is measured and wasted as per the procedure for narcotic drips. The residual narcotic must be disposed of in the presence of a second nurse. A notation is made in BCMA using the "Add Comment" function. The first nurse logs into BCMA and adds a comment to the IV "witnessed waste of 50 ml with". The second nurse then logs in to BCMA and adds a comment to the IV "wasted 50 ml". Discrepancies must be identified and reported following the hospital policy for reporting of a narcotic discrepancy. Wasted residual volumes missing greater than 3cc from the expected amount must be reported as a discrepancy. Cassette and tubing are disposed of in sharps container.

20. **Pharmacokinetic Monitoring:** Pharmacy provides pharmacokinetic dosing services for all patients on vancomycin and aminoglycoside antibiotics. Assistance with other drugs is provided upon request.

21. **Placebo Use:** Placebos are prohibited in the assessment and treatment of pain in all patients.

22. **Potassium Chloride for Injection Concentrate/Cardioplegic Solutions:** It is VHA policy that Potassium Chloride for Injection Concentrate USP will not be stored in any ward or similar site nor provided to the health care providers to be administered to the patient at bedside. In addition, other hypertonic injectable solutions will not be stored in patient care areas. VHA policy also requires that a pharmacy-managed Intravenous (IV) admixture program be responsible for the labeling, preparation, and distribution of IV admixtures. Understanding that some IV admixtures may not be prepared by the Pharmacy Service, practices and policies must be in place to ensure the IV admixtures not prepared by the Pharmacy Service are compatible with the policies that govern the pharmacy-prepared IV admixtures. Only pre-diluted or pre-mixed Potassium Chloride for Injection Concentrate USP can be administered under the immediate-use provision as described in the USP Chapter 797, "Pharmaceutical Compounding—Sterile Preparations." Reference: VHA Directive 2008-027, May 13, 2008.

A. Cardioplegic Solutions Dispensing and Storage:
   1. Cardioplegic solutions are only prepared by, or supplied by, the Pharmacy Service.
   2. Those solutions are hand-delivered by Pharmacy Service to the secure refrigerator in the operating room area. Cardioplegic solutions will NOT be tubed.
   3. Those solutions are clearly labeled “For Cardioplegia Only.”
   4. Those solutions will be secured in a locked refrigerator in the OR area.
   5. Access is limited to the cardiopulmonary bypass technician (perfusionist) and Pharmacy.

B. Use of Cardioplegic Solutions:
   1. Authorized personnel will remove needed cardioplegic solutions from the OR refrigerator.
   2. The perfusionists will label the cardioplegics solutions with a patient name.

Attachment F, High Risk Medication Index, Updated February 10, 2013 (cont)

3. The perfusionist will verify with the cardiac surgeon that the solution being used is the correct one for any particular patient.
4. The perfusionist will be responsible for returning unused bags to the secure refrigerator in the OR. These will be placed in the "Return" bin in the secure refrigerator. These bags will be picked up by pharmacy personnel and returned to pharmacy for disposal.

23. **Prochlorperazine (Compazine):** To minimize risk of tardive dyskinesia associated with long term use, this is limited to a thirty-day supply with no refills.

24. **Propofol Use:** Propofol is restricted to use in the operating room, by anesthesia staff, ICU patients that are intubated/ventilated and oral surgery. ICU providers and oral surgeons wishing to use propofol on non-intubated, non-ventilated patients must receive appropriate training, and be credentialed and privileged in deep sedation and rescue techniques.
Attachment F, High Risk Medication Index (cont)

25. **Self-Medication Programs:** Self-medication is not permitted for acute inpatients. See Attachment G for Self-medication guidelines for the Polytrauma Rehabilitation Transitional Care Unit.

26. **Thalidomide:**

A. Thalidomide prescribing is limited to practitioners who *personally* register with Celgene (the company that manufactures thalidomide). *Note*: Pharmacy is unable to enroll either the provider or patient with Celgene. To register, providers must agree to comply with the S.T.E.P.S™ program (System for Thalidomide Education and Prescribing Safety) developed by Celgene. This program includes pregnancy testing and contraception for women, informed consent, and participating in a mandatory and confidential outcomes registry managed by an academic epidemiological research group.
B. Providers are responsible for registering individual patients with Celgene. No patient will receive the drug unless they are registered in the S.T.E.P.S™ program.
C. Initiation of therapy must be approved by the DUE subcommittee.
D. Pharmacy is also registered with Celgene and will fill prescriptions only after receipt of an authorization to dispense number and a confirmation number for each prescription and verification the provider is a registered S.T.E.P.S™ participant AND the patient has an informed consent. Copies of completed informed consents will be kept in the patient's paper medical record. No refills are allowed and no prescription may be filled for more than a 28 dose supply, no partial cards will be dispensed. .
Prescriptions not filled within seven days of the order date must be rewritten by the provider.

27. **Therapeutic Interchanges:** These are approved by the P&T and ECMS Committee based on scientific and/or clinical data. Any interchange must provide an equivalent outcome and maintain the standard of care. Therapeutic interchanges may be accomplished through direct contact with the prescriber or (automatically) in the Pharmacy. Some conversions may be mandated at the VISN or national level. Generic substitutions will be made by Pharmacy Service based on FDA ratings. Products with an AB rating may be interchanged without individual review unless the medication has a narrow therapeutic index (such as carbamazepine, digoxin, phenytoin, warfarin). Patients affected by therapeutic interchanges are counseled as appropriate.

Attachment F, High Risk Medication Index, Updated February 10, 2013 (cont)

28. **Total Parenteral Nutrition (TPN):**

A. Prescribing/Ordering.
   1. TPN is initiated via CPRS order set.
   2. Solutions are provided in volumes for a 24 hour supply
   3. No new order is required when there is no change to the previous day's formula. Pharmacy will automatically deliver the next 24 hour supply by 6:00 p.m. (18:00).
   4. When changes in TPN formula are necessary they will be noted on the CPRS order set and sent to Pharmacy by noon of the day needed for a 6:00 p.m. (18:00) delivery time. Changes made after noon will be processed the following day. New initiation orders are processed upon receipt.

B. Administration.
   1. Nurses are authorized to hang dextrose/D20 in the rare circumstance when TPN is not available
   2. Administration requires central line access and IV tubing with a filter. If central line is not available, Peripheral Parenteral Nutrition may be ordered.
   3. No other IV solutions or additives except fat emulsions may be infused through the TPN line. IV fat emulsions are to be infused through the Y-injection sites below the filter and should be administered while the TPN remains infusing at the prescribed hourly rate.
   4. No manipulations (such as blood samples or CVP readings) are allowed through the TPN line.
   5. The TPN designated central line port will be **labeled** "TPN ONLY" for identification purposes. Other medications should not be "piggy-backed" into the TPN line (except for propofol and insulin).

29. **Urgent Care/Emergency Department Prescriptions:** These are limited to a 30 day supply without refills unless the patient has an upcoming scheduled clinic appointment.

30. **Warfarin:**

A. Inpatient Prescribing. Initial inpatient warfarin prescribing requires use of the Warfarin Initiation Order set which includes: (a) indications for therapy, (b) target INR range, and (c) anticipated duration of therapy.

B. Patient/Family Education. Once initiated, nursing and pharmacy are responsible for patient education and may use the pre-formatted template with explicit expected patient outcomes. Patients/family must meet the following outcomes prior to discharge: state why they are taking Warfarin; target INR range; symptoms of under or over anticoagulation; and follow-up monitoring plan (location/frequency).

C. Discharge Orders. These are considered complete when they include: indication of therapy; target INR range; location of follow-up; timeframe for initial follow-up; and actual prescription.

D. Other Required Components. Pharmacy consults Social Work to assist when follow-up is indicated outside of the Warfarin Clinic. An initial 30 day supply of medication is provided with no refills. *Exception:* Patients with active warfarin prescriptions who are being discharged from the hospital with no changes to their warfarin dose may be discharged while leaving their existing warfarin prescription active. A follow-up appointment will be scheduled with their warfarin monitoring provider.

E. Ongoing Monitoring for Adverse Events. This is conducted through the daily screening program by Continuous Improvement and close communication with Warfarin Clinic pharmacy staff.

F. Disposal/Waste: Unused pills/empty packages must be discarded in Black Pharmaceutical Waste Containers while in hospital.

Attachment G, Polytrauma Transitional Unit Self-Medication Program (SMP)

1. **PURPOSE**: To set forth policies and procedures for the Polytrauma Rehabilitation Transitional Care Unit's self-medication program (SMP).

2. **POLICY AND PROCEDURES**:

A. Enrollment in the SMP. Patients requiring the opportunity to learn and practice skills for self-management of their prescribed medications in order to maximize independence will be enrolled in the self medication program.

B. Patient Selection Criteria and Assessment

1. Assessment. A provider with prescriptive privileges will assess patients who may benefit from participating in a SMP prior to entry into the program. A progress note and provider order will document the patient has been assessed and is eligible for the SMP. The assessment will include the patient's degree of knowledge and understanding of the following for each medication: name, method of administration (appropriate frequency, routes of administration, dose, etc.), storage requirements, reason for taking, common side effects, integration of medications into the patient's lifestyle, possible barriers to compliance, possible barriers to learning, and procedures for requesting a change in medication regimen.
2. Categorization. Based on the results of the assessment, each patient will be categorized as independent or semi-independent. If semi-independent, the patient will be further subcategorized as a Level I, III, or IV (Level II is not available at this medical center). The chart in section 3 describes these levels of independence and provides specific guidance for medication dispensing, administration, monitoring, education and storage for each level. As patients develop the knowledge and skills necessary to manage their own medications, their self-medication status can progress throughout treatment. However, prior to a patient increasing to a higher SMP level, re-assessment and documentation of items listed above in 2B(1) must be completed by an RN and a provider order indicating the new level. *Note:* If a status change warrants closer medication supervision, any RN may decrease the level of independence or discontinue the patient's participation in the SMP and document in the chart.
3. Status Changes. If a patient status change (i.e. mental, physical) occurs and warrants closer medication supervision by staff or if the patient fails to comply with the patient contract agreement he/she signed, any qualified staff may decrease the patient's SMP level to the Level I protocol defined in the chart in section 3 or discontinue the patient in the SMP and document the change in the chart. Nursing personal will notify the nurse manager and provider during the day shift, or the supervisor and the Rehab on call resident during off tours. Nursing staff will take possession of the patient's medication and all of the patient's medications will be returned/destroyed per standard return policy and procedure. RN Nursing staff will create a nursing text order in CPRS indicating the change in SMP level or discontinuation. Pharmacy will be notified by nursing staff. As a result of the patient's status change (i.e. mental or physical) or failure to comply, the participant will require re-assessment by a provider with prescriptive privileges within 72 hours. Prior to re-entry into the SMP or increasing the patient to a higher SMP level, re-assessment and documentation of items listed above in 2B(1) must be completed by qualified staff and a provider order indicating the new SMP level must be obtained.
4. Suspension. If nursing personal finds a medication does not reconcile with the physician order (i.e. pill count reveals a dose not taken or a missing dose) the patient will then be placed on a SMP suspension. Nursing personnel will document the missed dose of self-medication. While on a SMP

suspension, the participant will resume and continue to follow the same SMP level which has been ordered and nursing personnel will be required to verify with the patient their medications have been taken as scheduled. They must also document this verification and the ongoing SMP suspension in CPRS each shift until the suspension has been discontinued by a provider with prescriptive privileges. A provider with prescriptive privileges will re-assess the patient within 72 hours. Based on the results of the re-assessment the provider may elect to drop the SMP suspension and enter a progress note indicating the patient is eligible to resume at the same SMP level or place a new order indicating a change in SMP level following the protocol listed in 2B(1).

5. Documentation. Upon initial enrollment in SMP, the provider must document in a progress note that the patient has been assessed and is eligible for the SMP. The level of patient independence will be included in the note. The provider will place an order to enroll the patient into the SMP and will indicate the level of independence.

C. Medication Selection Criteria.

- *Orders and assessments*--The provider will enter inpatient medication orders in accordance with the Medication Use Policy (TX-04). A licensed healthcare professional will review and assess the patient's medication regimen and document the regimen approved for self-medication in the patient's chart.
- *Controlled substances and investigational/study drugs*—will not be permitted in the SMP. These medications will be administered to patients by licensed staff using the inpatient unit dose system.
- *Tapering doses (up or down)*--will not be permitted in the SMP. These medications may be included once patient is on a stable dose.
- *Over the counter medications and herbal products*--will be permitted in the SMP in accordance with the Medication Use Policy (TX-04).
- *Intravenous or injection therapy*--will not be permitted in the SMP except for SQ insulin and SQ anticoagulants.
- *PRN or as-needed medications*--can be included in the SMP (except for controlled substances, which are prohibited).

D. Medication Dispensing.

- The pharmacist will finish the inpatient order in accordance with Pharmacy Service policy and procedures. The pharmacist will indicate the medication is a self-med and the level of SMP in the special instructions of each inpatient order that is included in the SMP (for example: "Self-Med Level 3"). The pharmacist will also edit the Self-Med field to indicate a hospital-supplied medication (HSM) for patients at Level III-V.
- For level III-V patient prescriptions, the pharmacist will generate an outpatient prescription label by entering the required data into the VISTA Outpatient Pharmacy package. Orders will be entered for a seven day supply.
- The patient will request and acquire self meds and refills according to the procedures agreed to by the unit and Pharmacy.
- A hard copy of the prescription from the provider for all C-II medications will continue to be required.
- Patients going on an approved pass or authorized absence will take their prescribed medications with them. Patients on SMP Level III and IV will be expected to continue to initial the MAR

while on pass and it will be reviewed by nursing upon return to monitor compliance. Prior to pass, nursing will ensure that the supply of medication in the patient's pill box is adequate for the length of the pass. If additional medication is needed they will be dispensed in bottles by the pharmacy and given to the patient with the instructions. For patients on SMP level I a family member or approved alternate will supervise the patient taking medications while on pass.

E. Patient Education.

- The nurse, program staff, and/or pharmacy staff will provide patient education concerning the indications, potential side effects, proper administration, and storage of medications; security and documentation requirements; the importance of compliance; and the procedure for and importance of reporting any adverse effect of medication to the nurse, pharmacist and or physician.
- Education will continue periodically until the patient successfully demonstrates understanding of items listed above and is able to independently self-administer medications.
- Education will be provided for each medication change or addition to the patient's regimen.
- Education shall be documented in an electronic progress note and include an assessment of the patient's learning needs, the person providing education, the education provided, and the level of understanding demonstrated and/or verbalized by the patient.
- If patient is SMP Level I, education will be provided to patient's family member or approved alternate prior to taking patient out on pass or authorized absence. This will address medication instructions and required monitoring of medications, including controlled substances.

F. Documentation of Medication Administration. This will be performed as outlined in 2B(2).

G. Medication Security.

- *Locking of Medications*--All self-medications dispensed to the patient must be kept in a locked cabinet/locker accessible only to the patient and qualified ward staff. Keys must be unique and not usable in other patients' cabinets or lockers. Exceptions to security requirements will be made for self-medication that must be stored under refrigerated conditions in the locked ward medication room.
- *Self Medication Contract*--Patients must agree in writing to comply with all security requirements in order to participate in the SMP. They will sign an agreement that includes a statement that the patient is responsible for the security of self-medications and the key issued to the patient.
- *Discontinued Medication*--Discontinued medications that have been dispensed to patients will be promptly returned to Pharmacy for destruction.

H. Medication Monitoring.

- *Administration*--Monitoring and documentation of medication administration will be based on patient's level of independence as described in 2B(2).
- *Clinical Monitoring*--Clinical monitoring of the patient's response to medications will be periodically recorded in the patient's progress notes. Clinical monitoring will include identification of target symptom; assessment of the efficacy of the medication on those target symptoms and of any adverse events associated with the use the medications (including the Patient's own perception about side effects and efficacy); reviewing relevant laboratory results, etc; and assessment of educational needs and barriers.

3. Reference Chart.

Key Functions	Level I	Level III	Level IV	Level V
Pharmacy Method of Dispensing	Unit dose	Outpatient Rx	Outpatient Rx	Outpatient Rx
Means of medication receipt	Pt requests each dose from nurse	Pt receives 7-day supply from pharmacy	Pt receives 7-day supply from pharmacy	Pt receives 7-day supply from pharmacy
Monitoring & documentation of medication administration	Nurse observes patient self-administration and documents in BCMA	(1)Nurse observes filling of pillbox, if used. (2) Patient documents daily self-admin of meds on printed 7-day MAR. (3)Nurse does review/visual count as determined by team and documents 2 times weekly.	(1)Nurse observes filling of pillbox, if used. (2) Patient documents daily self-admin of meds on printed 7-day MAR. (3)Nurse does review/visual count as determined by team and documents one time weekly.	(1)If clinically indicated, random spot check of meds is conducted. (2) No MAR required. (3) Nurse does review/visual count as determined by team and documents one time weekly.
Patient Education	Nurse provides education at each dispensing of medications	Pharmacy or Nursing provide education upon pt receipt of meds	Pharmacy or Nursing provide education upon pt receipt of meds	Appropriately credentialed staff provide education (including pillbox use) upon pt receipt of meds
Responsibility for medication storage	Nurse stores all medications in locked unit dose cart, locked medication room, or pyxis machine.	Patient stores own medications in locked cabinet	Patient stores own medications in locked cabinet	Patient stores own medications in locked cabinet

4. **RESPONSIBILITES:** These are detailed throughout section two of this attachment.
5. **REFERENCES:** VHA Handbook 1108.3, March 15, 2005, Self-Medication Program.
6. **FOLLOW UP RESPONSIBILITY:** Chief Nurse, Extended Care and Rehabilitation PSL.

Attachment H: Medication Administration Matrix

Staff Authorized to Administer Medications

	MD's	MD A	Dentists	Podiatrists	CRNA	PAs NPs	RNs	LPNs	Resp Therapists	EYE Techs	Nuc Med Techs	Radiology Techs	PT/OT	Pharmacist/ Pharmacy Students
ORAL/IM/SQ/ID/ TOPICAL MEDS	X	X	X	X	X	X	X	X						X****
IV PUSH	X	X			X	X	Per Med Policy				X***	X***		
MAINTENANCE FLUIDS	X	X			X	X	X	GS 5-6						
OTHER IV INFUSIONS	X	X			X	X	X							
TOPICAL IONTOPHORESIS													X	
IV PIGGYBACK	X	X			X	X	X	GS 5-6						
IV CHEMOTHERAPY	X*					X**/X***	X***							
ORAL CHEMOTHERAPY	X*					X**/X***	X***	X***						
JOINT INJECTIONS	X*	X		X*	X	X**/X***								
EPIDURAL INJECTIONS	X*	X			X									
NERVE BLOCKS	X*	X	X	X*	X									
PCA NARCOTICS	X	X			X	X	X							
EYE DROPS	X	X			X	X	X	X		X				
MOD SEDATION	X**	X	X*		X*	X**	X**							
DEEP SEDATION	ICU MD'S*	X*			X*									
NEBS/INHALERS	X	X			X	X	X	X	X					
RAD.MAT. INHALED	NucMed MD'S										X			
ORAL RAD. MAT. DIAG/THERAPY	NucMed MD'S										X	X		
RAD.MAT. IV PUSH	NucMed MD'S										X	X***		

*WITH APPROPRIATE CLINCAL PRIVILEGES
**WHEN INCLUDED IN PRACTICE AGREEMENT
***AFTER COMPETENCY VALIDATION
****FLU SHOTS ONLY

Attachment I, Anticoagulation Therapy Management

SUBJECT: Anticoagulation Therapy Management

1. **PURPOSE:** To ensure patients who are treated with anticoagulation therapy receive appropriate evaluation and management, so as to minimize the frequency and severity of bleeding and thromboembolic complications, and to maximize the effectiveness of intended therapy.

2. **POLICY, PROCEDURES AND RESPONSIBILITIES:** The improper use of anticoagulation drugs carries a significant potential for patient harm. Sub-therapeutic treatment intensity can result in serious thromboembolic complications, while supra-therapeutic treatment intensity can lead to serious bleeding complications. The Joint Commission's National patient Safety Goal 03.05.01 states, "Anticoagulation therapy poses risks to patients and often leads to adverse drug events due to complex dosing, requisite follow-up monitoring, and inconsistent patient compliance. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse events associated with the use of heparin (unfractionated), low molecular heparin (LMWH) and warfarin." Therefore a coordinated interdisciplinary approach is required for the safe and efficacious management of patients receiving anticoagulation therapy in both the inpatient and outpatient arena.

A. **Pharmacy Service Procedures**: Pharmacy implements and maintains defined and coordinated inpatient and outpatient anticoagulation management programs to individualize care provided to each patient who receives anticoagulation therapy and maintains policies and procedures that reduce the likelihood of patient harm associated with the use of anticoagulants.
    1. Inpatient Anticoagulation Services. These include the following:
        - Support for unfractionated heparin monitoring with dose titration.
        - Support for argatroban monitoring with dose titration.
        - Monitoring responses to warfarin anticoagulation and providing consultative support to practitioners who prescribe therapy.
        - Managing the ordering of inpatient low molecular weight heparin therapy to ensure usage in a manner consistent with the Enoxaparin Prescribing Guidelines.
        - Support to ensure the coordinated transition (hand-off) of the patient from inpatient to outpatient arenas.
        - Exceptions to inpatient management for intravenous heparin include when heparin is prescribed at a prophylactic, low-dose infusion rate of less than 1000 units/hour (typical prophylactic rate is 500 units/hour).
    2. Outpatient Anticoagulation Services. These include the following:
        - Comprehensive warfarin monitoring and dose titration at appropriate intervals.
        - Support to ensure the coordinated transition (hand-off) of the patient from outpatient to inpatient status.
        - Managing the ordering of outpatient low molecular weight heparin bridging therapy for Warfarin Clinic patients who need to undergo interruption of warfarin therapy for surgery or invasive procedures, to ensure usage in a manner consistent with the Enoxaparin Prescribing Guidelines.
        - Procedures to address patient no-show, cancellation appointments, or patients who are non-compliant with their treatment plan.

3. Pharmacy Procedures and Policies.
   - Only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags for anticoagulant medications will be purchased for use in the inpatient service, to the extent these types of products are available.
   - Outpatients will be supplied with only one tablet strength of warfarin (either 2 mg or 5 mg), except in rare circumstances where clinically indicated and in which the clinician has carefully assessed the patient's ability to properly take the correct dosage of warfarin using two different strengths of warfarin tablets. An additional exception is for patients who are extremely sensitive to warfarin and who require a dose of less than 10 mg per week. These patients will be prescribed only 1 mg tablets of warfarin with their Pharmacy narrative indicating this sensitivity.
   - Only programmable infusion pumps will be used to deliver intravenously administered heparin to inpatients. Only RNs can initiate/manage/discontinue Heparin infusions.
   - Approved, evidence-based protocols are established for the initiation and maintenance of anticoagulation therapy, appropriate to the medication used, for the condition being treated, and for potential medication interactions including:
     - Warfarin monitoring service by pharmacists for inpatients (with the exception of Cardiothoracic Service, which monitors their own patients).
     - Initiation and adjustment of warfarin therapy for outpatients.
     - Management of patients per protocol receiving intravenous heparin (standard and low intensity), enoxaparin, and IV Argatroban.
     - Frequency of INR testing that is consistent with nationally recognized guidelines (e.g. American College of Chest Physicians). Recommendations indicate INRs will be checked at an interval of no longer than 4 weeks in stable patients and more often in patients with unstable or non-therapeutic INR results. A maximum of 6 weeks may be permitted for stable patients if weather or transportation issues arise.
     - Manage supra-therapeutic INRs and/or bleeding for patients on warfarin therapy according to medical center policy PE-08, Critical Values, Critical Tests and Abnormal Values.
   - Laboratory tests (both baseline and ongoing monitoring) required for a variety of anticoagulation therapies are identified in section 2B, below and include provider response time to results.
   - A standardized process will be used for documenting INR results received from any non-VA laboratory and will include the name of the laboratory, date of the test and reference ranges on the test. One of two options will be used: 1) Use of a flag associated with the information in the objective portion of the CPRS progress note, or 2) Use of the Anticoagulation Software program when available.
   - Includes processes to address critical drug interactions when new medication is prescribed.
   - Ensures all outpatients on long-term anticoagulant therapy have included in their problem list in CPRS V code V58.61 (long term use of anticoagulants) when not previously entered by the provider.
   - Delineate the Anticoagulation Clinic as responsible for managing point-of-care INR testing including the documentation of appropriate patient selection, assessment,

competency testing, a communication plan and the recording of results in the patient's electronic medical record; the evaluation, selection and purchase of INR self-testing devices; validation of results; and compliance with self testing as defined in VHA Handbook 1106.1, Pathology and Laboratory Medicine Service (See Pharmacy Policy ACO-05).

B. Laboratory Monitoring Required with Anticoagulation Therapy

Anti-coagulation Medications:	Baseline Laboratory Tests	Ongoing Laboratory Tests	Frequency Laboratory Tests Response Timeframe
Heparin IV *Low and Standard Intensity Protocols*	CBC, PT, and aPTT	CBC and aPTT	aPTT at least daily with evaluation no longer than four hours following result availability
Heparin IV *Non-Protocol: Vascular 500 units/hour*	CBC, PT, and aPTT	CBC and aPTT	aPTT at least daily
Heparin SQ *Prophylactic*	CBC, PT, and aPTT	**	*If given in prophylactic doses, no monitoring is required*
Low Molecular Weight Heparin (LMWH) Enoxaparin, Dalteparin, anti-Xa inhibitors (fondaparinux) *Enoxaparin Protocols*	CBC, PT, aPTT, INR, and serum creatinine Nursing text order to monitor for signs of bleeding	Platelet count Nursing text order to monitor for signs of bleeding	Minimum of every other day (inpatients)
Argatroban *Low Dose and Standard Protocol*	CBC, INR, Argatroban aPTT	INR, Argatroban aPTT (if bridging to warfarin)	Argatroban aPTT daily and after dose changes
Warfarin *Order sets: Include clinical indications, target INR, anticipated duration of therapy and for discharge, when and where follow-up should occur.*	CBC and INR. Baseline INR cannot be obtained using point-of-care testing	CBC (at least annually) and INR	INR variable depending on patient stability. Outpatient minimum q 4 weeks if stable (may extend to 6 weeks for extenuating circumstances). Inpatient until stable. Results are reviewed no later than the close of the next business day.

**If box is blank, this means there is no set policy or protocol for labs/monitoring.

aPTT	Activated partial thromboplastin time	INR	International Normalized Ratio
Hgb	Hemoglobin	PT	Prothrombin time
Hct	Hematocrit	CBC	Includes Hgb, Hct, Plt

Note: INR is calculated from the PT so no need to include as a separate test.

C. **Nutrition and Food Service**: Generates a daily listing of all inpatients currently receiving warfarin therapy which results in a registered dietitian providing documented education using their food and medication interaction program.

D. **Patient Education**:
   1. *Warfarin*—Initial patient/family education for inpatients is initiated by nursing staff and incorporates requirements from the warfarin initiation order (requires clinical indication, target INR range, and anticipated duration of therapy). Patient education may include a variety of cognitive aids depending upon individual patient characteristics but will generally include the "Guide to Anti-Coagulation Therapy," use of audiovisual aids, a dosage calendar, and written materials regarding warfarin. Education is documented using the standardized CPRS template entitled "Warfarin Education" at a minimum on initial dose and upon discharge regardless of the patients' anticoagulation history. At the time of discharge the patient must at a minimum be able to state the reason s/he is on warfarin, state the symptoms/signs of both excessive and inadequate anticoagulation, and be able to state where his/her follow-up will be provided. Additional content will be completed upon warfarin clinic intake and during subsequent follow-up appointments. For a complete listing of required components in the CPRS Education Template (go CPRS Shared Templates/Education/Warfarin Ed.
   2. *Enoxaparin*—Nursing staff will ensure the following expectations are met prior to, or at the time of patient discharge/release. The patient must at a minimum be able to state the reason s/he is on enoxaparin, the dose to be taken, when and how to inject enoxaparin (return demonstration with saline or actual medication), the absence of a pork allergy, who to contact for possible problems, and the importance of follow-up blood testing and clinic appointments.

E. **Staff Education**: Education is provided to all prescribers and staff involved in caring for patients receiving anticoagulation therapy on at least an annual basis. Mid-level practitioners involved in managing anticoagulation therapy are required to have successfully completed a specialty training program in anticoagulation therapy management or be certified as an anticoagulation care provider (CACP) or complete an on-site anticoagulation training that includes both experiential and didactic learning strategies. This will be coordinated by the Education PSL via LMS.

F. **Monitoring and Evaluation of Anticoagulation Safety:** An ongoing performance improvement plan is in place to evaluate the safety of anticoagulation practices/processes. This will be coordinated by the Inpatient and Outpatient Program Coordinators in Pharmacy along with the Patient Safety Manager. At a minimum the plan will evaluate:
   1. INRs above the established critical value.
   2. Appropriate documented action has been taken on critical INRs within 24 hours of INR testing results.
   3. Bleeding events (adverse drug reactions).
   4. Thromboembolic events (adverse drug reactions).
   5. Unplanned sub-therapeutic INRs.
   6. Patient incidents, close-calls and near misses associated with anticoagulant medications (patient safety).

3. **REFERENCES:** VHA Directive 2009-003: Anticoagulation Therapy Management, February 2, 2009; VHA Handbook 1108.06, Inpatient Pharmacy Services; VHA Handbook 1108.05, Outpatient Pharmacy Services; VHA Handbook 1106.1, Pathology & Laboratory Medicine Service Procedures; VHA Handbook 1100.19, Credentialing and Privileging; VHA Pharmacy Benefits Management Services and Medical Advisory Panel, July 2008; Joint Commission Patient Safety Goal, 03.05.01- Anticoagulation; American College of Chest Physicians Guidelines: Antithrombotic and Thrombolytic Therapy, 8th edition, ECHEST. 2008: 133(6) June Supplement; Medical Center Policy PI-03, Patient Safety and Risk Management; Medical Center Policy PI-04, Attachment E, Pharmacy and Therapeutics Committee; Medical Center Policy TX-04, Medication Use, Attachment D, Monitoring of Medication Effects; Medical Center Policy PE-08, Critical Values, Critical Tests, and Abnormal Values; Pharmacy Service Internal Policies and Procedures ; Coagulation Lab Procedure Manual, Validation of New Lot Number of Routine Reagents, CO-01.112.01

4. **FOLLOW-UP RESPONSIBILITY:** Director, Pharmacy

Attachment J: IV Medication Administration Parameters (Updated July 2, 2012)

Effective:

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4J/SCI	ED	ICU
ABCIXIMAB (REOPRO)	**Bolus**-0.25 mg/kg over 1 minute 10-60 minutes before PTCA **Infusion**-10 mcg/min for 12 hours.		Manufacturer recommends using a 0.2 or 0.22 mm sterile filter during infusion or during admixture.	IVP								X					X	X
				IVPB														
				Infusion								X					X	X
ADENOSINE (ADENOCARD)	**First dose** - 6 mg over 1-2 Seconds. **Second dose**- 12 mg over 1-2 seconds in 1-2 minutes. **Third dose**-12 mg over 1-2 minutes	Yes	-Recommended to be given through a peripheral line (as close to the site as possible). -If given through a central line, reduce dose by 50%. -Only ACLS trained RN may administer -May have post conversion asystole, may flush, may have chest pain.	IVP								X					X	X
				IVPB														
				Infusion														
ALTEPLASE (tPA FLUSH)	**Dose: Alteplase 2mg/2ml SW in a 10ml syringe: Dwell Time: 1-2 hour. Repeat dose after 2 hours. Thaw syringe**		**-**For Occluded Intravenous Lines -Dialysis uses 2.5mg/2.5ml in 3ml syringes to unclog lines. -Must demonstrate competency to give.	IVP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
				IVPB														
				Infusion														
ALTEPLASE gtt (tPA Infusion)	**<u>Stroke</u>** **-Dose: 0.9 mg/kg of body weight, maximum of 90 mg total dose. 10% of dose given as bolus over 1 minute followed by remaining 90% over 60 minutes** **<u>Occluded Vessels</u>: Two bags are sent. A bag will be hung for each line, it takes approx. 30 ml to prime the tubing. Two infusion pumps will be needed. Dose: 10mg tPA in 500 ml NS.**		**-For Occluded Blood Vessels** **-By approval of Neurology Staff Only for stroke (Dr. Korchik and Dr. Castillo).** **-For MI is stocked in ED, SICU and MICU and given per protocol, which is kept in these areas.**	IVP														
				IVPB														
				Infusion													X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4J/SCI	ED	ICU
AMINOPHYLLINE	**Loading dose rate**: Not to exceed 25 mg/min. **Infusion**-0.1 to 1mg/kg/hr		Aminophylline/Theophylline conversion: Aminophylline 25 mg equals Theophylline 20 mg	IVP	X			X	X	X	X	X	X	X			A	X
				IVPB														
				Infusion	X			X	X	X	X	X	X	X			X	X
AMIODARONE (CORDARONE)	**For Ventricular arrhythmia:** **Initial Bolus dose** - 150 mg in 100 ml D5W over 10 minutes to be followed by infusion of 360 mg in D5W over 6 hours then 540 mg over 18 hours **For SVT:** 300 mg bolus over 10-15 minutes then 10-20 mg/kg/day **For Atrial tach:** 3-5 mg/kg over 30 minutes then 10-15 mg/kg/day for 24 hours	Yes	-Whenever possible should be administered through a central venous catheter port dedicated to that purpose. -Use volumetric infusion pump -In-line filter (5 micron) should be used -PVC tubing recommended -Infusions exceeding 2 hours must be administered in Excel type IV bags.	IVP														
				IVPB					X		X	X		X			X	X
				Infusion (**p bolus**)					X		X	X		X			X	X
ARGATROBAN	Initial dose of 2 mcg/kg/min (0.05 mcg/kg/min for hepatic insufficiency)		-No bolus dose necessary -Protect from light -Dose adjustments done by Pharmacy for patients on protocol	IVP														
				IVPB														
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
BUMETANIDE	**Intermittent dose:** 0.5 to 1 mg over 1 to 2 minutes. Recommended max 10 mg/day **Infusion:** 0.9 to 1 mg/hr		-Monitor BP q. 15 min x 2 -Do not administer faster than 1mg/min	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
CALCIUM CHLORIDE 10mlof 10% soln = 1 gm = 13.6 mEq = 270 mg calcium	No faster than 1 gm over 8 minutes		-Use large vein -May cause tachycardia and hypertension -Monitor BP and HR q 10 minutes x 3 Do not give IM or SQ	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion														

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
CALCIUM GLUCONATE 10 ml of 10% soln= 1 gm = 4.6 mEq = 93 mg calcium	No faster than 1 gm over 2 minutes		-Use large vein -May cause tachycardia and hypertension; monitor BP and HR q 10 minutes x 3 Do not give IM or SQ	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion														
CISATRICURIUM	**Bolus** 0.15-0.2 mg/kg **Intermittent-** 0.3 mg/kg **Inf-**1-2 mcg/kg/min, Rarely 3 mcg/kg/min may be needed	Yes	-Protect from light -Patient must be intubated	IVP														X
				IVPB														
				Infusion														X
50% DEXTROSE	3 ml/min		-If too fast, causes pain at site -Use large bore IV -Watch glucose and VS closely	IVP	X	X	X	X	X	X	X	X	X	X	X	X	X	X
				IVPB														
				Infusion														
DIAZEPAM (VALIUM)	Not to exceed 5 mg/min		-Monitor Respirations -Give into a running IV to avoid thrombosis **-IV push only-Do not dilute**	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB														
				Infusion														
DIGOXIN (LANOXIN)	0.125-0.5 mg/day	**Yes for IV Push** No for IVPB	**-Push**-over 1-5 minutes **-IVPB**-over 30 minutes -Prevent low serum K+ -Monitor Rhythm -Monitor for s/s of toxicity ***No loading dose; Maintenance ONLY**	IVP					X		X	X		X			X	X
				IVPB		X *		X	X	X	X	X	X	X		X	X	X
				Infusion														

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
DIGOXIN IMMUNE FAB (DIGIBIND)	Depends on patient's digoxin levels, ½ to 20 vials (19-600 mg)	Yes	-**Push**-only if cardiac arrest is imminent -**IVPB**-Administer singe dose over 30 minutes through a 0.22 micron filter	IVP													X	X
				IVPB													X	X
				Infusion														
DILTIAZEM HCL (CARDIZEM)	**Bolus**-0.25 mg/kg over 2 minutes, 15 minutes later 0.35 mg/kg over 2 minutes **INF**- 5 to 15 mg/hr	Yes	**Push**- Doses over 2 minutes	IVP					X		X	X		X			X	X
				IVPB														
				Infusion					X		X	X		X			X	X
DOBUTAMINE (Dobutrex)	2.5-40 mcg/kg/min	Yes	*3K 5mcg/kg/min maximum	IVP														
				IVPB														
				Infusion								X *					X	X
DOPAMINE (INTROPIN)	1-20 mcg/kg/min	Yes	Low Dose: 3 mcg/kg/min High Dose: 10 mcg/kg/min *Low Dose on 3K (3mcg/kg/min)	IVP														
				IVPB														
				Infusion								X *					X	X
ENALAPRILAT (VASOTEC)	0.625mg-5 mg over 5 minutes Q6H	Yes	**-Push:** Doses over at least 5 minutes. Monitor BP q. 15 min x 3 -Observe UOP, electrolytes -Observe for sudden swelling of lips, tongue	IVP					X		X	X		X			X	X
				IVPB					X		X	X		X			X	X
				Infusion														
EPINEPHRINE HYDROCHOLORIDE (ADRENALIN)	**CPR:** 1 mg IV Q3-5 minutes up to 0.2 mg/kg Q3-5 minutes **INF:** 1-10 mcg/min or 0.03-0.06 mcg/kg/min or titrate to effect	Yes	For Anaphylaxis-Give IVP Bolus Do not use if discolored. Protect from light	IVP	X	X	X	X	X	X	X	X	X	X	X	X	X	X
				IVPB													X	X
				Infusion													X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
EPOPROSTENOL FOR IV USE (FLOLAN IV)	**RATE:** Initiate at 2ng/kg/min & increase by 2ng/kg/min every 1.5 minutes or longer until dose-limiting effects observed (N&V, HA, flushing, hypotension). Chronic inf: initiate at 4ng/kg/min less than the max. tolerated rate during acute use.		-Reconstituted soln stable 48 hours refrigerated & light protected (or 40 hours refrig +8 hours hanging at room temp). Can infuse longer than 8 hours, if cold pack wrapped around solution. -IV tx for primary pulmonary HTN (vasodilator, inhibits platelet aggregation) -Do NOT reconstitute or mix with any other solutions prior to or during administration. **Stable only when reconstituted with sterile diluent** for **Flolan.**	IVP														
				IVPB														
				Infusion								X					X	X
EPTIFIBATIDE (INTEGRILIN)	**Bolus**-180 mcg/kg (max 22.6 mg) IV push **Inf**- 2 mcg/kg/min, max 15 mg/hr		**Bolus**- over 1-2 minutes.	IVP								X					X	X
				IVPB														
				Infusion								X					X	X
ESMOLOL (BREVIBLOC)	**Load-**500 mcg/kg over 1 minute **Inf-**25-200 mcg/kg/min, max 300 mcg/kg/min.	Yes	Usually begin with a loading dose and followed with a maintenance infusion. Doses >100 mcg./kg/min are not recommended.	IVP								X					X	X
				IVPB														
				Infusion								X					X	X
FENTANYL	**IV/IM**-Usually 50 to 100 mcg/dose over 1-2 minutes for IV administration **Inf-**Rates vary based on patient need, usual starting dose is 25-50 mcg/hour	No	May be given IVP or infusion/PCA * PCA Pumps can be used everywhere in hospital.	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
FUROSEMIDE (LASIX)	**Dose:** Varies Greatly **RATE**: Direct injection over 1-2 min. Inf: max=4mg/min **IVPB:** 50 ml D5W or NS; pH should be adjusted to >5.5 (prevent precipitation) **Inf:** 200 mg in D5W (or NS) 100 ml		-Protect from light-Do NOT use if discolored. - Do NOT refrigerate (may result in crystallization)	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
HALOPERIDOL LACTATE (HALDOL)	**Intermittent-**1-600 mg/day in divided doses **Inf-**Up to 40 mg/hr IV		Maximum rate of 5 mg/min Flush line with D5W before and after administration	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion													X X	X
HEPARIN SODIUM	SQ: 10,000-20,000 USP units, initially, then 8,000-10,000 USP units q 8H or 15,000-20,000 USP units q 12H or as determined by coag test results. IVP: 10,000 USP units initially, then 5,000-10,000 USP units q 4-6H or 100 USP units per kg. body wt. q 4H, or as determined by coag test results. Infusion: 20,000-40,000 USP units in 1000 ml of 0.9% sodium chloride injection administered over 24H period.		**-Bolus dose normally ordered b/4 infusion** **-Monitor APTT per order** **-Dose adjustment done by Pharmacy for patients on protocol.**	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB														
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
HYDRALAZINE (APRESOLINE)	10-20 mg IV q4-6 hours		**IVP**- rapid IV push May be given IM Monitor BP Closely	IVP				X	X	X	X	X	X	X	X	X	X	X
				IVPB				X	X	X	X	X	X	X	X	X	X	X
				Infusion								X					X	X
HYDROMORPHONE (DILAUDID)	**Inf-**Usual starting dose 0.2-0.5 mg/hr **IV/IM-**2mg q4-6h		**IVP**- over 4-5 min Monitor P, HR q 5 min x 4 Can be given IM, SQ, IV INCLUDES PCA PUMP	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion*	X	X		X	X	X	X	X	X	X	X	X	X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
IBUTILIDE (CORVERT)	1 mg IV over 10 minutes for patients > 60kg, 0.01 mg/kg for patients < 60kg. May repeat in 10 minutes if no response to 1st dose	Yes	A second dose of equal strength may be administered if the dysrhythmia does not terminate within 10 minutes after the end of the initial dose. -Observe QT q 1h x 4h or until back to baseline. -Monitor BP, HR & rhythm q 5 min x 4 -Check Mg prior to administration. This med may cause Torsades.	IVP								X					X	X
				IVPB								X					X	X
				Infusion														
INSULIN gtt, HUMAN	**Dilution:** 125 units/250 ml NS (or D5W), if the rate is greater than or equal to 3units/hour. **RATE**: titrated to response		*Use **Regular Insulin Only.** ***3K (Per 3K protocol)**	IVP														
				IVPB														
				Infusion								X *					X	X
IRON DEXTRAN (INFERON)	**May be given IV or IM (Z track method for IM)** **Test dose: 25 mg. IV (undiluted) over 5 min (or give IM) then wait 1 hour-OR-the total dose is diluted in 250 to 1000 ml of NS. A few milliliters is slowly infused as a test. If no reaction occurs after 15 min, the solution is infused over 4-6 hours.** **Max Dose: 500-3000 mg/dose** **Rate: 1-6 hours. Do NOT exceed 50 mg. iron/minute**		-Fatal and nonfatal anaphylactic reactions have been reported after the administration of iron injection; iron injections should be administered only when resuscitation treatment is readily available.	IVP														
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion														
ISOPROTERENOL (ISUPREL)	2-10 mcg/min, 30 mcg/min max	Yes	**IVP-**Over 2 minutes; may repeat every 10 min; patient should remain supine. Can be given IV, IM, SQ	IVP													X	X
				IVPB														
				Infusion													X	X
LABETALOL	**IVP-**20 mg over 2 min. May repeat with doses of 40 mg to 80 mg at 10 minute intervals until desired BP obtained, max total dose of 300 mg. **Inf-**2 mg/min with total dose up to 300 mg or 1-180 mg/hour	Yes	Monitor BP, HR q 5 min x 3; then q 30 min x 2	IVP					X		X	X		X			X	X
				IVPB														
				Infusion								X					X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
LORAZEPAM	**IVP-** 2 mg/min **Inf-**Up to max 30 mg/hr continuous infusion-**NO EXCEPTIONS**		Dilute with equal volume of D5W -Monitor BP, RR, LOC , Oxygen Saturation levels Discontinue if serum osmolality greater than 350	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB														
				Infusion													X	X
MAGNESIUM SULFATE	IVPB-1-2 gm in 20ml syringe of sterile water or bag D5W 50 ml over 20 min 4-5 gm in 250 ml D5W over 60 min		-Can be infused no faster than 150 mg/min	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
MANNITOL	12.5-100 gm Do not exceed 12.5 gm/3-5 minutes		Push: over 3-5 minutes IVPB: Over 30-90 minutes Check for cystallization. Use 0.2 micron filter. Do not refrigerate	IVP													X	X
				IVPB													X	X
				Infusion													X	X
METOPROLOL TARTRATE (LOPRESSOR)	**Angina**: 5mg q2 min x3, then 2-5mg q1h to HR of 55-60 OR 5mg q 2 min x 3 **PVCs**: 0.2mg/kg **SVTs**: 5-15mg admin as 5mg over 2.5min @ 7.5min interval **MI** : 5mg q 2 min x3 **NPO-**5-10 mg q6h	**Yes for angina, PVCs, SVTs, MI** No for maint. dose for NPO	-Monitor BP, HR q 5 minutes x 3; then q. 30 min x 2.	IVP		X			X		X	X		X			X	X
				IVPB		X			X		X	X		X			X	X
				Infusion								X						
MIDAZOLAM (VERSED)	**IVP-** Initial dose 2-5 mg slow push over at least 2 minutes **Inf-** 0.1-20 mcg/kg/min		-Monitor for Respiratory compromise and hypotension. -Titrate to pt. effect. -IM, IVP, IV infusion -Use flumazenil for reversal -Oxgen Saturation Monitoring	IVP		X			X		X	X		X			X	X
				IVPB														
				Infusion		X											X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
MILRINONE (Primacor)	**Load:** 50mcg/kg over 10 minutes **Maint:** 0.375 to 0.75 mcg/kg/min max	Yes	Can cause or worsen ventricular or supra-ventricular arrhythmias. Titrate to response Adjust for renal failure	IVP								X					X	X
				IVPB								X					X	X
				Infusion								X					X	X
MORPHINE	**Inf-**Rates vary s based on pt need but usually starting in 1-5 mg/hr range. **IV/IM-**1-5 mg q4-6 hours but varies by patient need		Can be given IV/IM/SQ	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
NITROGLYCERIN	**Inf-**Initial dose 5 mcg/min **CAUTION**-may also be ordered mg/kg/min Usual range 0-3 mcg/kg/min	Yes	Infusion should be titrated to BP parameters and/or relief of patient symptoms.	IVP														
				IVPB														
				Infusion								X					X	X
NITROPRUSSIDE (NIPRIDE)	**Inf**- Initial rate of 0.3 mcg/kg/min, maint rate of 0.3 to 10 mcg/kg/min Titrate to BP parameter orders	Yes	Protect from light Use D5W only. All Nitroprusside infusions will have sodium thiosulfate added to bag to prevent cyanide toxicity.	IVP														
				IVPB														
				Infusion													X	X
NOREPINEPHRINE (LEVATHERANOL, LEVOPHED)	**Inf-** Usual starting dose is 8-12 mcg/min. Maint dose of 2-4 mcg/min Max 68 mg/day	Yes	Extravasation causes ischemia and leads to sloughing and necrosis	IVP														
				IVPB														
				Infusion													X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
OCTREOTIDE ACETATE (SANDOSTATIN, SOMATOSTATIN)	Diarrhea: Initially 150-750 mcg/day SQ in 2-4 divided doses then up to 450 mcg/day **INF**: Esophageal varices: 50 mcg bolus then 25-50 mcg/hr for 2-5 days		IV administration generally has been reserved for acute management of carcinoid crisis and for treatment of GI tract bleeds.	IVP				X	X	X	X	X	X	X		X	X	X
				IVPB				X	X	X	X	X	X	X		X	X	X
				Infusion				X	X	X	X	X	X	X			X	X
PANCURONIUM BROMIDE (PAVULON)	**Inf-**Initial dose of 0.1 mg/kg then 0.06 to 0.1 mg/kg/hr **Intermittent-**0.05 mg/kg every 1-2 hours	Yes	Patient must be intubated and should receive concomitant sedation.	IVP														X
				IVPB														
				Infusion														X
PANTEPRAZOLE (PROTONIX)	**IVPB**: 40mg IV QD (in 100 ml NS) **Loading Dose**: 80 mg (in 100 ml NS) Infusion: 80 mg. load + 8mg/hrx72 hours **RATE: IVPB**-100 ml over 15 min. **IVP**-40mg-80mg over 2 min **ADMIN: IV line MUST be flushed with either D5W or NS or LR before and after administration**. May run through Y-site with above fluids.		-Reconstitute 40 mg. vial w/10cc NS -May give IVP after reconstituting (40mg/10 ml NS or 80 mg/20ml NS) or dilute reconstituted 40 mg-80mg in 100 ml NS (or D5W) and give IVPB over 15 minutes-stable 24 hours)	IVP	X	X		X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
PHENOBARBITAL	Maintenance dose of 200-600 mg/day usually IM or IVP		PUSH: Not more than 60 mg./min. Do not give SQ	IVP	X	X	X	X	X	X	X	X	X	X	X	X	X	X
				IVPB	X	X	X	X	X	X	X	X	X	X	X	X	X	X
				Infusion														
PHENYLEPHRINE (NEO-SYNEPHRINE)	**Bolus-**200 to 500 mcg over 20-30 seconds **Inf-**: Initial dose of 100-180 mcg/min until BP stable then 40-60 mcg/min	Yes	SQ, IM, slow IVP, IV infusion	IVP													X	X
				IVPB														
				Infusion													X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
PHENYTOIN (DILANTIN)	**Load-**10-15 mg/kg **Maint**- 3-5 mg/kg/day or as needed to maintain levels Max of 1.5gm/24hr		**-Do not exceed 50mg/minute** -Do not refrigerate -Do not dilute -Must turn off primary line when giving phenytoin -IV is preferred route -Must flush line with saline before and after-SASH flush -Pulse Oximetry Required *MAINTENANCE-NO LOADING DOSE	IVP													X	
				IVPB	X *			X *	X	X *	X	X	X *	X	X	X *	X	X
				Infusion														
PHYTONADIONE (AQUA MEPHYTON, Vit K)	1-25 mg daily, maximum of 50 mg		IM or SQ preferred. IVPB: Maximum rate is 1 mg/min.	IVP														
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion														
POTASSIUM CHLORIDE	Varies by patient		IVPB: If administering via peripheral site, maximum dose of 10 mEq/hr. If administering via central line, maximum rate not to exceed 20 mEq/hr. Do not exceed 80 mEq/liter	IVP														
				IVPB	X	X		X	X	X	X	X	X	X	X	X	X	X
				Infusion	X	X		X	X	X	X	X	X	X	X	X	X	X
POTASSIUM PHOSPHATE	Varies by patient but usually 10mM per dose		Infuse over 1-6 hours, usually over 4 hours.	IVP														
				IVPB	X	X		X	X	X		X	X	X	X	X	X	X
				Infusion	X	X		X	X	X		X	X	X	X	X	X	X
PROCAINAMIDE (PRONESTYL)	**Load-**1 gm over 30-60 minutes **Inf-**2-6 mg/min or 0.02-0.08 mg/kg/min	Yes	Do not exceed 25-50 mg/min Monitor levels	IVP														
				IVPB					X		X	X		X			X	X
				Infusion					X		X	X		X			X	X

Agent	Dose & Rate	Cardiac Monitor Required	Comments		CLC	End of Life	1K	2L	2LS	3F	3FS	3KS	3L	3LS	4ES/OBS	4JSCI	ED	ICU
PROPOFOL (DIPRIVAN)	**Bolus-**10-40 mg over 10 seconds **Inf-**5-200 mcg/kg/min depending upon level of sedation needed	Yes	Patient must be intubated., for use only in ICUs and OR Contains no preservative, bottle good for only 12 hours once spiked. Tubing must be changed Q12 hours.	IVP														X
				IVPB														
				Infusion														X
3% SODIUM CHLORIDE	**Hyponatermia-**10-40 ml/hour **To decrease intracranial pressure-**250ml bolus	Yes No	For hyponatremia can be given anywhere. For intracranial pressure-must be in ICU	Infusion Only	X	X		X	X	X	X	X	X	X	X	X	X	X
VASOPRESSIN (PITRESSIN)	**Cardiac Arrest**: 40 units IV as a single, one-time dose may be used as an alternative to epinephrine **Hypotension/Shock**: for its pressor effect at 0.04-0.1 unit/min (2.4-6 units/hr) **Use in GI Hemorrhage**: Rarely used anymore as Octreotide is now the drug of choice. Initial dose 0.2 unit/min (12 units/hr); increase each hour by 0.2 unit/min (12 units/hr) until hemorrhage is controlled. A prudent dosage limit is 1 unit/min (60 units/hr). After 12 hours of control of the hemorrhage the dose of vasopressin may be decreased by half, then it may be stopped within the next 12 to 24 hours.	Yes	**CAUTION: MAY BE ORDERED UNITS/MIN OR UNITS/HOUR-VERIFY DOSE** Extravasation precaution	IVP													X	X
				IVPB														
				Infusion													X	X
VECURONIUM (NORCURON)	**Bolus-**0.08-0.1 mg/kg **Inf-**0.04-0.1 mg/kg/hr	Yes	Patient must be intubated and should receive concomitant sedation. Protect from light	IVP														X
				IVPB														
				Infusion														X

Attachment K: Continuous Subcutaneous Medication Infusion

1. **PURPOSE:** To standardize the administration of subcutaneous (SC) medications by infusion to veterans on the Palliative Integrated Care (PIC) unit at the Minneapolis VA Health Care System.

2. **POLICY AND PROCEDURES:**

   A. **INDICATIONS/SUPPORTIVE DATA:** SC infusion is used for the administration of the following drugs: morphine, hydromorphone, midazolam, and fentanyl. This administration option will be available for patients whose symptoms can not be managed by other routes of administration. SC infusion offers an alternative route of parenteral administration for patients. A provider's order must be written that specifically states the solution/medication to be administered, dose, frequency is that of continuous, and route is for subcutaneous infusion.***solutions available for infusion in attachment A. Subcutaneous infusions will be limited to those listed in this attachment only and administered by1D RN's and Float RN's with demonstrated competency only. Please note subcutaneous infusions are an off-label use for most medication. IV solutions for subcutaneous use will be labeled bright colored auxiliary sticker that states "For subcutaneous infusion only."**

   B. **EQUIPMENT:**
   - Prescribed solution(s) for subcutaneous infusion from Pharmacy
   - Small gauge Teflon catheter, or alternatively a Medtronic Minimed Silhouette or similar approved SC device
   - ChloraPrep Swabs
   - Alcohol Swabs
   - Tape
   - Transparent Dressing
   - I. V. Tubing
   - IV Infusion Pump

Attachment K: Continuous Subcutaneous Medication Infusion (continued)

C. **PROCEDURE:**

STEPS (1DRN's and Float RN's with demonstrated competency only)	**KEY POINTS**
1. Attach device or needle to I.V. tubing and prime with solution to be infused.	This bleeds the entire line of air and ensures immediate administration of medication.
2. Set up I .V. infusion pump system according to manufacturer's instructions.	Personnel trained in the use of pump used for subcutaneous infusion prepare (program) pump.
3. Select and prepare SC site by cleansing with ChloraPrep swab and let dry.	Recommended sites are the abdomen, thigh, and upper arm. Avoid bony prominences, edematous areas, scar tissue, patient's waistline and chest area (potential pneumothorax).
4. Pinch up the skin and insert the device or needle according to standard procedures.	Use sterile technique. Small gauge Teflon catheters have been shown to provide an effective alternative to the metal butterfly needle. Check to ensure needle is flush with the skin.
5. Tape the device or needle in place, coil the tubing and cover the site with a transparent dressing.	Do not cover the insertion site with tape.
6. Date, time, and initial the dressing.	
7. Start the infusion and monitor the site. (Medications/solutions being administered must be scanned into BCMA.)	Connect the infusion to the SC line and prime the line. Then attach line to the butterfly cannula and start infusion. Maximum infusion rate is three (3) ml/hour (See Attachment A below for mg/ hr). Check for leaking around catheter site at one hour after initiating infusion.
ASSESSMENT	KEY POINTS
Select patients with adequate adipose tissue.	Emaciated patients are contraindicated, as well as patients who are restless, agitated, confused, or require medical restraint.
Site assessment is every shift and PRN.	If there is local erythema, edema, pain, or leakage from the site, site rotation is necessary.
Change site every 3 days more frequently if irritations or signs/symptoms of infection are observed. Change dressing prn.(if dressing soiled or loose; etc.).	
Assessment of patient response to a narcotic infusion and his/her comfort level according to hospital pain policy and medication policy	

D. **DOCUMENTATION**: As per unit routines and according to hospital protocols, this may include CPRS, I.V. Flow Sheet, BCMA, I&O Flow Sheet, PCA/Narcotic infusion flow sheet.

Attachment K: Continuous Subcutaneous Medication Infusion (continued)

E. **INFECTION CONTROL:**
1. Maintain sterile technique when preparing the infusion system, and the infusion site.
2. Maintain sharps safety as per hospital policy.

F. **SAFETY PRECAUTIONS/REPORTABLE CONDITIONS:**
1. Maximum infusion rate is three (3) ml/hour.
2. Site rotation is every three days unless site assessment indicates a need for earlier rotation.

G. **DRUGS AND SOLUTIONS FOR SUBCUTANEOUS INFUSIONS:**
1. Morphine prepared to a concentration of 5mg/ml. Maximum infusion rate is 15mg/hr
2. Hydromorphone (Dilaudid) prepared to a concentration of 2.5mg/ml. Maximum infusion rate is 7.5 mg/hr.
3. Midazolam prepared to a concentration of 0.5 mg/ml. Maximum infusion rate 1.5mg/hr
4. Fentanyl prepared to a concentration of 20mcg/ml or 50mcg/ml. Maximum infusion rate of 150mcg/hr (www.palliative.org/pc/clinicalinfo/scchartfeb05.pdf).

3. **REFERENCES:**

Mace, David, R. Ph, Drug Information Specialist, Drug Information Section, Pharmacy Service (119D), Bay Pines MVAHCS, *"Drugs on Standing Order List Which Can Be Given by Continuous Subcutaneous Infusion" (CSI).* July 8, 2002.

Torre, M.C., "Subcutaneous Infusion: Non-Metal Cannulae vs. Metal Butterfly Needles", British Journal of Community Nursing, 2002, Vol. 7, No. 7, p. 365-369.

Kamal, AH and Bruera, E. Hypodermoclysis. Facts Facts and Concepts. October, 2009. Available at: http//www.eperc.mcw.edu/factfact/ff_220.htm

Hospice and Palliative Care Formulary USA, 2nd ed. 2008, pp.497-508

4. **FOLLOW-UP RESPONSIBILITY:** Program Director, Hospice and Palliative Care

Attachment L: Information Regarding Request for Temporary Reassignment of Duties

Anti-Neoplastic Temporary Reassignment

You have requested a temporary reassignment of duties because you are attempting to conceive a child. The temporary reassignment will result in you not working with chemotherapy drugs. It will also result in you not performing all of the essential elements of the position for which you were hired.

You will initially be granted up to one year of temporary reassignment after receipt and review of the appropriate medical documentation from your provider. The documentation should clearly indicate that you are trying to conceive a child and should not be exposed to chemotherapy drugs. You should provide this medical documentation along with a written request for a temporary reassignment to your supervisor. Your request will be forwarded to your chief of service for consideration.

If after one year you have not conceived, you may request a second year. Your request must be in writing and include medical documentation from your provider. You should provide your request and the documentation to your supervisor. Requests for extensions up to one year will be granted with appropriate documentation.

Requests for additional time will be considered on a case-by-case basis and will be forwarded to your chief of service for consideration.

If you anticipate conception taking more than two years it is advised you look for an alternate position that does not include exposure to anti-neoplastic agents as an essential function of your job.

Temporary One-Year Reassignment Approved _____
Date_____

Acknowledgement of Reassignment _____
Date_____

Extension of Reassignment Approved _____
Date_____

Acknowledgement of Reassignment_____
Date_____

Attachment M, Inpatient Self Management of Subcutaneous Insulin Pumps (New 7/2/12)

Purpose: To provide guidelines and establish safe practices regarding the use of personal insulin pumps during hospitalization. Self-managed insulin pump is a subcutaneous insulin pump issued either by the VA or an outside provider, which the patient is using and managing independently while in the hospital setting.

Policy: It is the policy of the Minneapolis VA Health Care System to allow the use of personal insulin pumps during in-patient hospitalizations whenever appropriate diabetes self-management can be carried out. Patients will be assessed for appropriateness of continuing insulin pump therapy by the health care team.

Responsibility:

a. Medicine/endocrinology staff are responsible for monitoring the use of Personal Subcutaneous Insulin Pumps throughout the medical enter.
b. Primary and Specialty attending providers are responsible for the patient during his/her admission.
c. Patient and/or family members will be notified about the continuation or discontinuation of the personal insulin pump by the admitting physician and the nurse responsible for the patient's care.
d. Patient must agree to all guidelines noted in *Continuous Subcutaneous Insulin Pump Therapy Patient Contract* (see Attachment M-1).

Eligibility:

a. Patients admitted to the medical center who have been using a personal subcutaneous insulin pump prior to admission and have agreed to the terms of the *Continuous Subcutaneous Insulin Pump Therapy Patient Contract*.
b. Patients must be able to perform these self-care tasks:
    i. Adjusting and reprogramming the basal rate
    ii. Determining and programming bolus doses
    iii. Filling the reservoir with insulin
    iv. Priming and inserting an infusion set
    v. Site care and rotation
c. Patients may be denied use of a personal subcutaneous insulin pump after admission for any of the following conditions, as determined by the responsible attending physician:
    i. Altered state of consciousness
    ii. Impaired judgment
    iii. Risk of suicide
    iv. Prolonged instability of blood glucose levels during hospitalization
    v. Patient refusal or inability to participate in pump care and management per *Continuous Subcutaneous Insulin Pump Therapy Patient Contract* agreement.

Attachment M, Inpatient Self Management of Subcutaneous Insulin Pumps (New 7/2/12)

Procedure:

a. When a patient with a personal insulin pump is admitted, an endocrine consult will be immediately entered into CPRS through the provider's admission order set.
b. The *Continuous Subcutaneous Insulin Pump Therapy Patient Contract* will be initiated by the admitting provider.
c. Patients' ability to manage the pump will be assessed upon admission and with any change in condition by the medical and nursing staff. If the patient's condition changes and s/he becomes unable to participate in insulin pump care, the pump will be discontinued and insulin therapy by other methods will be initiated.
d. A specific provider order must be obtained using the Inpatient Personal Subcutaneous Insulin Pump Therapy Order Set. Until orders are obtained continue insulin pump settings and orders as ordered outpatient. Orders must include:
    i. Target range for blood glucose
    ii. Type of insulin
    iii. Reservoir volume of insulin pump
    iv. Basal rate
    v. Bolus insulin to carbohydrate ratio
    vi. Sensitivity (Correction factor)
    vii. Active Insulin Time, and
    viii. Frequency of infusion set change
e. While the patient is using a self-managed insulin infusion pump, no other subcutaneous or IV insulin is administered unless specifically ordered by the provider for off-pump periods or pump malfunction coverage.
f. For patients with two consecutive glucose levels greater than 250, and the problem remains unresolved after troubleshooting, the pump will be discontinued and physician will be notified for insulin therapy orders.
g. All patients with personal subcutaneous insulin pumps must have the Hypoglycemic Protocol ordered.
h. *For insulin pumps managed through the VA:* Throughout the duration of the hospitalization, non-medication supplies for personal subcutaneous insulin pump will be provided through outpatient pharmacy. Insulin will be obtained from the inpatient pharmacy in pre-filled syringes and scanned into BCMA upon pump refill for all inpatients.
i. *For insulin pumps managed outside the VA:* non-medication supplies must be supplied by the patient.
j. Hospital glucose meters will be used by hospital staff to check patient blood glucose levels per orders (at minimum before meals and at bedtime).
k. Additional glucose testing done by patient will be documented on the *Patient Bedside Insulin Pump Record Form* (see Attachment M-2), using personal glucose meter. Per provider orders, patients may adjust the insulin pump and manage their own insulin to maintain near normal glucose values.
l. Refer to Custom Procedure *Inpatient Self Management of Subcutaneous Insulin Pumps* in Lippincott for specific procedure details.
m. The nurse will notify Endocrine provider if a patient fails to adequately document all required information on *Patient Bedside Insulin Pump Record Form*.

Attachment M, Inpatient Self Management of Subcutaneous Insulin Pumps (New 7/2/12)

References:

1. VA Medical Center, Cleveland OH 'Inpatient Personal Subcutaneous Insulin Pump Policy 120-017'
2. Leonhardi, B.J, & Boyle, M.E, &Beer, K.A, &Seifert, K.M, & Bailey, M, & Miller-Cage, V., & Castro, J.C, & Bourgeois, P.B, & Cook, C.B, (2008). Use of Continuous Subcutaneous Insulin Infusion (Insulin Pump) Therapy in the Hospital: A Review of One Institution's Experience. *Journal of Diabetes Science and Technology.* Vol 2; Iss.6: 948-962.
3. Lee SW, Im R & Magbual (2004). Current perspectives on the use of continuous subcutaneous insulin infusion the acute care setting and overview of therapy. *Critical Care Nurse Quarterly.* 27:172-184.
4. Medical Center Policy #NR-02E, Hypogylcemia/Hyperglycemia and Bedside Capillary Glucose Testing
5. VHA Handbook 1106.1, Pathology & Laboratory Medicine Service Procedures

Attachment M-1, Continuous Subcutaneous Insulin Pump Therapy Patient Contract (New 7/2/12)

For your safety and optimal medical care during this hospitalization, we request that you agree to the following recommendations. If you feel that you cannot agree to these recommendations, we would like to treat your diabetes with insulin injections and request that you discontinue the use of your insulin pump.

During my hospital stay, I will agree to:

1. Document my basal rate on the flowsheet. Changes in any of my basal rate will only be made with a doctor's order.
2. Document any bolus dose I give based on my blood sugar and/or carbohydrate intake on the flowsheet.
3. Change the infusion set every 48-72 hours or as needed for:
    a. Skin problems, or
    b. Two blood sugar readings greater than 250 mg/dl in a row.
4. Notify nursing staff when pump requires non-medication pump supplies.
5. Notify nursing staff when pump requires insulin refill.
6. Allow the nursing staff to check my blood sugar with hospital meter per orders, and I will document any additional blood sugar that I check on the flowsheet.
7. Report any signs of low blood sugar to the nurse immediately.
8. Report any pump problems to the nurse.
9. Ask questions that I may have about the use of the pump or doctor's orders.

I also understand that my pump may be discontinued and a different insulin delivery given for any of the following:

a) A doctor's order
b) Changes in my judgment
c) Changes in my level of awareness or consciousness
d) An x-ray procedure/MRI/CT (may include pump removal of tubing disconnect and/or removal of the pump and tubing by a physician's order)
e) Other reason deems necessary by the medical staff.

_____ _____

Patient Signature Date

_____

_____

Provider Signature Date

Attachment M-2, Patient Bedside Insulin Pump Record Form, (New 7/2/12)

Patient Bedside Insulin Pump Record Form

Patient Label Here

(This form must be placed in paper chart when completed)

Date:	MN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Glucose																								
Basal rate																								
Bolus rate																								
Carbohydrates																								
Infusion Set Change																								

Date:	MN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Glucose																								
Basal rate																								
Bolus rate																								
Carbohydrates																								
Infusion Set Change																								

Date:	MN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Glucose																								
Basal rate																								
Bolus rate																								
Carbohydrates																								
Infusion Set Change																								

Date:	MN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Glucose																								
Basal rate																								
Bolus rate																								
Carbohydrates																								
Infusion Set Change																								