NURSING HOMES- ADDITIONAL Clarification for Guidance related to Medication Errors and Pharmacy Services- 13-02- NH

In our November 2012 newsletter, new surveyor guidance was provided entitled "Administration of Medications via a Feeding Tube". The guidance noted that professional standards of practice must be followed when administering medications via feeding tube; specifically that all medications should be administered separately (not mixed together) and that the tube must be flushed between each medication. Thus, failure to "pre-flush" prior to medication administration, failing to flush between each medication, and/or failure to "post-flush" the tube at the conclusion, or failure to administer all medications separately would result in the assessment of a single (1) medication error which would be included in the calculation of the facility's medication error rate. A number of providers have expressed a concern over the prospect of being assessed for multiple errors if a staff person is observed failing to flush between several medications for a single resident. However, even though the staff person might neglect to flush between one or more of the resident's medications, only one error will be cited as the result of failure to flush.

While it is a customary practice to use approximately 30 ml. of water for both pre-flushes and post-flushes, this new guidance does not specify the appropriate amount of water needed for flushing between medications…..the amount could be as little as 5 ml. of water, depending on the medication or other factors. As a result, if the facility's failure to properly administer medications via a feeding tube in this manner results in a citation under F332, the surveyor has been instructed to also investigate F425 (Pharmacy Services) to determine if the facility's policies for administering medications via feeding tube meet current professional standards of practice.

Several providers have expressed concern that, for residents who receive numerous medications (e.g., 10 or more medications, etc.) per schedule, they might be placed at risk for "fluid overload", or that they may simply be unable to tolerate the excess fluids needed for the multiple flushes between medications. In cases such as this, we need to remember three points:

- The new guidance does not specify the amount of water to be flushed between medications.
- If a resident cannot tolerate this action (for example, if there is a risk of "fluid overload", or if the excess fluids required causes discomfort for the resident), the facility would need to notify and discuss this with the resident's Physician, the Physician could write an order, related to any changes that he/she deems necessary, regarding how the medication should be delivered. The resident's Plan of Care should include this information as well.
- The CMS communique noted that (regarding this ruling) "an exception would be if there is a physician's order that specifies a different flush schedule for an individual resident, for example because of a fluid restriction".

As a reminder, in light of the recent revision of the surveyor guidance, facilities should review their policies regarding medication administration via feeding tubes to ensure their policies conform to the latest standards of professional practice.

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