STATE OF WASHINGTON
DEPARTMENT OF HEALTH
*Olympia, Washington 98504*

November 12, 2015

The Honorable Randi Becker
Washington State Senator
Post Office Box 40466
Olympia, Washington 98504-0466

The Honorable Eileen Cody
Washington State Representative
Post Office Box 40600
Olympia, Washington 98504-0600

Dear Senator Becker and Representative Cody:

The purpose of this letter is to report on the Pharmacy Quality Assurance Commission's (commission) efforts pursuant to the budget proviso related to long-term care pharmacies in Engrossed Substitute Senate Bill (ESSB) 6052, section 219(11) (Laws of 2015). This proviso requires the commission to engage in a stakeholder process to develop statutory standards and protocols specific to long-term care pharmacies. It also requires the commission and Department of Health (department) to recognize the applicability of medication orders in long-term care facilities and the relationships between professions in conveying chart orders to the long-term care pharmacy.

This letter includes:

- A synopsis of the commission's efforts to engage stakeholders and interested parties.
- Draft statutory language provided jointly by the Washington Health Care Association (WHCA) and Washington State Pharmacy Association (WSPA) (Enclosure 1).
- Commission comments addressing the draft statutory language (Enclosure 2).
- All written comments received from stakeholders (Enclosure 3).

**Collaboration between Commission and Stakeholders**

A department workgroup was established to help inform this effort. The workgroup members included:

- Executive Director of the commission.
- Two commission staff members.
- Deputy Director of the Office of Investigation and Inspection.

The workgroup created an interested parties list, including, but not limited to:

- Pharmacy and healthcare associations.
- Long-term care associations and agencies.
- Nursing Care Quality Assurance Commission.
- Federal Drug Enforcement Agency.
- Local unions.
- Department of Social and Health Services.
- Other Department of Health programs involved in long-term care.

The workgroup shared all information and notices of meetings with the interested parties list as well as the commission Listserv and held three stakeholder public meetings between July 2015 and August 2015. At these meetings stakeholders discussed key issues related to the practice of long-term care pharmacy, and helped the workgroup identify potential solutions. Following the final in-person stakeholder meeting on August 17, 2015, the workgroup accepted written comments proposing specific language for statutory definitions or additional commentary through September 4, 2015.

Two subsequent special meetings of the commission were held in October 2015 where a quorum of commission members received additional stakeholder input related to long-term care pharmacy statutory recommendations. Based on stakeholder testimony and commission deliberation, the commission supports moving forward for your consideration the draft statutory language jointly proposed by WHCA and WSPA and included in Addendum A. The commission believes this draft best represents the collective concerns heard through the stakeholder process.

The commission supports the use of this letter as a working template for proposing new statutes. The draft statutory language in Enclosure 1 includes key items that should be included in any proposal:

- Definitions for:
    - Chart orders
    - Long-term care facility
    - Agent of the prescriber
    - Closed door long-term care pharmacy
    - Administrative long-term care personnel

- Processes for:
  - Communicating/transmitting chart orders to long-term care pharmacies
  - Use of E-kits and supplemental dose kits
  - The use of automated drug distribution devices (ADDD)
  - Storage of prescription records
  - The repackaging and dispensing of unused, returned drugs
  - Shared pharmacy services

There are additional topics the commission felt needed further discussion. The specific concerns of the commission regarding the draft statutory language are included in Enclosure 2.

Should the legislature find the draft statutory language appropriate to adopt into law, the commission recommends a broad statutory approach providing structural flexibility for future technologies or accepted pharmacy practices, along with direction to the commission to develop more specific long-term care pharmacy standards in rule where appropriate.

**Future Commission Rule Work**

The commission plans to continue its ongoing work with stakeholders to update long-term care pharmacy rules and will incorporate any resulting legislation enacted in 2016 into that effort.

For additional information or if you have any questions, please contact Lisa Hodgson, Acting Executive Director for the Pharmacy Quality Assurance Commission at (360) 236-2927 or lisa.hodgson@doh.wa.gov.

Sincerely,

Albert Linggi, R.Ph. M.B.A
Chairman, Pharmacy Quality Assurance Commission

Enclosure 1

# Draft Statutory Language Provided Jointly by WHCA and WSPA

October 1, 2015

**MEMORANDUM**

TO: Washington State Pharmacy Quality Assurance Commission & Interested Stakeholders

FROM: Robin Dale, CEO, Washington Health Care Association
Jeff Rochon, CEO, Washington State Pharmacy Association

RE: Recommendations for Washington LTC Pharmacy Statute

We appreciate the opportunity to provide you with the WHCA/WSPA recommendations for LTC pharmacy statute in the State of Washington. Our effort is intended to ensure that on-going, safe and effective pharmacy services are delivered to the residents served in Washington long term care settings.

Thousands of Washington citizens rely on access to timely pharmacy services to treat complex and significant medical conditions. As a coalition representing long term care providers and pharmacists, we are committed to a thoughtful approach to this important task.

Representatives from our coalition have attended each of the three stakeholder meetings convened specifically to discuss potential recommendations for statutory language (July 15, August 10 and August 17). The stakeholder meetings were helpful in shaping our recommendations to the Commission. The National Association of Pharmacy Boards has also provided significant guidance related to the practice of long term care pharmacy, and we also looked to that body of work for guidance. Additional internal dialogue, research and providers' experience in other states also helped shape the recommendations contained here.

Of most significance is our recommendation to create a separate subchapter for long term care pharmacy in Chapter 69.41 RCW. While there is a lack of statutory support for the current practice of long term care pharmacy, the current standards of practice are long-standing here in Washington State, and we believe that these recommendations form the statutory framework to ensure long term care patients have safe and timely access to medications. We have provided a summary of each recommended section, along with recommendations for statutory language.

From our perspective, it is a top priority to ensure that nurses continue to serve as the link between physicians, pharmacists and residents. Both SNFs and ALFs work with consulting pharmacists. Nurses in these settings are key to quality of care, serving as the link between physician and pharmacist. We were pleased that the Legislature affirmed the importance of this work through the budget proviso in the 2015-17 operating budget:

> ESSB 6502 Section 219 (11)(b): When inspecting and reviewing long-term care pharmacies, the pharmacy quality assurance commission and the department of health shall recognize the applicability of medication orders in long-term care facilities and recognize the essential relationship between the practitioner, the long-term care facility registered nurse, and the pharmacist in conveying chart orders to the long-term care pharmacy.

The National Association of Boards of Pharmacy acknowledges the need for using chart orders in long term care: "In the current long-term care practice setting, caregivers commonly refer to the patient's

medical chart to determine when a prescription drug refill is needed and to record, monitor, and make necessary changes to a patient's medication therapy. The caregiver or health professional administering the medication uses the 'chart order' within the medical chart as the reference for completing the medication administration record. This one consistent record is essential to the delivery of quality health care and to ensure that medication administration errors are minimized."

Nurse agency with receiving telephone orders is also an issue. It is currently legal to verbally transmit orders to a pharmacy. We have offered recommendations for statutory language to allow a prescriber's agent to transmit a telephone order via fax, forward a signed MD order via fax and transmit orders via approved electronic health record system. In addition, in some scenarios such as assisted living facilities it is common for a nurse aide or other staff to transmit a prescription on behalf of a resident; the final statute should not block that standard and reasonable practice.

We have also attempted to provide some clarification and distinction so that an e-kit is distinguished from an automated drug dispensing device.

Additionally, we suggest that in the interest of patient choice, any licensed pharmacy should be able to provide long term care pharmacy services. But, we note that specialized long-term care pharmacies perform certain administrative services that in other institutional contexts such as hospitals would not be overseen by a licensed pharmacist. We thus suggest that specialized, closed-door long term care pharmacies be separately recognized and allowed different operational constraints than other pharmacies, including a different pharmacist-to-tech ratio.

We recognize the careful balance to be achieved between state laws and the regulations that implement those requirements. In some cases, additional regulatory clarification and/or updated guidance to inspectors may also be necessary to ensure the safe practice of long-term care pharmacy. We believe that our suggested statutory language provides a reasonable framework ratifying longstanding industry practices, while preserving substantial discretion for PQAC to promote quality care by responding over time to changes in patient needs, technology, and the marketplace.

We are fully committed to on-going work on this project and look forward to further dialogue and opportunity to educate the PQAC about the long term care sector in Washington.

# Draft Long-Term Care Pharmacy Statute Amendments

Washington Health Care Association

8/31/2015

## SUMMARY

**§1, Intent: new section in RCW 69.41**

- Recognize legislative intent to regulate LTC pharmacies somewhat differently than retail or hospital pharmacies.

**§2, Definitions: new section in RCW 69.41**

- Define relevant care settings.
  - LTC facility includes NF, AL, and AFH.
  - Hospice program includes both Medicare and state-licensed hospice.
- Define closed door long-term care pharmacy for purpose of reduced pharmacy tech ratio requirements.

    - Solely serving patients who reside at or are otherwise associated with LTC facilities or hospice programs.
    - Not open to the general public for retail; but does not preclude limited mail-order or retail operations for residents of participating facilities.
- Define other key terms.

**§3, <u>LTC Pharmacies</u>: new section in RCW 69.41**

- Chart orders are a valid prescription when signed by the prescriber's agent, with the prescriber's signature to follow in accordance with good medical practice (that is, per the licensing requirements applicable to the prescriber and the facility).
- Licensed staff in a LTC facility are understood to be acting as the prescriber's agent when given a verbal order and asked to enter it into the patient's medical record.
- A pharmacy may accept and fill a prescription based on records transmitted by the LTC facility staff, including chart orders not yet signed by the prescriber and re-transmitted fax prescriptions.
- LTC pharmacy may "resupply" medications where a signed chart order is continuing in effect and thus there is no new prescription as is required for a refill.
- Codify the use of both e-kits and supplemental dose kits, stored in either a container or in a "device" to include an ADDD box.
- Allowing shared pharmacy services in LTC pharmacies.
- In first-dose and other situations where there is an immediate need for patient access, the prescription may be filled through shared pharmacy services on a satellite basis without transferring the prescription.
- Return and re-use of unit dose and modified unit dose blister packs is allowed.
- Tech ratio for closed door LTC pharmacies is different from retail/hospital settings. Ancillary staff performing administrative tasks do not count toward the tech side of the ratio.

**§4, <u>Nursing Home Medication Orders</u>: amending RCW 74.42.230**

- Allows medication order to be continuing rather than time-limited.
- Clarifies use of verbal orders.
- Nurse can transmit orders to the pharmacy by phone, fax, or e-prescription.

**§5, <u>Electronic Transmission of Prescription Information</u>: amending RCW 69.41.055**

- Prescriber's agent can e-sign and transmit electronically.

**§6, <u>Prescription Records</u>: amending RCW 18.64.245**

- For facsimile prescriptions, there is no need to print the image with the prescription number and other necessary information, as long as that information is digitally linked to the fax image in the pharmacy's electronic record-keeping system.

**§7, <u>Tamper Resistant Pads</u>: amending RCW 18.64.500**

- Exemption from use of tamper resistant pads broadened to include all LTC facilities and hospice programs, not just nursing homes.
- Clarify that a chart order may be written and signed by either the prescriber or the prescriber's agent.

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**Sec. 1.** INTENT.

The legislature finds that safe and timely access to prescription medications by residents of long-term care facilities and hospice patients is a crucial public health issue. The legislature further finds that the practice of pharmacy in the context of long-term care facilities and hospice programs is different from the practice of retail pharmacy or hospital pharmacy in certain material ways. In particular, the ability of medical practitioners to delegate chart entry and transmission of prescriptions is an important practice for quality of care in long-term care in that both the medical practitioner and the pharmacy serving the residents or patients are generally located off site, including at times when the resident or patient may be in urgent need of medication. It is the intent of the legislature to establish efficient and sensible regulatory guidelines for pharmacies to provide safe, timely, and high quality pharmacy services to long-term care facilities or programs and their residents or patients.

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**Sec. 2.** NEW SECTION. A new section is added to chapter 69.41 RCW to read as follows:

As used in Section 3 of this Act, the following terms have the meanings indicated unless the context clearly requires otherwise:

(1) "Administrative long-term care pharmacy personnel" means pharmacy ancillary personnel in a closed door long-term care pharmacy who perform administrative tasks not associated with immediate dispensing of drugs, without regard to whether the ancillary personnel is registered under chapter 18.64A RCW. Administrative tasks include but are not necessarily limited to medical records maintenance, billing, prepackaging unit dose drugs, inventory control, delivery, and

processing returned drugs, in a long-term care pharmacy.

(2) “Chart order” means a lawful order for a drug or device entered on the chart or medical record of a resident of a long-term care facility or a patient of a hospice program, by an authorized practitioner or his or her designated agent.

(3) "Closed door long-term care pharmacy" means a pharmacy licensed under the provisions of chapter 18.64 RCW that provides pharmaceutical care to a defined and exclusive group of patients who have access to the services of the pharmacy because they are treated by or have an affiliation with a long-term care facility or hospice program, and that is not a retailer of goods to the general public.

(4) “Hospice program” means a hospice program certified or paid by medicare under Title XVIII of the federal social security act, or a hospice program licensed under chapter 70.127 RCW.

(5) "Long-term care facility" means a nursing home licensed under chapter 18.51 RCW, an assisted living facility licensed under chapter 18.20 RCW, an adult family home licensed under chapter 70.128 RCW, and such other care settings as may be determined by the commission.

(6) “Shared pharmacy services” means a system that allows a participating pharmacist or pharmacy pursuant to a request from another participating pharmacist or pharmacy to process or fill a prescription or drug order, which may include but is not necessarily limited to preparing, packaging, labeling, data entry, compounding for specific patients, dispensing, performing drug utilization reviews, conducting claims adjudication, obtaining refill authorizations, reviewing therapeutic interventions, and/or reviewing chart orders.

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**Sec. 3.** NEW SECTION. A new section is added to chapter 69.41 RCW to read as follows:

(1) A chart order shall be considered a prescription provided that it contains:

(a) the full name of the patient;

(b) date of issuance;

(c) name, strength, and dosage form of the drug prescribed;

(d) directions for use; and

(e) an authorized signature:

(i) if a written order, the order must contain the prescribing practitioner's signature or the signature of the practitioner's authorized agent (including the name of the prescribing Practitioner); or

(ii) if an electronic or digital order, the order must contain the prescribing practitioner's electronic or digital signature, or the electronic or digital signature of the practitioner's authorized agent (including the name of the prescribing Practitioner).

(2) A licensed nurse, pharmacist, or physician practicing in a long-term care facility or hospice program may act as the practitioner's agent for purposes of this chapter, without need for a written agency agreement, to document a medication order in the patient's medical record on behalf of the prescribing practitioner pending the prescribing practitioner's signature; or to communicate a prescription to a pharmacy whether telephonically, via facsimile, or electronically. The communication of a prescription to a dispenser by the prescriber's agent shall have the same force and effect as if communicated directly by the authorized practitioner.

(3) Nothing in this chapter shall prevent a licensed nurse, pharmacist or physician from transmitting a chart order on behalf of the authorized practitioner pursuant to RCW 74.42.230.

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(4) A pharmacy may dispense drugs to the resident of a long-term care facility on the basis of a written or digitally signed prescription sent via facsimile copy by the prescriber to the long-term care facility, and communicated or transmitted to the pharmacy pursuant to subsections (2) or (3).

(5) A pharmacy may resupply a prescription to a patient at a long-term care facility pursuant to a valid chart order that is signed by the prescribing practitioner, is not time limited, and has not been discontinued.

(6) A pharmacy or pharmacist may provide a limited quantity of drugs to a licensed nursing home or hospice program without a prescription, for emergency administration by authorized personnel of the facility or program pursuant to a valid prescription. The drugs so provided shall be limited to those required to meet the immediate therapeutic needs of residents or patients and which are not available from any other authorized source in sufficient time to prevent risk of harm by delay resulting from obtaining such drugs from other sources. Such emergency kits shall be secured in a container or device to prevent unauthorized access, and to ensure a proper environment for preservation of the drugs.

(7) In addition to or in connection with the emergency kit authorized under subsection (2), a licensed nursing home may maintain a supplemental dose kit for supplemental nonemergency drug therapy. Such supplemental dose kits shall be secured in a container or device to prevent unauthorized access, and to ensure a proper environment for preservation of the drugs.

(8) A pharmacy may outsource shared pharmacy services for a long-term care facility or hospice program to another pharmacy, provided that the outsourcing pharmacy:

(a) obtains approval from the long-term care facility or hospice program to

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outsource shared pharmacy services for the facility's or program's residents or patients, and

(b) provides a copy of the prescription or order to the pharmacy providing the shared pharmacy services.

(9) Shared pharmacy services may be used for, but are not limited to, the purpose of ensuring that drugs or devices are attainable to meet the immediate needs of residents of the long-term care facility or hospice program, or when the outsourcing pharmacy cannot provide services on an ongoing basis. Where a pharmacy uses shared pharmacy services to have a second pharmacy provide a first dose or partial fill of a prescription or drug order to meet a patient's or resident's immediate needs, the second pharmacy may dispense the first dose or partially filled prescription on a satellite basis without the outsourcing pharmacy being required to fully transfer the prescription to the second pharmacy.

(10) A pharmacy may repackage and dispense unused drugs returned by a long-term care facility or hospice program to the pharmacy in per-use blister packaging, whether in unit dose or modified unit dose form. The commission shall adopt rules providing for the safe and efficient repackaging and reuse of unused drugs returned to a pharmacy from a long-term care facility or hospice program.

(11) The commission shall adopt reasonable task-based standards regarding the ratio of pharmacists to pharmacy ancillary personnel in a closed door long-term care pharmacy. For the purpose of such standards, administrative long-term care pharmacy personnel shall not be considered to be practicing as pharmacy technicians requiring pharmacist oversight while performing administrative tasks.

(12) The commission may adopt rules implementing this section.

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**Sec. 4.** RCW 74.42.230 and 1994 sp. s. ch. 9 § 751 are each amended to read as follows:

(1) The resident's attending or staff physician or authorized practitioner approved by the attending physician shall order all medications for the resident. The order may be oral or written and shall be limited by time, unless specified as continuing in effect until discontinued by a physician or authorized practitioner. An "authorized practitioner," as used in this section, is a registered nurse under chapter 18.79 RCW when authorized by the nursing care quality assurance commission, an osteopathic physician assistant under chapter 18.57A RCW when authorized by the committee of osteopathic examiners, or a physician assistant under chapter 18.71A RCW when authorized by the medical quality assurance commission.

(2) An oral order shall be given only to a licensed nurse, pharmacist, or another physician. The oral order shall be recorded and physically or electronically signed immediately by the person receiving the order. The attending physician shall sign the record of the oral order in a manner consistent with good medical practice.

(3) A licensed nurse, pharmacist, or another physician receiving and recording an oral order may, if so authorized by the physician or authorized practitioner, communicate that order to a pharmacy on behalf of the physician or authorized practitioner. The order may be communicated verbally by telephone, by facsimile manually signed by the person receiving the order pursuant to subsection (2), or by electronic transmission pursuant to RCW 69.41.055. The communication of a resident's order to a pharmacy by a licensed nurse, pharmacist, or another physician acting at the prescriber's direction shall have the same force and effect as if communicated directly by the delegating physician or authorized practitioner.

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**Sec. 5.** RCW 69.41.055 and 1998 ch. 222 § 2 are each amended to read as follows:

(1) Information concerning an original prescription or information concerning a prescription refill for a legend drug may be electronically communicated between an authorized practitioner and a pharmacy of the patient's choice with no intervening person having access to the prescription drug order pursuant to the provisions of this chapter if the electronically communicated prescription information complies with the following:

(a) Electronically communicated prescription information must comply with all applicable statutes and rules regarding the form, content, recordkeeping, and processing of a prescription or order for a legend drug;

(b) The system used for transmitting electronically communicated prescription information and the system used for receiving electronically communicated prescription information must be approved by the ~~board~~commission. This subsection does not apply to currently used facsimile equipment transmitting an exact visual image of the prescription. The ~~board~~commission shall maintain and provide, upon request, a list of systems used for electronically communicating prescription information currently approved by the ~~board~~commission;

(c) An explicit opportunity for practitioners must be made to indicate their preference on whether a therapeutically equivalent generic drug may be substituted;

(d) Prescription drug orders are confidential health information, and may be released only to the patient or the patient's authorized representative, the prescriber or other authorized practitioner then caring for the patient, or other persons specifically authorized by law to receive such information;

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(e) To maintain confidentiality of prescription records, the electronic system shall have adequate security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of these records. The pharmacist in charge shall establish or verify the existence of policies and procedures which ensure the integrity and confidentiality of prescription information transmitted to the pharmacy by electronic means. All managers, employees, and agents of the pharmacy are required to read, sign, and comply with the established policies and procedures; and

(f) The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of the prescription drug order received by way of electronic transmission, consistent with federal and state laws and rules and guidelines of the ~~board~~commission.

(2) The electronic or digital signature of the prescribing practitioner's agent on behalf of the prescribing practitioner, pursuant to a valid order and authorization, shall constitute a valid electronic communication of prescription information. Such an authorized signature and transmission shall not constitute an intervening person having access to the prescription drug order.

(3) The ~~board~~commission may adopt rules implementing this section.

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**Sec. 6.** RCW 18.64.245 and 2013 ch. 19 § 17 are each amended to read as follows:

(1) Every proprietor or manager of a pharmacy shall keep readily available a suitable record of prescriptions which shall preserve for a period of not less than two years the record of every prescription dispensed at such pharmacy which shall be numbered, dated, and filed, and shall produce the same in court or before any grand

jury whenever lawfully required to do so. The record shall be maintained either separately from all other records of the pharmacy or in such form that the information required is readily retrievable from ordinary business records of the pharmacy. All recordkeeping requirements for controlled substances must be complied with. Such record of prescriptions shall be for confidential use in the pharmacy, only. The record of prescriptions shall be open for inspection by the commission or any officer of the law, who is authorized to enforce chapter 18.64, 69.41, or 69.50 RCW.

(2) Where a pharmacy receives a prescription in digital or electronic format through facsimile equipment transmitting an exact visual image of the prescription, or through electronic communication of prescription information, the digital or electronic record of every such prescription dispensed at such pharmacy shall constitute a suitable record of prescriptions, provided that original or direct copy of the prescription is electronically or digitally numbered or referenced, dated, and filed in such form that the information required is readily retrievable.

(3) A person violating this section is guilty of a misdemeanor.

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**Sec. 7.** RCW 18.64.500 and 2013 ch. 19 § 30 are each amended to read as follows:

(1) Effective July 1, 2010, every prescription written in this state by a licensed practitioner must be written on a tamper-resistant prescription pad or paper approved by the commission.

(2) A pharmacist may not fill a written prescription from a licensed practitioner unless it is written on an approved tamper-resistant prescription pad or paper, except that a pharmacist may provide emergency supplies in accordance with the commission

and other insurance contract requirements.

(3) If a hard copy of an electronic prescription is given directly to the patient, the manually signed hard copy prescription must be on approved tamper-resistant paper that meets the requirements of this section.

(4) For the purposes of this section, "tamper-resistant prescription pads or paper" means a prescription pad or paper that has been approved by the commission for use and contains the following characteristics:

(a) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription form by the practitioner; and

(c) One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(5) Practitioners shall employ reasonable safeguards to assure against theft or unauthorized use of prescriptions.

(6) All vendors must have their tamper-resistant prescription pads or paper approved by the commission prior to the marketing or sale of pads or paper in Washington state.

(7) The commission shall create a seal of approval that confirms that a pad or paper contains all three industry-recognized characteristics required by this section. The seal must be affixed to all prescription pads or paper used in this state.

(8) The commission may adopt rules necessary for the administration of chapter 328, Laws of 2009.

(9) The tamper-resistant prescription pad or paper requirements in this section shall not apply to:

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(a) Prescriptions that are transmitted to the pharmacy by telephone, facsimile, or electronic means; or

(b) Prescriptions written for inpatients of a hospital, outpatients of a hospital, residents of a ~~nursing home~~long-term care facility as defined in Section 2 of this Act, patients of a hospice program, inpatients or residents of a mental health facility, or individuals incarcerated in a local, state, or federal correction facility, when the health care practitioner authorized to write prescriptions or his or her designated agent writes the order into the patient's medical or clinical record, the order is given directly to the pharmacy, and the patient never has the opportunity to handle the written order.

(10) All acts related to the prescribing, dispensing, and records maintenance of all prescriptions shall be in compliance with applicable federal and state laws, rules, and regulations.

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Enclosure 2

# Commission recommended amendments to WHCA/WSPA Statutory Recommendations

The Commission is recommending the consideration of the following amendments to the draft statutory language in Enclosure 1 to provide for greater clarity and flexibility for patients and stakeholders involved in Long-Term Care pharmacy practice.

## Section 2(1)

The term administrative pharmacy technician could be alternative language to consider. The duties permitted in statute should not exceed those of a licensed pharmacy assistant. This administrative pharmacy technician position could be utilized in other areas of pharmacy practice, such as in a Health System.

(1) "Administrative long-term care pharmacy ~~personnel~~ technician" means a pharmacy ~~personnel~~technician in a closed door long-term care pharmacy who performs administrative tasks not associated with immediate dispensing of drugs, without regard to whether the ancillary personnel is registered under chapter 18.64A RCW. Administrative tasks include but are not necessarily limited to medical records maintenance, billing, prepackaging unit dose drugs, inventory control, delivery, and processing returned drugs, in a long-term care pharmacy or other health systems settings.

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## Section 3 (1)

There should be consideration given to adding "stop date "(if applicable) to provide for clarity of an element of the chart order.

(1) A chart order shall be considered a prescription provided that it contains:

(a) the full name of the patient;

(b) date of issuance;

(c) name, strength, and dosage form of the drug prescribed;

(d) directions for use; ~~and~~

(e) an authorized signature~~.~~;

*(f)* a order stop date if applicable:

(i) if a written order, the order must contain the prescribing practitioner's signature or the signature of the practitioner's authorized agent (including the name of the prescribing Practitioner); or

(ii) if an electronic or digital order, the order must contain the prescribing practitioner's electronic or digital signature, or the electronic or digital signature of the practitioner's authorized agent (including the name of the prescribing Practitioner).

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## Section 3, (3)

To avoid limiting current reasonable and authorized practices in assisted living and community-based care settings, the commission recommends re-phrasing this section to state:

(3) Nothing in this chapter shall prevent ~~a licensed nurse, pharmacist or physician~~ an authorized credentialed employee of a long-term care facility from transmitting a chart order ~~on behalf of the authorized practitioner~~ pursuant to RCW 74.42.230, or transmitting a prescription on behalf of a resident to the extent otherwise authorized by law.

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## Section 3, (6)

To allow for more flexibility, the commission recommends re-phrasing this section to include a locked room as an option for stakeholders.

6) A pharmacy or pharmacist may provide a limited quantity of drugs to a licensed nursing home or hospice program without a prescription, for emergency administration by authorized personnel of the facility or program pursuant to a valid prescription. The drugs so provided shall be limited to those required to meet the immediate therapeutic needs of residents or patients and which are not available from any other authorized source in sufficient time to prevent risk of harm by delay resulting from obtaining such drugs from other sources. Such emergency kits shall be secured in a locked room, container, or device to prevent unauthorized access and to ensure a proper environment for preservation of the drugs.

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## Section 3, (7)

The commission recommends adding new language that states administration of drugs from supplemental dose kit must be pursuant to a valid prescription or chart order. Additionally, we recommend including a locked room as an option for storage of supplemental dose kits.

(7) In addition to or in connection with the emergency kit authorized under subsection (2), a licensed nursing home may maintain a supplemental dose kit for supplemental nonemergency drug therapy. Such supplemental dose kits shall be secured in a locked room, container or device to prevent unauthorized access, and to ensure a proper environment for preservation of the drugs. Administration of drugs from supplemental dose kit must be pursuant



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to a valid prescription or chart order.

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## Section 3, (9)

The commission is recommending that the pharmacy providing a partial medication supply be required keep a copy of the order or prescription and the amount dispensed, as well as notify the long term care pharmacy of the quantity provided.

(9) Shared pharmacy services may be used for, but are not limited to, the purpose of ensuring that drugs or devices are attainable to meet the immediate needs of residents of the long-term care facility or hospice program, or when the outsourcing pharmacy cannot provide services on an ongoing basis. Where a pharmacy uses shared pharmacy services to have a second pharmacy provide a first dose or partial fill of a prescription or drug order to meet a patient's or resident's immediate needs, the second pharmacy may dispense the first dose or partially filled prescription on a satellite basis without the outsourcing pharmacy being required to fully transfer the prescription to the second pharmacy. The supplying pharmacy must retain a copy of the prescription or order on file, a copy of the dispensing record (or fill), and must notify the Long Term Care Pharmacy of the service and quantity provided.

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## Section 3 (10)

Some pharmacy operators opposed the concept of return and reuse of medications, while others agreed. The Commission recognizes the importance of this issue and feels that additional rules would be necessary to provide for patient safety.

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## Section 4, (1)

The commission recommends adding a pharmacist operating under a CDTA or similar language.

(1) The resident's attending or staff physician or authorized practitioner approved by the attending physician shall order all medications for the resident. The order may be oral or written and shall be limited by time, unless specified as continuing in effect until discontinued by a physician or authorized practitioner. An "authorized practitioner," as used in this section, is a registered nurse under chapter 18.79 RCW when authorized by the nursing care quality assurance commission, an osteopathic physician assistant under chapter 18.57A RCW when authorized by the committee of osteopathic examiners, a physician assistant under chapter 18.71A RCW when authorized by the medical quality assurance commission, or a pharmacist operating under a Collaborative Drug Therapy Agreement.

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## Section 4, (3)

To avoid limiting current reasonable and authorized practices in long term care pharmacy, the commission recommends adding, "Nothing in this provision shall limit the authority of a licensed nurse, pharmacist, or physician to delegate to an authorized agent, including but not limited to delegation of operation of a facsimile machine by credentialed facility staff, to the extent consistent with his or her professional license."

(3) A licensed nurse, pharmacist, or another physician receiving and recording an oral order may, if so authorized by the physician or authorized practitioner, communicate that order to a pharmacy on behalf of the physician or authorized practitioner. The order may be communicated verbally by telephone, by facsimile manually signed by the person receiving the order pursuant to subsection (2), or by electronic transmission pursuant to RCW 69.41.055. The communication of a resident's order to a pharmacy by a licensed nurse, pharmacist, or another physician acting at the prescriber's direction shall have the same force and effect as if communicated directly by the delegating physician or authorized practitioner. Nothing in this provision shall limit the authority of a licensed nurse, pharmacist, or physician to delegate to an authorized agent, including but not limited to delegation of operation of a facsimile machine by credentialed facility staff, to the extent consistent with his or her professional license.

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## Section 5, (1) (c)

The commission recommends amending this section to read as follows:

(c) An explicit opportunity for practitioners must be made to indicate their preference on whether or not an ~~therapeutically~~ equivalent generic drug may be substituted. Nothing in this section shall limit the ability of practitioners and pharmacists to permit substitution by default under a prior-consent authorization.

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**Additional comments:**

## Section 3

There is reference to storing drugs in a "device." Currently in WAC 246-872-030, restocking of automated drug distribution device is limited to a pharmacist, pharmacy intern, or pharmacy technician. The commission pharmacy technology committee has heard requests by long term care pharmacies to consider allowing a registered nurse or licensed practical nurse to restock medications delivered to a long term care facility by a pharmacy. The commission would recommend rule authority to clarify additional requirements for training and product tracking by the providing pharmacy.

( 6) A pharmacy or pharmacist may provide a limited quantity of drugs to a licensed nursing home or hospice program without a prescription, for emergency administration by authorized personnel of the facility or program pursuant to a valid prescription. The drugs so provided shall be limited to those required to meet the immediate therapeutic needs of residents or patients and which are not available from any other authorized source in sufficient time to prevent risk of harm by delay resulting from obtaining such drugs from other sources. Such emergency kits shall be secured in a container or device to prevent unauthorized access, and to ensure a proper environment for preservation of the drugs. Registered nurses or licensed practical nurses may restock such devices to provide for patient access.

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Enclosure 3

## Additional Stakeholder Comments on Long Term Care Pharmacy

The following comments were provided by stakeholders and workgroup participants in the Commission process.

### CVSHealth

Thank you for providing CVS Health an opportunity to respond and provide comments regarding the Long-Term Care pharmacy statutory language project. CVS Health believes that these statutory changes and future regulations will enhance access to medications to the high-acuity elderly population residing in long-term care communities.

CVS Health and its subsidiary Omnicare, Inc. are the leading provider of comprehensive pharmacy services to residents of long term care facilities ("LTCFs") in the United States. Omnicare serves more than one million long term care residents in 47 states and the District of Columbia. It employs a number of experts on the dispensing of medication in various long-term care settings, as well as many consultant pharmacists who assist its LTCF and patient customers in understanding the impact of such medicines.

We will provide specific comments to the definitions requested and in the end of the document provide additional terms which the Long-Term Care sub-committee may wish to consider in its deliberation.

- **"Drug Orders"**: *CVS Health supports the use of the NABP model definition of "Chart Order" and accompanying definitions for pharmacies servicing Long-Term Care Facilities ("LTCFs"). CVS Health would not support a "duration of use" element in either statute or rule because: (i) LTCF patients are generally more "high acuity" which results in period turn-over, (ii) certain LTCF settings already require "short cycle medication pursuant to CMS requirements, and (iii) pharmacies attempt to work with LTCF settings to coordinate medication availability and duration based on tailored care plans through written policies and procedures.*
    - "Chart Order" means a lawful order entered on the chart or a medical record of an inpatient or resident of an institutional facility by a practitioner or his or her designated agent for a drug or device and shall be considered a prescription drug order provided that it contains:
        - the full name of the patient;
        - date of issuance;
        - name, strength, and dosage form of the Drug prescribed;
        - directions for use; and
        - if written, the prescribing Practitioner's signature or the signature of the Practitioner's agent (including the name of the prescribing Practitioner); or if electronically submitted, the prescribing Practitioner's electronic or digital signature.
    - "Institutional Facility" means any organization whose primary purpose is to provide a physical environment for patients to obtain health care services, including but not limited to a(n):
        - hospital;
        - Long-Term Care Facility;

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        - convalescent home;
        - nursing home;
        - extended care facility;
        - mental health facility;
        - rehabilitation center;
        - psychiatric center;
        - developmental disability center;
        - Drug abuse treatment center;
        - family planning clinic;
        - penal institution;
        - hospice;
        - public health facility; and
        - athletic facility.

    - "Long-Term Care Facility" means a nursing home, retirement care, mental care, or other facility or institution that provides extended health care to resident patients.

- **"Long-term care pharmacy"**: *CVS Health would recommend that the legislature and the Board of Pharmacy continue to license pharmacies under the same authority; however, in administrative rule making the Board of Pharmacy should be allowed to regulate pharmacies which service Long-Term Care Facilities in a manner consistent with the new statute and regulation. If the legislature or Board of Pharmacy were to support a specific definition and license status for a closed-door, LTC pharmacy it would severely limit pharmacies capabilities to service other patients outside of the LTCF setting.*

- **"Shared Pharmacy Services"** : *CVS Health supports the use and NABP definition of Shares Pharmacy Services. In addition, CVS Health believes that allowing shared pharmacy services can enhance patient care, reduce error rates, and allow pharmacists in the LTCF setting the ability to focus on patient needs.*

- **"Electronic Communications" & "Storage of Electronic Records":** *CVS Health encourages and is an adopter of electronic records. CVS Health supports the use of electronic prescriptions and electronic chart orders. We request that the legislature maintain a broad definition to account for the various electronic chart order vendors and capabilities. CVS Health supports any measure which would require that electronic records be compliant with DEA standards (21 C.F.R. 1311 et. seq.) and that records be "readily retrievable" for inspections related to the Board of Pharmacy, Department of Health , Medicaid Program and other relevant government oversight agencies.*

- "**Return and reuse of drugs**": *CVS Health supports the return and reuse of Legend drug products that are originally dispensed to an Institutional Facility in USP-approved blister packaging. CVS Health also wants to make the legislature aware that certain drugs that are returned for reuse or disposal may need to be destroyed in a manner consistent with federal and state hazardous waste environmental standards.*

- **"Pharmacist/ technician ratio"**: *CVS Health would support a proposal by the commission to clarify and correct the pharmacy technician ration to a 3:1 standard. Alternatively, CVS Health believes the legislature should provide the Board of Pharmacy broad authority to waive or change this standard under the Board of Pharmacy's rulemaking authority.*

- "**Transfer (satellite) doses**": *CVS Health supports the use of chart orders in retail pharmacy settings for the limited purpose of supplying non-controlled substance medication to residents of Institutional Facilities. The same pharmacy standards should apply to all pharmacies servicing LTCF or other Institutional Facilities. See Idaho regulation.*

- **"Facility formulary"**: *CVS Health supports the use of formularies in Institutional Facilities. Formularies allow for prudent management of drug costs and facilitate uniform and consistent medication therapy monitoring standards. CVS Health would ask that the legislature review a recent statute passed by the State of Colorado as reference to the benefit and use of facility formularies.*

    - http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont3/5C1A5B10580C113687257DDA007EA9E6?open&file=192_enr.pdf

- **"Automated devices"**: *CVS Health encourages the use of automation inside of its pharmacies and within LTCF settings. Any definition of automated device should be broad enough to encompass both type of automated functions. CVS Health would ask that the legislature review a recent definition promulgated by the State of Missouri in reference to automated devices.*

    - 20 CSR 2220-2.900 Automated Dispensing and Storage Systems…"(1) Automated dispensing and storage systems (hereafter referred to as automated system or system) are hereby defined to include, but are not limited to, mechanical systems that perform operations or activities, relative to the storage, packaging or dispensing of medications, and which collect, control, and maintain all transaction information…."

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## Phillip Luther RPh.
## Village Pharmacy Services

This very question was on my mind as I was driving home from the last meeting. I feel that it is paramount that the statute and rule changes that are being sought after only apply to Pharmacies that are closed door and practice only Long Term Care Pharmacy.

Definitions will be important.

What is a Long Term Care Pharmacy? I believe they should be closed door and specifically licensed by the state that way. Many retail Pharmacies "dabble" in Long Term Care. Our argument is they cannot provide the level of service that we do. Also I would be concerned about Retail using these statues inappropriately. (e.g. They have 20 Long term care patients so they feel they could use Long Term Care Tech ratios).
My thought is to specifically license LTC Pharmacy and the statue/rule changes apply to these Pharmacies only.

What is a Long Term Care Facility?
-Skilled Nursing
-Assisted Living
-Adult family home
-Hospice
-Home Care

What is a Long Term Care Patient?
-What criteria will be used to define these patients.

Once again I would like to commend the commission for this undertaking. It is very important work and will go a long way in improving patient care in the Long Term Care Setting.

I have a very well rounded perspective as I am fully engaged in both Retail and Long Term Care operations.

Greg Milanich

**"Long-term care facility"** means nursing homes licensed under chapter 18.51 RCW, assisted living facilities licensed under chapter 18.20 RCW, and adult family homes licensed under chapter 70.128 RCW. **Alternative:** "Long-Term Care Facility" means a nursing home, retirement care, mental care, or other facility or institution that provides extended health care to resident patients

**"Long Term Care Pharmacy"** means a place where the practice of pharmacy is conducted, properly licensed under the provisions of chapter 18.64 RCW by the Washington Pharmacy Quality Assurance Commission, servicing at least one long-term care facility".

**"Facility Formulary"** means a continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health that includes an ongoing process through which a Long-Term Care Facility establishes policies regarding the use of drugs, therapies, and drug-related products and identifies those that are most medically appropriate to best serve the health interests of a given patient population.

**"Chart Order"** means a lawful order entered on the chart or a medical record of an inpatient or resident of a Long Term Care Facility by a Practitioner or his or her designated agent for a Drug or Device and shall be considered a Prescription Drug Order provided that it contains:

a. the full name of the patient;
b. date of issuance;
c. name, strength, and dosage form of the Drug prescribed;
d. directions for use; and
e. the prescribing Practitioner's signature or the signature of the Practitioner's agent (including the name of the prescribing Practitioner). The signatures may be electronic or digital if electronically submitted.

**"Practitioner"** means a physician under chapter 18.71 RCW; and osteopathic physician or an osteopathic physician and surgeon under chapter 18.57 RCW; a dentist under chapter 18.32 RCW; a podiatrist under chapter 18.22 RCW; an osteopathic physician's assistant under chapter 18.57A RCW when authorized by the committee of osteopathic commissioners; a physician's assistant under chapter 18.71A RCW when authorized by the board of medical examiners; a registered nurse when authorized by the board of nursing under chapter 18.88 RCW, or a pharmacist under chapter 18.64 RCW.

**"Closed Door Pharmacy"** means a place where the practice of pharmacy is conducted, properly licensed under the provisions of chapter 18.64 RCW by the Washington Pharmacy Quality Assurance Commission, servicing a limited patient population and is not open for dispensing to the general patient population".

**"Shared Pharmacy Services"** means a system that allows a participating Pharmacist or Pharmacy pursuant to a request from another participating Pharmacist or Pharmacy to process or fill a Prescription Drug Order, which may include preparing, packaging, Labeling, Compounding for specific patients, Dispensing, performing Drug Utilization Reviews, conducting claims adjudication, obtaining refill authorizations, reviewing therapeutic interventions, and/or reviewing institutional facility orders.

**"Agent"** means in regards to drug orders is a licensed nurse, registered nurse or licensed practical nurse, acting on behalf of a practitioner to electronically or telephonically communicate inpatient drug orders to a Long Term Care Pharmacy.

**"First Dose Pharmacy'** means a pharmacy that has agreed with a long-term care pharmacy to provide limited drug doses for the immediate need for an inpatient in a long-term care inpatient when the long-term pharmacy is not able to provide in a timely basis.

**"Starter Kit'** means a supply of drugs that may be required to meet the therapeutic needs of patient and

not available from other authorized sours in sufficient time to prevent risk of harm to patients by delay resulting from obtaining from other sources. (Note: This can be used to replace Emergency and Supplemental Kits.)

**"Automated Pharmacy System"** is a mechanical system that performs operation or activities, other than compounding or administration, relative to the storage, packaging, dispensing, or distribution of drugs which collect, control, and maintain all transaction information.

**"Administrative Pharmacy Technicians"** means pharmacy support staff in a long-term care pharmacy that performs tasks not associated with immediate dispensing of drugs. Tasks include medical records, billing, prepackaing unit dose drugs, inventory control, and processing returned drugs.

**"Administrative Pharmacy Technicians"** means pharmacy support staff in a long-term care pharmacy that performs tasks not associated with immediate dispensing of drugs. Tasks include medical records maintenance, billing, prepackaing unit dose drugs, inventory control, and processing returned drugs.

**Current Labeling Requirements for Reference:**

Labeling of drugs.

(a) The label for each legend drug which is not dispensed in a unit dose shall have the name and address of the pharmacy from which the drug was dispensed; the prescription number; the physician's name; the resident's full name; the date of issue; the initials of the dispensing pharmacist; the name and strength of the drug; a controlled substances schedule, if any; the amount (e.g., number of tablets or cc's) of the drug dispensed, and the expiration date. In the case of a compounded drug which contains Schedule II or III controlled substances, the quantity of each controlled substance per cc or teaspoonful shall be shown on the label.

(b) In a unit dose drug distribution system, a clear, legible label shall be printed or affixed securely to each unit dose package. Each unit dose drug label shall include: the name, strength and, for each unit dose package, the dosage amount of the drug; the expiration date for any time-dated drug; the lot or control number; and controlled substances schedule number, if any. Each individual drug compartment shall be
labeled with the full name of the resident whose drug the compartment contains and the name of the resident's physician.

(c) Nonlegend drugs shall be clearly labeled with at least the patient's name, date of receipt by the facility, as well as display a manufacturer's original label or a pharmacy label if repackaged by the pharmacist. Nonlegend drugs supplied by the Long-Term care facility pursuant to WAC 388-88-050 need not be labeled with the patient's name.

(d) A label on a container of drugs shall not be altered or replaced except by the pharmacist. Drug containers having soiled, damaged, incomplete, or makeshift labels shall be returned to the pharmacy for relabeling or disposal. Drugs in containers having no labels or illegible labels shall be destroyed.

## Nursing Care Quality Assurance Commission (NCQAC)

As requested by the legislature[1], the Washington State Pharmacy Quality Assurance Commission (PQAC) held two Public Meetings in August 2015 to support the development of long-term care (LTC) pharmacy statutes. These Public Meetings continued previous stakeholder conversations that PQAC had launched in spring 2015.

Washington's legislature, PQAC, and the Nursing Care Quality Assurance Commission (NCQAC) recognize that licensed practical and registered nurses are central to the LTC workforce and play an essential, interprofessional role with practitioners and pharmacists in LTC settings. As a result, NCQAC participated in the Public Meetings and, in this document, contributes comments to support PQAC's development of statute recommendations for the legislature.

The comments in this document are focused to key areas where nursing scope and practice intersect with LTC pharmacy processes and practices to assure the delivery of safe, quality care.

NCQAC values collaboration with PQAC in this effort to address the need for LTC pharmacy statutes

aimed at supporting public safety.

[1](Engrossed Substitute Senate Bill 6052, § 219(11), Laws of 2015 3d sp. sess.)

## Driving Principles for Nursing Scope and Practice

- In order to support the health needs of the public safely and effectively, nurses must practice to "the full extent of their education and training" and as "full partners with physicians and other health care professionals . . . ." (Institute of Medicine [IOM], 2010a, p. 1)

- Washington's statutes and rules must continue to support and not restrict the scope, practice, and partnering ability of nurses working to the full extent of their education and training: "Scope-of-practice regulations in all states should reflect the full extent not only of nurses but of each profession's education and training. Elimination of barriers for all professions with a focus on collaborative teamwork will maximize and improve care throughout the health care system" (IOM, 2010b, p. 4)

- Nurses currently play a central role in assuring quality in LTC delivery, and health care's reliance on nurses' knowledge, judgment, and skill for quality care will only increase as our population ages; for the purposes of this document, "quality" care is defined as care that is safe, effective, efficient, timely, person-centered, and equitable (IOM, 2001, p. 6).

## NCQAC's Specific Comments

1. **Identify licensed practical and registered nurses explicitly as agents of the practitioner (prescriber)**:

   Licensed registered and practical nurses currently use their knowledge, skill, and judgment to act as agents of practitioners in all care settings and do so in accordance with Washington statute by either, "the executing of a medical regimen" (RCW 18.79.040[1][e]) or "aspects of the designated nursing regimen" (RCW 18.79.060) as prescribed by practitioners. Making this important nursing role explicit with regards to long-term care pharmacy statutes will assure clarity and prevent unnecessarily restrictive interpretations of nursing scope and practice.

2. **Use language that allows for the full scope and practice of nurses:**

   A. **As agents of the practitioner (prescriber) in transmitting practitioner orders to pharmacies, regardless of the means of communication or technology approved for use**: The application of nursing knowledge, judgment, and skill in transmitting practitioner orders to LTC pharmacies is not affected by--and should not be restricted by--the various means of approved transmission. Communication technologies are continually evolving and vary across long-term care sites. Nurses need to be able to use their full scope of practice to meet the care needs of residents in transmitting practitioner (prescriber) orders to pharmacies--whether those orders are taken and transmitted verbally, via fax, through electronic means such as an electronic health record system, or through evolving technologies that eventually receive approval for use,

   B. **With medication management in LTC settings, regardless of the approved system(s) for use:** Again, the application of nursing knowledge, judgment, and skill in implementing residents' medical regimen or aspects of their designated nursing regimen as prescribed by practitioners is

not affected by—and should not be restricted by—advancements in approved technologies, including Automated Drug Dispensing Devices.

C. **In the use of a chart or drug order as a prescription drug order with pharmacies:** Including this in statute captures a key workflow process that has been successful in LTC settings and that uses nurses' knowledge, judgment, and skill to support safety as well as quality (where quality is defined as care that is safe, effective, efficient, timely, patient-centered, and equitable). The specific recommendation here is to include in statute the National Association of Boards of Pharmacy's (NABP's) Model Rule definition for "Chart Order[2]" which PQAC currently has listed as "Drug Orders." The term "Chart Order" is preferable to "Drug Orders" because it is broader and inclusive of non-medication orders, such as those for equipment or devices. The ultimate intent with this recommendation is that the definition of "Chart Order" will work in concert with the explicit identification of licensed nurses as agents of the practitioner [prescriber], per NCQAC comment #1 above.

[2]"Chart Order" means a lawful order entered on the chart or a medical record of an inpatient or resident of an Institutional Facility by a Practitioner or his or her designated agent for a Drug or Device and shall be considered a Prescription Drug Order provided that it contains: (1) the full name of the patient; (2) date of issuance; (3) name, strength, and dosage form of the Drug prescribed; (4) directions for use; and (5) if written, the prescribing Practitioner's signature or the signature of the Practitioner's agent (including the name of the prescribing Practitioner); or if electronically submitted, the prescribing Practitioner's electronic or digital signature.

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Christin Scripa, PharmD
Providence Infusion and Pharmacy Services


Thank you for the opportunity to provide input into the issues that currently face closed door pharmacies in the State of Washington with regard to regulatory compliance. I have participated in each of the Kent/Seattle area meetings. The information I have documented below elaborates on the items that have been brought forth during these meetings. I felt that it might be helpful if there were specific examples given on the issues so I have provided some examples of the various types of orders we see in LTC pharmacy practice.

I realize that some issues may be best addressed at the Commission level, with the largest of the issues (orders vs prescriptions) addressed at the legislative level. My hope is that any issues addressed at the Commission level are also dealt with quickly.

1. Orders vs prescriptions – LTC facilities (SNF's) now have an acute patient care model for their TCU's (Transitional Care Units) and order processing needs to mirror what is done in the

hospital setting.

a. Samples of LTC orders attached -
   i. Handwritten chart orders
   ii. Computer generated version of orders done at the facility.
   iii. Hospital transfer order (facility admit nurse generally reviews these orders verbally with the admitting physician at the facility and notes verification on these orders with her name, name of verifying MD, date, time. These are then relayed to pharmacy for processing as prescriptions)
   iv. Coumadin flow sheet as order – it is standard for facilities to track INR and Coumadin doses on a sheet such as this. Use of this flow sheet as the order reduces risk of error since it is not "re-transcribed" as a separate chart order.
b. Two signature line requirement for Rx needs to be void for LTC setting – this is an archaic requirement designed to benefit pharmaceutical companies and should be eliminated from ALL Rx requirements (including retail), in my opinion. A statement such as "substitution permitted, unless otherwise noted" should suffice.
c. Quantity and refill number should not be required except for Controlled Substances. The "order" should stand as an open ended medication order that can be filled by a closed door pharmacy for as long as the patient is there or 1year (whichever comes first).
d. Nurses at the facility should be able to act as the agent of the prescriber for legend drugs.
e. Patient address and prescriber address can be readily retrievable from the pharmacy software and not required to be documented on the filed "order/prescription"
f. Length of term of an order entered as a prescription by pharmacy should be open ended (1year) since providers are required to renew orders at the facility on an ongoing basis and any changes would be routed to pharmacy as a new order. (see "C above)
g. Controlled Substance requirements should stand.
h. Faxing of C-11 scripts and partial fill of C-11 prescriptions for LTC facilities and Hospice patients should stand.
i. ALF and AFH – how will regulations relate to them? Definitely need to make the above changes for facilities licensed as true long term care; perhaps **certain components** of this should flow to ALF and AFH, but I don't agree that all should, given the credentials

of the staff in these settings. The focus of this 11order" vs 11 prescription" legislative re-write should be for facilities licensed as true Long Term Care facilities (in my opinion).

j. Pharmacy should be allowed to satellite medications from a retail pharmacy based on a prescription 11order" and law should specify number of 11days supply" you are allowed to satellite through an outside pharmacy

2. Automated dispensing cabinets -
   a. Should be allowed for storage and dispensing of emergency kit medications.
   b. Should be allowed for regular dose dispensing in those facilities which desire to have medications dispensed this way.
3. Re-packaging of medications - WAC 246-869-255



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a. Gap exists for VA patients who reside in ALFs if pharmacies are not allowed to repackage since VA does not currently offer this service. (confirmed by phone call to the local VA pharmacy 2 weeks ago)
b. There is reference to re-packaging of OTC medications in the current Extended Care Facility chapter. Legal interpretation needed - Is this allowed under current law? Can it be allowed in the future? This is one way family members try to save money.

4. Hospice -
   a. Hospice nurses should be able to act as the agent of the prescriber for relaying of prescriptions for Legend drugs even though they aren't employed by them. In discussion during one of the work group meeting, it appears that pharmacies have a different interpretation or have been told different things by inspectors in this regard so specific clarification in the rules/statutes should be made to address Hospice.
   b. Review and sign off of a medication profile by a Hospice provider should allow pharmacy to fill these medications as prescriptions (also order vs prescription issue). – see attached.
   c. Review and sign off of general comfort orders (OTC meds) by a Hospice provider should allow pharmacy to fill these medications as prescriptions. Due to the manner in which these items are billed, we actually fill OTC's as prescriptions. – see attached.
5. Return/ re-use of medications -
   a. Clarification on whether medication disposal by the dispensing pharmacy for ALF/ AFH patients is allowed. If they are classified as "Long term care" then it should be; Re-use would not be appropriate since some ALFs allow patients to store medications in their rooms, but "disposal service" by pharmacy is needed for these facilities. Same question for AFH's. It is extremely cumbersome for ALF/AFH facilities to dispose of medications if it cannot be done through the dispensing pharmacy.
   b. Re-use of medications for true LTC facilities should continue to be allowed. LTC facilities are typically reimbursed at a capitated rate by Medicare A for TCU patients. As a result, they are "at risk" financially for the cost of the pharmaceuticals dispensed to TCU patients. The return/ re-use regulation allows LTC facilities to recoup some of the money they have spent for TCU patients. We are in a period of declining reimbursement, yet it seems inspectors are making a heavy push through strict interpretation of the regulation to discourage closed door pharmacies from taking LTC facility returns.

Please let me know if you have any questions about any of my comments above or regarding the material samples that I have provided.

Again, thank you for the opportunity to participate in this process.

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# PHVSICIANS·. ORDERS..

SAMPLE LTC chart der

NAME
ROOM NO.
(DAI!SS)
GHPT
PHYSJClAfll

Drug larg1

| Date & Time | Another brand of drug identical in form and content may be dispensed unless checked ☐ | DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS | Nurse's Initials |
|---|---|---|---|
| 6/29/15 | Speech Pathology - Clarification - Order | | |
| | Diet: Regular Texture | | |
| | Thin liquids | | |
| | Meds as tolerated. | | |
| | No adaptive Equipment. | | |
| | → noted 6/29/15 | | |
| 7-27-15 | ✓ Miralax to PRN. | | |
| | ✓ Discontinue No. 2 tablets | | |
| 8/21/15 | DRO: diff RMP start xe_v | | |
| | ✓ Levaquin 500mg PO x 1 in AM if able to swallow for respiratory infection | | |
| | ✓ Tylenol suppository 650mg rectally Q4-6H PRN for pain/fever | | |
| | ✓ Morphine sulfate 20mg/mL - give 10-20mg SL Q hour PRN for SOB/dyspnea. | | |
| | T.O. Dr. Neeta Bhagat/Rachel Simons RN | | |
| | noted U-S2 0630 8/21/15 | | |



PLEASE!USE BALL,POINT-·PEN ONIY

SAMPLE ORDER SET FROM SNF AFTER ENTRY INTO THEIR COMPUTER SYSTEM



# PHYSICIAN ORDERS

| FACILITY | CYCLE START | CYCLE END |
|---|---|---|
| PROVIDENCE MARIANWOOD | 8/1/2015 | 8/30/2015 |

| DIO | ORDER DATE | ORDER CODE | TIME | ORDER TEXT | DESC. TEXT |
|---|---|---|---|---|---|
| | ********** | | | ********** | |
| | * Facility pharmacy service provider may utilize | | | * | |
| | * chart orders written for the patient as prescriptions. | | | * | |
| | * Orders are in effect for 60 days. | | | * | |
| | * Generic substitution is permitted unless otherwise | | | * | |
| | * specified. | | | * | |
| | ********** | | | ********** | |
| | 08/20/2015 | DIAB2 | ACES | Diabetic - Fingerstick BG BEFORE MEALS and at BEDTIME notify provider if blood sugars below 70 of above 400 | BG |
| 08/28/2015 | 08/20/2015 | MEDS | QHSFL | TUBERCULIN/PPD 5 IU/0.1 ML SOL (Tuberculin) Give 0.1ml Intradermal per facility protocol On 20th, 27th | Site |
| 09/05/2015 | 08/20/2015 | MEDS | BIDFL | VSL#3 CAP (Lactobacillus Combination Probiotic) 1 capsule Oral TWICE daily (flexible) for probiotic | |
| | 08/20/2015 | MEDS | Q12H | NYSTATIN 100000 U/GM POW (Nystatin) 1 application Topical under breast and groin every TWELVE hours for rash | |
| 08/29/2015 | 08/20/2015 | MEDS | Q6ATC | VANCOMYCIN 500 mg/10 ml (Vancomycin Hydrochloride) take 10 ml Oral every SIX hours for C-diff | |
| | 08/20/2015 | MEDS | QHSFL | GABAPENTIN 300 MG CAP (Gabapentin) 300 mg Oral at BEDTIME (flexible) for pain | |
| | 08/20/2015 | MEDS | BIDFL | CARVEDILOL 6.25 MG TAB (Carvedilol) 6.25 mg Oral TWICE daily (flexible) for hypertension hold for SBP below 100 | BP Sys BP Dia |
| | 08/20/2015 | MEDS | QD08 | LASIX 80 MG TAB (Furosemide) 80 mg Oral DAILY every 2 days for CHF HTN volume overload hold for SBP below100 | BP Sys |
| | 08/20/2015 | MEDS | QAMFL | LASIX 120 MG TAB (Furosemide) 120 mg Oral every 2 days in the morning for HTN CHF volume overload hold for SBP below 100 | BP Sys |
| | 08/20/2015 | MEDS | QD08 | OMEPRAZOLE 20 MG ECC (Omeprazole) 20 mg Oral DAILY for Acid Reflux | |
| | 08/20/2015 | MEDS | AC | HUMALOG 100 U/ML SUS (Insulin Lispro, Recombinant) 25 units Subcutaneous BEFORE each meal for diabetes | BG Site Units |
| | 08/20/2015 | MEDS | QD08 | JANUVIA 25 MG TAB (Sitagliptin Phosphate) 25 mg Oral DAILY for diabetes | |
| | 08/20/2015 | MEDS | QHSFL | LANTUS 100 U/ML SOL (Insulin Glargine, Recombinant) 50 units Subcutaneous at BEDTIME (flexible) for diabetes | BG Site Units |
| | 08/20/2015 | MEDS | QHSFL | LIPITOR 20 MG TAB (Atorvastatin Calcium) 20 mg Oral at BEDTIME (flexible) for hyperlipidemia TI- for simvastatin 40 mg po at bedtime | |
| | ********** | | | ********** | |

CONTINUED ON NEXT PAGE

Advance Directives:

| PPD 1 | PPD 1 Re | PPD 2 | PPD 2 Re | DNU/PNU | DNU/PLUV |
|---|---|---|---|---|---|

| PHYSICIAN | PHONE NO. | ALTERNATE PHYSICIAN | PHONE NO. |
|---|---|---|---|
| SWEDISH RESIDENTIAL, CARE TEAM | 2069171956 | | |

| DIAGNOSES | ALLERGIES |
|---|---|
| REHABILITATION PROC NEC; Functional digestive disorders, not elsewhere clas21 led.; '..lr...spec1 2d ftnc: on2:.. d:,orde.:· of i!itestine; INT INF CLS!'RDIN DE'CILE:: J.:.dber:es ;l:e:li:-:i:..s, 6ia.be'Ces lol.tth unspec1t1ed comp.1c3:. o1.. type 2'1.OF une.pec:i.).ed type, nor 3t.ar.ed as ur.c:..;;t.ro:. t:d; Rypex;t..cr s:...le | AUGMENTIN-LISINOPRIL-SULFA (SULFONAMIDE) |

| RECORD NO. | LOCATION | BIRTHDATE | AGE | ADMIT DATE | PAGE |
|---|---|---|---|---|---|
| | | | | 08/20/2015 | 1 |

# PHYSICIAN ORDERS

| FACILITY | CYCLE START | CYCLE END |
|---|---|---|
| PROVIDENCE MARIANWOOD | 8/1/2015 | 8/30/2015 |

| G/C | ORDER DATE | ORDER CODE | TIME | ORDER TEXT | DESC TEXT |
|---|---|---|---|---|---|
| | 08/20/2015 | MEDS | BIDFL | AMLODIPINE 5 MG TAB (Amlodipine Besylate) 5 mg Oral TWICE daily (flexible) for hypertension | BP Sys BP Dia |
| | 08/20/2015 | MEDS | QAMFL | ASPIRIN 81 MG chewable TAB (Aspirin) 81 mg Oral each MORNING (flexible) for CAD | |
| | 08/20/2015 | MEDS | BIDFL | FERROUS SULFATE 325 MG ECT (Ferrous Sulfate) 325 mg Oral TWICE daily (flexible) for Nutritional Supplement | |
| | 08/20/2015 | MEDS | BIDFL | VITAMIN C 500 MG TAB (Ascorbic Acid) 500 mg Oral TWICE daily (flexible) for Nutritional Supplement | |
| | 08/20/2015 | MEDS | QAMFL | VITAMIN D3 5000 IU TAB (Cholecalciferol) 5000 Iu Oral each MORNING (flexible) for Nutritional Supplement | |
| | 08/20/2015 | MEDS | BIDFL | CRANBERRY 475 MG CAP (Cranberry) 475 mg Oral TWICE daily (flexible) for Nutritional Supplement | |
| | 08/20/2015 | MEDS | QAMFL | VITAMIN B COMPLEX CAP (Vitamin B Complex) 1 capsule Oral each MORNING (flexible) for Nutritional Supplement | |
| | 08/20/2015 | MEDS | QAMFL | CITRACAL 950 mg (Calcium/Vitamin D) 950 mg Oral each MORNING (flexible) | |
| | 08/20/2015 | DIET | | Diet- Regular regular thin | |
| 08/31/2015 | 08/20/2015 | TREAT2 | SPEC | PPD Results As Specified On 23rd, 30th | Result |
| | 08/20/2015 | TREAT2 | | weekly skin assessment | |
| | 08/20/2015 | TREAT2 | | pt is on isolation for C-Diff | |
| | 08/20/2015 | TREAT2 | | monitor loose stool | Amount |
| 08/24/2015 | 08/20/2015 | TREAT2 | | daily weight update provider if weight up 3 lbs or more | |
| | 08/20/2015 | TREAT2 | | weight three times weekly notify provider when weight is up 3 lbs or more | Weight |
| | 08/20/2015 | TREAT2 | | encourage hydration | Amount Tot In |
| | 08/20/2015 | OTHER | | Referral- Physical Therapy evaluation and treatment | |
| | 08/20/2015 | OTHER | | Referral- Occupational Therapy evaluation and treatment | |
| | 08/20/2015 | MEDS | PRN | TYLENOL ES 500 MG TAB (Acetaminophen) equal to 1000 mg Oral PRN three times daily for Pain | Pain S |
| | ********** | ********** | ********** | ********** | |
| | ********** | ********** | ********** | ********** | |
| | ********** | ********** | ********** | ********** | |
| | ********** | ********** | ********** | ********** | |
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| | ********** | ********** | ********** | ********** | |
| | ********** | ********** | ********** | ********** | |
| | ********** | ********** | ********** | ********** | |
| | ********** | ********** | ********** | ********** | |

CONTINUED ON NEXT PAGE

Advance Directives:

| PPD 1 | PPD 1 Re | PPD 2 | PPD 2 Re | DNR/PNO | DNR/FLUV |
|---|---|---|---|---|---|

| PHYSICIAN | PHONE NO | ALTERNATE PHYSICIAN | PHONE NO |
|---|---|---|---|
| SWEDISH RESIDENTIAL CARE TEAM | 2063171956 | | |

REHABILITATION PROCNEC; Functional impairment disorders, nec; classified elsewhere; classified, unspecified; DIAGNOSES disorder of

ir.:.est:ine; INT INP CLSTRDIDM Df\:::IJ:..£; Diabe:ss 7ii8ll.i-r.us, diaber:es "..;ith unspecified ccmp2.icaLio0, type II or un.specif isO 1:yp2,.. not .st:at.ed as u:::iconr.ro=.led; Hypen::e:nslve

ALLERGIES

AUGMENTIN-LISINOPRIL-SULFA (SULFONAMIDE)

' 'iBJtr.!;0111S i..,"!;JA;GilF'.i>'GJMIT;Q.o.IJ!E'.';;| AfAc"

08/20/2015 2

REHABIL:::'A'"ION 13OC UEC; F'unc1:lona; eUge2:1ve d:se:rerE; '.:l D=
el'sewhe:t'e classif:ied, 'unspac:1'nad f1. ric-cio:1al diswrder cf intesrclnt:; INT
INF Cl.S!RDitJM DE CILE; Diabst-=s 'l'c:ll:i.t:..s, diabe1:es w1::h unspec f ied
c:ompl:cat..:.on, ;)DC II of
unspecified i:ype

| FACILITY | CYCLE START | CYCLE END |
|---|---|---|
| PROVIDENCE MARIANWOOD | 8/1/2015 | 8/30/2015 |

| ORDER DATE | ORDER CODE | TIME | ORDER TEXT | DESC TEXT |
|---|---|---|---|---|
| | | | ********** | |
| | | | ********** | |
| | | | ********** | |
| | | | * * | |
| | | | * Nurse's Signature: Date: 8/20/15 * | |
| | | | * * | |
| | | | * I have reviewed & approve of the residents plan of care. * | |
| | | | * | |
| | | | * Physician Signature: | |
| | | | ********** | |
| | | | 8/20/15 Admit | AHP |

Advance Directives:
PPD 1 PPD 1 Re PPD 2 PPD 2 Re DNU PNU DNU FLUV

| PHYSICIAN | PHONE NO. | ALTERNATE PHYSICIAN | PHONE NO. |
|---|---|---|---|
| SWEDISH RESIDENTIAL, CARE TEAM | 2063171956 | | |

| DIAGNOSES | ALLERGIES |
|---|---|
| | AUGMENTIN-LISINOPRIL-SULFA (SULFONAMIDE) |

SAMP HOSPITAL DISCHARGE ORDER

OVERLAKE MEDICAL CENTER

(f)OVERLAKE
Mb'DICAL ClHHCS

Patient Information

| Patient Name | Sex | DOB |
|---|---|---|
| | Male | |

Discharge Summaries by Julie Chuan, MD at 8119/2015 7:49 AM

Author: Julie Chuan, MD 8/19/2015 7:51 AM | Service General Medicine Note TIme: 8/19/2015 7:49 AM | Author Type: Physician Filed: Status: Signed

Editor: Julie Chuan, MD (Physician)
Ho.spit.al Medicine Discharge Summary

Patient: Date of Bili

Admission Oate: 8/15/2015 Discharge

Date: 8/19/2015 Consultations:
Patient Care Team:
Sigrid Barnickel, MD as PCP General (Family Medicine)
Amy Markezich, MD as Consulting Physician (Pulmonary Disease) Kier Jordan-Keith, ARNP as Nurse Practitioner (Anticoagulation) Philip W King, MD as Consulting Physician (Nephrology)
Michael Swistak, MD as Consulting Physician (Cardiology)
Thomas Hamilton. MD as Consulting Physician (Endocrinology)
Silas Talbot Marshall. MD as Consulting Physician (Orthopedic Surgery)

Admission Chief Complaint: right intertroc fx
Hip fracture

Discharge Diagnoses:
Acute right intertrochanteric hip fracture status post ORIF with gamma nail on 8/16/2015 Chronic kidney disease stage IV

**Past Medical History**

| Diagnosis | Date |
|---|---|
| • Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled | |
| • Unspecified hypothyroidism | |
| • Mixed hyperlipidemia | |
| • Atrial fibrillation | |
| • Unspecified urinary incontinence | |
| • Chronic kidney disease, stage IV (severe) | |
| • Allergic rhinitis, cause unspecified | |
| • Phlebitis and thrombophlebitls of other deep vessels of lower extremities | |

DRAFT

- Glaucoma
- Macular degeneration
- Neuropathy of leg
  *both legs*
- Hypertension
- History of blood clots
  *dvt in calf*
- Cancer
  *prostate and skin cancer*

Hospital Course:

"'mTis a pleasant 90-year-old gentleman who has chronic kidney disease stage IV, chronic atrial fibrillation on Coumadin, and diabetes who comes in after tripping and falling at home. He normally walks fairly well with a cane but is limited due to his breathing. He had some recent outpatient workup by hls cardiologist with a stress echo is benign and referred to his pulmonologist plans for pulmonary function tests in the near future. He does have chronic kidney disease stage IV which has been stable for the last 5 years according to his wife. In the emergency room his found to have a right intertrochanteric hip fracture and his admitted for surgical treatment.

He was seen by Dr. Silas Marshall in consultation and taken to the operating room the morning after admission. He had a gamma nail of the right hip without any immediate complications. Postoperatively hs is doing well and his pain was controlled. He is very limited with his mobility and will need aggressive rehabilitation.He's been cleared from the surgical standpoint and remains welghtbearing as tolerated. He has been referred over to Marionwoodd rehab for ongo1ng therapy.

Hls other issues including his chronic kidney was stable. He was given some Lasix and his potassium has remained stable as well as a dose of Kayexalate. No further intervention is warranted and his creatinine is stable at 3.5. He also has a fair amount of sinus congestion and was started on bronchodilators, Mucinex, and nasal saline. He'llfollowup with Dr. Markezich when he is more stable from a rehab standpoint to pursue pulmonary function tests were infurther evaluation. Echocardiogram was done recently as an outpatient with his cardiologist, Dr. Swistak which was negative. Hls coumadin will need to be adjusted for goal INR 2-3.

Discussed the plan of care with the patient and his wife and they're both in agreement with going to rehabHitation.

Discharge Medications:

Home Medication Instructions

Printed on:08/19/15 0751

| Medication Information | |
|---|---|
| acetaminophen (TYLENOL) 500 MG tablet<br>Take 500 mg by mouth every 6 (six) hours as needed for Pain (1 TAB AM THEN 1 TAB PM).<br>Do not exceed 4000 mg of acetaminophen/24 hours.<br>If 65 or older, do not exceed 3000 mg of acetaminophen/24 hours. | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| cholecalciferol, vitamin D3, 4,000 unit Cap<br>Take 1 capsule by mouth daily. | | | | | | | | | vitamin D deficiency |
| CYANOCOBALAMIN, VITAMIN B-12, Strength?<br>(VITAMIN B-12 ORAL)<br>Take 1 tablet by mouth daily. 1000 mcg | | | | | | | | | vitamin B complex deficiency |
| fluticasone (FLONASE) 50 mcg/Actuation nasal<br>2 sprays by Nasal route daily. | | | | | | | | | allergic rhinitis |
| FREESTYLE LITE STRIPS<br>TEST THREE TIMES A DAY | | | | | | | | | |
| furosemide (LASIX) 40 MG tablet<br>80 mg in AM and 40mg in the PM. | | | | | | | | | HTN |
| GLUC SU/CHONDRO SU A/VIT C/MN<br>(GLUCOSAMINE 1500 COMPLEX ORAL)<br>Take by mouth. As directed 500/400 | | | | | | | | | Supplement/ joint health |
| guaiFENesin (MUCINEX) 600 mg 12 hr tablet<br>Take 1,200 mg by mouth daily. | | | | | | | | | cough/congestion |
| insulin glargine (LANTUS) 100 unit/mL injection<br>3 units at bedtime SubQ | | | | | | | | | DM type II |
| insulin lispro 100 unit/mL InPn<br>8 units with breakfast and lunch and 6 with dinner SubQ | | | | | | | | | DM type II |
| latanoprost (XALATAN) 0.005 % ophthalmic solution<br>1 drop into affected eye every evening Both eyes | | | | | | | | | glaucoma |
| levothyroxine (SYNTHROID, LEVOTHROID) 112 MCG tablet<br>1 tablet by mouth every morning on an empty stomach once a day | | | | | | | | | hypothyroidism |
| lisinopril (PRINIVIL,ZESTRIL) 5 MG tablet<br>Take 5 mg by mouth daily. | | | | | | | | | HTN |
| loratadine (CLARITIN) 10 mg tablet<br>Take 10 mg by mouth 3 (three) times a week. | | | | | | | | | allergic rhinitis |
| magnesium hydroxide concentrate (MILK OF MAG) 2,400 mg/10 mL Susp | | | | | | | | | |

T-I

Hetty will clarify dose with provider

Hetty 8/19/15

| | | | | | | |
|---|---|---|---|---|---|---|
| ake 10 mls by mouth 2 (two) times dally. CHANGE TO PRN WHEN HAVING REGULAR BOWEL MOVEMENTS | | | | | | Constipation |
| omeprazole (PRILOSEC OTC) 20 MG tablet<br>Take 20 mg by mouth daily. | | | | | | GI protection |
| oxyCODONE (ROXICODONE) 5 MG immediate release tablet<br>ake 1-2 tablets (5-10 mg total) by mouth very 4 (four) hours as needed. | | | | | | pain 338 |
| paricalcitol (ZEMPLAR) 1 MCG capsule<br>~~Take by mouth daily~~ 1 po daily except 2 PO on Sundays | V/o per Hetty | 8/19/15 | | | | CKD Stage IV |
| peg 400-propylene glycol (SYSTANE) 0.4-0.3 % Drop<br>1 drop into affected eye as needed | Both eyes Pharmacy? | | | TWF PRN | per Hetty | dry eyes |
| polyethylene glycol (GLYCOLAX) 17 gram packet<br>Take 17 g by mouth daily. | | | | | | Constipation |
| pravastatin (PRAVACHOL) 20 MG tablet<br>Take 20 mg by mouth daily at bedtime. | | | | | | mixed hyperlipidemia |
| senna-docusate (SENOKOT-S) 8.6-50 mg per tablet<br>Take 1 tablet by mouth 2 (two) times daily. | | | | | | Constipation |
| senna-docusate (SENOKOT-S) 8.6-50 mg per tablet<br>Take 2 tablets by mouth 2 (two) times daily. | | | to house supply | | per Hetty OW 8/19/15 | |
| sodium bicarb-sodium chloride (NEILMED NASAFLO) Pack<br>by Nasal route daily as needed. | | | | | | allergic rhinitis |
| sodium bicarbonate 648 MG tablet<br>~~Take 650 mg by mouth.~~ 1/2 tablet daily (325mg) | (po) V/o per Hetty | 8/19/15 | | | | gastric hyperacidity |
| sodium chloride (OCEAN) 0.65 % nasal spray<br>2 sprays by Nasal route 4 (four) times daily. | | | | | | allergic rhinitis |
| UNABLE TO FIND<br>OTC pressure vision → "Preservision"<br>1 tablet po BID. | V/o per Hetty | 8/19/15 | | | | |
| warfarin (COUMADIN) 5 MG tablet | | | | | | |

warfarin 5mg

warfarin 5mg PO d.4

| Take 1 to 1 and 1/2 tablets PO daily or as directed by the anticoagulation clinic. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Next | INR | tomorrow | | |

No per Hetty 8/19/15

Verified with Dr. William McLee Jessica, RN 1:28pm

**~~Outpatient Followup Issues (including pending test results)~~:**
Coumadin oal INR 2-3 - stop subQ heparin when INR >2
Weight bearing as to ferat 6d bilateral L
Continue physical and occupational therpay

Significant Test Results and Procedures
Right hip gamma nail 8/16/2015

INR is currently 1.2. But no heparin order ?)
Hetty 8/19/15

Follow-up;
SIGRID BARNICKEL, MD (General) in 5-7 days
Dr. Silas Marshall in 10-12 days

Condition on discharge:
Exam significant for
Filed Vitals:

| | 08/18/15 0505 |
|---|---|
| BP: | 120/63 |
| Pulse: | 94 |
| Temp: | 37.2 °C (99 °F) |
| Resp: | 18 |
| Sp02; | 93% |

Add on order Heparin 5000 units/mL SQ 5000 units q12hr per Hetty 8/19/15 @ 4:00 pm

Constitutional: awake, alert, NAD, hard of hearing
HEENT: PERRLA bilaterally, neck supple Cardiovasc:
RRR, no m/r/g. DP pulses bilaterally
Respiratory: CTA bilaterally, good air movement throughout. No wheeze/rhonchi/rales GI:Abdomen
soft. non-tender, non-distended with 8Sx4. No rebound/guarding
GU: No CVA tenderness
Musculoskel: No joint effusion or deformity
Heme/Lymph: No edema. No bruising Neuro:
AAO x 3, moves all extremities well Skin: right
hip covered
Psych: Normal affect and mood Administrative

Data:

I certify that inpatient services for greater than two midnights were medically necessary for this patient.
Please see MD progress notes for additional information about the patient's course of treatment

CMS Core Measures:

WARFARIN MONITORING

**The warfarin flow sheet below authorizes pharmacy to dispense a quantity sufficient to allow the patient to get to their next INR draw date +1. Generic substitution permitted unless otherwise noted.**

**IMPORTANT:** Put a sticker with resident name and date of birth on lower left of page. Complete each item. Enter orders into physician's orders in addition to this flow sheet. Fax form to Providence Oral Dose Pharmacy after every PT/INR.

Diagnosis or reason for warfarin _____

INR goal range _____ Length of treatment _____

| Date of PT/INR | Current WARFARIN dose | INR Result | NEW Dose OR NO CHANGE | Next PT/INR | Provider name | Nurse Initials |
|---|---|---|---|---|---|---|
| | | | | | | |

Resident Name _____ Physician _____ Room # _____

DRAFT

Instructions for using the WARFARIN Monitoring Form

1. Put a sticker with resident name and date of birth in the lower left corner of the form.

2. Complete form and fax to Providence Oral Dose Pharmacy each time a resident has a PT/INR drawn.

2. Call the Physician or ARNP with the current WARFARIN dose **AND** the INR result. Enter the new dose or write "no change" after obtaining orders. (PLEASE NOTE: EACH NEW ORDER MUST HAVE A PHYSICIAN'S ORDER WRITIEN. THIS SHEET DOES NOT TAKE THE PLACE OF A NEW ORDER.)

PLEASE NOTE: if the following do not match, the sheet may not be complete. Check it carefully before calling the Physician/ARNP for orders.

- The "Next PT/INR" date and the "Date of PT/INR" on the next line should be the same.
- The WARFARIN dose ordered should be the same as the "Current warfarin dose" in the next line.

**SAMPLE CHARTING FOR WARFARIN MONITORING FORM**

Diagnosis or reason for warfarin: Atrial Fibrillation – 427.31 INR goal range: 2-3

Length of treatment:

Long term - indefinitely

| Date of PT/INR | Current WARFARIN dose | INR Result | NEW Dose OR NO CHANGE | Next PT/INR | Provider name | Nurse Initials |
|---|---|---|---|---|---|---|
| 7/16/13 | 3mg | 2.2 | No change | 8/13/13 | J. Smith ARNP | AB |
| 8/13/13 | 3mg | 3.3 | Hold today, then 2.5 mg daily | 8/16/13 | J. Smith ARNP | CD |
| 8/16/13 | 2.5 mg | 2.5 | No change | 9/10/13 | B.Jones, MD | EF |

Resident Name | Physician | Room #

DRAFT

## Agency Medication Profile

**Customer:**

PfVfdri H@pJc of SHttle

Pnividem.ie Hopiee S25 Pon11!.1a*Ave* N Ste

**Customer ID:** Sti!ttl$1, WA

**DOB:**

**Allergy**

No Known Allergy

| Current Medications | Ordered | Begin Date/Time | End Date/Time |
|---|---|---|---|
| **ACETAMINOPHEN 650** SUPP.RfiC'f C1mgory: NON-NARCOTIC ANALGESICS | 8/3/2015 | 8/3/2015 | |
| 1 SUF'P RECTAL Every 4 needed 11 | | S/3/2015 | |
| Order Notes; PAIN / , ONE SUPPREOTAI. YQ 4HRS AS NEEDED FOR PAIN/ FEVER **IN HOSPICE COMFORT KIT" | | | |
| Coverage: HS Provider | | | |
| ATIOP'n..i;;; UUATI: 1% DROii'!!'£ | 8/3/2015 | 8/3/2015 | |
| tegory: OPHTHALMIC PREPARATONS | | | |
| 12 DROPS Om!or Sub Ingul cWIII')I4 hO!JI'I ■ needed | | 8/3/2015 | |
| Order Notet: ..,=,_,,.. e.,.i,..,1t.i'.e., GMS ONE DROP FOR EXCESSIVE SECRETIONS. 1Nc;t<it::.JI\. t: NEXT BY 1 ORO UP TO MAX 4 DROPS EVERY FOUR HOURS AS NEEmED. *""IN HOSPICE COMFORT KIT"" | | | |
| Covemee:HS Prl'.lvidlllr | | | |
| CARVEDIL.OI Imf;l TABLET | 713112015 | 713112016 | |
| c1111tl1t:10lry: OTHE CAROIOVASCUI.AR PREPS | | | |
| 1 tab OR.Al 2 timaa cmily | | 7/31/2015 | |
| Order Notes: HTN | | | |
| Coverage: HS Patient | | | |
| **DULCOLAX 5 mg TABLET DR** | 7/31/2015 | 7/31/2015 | |
| Category: LAXATIVES | | | |
| 1 tab ORAL Daily, as needed | | 7/31/2015 | |
| Order Notes: constipation | | | |
| Coverage: HS Provider | | | |
| **GABAPENTIN 300 mg CAPSULE** | 7/31/2015 | 7/31/2015 | |
| Category: ANTICONVULSANTS | | | |
| 3 cap ORAL 3 times daily | | 7/31/2015 | |
| Order Notes: LE neuropathy pain | | | |
| Coverage: HS Provider | | | |

## Agency Medication Profile

Customer: Customer

| Current Medications | Ordered | Begin Date/Time | End Date/Time |
|---|---|---|---|
| HALOPl:RSOOL &>.G mia TMLl!T | 8/3/2015 | 8/3/2015 | |
| oati OfY: AiAAACTJCS-TRANQUL!ZERS | | | |
| 1.2 TASS Orlill or mma! or i1.1bUn9W1I 1hour a' 81312015 | | | |
| Qftir Notoo: TAKE 1 TAB PRN AGITATION OR NAUSEA. MAY INCREASE HOURLY !JOSE TO 2 TABS IF INEFFECTIVE, TO EXCEED flMG (10 &iibt) IN 12HR$ UNI..ESS INSTRUCTED HOSPICE. OK TO CRUSH «*IN HOSPICE COMFORT K!PI!r | | | |
| Coverage: HS Provide | | | |
| MCltimJIM A.O 2 mg TABUI!i | 7/31/2015 | 7/31/2015 | |
| caory: ANT!OIARRHSALS | | | |
| 1 b OAAl. Every 4 - 6 hours as needed 7/31/2015 | | | |
| Order Notes: loose stool, diarrhea | | | |
| Coverage: HS Provider | | | |
| LORAZEPAM 0.5 mg TABLET | 8/3/28/3/2015 | | |
| Category: ATARACTICS-TRANQUILIZERS | | | |
| 1-2 TABS or rlCtES !or Ev111ry 1 noo:i 8/3/2015 | | | |
| Order Nmes: TAKE 1 PRN ANXIETY. MAY HOURI..V OOSE TO 2 TABS IF INEFFECTIVE, NOT SXCSEO 4MG N 4 HOURS. OK TO CRUSH TAB 111 IN HOSPICE COMFORT KIT** | | | |
| Coverige: HS Providsr | | | |
| LOSARTAN POTASSIUM 10 mg •nlflill'.. | 1B12016 | 8131 2015 | |
| Omsory. ANTIHYPERTENSIVES | | | |
| 1 b IJ!ly | | 8/3/2015 | |
| Omer Nam: HTN | | | |
| CovergIll: Undmermlned | | | |
| MORPHNE IULFAT SOLUTION 100 mg/5 mL (20 mg/mL) | 8/3/2015 | 8/3/2015 | |
| ct1isi.:101rv: NARCOTIC AW\I..GIESIC | | | |
| 1.2 MML Omlor Sublfng1.u/11 Ev 1 hour u r!Hded 1/3/201! | | | |
| Notwo: TAKE 5MG AS NEEDED FOR PAIN OYSPNEA. MAY HOURI..Y DOSE TO 10MG IF AND THEN UP TO 20MG IF *'IN HOSPICE COMFORT !<IT" | | | |
| CUVIllmg: HS PI'O\ldeir | | | |
| M U..TIVITAMINS TABLET | 7131/2015 | 713112015 | |
| C1it111>go1ry: MULTMTAMINS | | | |
| 1tiab OAAL 011!1iy 71:3112011.5 | | | |
| Order NotN: 1>;Im11:111'!ln'1!"lt | | | |
| Coverag:HS Patlent | | | |

Prlaef: 8/4/2016 9:32:45AM

hU

DRAFT

## Agency Medication Profile

**Customer:** **Customer ID:**

| Current Medications | Ordered | Begin Date/Time | End Date/Time |
|---|---|---|---|
| NYSTATIN 1@l),00 1.mlL ORAL l!JSf<br>Cllni!'l'l'lIC!V. ANT!FUNGAI..S | 8/3/2015 | 8/3/2015 | |
| 5 ml ORAL 4 times daily<br>Coverage: Undetermined | | S/3/2015 | |
| OXYCODONE HCL 5 mg TABLET<br>Category: NARCOTIC ANALGESICS | 1l3l12015 | 1B1/2016 | |
| 1 tab ORAL Every 4 hours as needed<br>Order Notes: pain<br>Coverage: HS Provider | | 7/31/2015 | |
| PROCHLORPERAZINE MALEATE 10 mg TABLET<br>Category: ANTINAUSEANTS | 7/31/2015 | 7/31/2015 | |
| 1ttiil:i ORAL Every 8 hours as needed<br>OrderNomi: *nlv*<br>Covert191HS Pri.WldEir | | 7/31/2015 | |
| MVASTATIN 21:J mg TABLET<br>cat1 go1iy: L!POTROPICS | 7131/201$ | 713112015 | |
| 1tab At bedtime<br>Order Not!!!is: lower cl'loleetere1l<br>Gr.I, HS Patient | | 7B112015 | |
| VITAMIN D3 1,000 unit CAPSULE<br>Cateigory: FAT 1;1vi.vi:n c:: VITAMINS | 7/31/2015 | 7/31/2015 | |
| 1tap ORAL Dally<br>Notn: s1.1pp!ment<br>Ct:>Vrege; HS Pant | | 7/31/2015 | |

**Total Medications With 'Current' Status:** 16

I authorize that the above Hospice-covered medications are continued through Providence Hospice. This also serves as prescription authorization with substitution permitted by their designated pharmacy for up to one year.

Signature: X (Ying Cui, MD)

Date: X 8/4/15

**Printed:** i/412015 1l:rl:23AM
Pa111@3oU

DRAFT

HOSPIC

# Patient Information Facesheet

| | | | | | |
|---|---|---|---|---|---|
| **Patient ID:** | 00295383 | **Admission Type:** | HS | **Report Date:** | 08/04/2015 |
| **Admit ID:** | 00177162 | **Admission Status:** | Y | **Referral Date:** | 07/23/201 'i |
| **Pri"!:Y ;1ng:** | Englh | **Age:** | 68 | **Date of Birth:** | |

/ General omfort Ord d(t.) not supersede any current patient orders. These orders may only be activated after hOPTce rilirseasses ment and/or hospice nurse consultation.

Allergies : Maxzide

1. If primary care physician or nursing facility physician is unavailable, the Hospice Medical Director or designated replacement may assist in the management of the patient.
2. Medication Administration. May crush tablets and open capsules per policy.
3. May use liquid equivalent of the general comfort orders if patient is unable to swallow.
4. Fever: Acetaminophen 325 - 650 mg. PO/PR suppository every 6hours prn for temperature > 101
5. Mild/Moderate Pain: Acetaminophen 325 - 650mg. PO/PR every 6hours prn pain mild to moderate. Do not exceed 3000mg/24 hours from all sources, including but not limited to combination pain meds, cold preparations and sleep aids.
6. Dry, itchy eyes: Artificial tears to both eyes hourly p.r.n. for comfort
7. Heartburn: Aluminum 200mg/Magnesium 200mg/Simethicone 20mg-5ml. May give 10mls PO every 6 hours p.r.n. for epigastric burning. May increase to 20mls if ineffective.
8. Gas: Simethicone 80mg PO every 4 hours p.r.n. for gas. May increase to 160mg if 80mg is ineffective. 9. GI Upset: Ranitidine 150mg po bid for GI upset
10. Itching: Hydrocortisone 1% cream apply thin film to affected area four times daily prn for itching. 11. Dry Mouth: Artificial Saliva as needed for oral comfort
12. Cough: Guiafenesin 100mg/ Sml. Give 5 ml po q4h prn for cough. May increase to 10mls if Sml s ineffective
13. Loose Stools: After checking for impaction and adequate bowel sounds, may give Loperamide 2mg. Give 4mg with first loose stool, followed by 2mg after each loose stool, up to 16mg per day. Call attending for further instructions if no improvement within 48 hours.

Bowel Care

1. Begin laxative simultaneously with any opioid analgesic. 2. Senna 8.6mg one to four tablets by mouth up to 2 times daily as needed (Approx. 1 tab per each 15 mg oral morphine equivalent). May use liquid equivalent.
3. Polyethylene glycol. Dissolve 17g of powder ( 1 heaping teaspoon) in 4-8 ounces of beverage once daily as needed.
a. If no BM within 24 hours, may add Bisacodyl Smg by mouth.
b. If no BM within 48 hours, may add bisacod'tl 10 mg by mouth or 10 mg rectally daily as needed c. If no BM within 72 hours:
- Assess for impaction. If impacted may manually dis-impact and may use mineral oil and/or phosphate enema as needed
If not impacted, use Magnesium Citrate 8 oz. by mouth as needed.
- If bowel function still not satisfactory, consult Attending, Pharmacist or Medical Director for other options
- Do not administer rectal medications in neutropenic or thromobocytopenic patients without consulting with patient's attending or the Medical Director.
- If patient requires manual disimpaction, consider pre-treatment with analgesic or sedative.

Verbal orders received from Dr. Burnside 7/25/2015 )

SN Lee, Ellyn Minkyung MD 07/26/2015

Frequency

s:J

Order **Text:** Seattle

Plr';rex Order

C12nge dressing around catheter 2x/week or FRN for saturation. Drain 500 cc per week or up to every 3 d2ys for symptom relief. Do not drain more than twice weekly

SN Lee, Ellyn Minkyung MD 07/26/2015

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5"

DRAFT

Remarks Concerning Draft of LTC Document
October 2015
Nancy Hecox, PharmD CDP PRS
Commission Member

Thank you for the opportunity to prepare remarks concerning the WHCA draft for Long Term Care. It is my opinion that new legislation and rules are needed in the area of LTC and that LTC, NH, AH and Hospice should have distinct and separate rules as this health care model has evolved and moved away from the current rules.

I would like to voice some concerns, however that were put forward by the WHCA and WSPA. I want to voice the concerns of the largest group of stakeholders that did not get included in this process, the patient's of the state of WA. I believe it is my job as a Commissioner to stand fast and be this voice.

My first concern:

1. The opinion of the business and association are valuable, but not always an endpoint, and that research based evidence and inspection (real life, observable) information must be considered in our quest to protect the interests of our patients. It is paramount to gather all information from all sides to make the best possible decisions. The interests of the few do not fully provide a picture of the risk and complexity of our craft.
2. It is every pharmacist's nightmare to be caught in an error, to be pressured to meet business metrics and prescription quotas, to feel helpless and unsupported to provide patient care. Thus, this voice, the pharmacist employee must be considered as well even though they were left out of this process as well. Employee pharmacists tell me that they did not voice an opinion due to the threat of losing their jobs. They feel over burdened by a frantic workload and are worn out. They also hope that someone else will step in, and are just hopeful that the outcome is just and safe.
3. Legislative changes and rule writing must anticipate rapid technology advances so that these new laws are not obsolete in six months time. It is possible to envision the demise of the LTC industry, as this is just a distribution model. Perhaps the nursing home should have an HCE like license where they purchase their own drug supply, billing for the drugs they administer through ADDDS. Better patient care can be delivered by a set of rounding physicians and pharmacists who review each patient's chart at least 4 times per month. This is a cost effective and ensures safety for everyone.

Specifically:

1. Under section 2, concerning changing the tech ratio. **Research link**: http://www.pharmacytimes.com/news/pharmacisttechnician-ratios-require-more-evaluation It is unclear from the research noted in this article what the proper ration for pharmacist to technician exists that promotes patient safety while providing operational efficiency. Issues about the technician ratio and administrative tasks have been raised by pharmacies outside the LTC field, so the issue might become complex during legislative consideration. My concern, and observations from inspectors, confirm that the technician designated as "administrative", when slow, have stepped into the production line, moving freely back and forth. The ratio is in place to protect the patient ultimately, by easing the pharmacist's burden (interruptions in supervision). My employer has two pharmacy assistants in this position, performing administrative functions, and this seems to work quite well. I think this position is unneeded and becomes a burden on the employee pharmacist trying to manage workload. Remember, if the administrative technician has access to patient records and they edit override codes, etc, then they are in the production line and must be counted.

Under section 3, concerning Chart Orders. It is unfortunate that some companies continue to function under a paper based, handwritten, verbal order based system that is outdated and fraught with room for error. Everyone else must comply with EMR application. **Research link**: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3270933/ EMR systems support the seamless flow of information between providers, delivering a higher quality of care to patients. As noted in this article, the information needed in a "chart note" would be immediately available to the pharmacist, who would also see critical information for medication review that includes that patient's kidney and renal function status, the patient's current weight and critical lab values, chronic medical conditions and diagnoses. EMR supports pharmaceutical care clinical decisions in real time without the

problems of poor penmanship, and excessive phone calls to gather needed information for medication review. I have several concerns here. If the legislature sees fit to allow shared pharmacy services, then a "chart order" must contain the following information:

a. Patient's full name
b. Date of Birth
c. Allergies
d. Full name, strength and directions for use of drug order
e. Chronic medical conditions
f. Diagnosis for use of this order (now needed for pain medication)
g. Signature of prescriber in timely manner (2 days, as with hospital regs)

This shared pharmacy has no information on a new patient, and no way to gather this information. It would be impossible to responsibly fill any prescription without this information.

If this process does happen, it can only be used for legend drugs. For controlled substances, one must be sure that the practitioner actually issued the order. There is no system that exists with a "no signature" system, as it is fraught with loss of checks and balances inherently built in for safety.

Practitioners should have access via VPN to issue orders to send to the pharmacy and the ADDDs. This would make all of this discussion moot.

2. Also under Section 3, Shared pharmacies, satellite pharmacies : I have a concern about billing. Currently, the LTC pharmacy types up what looks like a transfer so the satellite pharmacy can fill a set amount of "starter doses". The satellite pharmacy treats this information as a transfer because they don't get a physician signature, and it looks like a transfer. They complete the order and bill the LTC for the doses. The LTC then generates a false prescription claim to the patient's insurance for the "starter doses", gets reimbursed and paid a dispensing fee. But they never actually dispensed this medication. Then immediately after this, they generate the real prescription for the remaining quantity, billing again. This seems like fraud to me, and is current practice.
3. Under Section 3, the return and reuse of blister packs. Current legislation in other states can be found at: **Current legislative regulations**: http://www.ncsl.org/research/health/state-prescription-drug-return-reuse-and-recycling.aspx There are restrictions designed to assure purity, safety and freshness of the products, but it is clear that most states allow some provisions for donating and prescription drug "recycling," "repository" or "redistribution" programs for unused medication. The FDA and EPA information can be found at http://www.fda.gov/drugs/drugsafety/drugintegrityandsupplychainsecurity/drugsupplychainsecurityact/ucm376829.htm Clearly, the legislature will have to consider federal law and rule. We must assure that medication that leaves the pharmacy control was stored correctly, not tampered with, was heated, contaminated, etc. And there are violations concerning invoices, documents, records as dictate by the Drug security supply chain act.
4. Under section 3, concerning e-kits, supplemental dose kits, and ADD devices: My concern is the resistance of institutions to implement the use of ADD devices. I understand that this seems cost prohibitive, but it I support the use of ADDs as a means to eliminate drug waste, secure medications, reduce costs, save time in providing medication dosages to patients and improve patient safety. Pharmacies should move from traditional bubble packaging to the use of ADDs. The use of ADDS eliminates the need for emergency drug kits, or tackle box like devices. Unfortunately, it is necessary to legislate for the future. A great reference can be found at: http://www.talyst.com/wp-content/uploads/Talyst_White_Paper_Medication_Waste_LTC.pdf

DRAFT

10/20/ 15

Fellow commission members:

Sorry my response is a little slow. After reading the comments and draft language, I have a few of my own.

I agree with much of what Chris B has said, with some differences:

1) "administrative techs": this is a backdoor process to increase the RPh/tech ratio. It has grave potential to decrease patient safety and we should never allow this under any circumstances. If stakeholders want more ancillary employees, then go the route to change the ratio. End of discussion. Anyone who has ever worked in a retail or hospital or HMO pharmacy (or a LTC pharmacy) knows how this will play out: you will have an increased number of VAs and VBs sending data to a lone RPh who will be overwhelmed and, eventually, make errors, some of which will be very serious. I've seen this in countless disciplinary cases.

2) "agent of a provider" I agree RNs and LPNs may transcribe provider orders, CNAs may not; it is practice beyond scope of credential.

3) "return of medication" I am extremely uncomfortable with taking back drugs from a different pharmacy. How do you know what the expiration date really is, how was the drug stored, did patient or patient's family have access to the drug, was the drug under the control of the facility at all times? Way to much risk to assume, in my opinion.

4) " patient stored data" ALL pharmacies (LTC, retail, etc) must have allergy and chronic conditions. LTC, due to their patient population, should have at least the basics of age, sex, SCr (so they can calculate the crcl). Most pharmacy systems can do allergy, DUR and therapeutic duplication.

Thanks, Gary Harris, R.Ph

Pharmacy Commissioner

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**From:** Roper, Joyce (ATG)
**Sent:** Tuesday, October 20, 2015 6:23 PM

**Subject:** FW: DRAFT LTC
**Importance:** High

In reviewing these attachments, I have a question about the recommendation in the draft statutory language to add the first three sections into chapter 69.41 RCW, the legend drug act. Since I expect long term care will also include controlled substances, placing the first three sections in chapter 69.41 RCW restricts the application of those three sections to legend drugs (not controlled substances). Controlled substances are regulated under chapter 69.50 RCW. Since the intent of this legislation seems to include controlled substances dispensed and distributed at long term care facilities, modifying the two association's proposal to add those first three sections into either chapter 18.64 RCW or creating a separate chapter, 18.64B RCW, would not restrict the application of those three sections to only legend (non-controlled) drugs and would better fulfill their intent.

Joyce