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ISMP
An ECRI Institute Affiliate

Acute Care ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

Two new Best Practices in the *2020-2021 Targeted Medication Safety Best Practices for Hospitals*

ISMP has released its ***2020-2021 Targeted Medication Safety Best Practices for Hospitals*** (www.ismp.org/node/160). The purpose of the ***Targeted Medication Safety Best Practices*** is to identify, inspire, and mobilize widespread, national adoption of consensus-based Best Practices to address recurring problems that continue to cause fatal and harmful errors despite repeated warnings in ISMP publications. The Best Practices, which are reviewed by an external expert advisory panel and approved by the ISMP Board of Trustees, are designed to be realistic and have already been successfully adopted by numerous organizations. Equally important, their implementation can vastly improve medication safety and reduce the risk of significant patient harm.

Two New Best Practices for 2020-2021

First introduced in 2014 with 6 Best Practices, the ***Targeted Medication Safety Best Practices for Hospitals*** are reviewed and updated every 2 years. The 2020-2021 list now comprises 16 Best Practices, including 2 new ones described below:

New Best Practice ⑮: Opioid Prescribing

Verify and document a patient's opioid status (naïve versus tolerant) and type of pain (acute versus chronic) before prescribing and dispensing extended-release and long-acting opioids.

- Default order entry systems to the lowest initial starting dose and frequency when initiating orders for extended-release and long-acting opioids.
- Alert practitioners when extended-release and long-acting opioid dose adjustments are required due to age, renal or liver impairment, or when patients are prescribed other sedating medications.
- Eliminate the prescribing of fenta**NYL** patches for opioid-naïve patients and/or patients with acute pain.
- Eliminate the storage of fenta**NYL** patches in automated dispensing cabinets (ADCs) or as unit stock in clinical locations where acute pain is primarily treated (e.g., in the emergency department [ED], operating room, postanesthesia care unit, procedural areas).

Best Practice 15 has replaced Best Practice 12, which focused solely on eliminating the prescribing of fenta**NYL** patches for opioid-naïve patients and/or acute pain, and eliminating the storage of fenta**NYL** patches in areas where acute pain is primarily treated.

New Best Practice ⑯: ADC "Override" Feature

a) Limit the variety of medications that can be removed from an ADC using the override function.

b) Require a medication order (e.g., electronic, written, telephone, verbal) prior to removing any medication from an ADC, including those removed using the override function.

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SAFETY briefs

Should the PillCrusher syringe be used for crushing tablets? In light of USP <800>, hospital pharmacy staff reported evaluating potential devices for pill crushing. One that stood out was the 60 mL PillCrusher syringe, which is an enteral syringe that can be used to crush and dissolve tablets while contained in the syringe. According to the manufacturer, this can also be used to administer medication directly to the patient (www.ismp.org/ext/343). The syringe can also be used for enteral irrigation. A YouTube video demonstrates how the syringe is used (www.ismp.org/ext/344).

The Welcon brand PillCrusher syringe by Nurse Assist is available through several

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Figure 1. Plunger's teeth broke when used with a hard-to-crush tablet.

Become an ISMP Fellow

ISMP fellowships can help you grow in your career and make major contributions to medication safety worldwide. ISMP is now accepting applications for three unique programs that begin this summer/fall—the **ISMP Safe Medication Management Fellowship**, the **ISMP International Medication Safety Management Fellowship**, and the **FDA/ISMP Safe Medication Management Fellowship**. The deadline for applications is **March 31, 2020**. For more information, including program descriptions and the application, visit: www.ismp.org/node/871.

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c) Monitor ADC overrides to verify appropriateness, transcription of orders, and documentation of administration.

d) Periodically review for appropriateness the list of medications available using the override function.

- Restrict medications available using override to those that would be needed emergently (as defined by the organization) such as antidotes, rescue and reversal agents, life-sustaining drugs, and comfort measure medications such as those used to manage acute pain or intractable nausea and vomiting.

Survey to Measure Baseline Implementation of New Best Practices

ISMP is conducting a short survey to get a sense of the baseline level of implementation of these 2 new Best Practices. We would appreciate your participation in this survey regardless of whether you have implemented the Best Practices. Please complete the survey online by **April 17, 2020**, by visiting: www.ismp.org/ext/350. The survey questions are provided on **page 6** for your review prior to taking the online survey.

Other Changes for 2020-2021

Five of the 2018-2019 Best Practices were revised or archived in 2020 (changes displayed in red font, when appropriate):

Best Practice ④: Pharmacy Dispensing in Oral/Enteral Syringes

Ensure that all oral liquid medications that are not commercially available in unit dose packaging are dispensed by the pharmacy in an oral syringe or an enteral syringe that meets the International Organization for Standardization (ISO) 80369 standard, such as ENFit. (Previously, the Best Practice called for pharmacy to dispense oral liquid medications in an "oral or ENFit syringe." The change was made should another ISO-compliant product become available.)

Best Practice ⑤: Dosing Devices that Measure Only in Metric Scale

Purchase oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale. In addition, if patients are taking an oral liquid medication after discharge, educate patients to request appropriate oral dosing devices to measure oral liquid volumes in milliliters (mL) only. (Previously, the Best Practice recommended supplying patients "with [or provide a prescription for] oral syringes, to enable them to measure oral liquid volumes in milliliters [mL]." The change was made because not all patients need a prescription, and the measuring device should only measure in mL.)

Best Practice ⑥: Glacial Acetic Acid

Eliminate glacial acetic acid from all areas of the hospital. (This Best Practice was archived because hospitals have shown progress in removing or replacing it with vinegar or commercially available diluted acetic acid to prevent accidental use.)

Best Practice ⑧: Programmable Infusion Pumps with DERS

a) Administer medication infusions via a programmable infusion pump utilizing dose error-reduction systems (DERS). (Previously, this Best Practice recommended administering "high-alert IV medication infusions" via programmable infusion pumps with DERS. The change was made to broaden the scope to all medication infusions. New elements [b, c, d, and bullet points—next page] added a metric component, reconciliation between the library and electronic health records [EHRs], and planning for interoperability.)

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medical equipment distributors. The pharmacy staff decided to try it out with a tablet that nurses found hard to crush—sodium chloride 1 g tablets (Westminster Pharmaceuticals). When they tried to crush the tablet per the manufacturer's instructions, the tablet "shredded" the plunger's plastic grinding teeth and some other plastic components, while the tablet was barely scathed (**Figure 1**, page 1). Incidentally, the syringe has a tapered tip used to connect with feeding tubes but is not ENFit compatible. It also has an orange cap that could be a choking hazard if the capped device is used for oral administration or if the cap is left at the bedside or around children.

The company warns against use for tablets that aren't supposed to be crushed (e.g., long-acting, enteric coated). Still, nurses who use these syringes may not know which tablets should not be crushed with this device. As healthcare organizations transition to ENFit, having a syringe that is not compliant, that cannot crush all medications, and where you might get plastic residue from the teeth seems to severely limit its usability and even create some danger. We, therefore, suggest using another type of pill crusher, and transferring the crushed tablet to a cup and/or ENFit oral syringe for dilution and administration.

Good communication between nurses and pharmacists is a must when dosage forms need to be altered (crushed) or changed (tablet to liquid). Some pharmacies assist nurses by crushing the tablets while in their unit dose packaging, using another means of preparing and packaging a crushed tablet dose, or replacing tablets with unit dose liquids when possible. Also, many tablets can be dispersed in water without the need for crushing, and drawn into an oral/enteral syringe, as with dry powder immediate-release capsule contents. In this case, the standard tip ENFit devices would work. ASPEN has a safe enteral nutrition practices document with a section on medications via feeding tube (Boullata JI, Carrera AL, Harvey L, et al. ASPEN safe practices for enteral nutrition therapy. *JPEN J Parenter Enteral Nutr.* 2017;41[1]:15-103), as well as a Guidebook on Enteral Medication Administration (www.ismp.org/ext/352).

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NEW b) Maintain a 95% or greater compliance rate for the use of DERS.

NEW c) Monitor compliance with use of smart pump DERS on a monthly basis.

NEW d) If your organization allows for the administration of an IV bolus or a loading dose from a continuous medication infusion, use a smart pump that allows programming of the bolus (or loading dose) and continuous infusion rate with separate limits for each.

- **Allocate resources for ongoing maintenance, updating, and testing of the software and drug library for all smart infusion pumps.**
- **Ensure drug library content is consistent with the drug information and nomenclature (e.g., drug name, dosing units, dosing rate) in the EHR.**
- **Plan for the implementation of bi-directional (i.e., auto-programming and auto-documentation) smart infusion pump interoperability with the electronic health record.**

Best Practice ⑪: Ingredient Verification Prior to Mixing

When compounding sterile preparations, perform an independent verification to ensure that the proper ingredients (medications and diluents) are added, including confirmation of the proper amount (volume) of each ingredient prior to its addition to the final container.

REMOVED: At a minimum, perform this verification for all high-alert medications (including chemotherapy and parenteral nutrition), pediatric/neonatal preparations, pharmacy-prepared source/bulk containers, products administered via high-risk routes of administration (e.g., intrathecal, epidural, intraocular), and other compounded sterile preparations that the organization believes are high-risk. (This bullet point was removed to broaden the scope of this Best Practice to all compounded sterile preparations.)

Prior Survey Results

Prior to releasing the ***2020-2021 Targeted Medication Safety Best Practices for Hospitals***, ISMP conducted a survey between June and July 2019 to measure progress with implementing the existing 2018-2019 Best Practices. These results were presented at the American Society of Health-System Pharmacists (ASHP) Midyear Clinical Meeting on December 11, 2019. In case you missed that presentation, we have provided an overview of the survey findings in **Table 1** (page 4). Most of the 347 survey respondents were from large US hospitals with more than 100 beds (78%). Approximately half of all hospitals had one or more full- or part-time medication safety officer(s) (MSO[s]). Hospitals with an MSO tended to report full compliance with the Best Practices more frequently than hospitals without an MSO, with one exception. Eliminating injectable promethazine from the hospital, Best Practice #13, has been fully implemented (36%) in hospitals WITHOUT an MSO more frequently than in hospitals with an MSO (28%).

Conclusion

Hospitals and health systems should focus their medication safety efforts over the next 2 years on these 2020-2021 Best Practices. The rationale for recommending the Best Practices, along with related ISMP publications and guidelines for additional information, can be found in the full document. Related documents that might be helpful to hospitals include Frequently Asked Questions (FAQs) (www.ismp.org/node/14369) and an Implementation Worksheet (www.ismp.org/node/1506). Also, please don't forget to complete our short survey (www.ismp.org/ext/350) on the 2 new Best Practices for 2020-2021.

Table 1 appears on page 4 — Best Practices >

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HIGH-ALERT

Teva look-alike labels. We have received several complaints about look-alike labeling with various Teva products. Since a recent product redesign, many of the company's generic medications look alike, which can lead to selection of the wrong medication from storage. Medications have also been placed in the wrong location, which can contribute to the potential for errors.

In the past week alone, ISMP has received two error reports regarding mix-ups between methotrexate 2.5 mg and medroxyPROGESTERone 2.5 mg (**Figure 1**). In one case, medroxyPROGESTERone was dispensed instead of methotrexate. The patient recognized the error after she got home, then returned the wrong tablets and exchanged them for the correct tablets. In the other case, a close call occurred when a methotrexate 2.5 mg stock bottle was

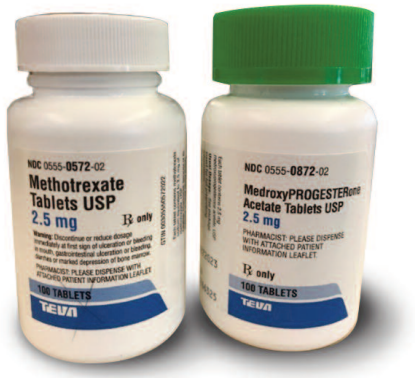

Figure 1. Complaints have been received about the similar appearance of labels on Teva generic products.

selected instead of a medroxyPROGESTERone 2.5 mg bottle when filling the prescription. Both are 2.5 mg tablets, and the drug names both begin with the letters "M-E" so the products are often stored near one another if stocked alphabetically. Also, the national drug codes (NDCs) are almost the same except one has a "5" and one has an "8," which may look similar depending on printing. The methotrexate cap is a different color, but caps may be interchanged, which increases the risk of mix-ups and potential product contamination from a hazardous drug (methotrexate).

The pharmacy that reported this has now placed one of the medications in a "fast mover" section to separate its storage, and they have also asked their pharmacy contracting source to request a different manufacturer for one of the medications.

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Table 1. Adherence with *2018-2019 Targeted Medication Safety Best Practices for Hospitals* (N=347)

Best Practice (2018-2019)		Adherence (%)			Common Barriers/Comments
		None	Partial	Full	
#1	Dispense vin**CRIS**tine in a minibag (adults)	5	7	88	Minibag shortage
	Dispense vin**CRIS**tine in a minibag (pediatrics)	9	7	84	Resistance, concern about extravasation
	Dispense other vinca alkaloids in a minibag	7	8	85	Lack of urgency
#2	Use a weekly dosage regimen default for oral methotrexate orders	19	13	68	Not on formulary so manual order entry required
	Require a hard stop verification (or clarification if a hard stop is not possible) of an appropriate indication for daily orders	30	25	45	Software inability; not a priority; part of a larger health system that is unwilling to change
	Provide education for patients discharged on oral methotrexate	26	37	37	Difficulty identifying patients discharged on oral methotrexate
#3	Weigh patients as soon as possible on admission/outpatient/ED encounter (avoid stated, estimated, historical weights)	3	54	43	ED not weighing all patients; using stated weights unless prescribed a weight-based medication
	Measure and document patient weights in metric units only	10	40	50	Beds/scales do not lock to metric units; EHR allows entry in pounds
#4	All oral liquid medications not commercially available in unit dose packaging are dispensed by the pharmacy in an oral/ENFit syringe	12	27	61	Shortage of large oral syringes; leaking oral syringes;syringes won't fit in ADC
#5	Purchase oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale	5	17	78	Availability and cost; hard-to-read marks on metric-only cups; OTC products with noncompliant dosing device
#6	Eliminate glacial acetic acid from all areas of the hospital (now archived for 2020)	8	7	85	Available for order through materials management; still in the lab
#7	Segregate, sequester, differentiate NMBs from other medications, wherever they are stored	4	21	75	Not segregated in the pharmacy, code trays, anesthesia trays/carts
	Eliminate the storage of NMBs in areas of the hospital where they are not routinely needed	2	11	87	Leadership/pharmacy has not made this a priority
	In areas where they are needed, place NMBs in a sealed box or, preferably, in a rapid sequence intubation (RSI) kit	7	21	72	Pushback from nurses in critical care regarding storage in sealed boxes
	Place labels on all NMB storage bins, ADC pockets, syringes, IV bags: "WARNING: PARALYZING AGENT—CAUSES RESPIRATORY ARREST—PATIENT MUST BE VENTILATED"	7	21	72	Auxiliary warning does not specify that the NMB will cause respiratory arrest or that the patient must be ventilated
#8	Administer high-alert IV medication infusions via a programmable infusion pump with DERS	1	14	85	Anesthesia noncompliance; bypassing the library; overridden alerts
#9	Appropriate antidotes, reversal agents, and rescue agents are readily available with directions for use, and protocols/coupled order sets allow their emergency administration	3	53	44	High cost of newer anticoagulant reversal agents; drug shortages; do not have standardized protocols and/or order sets for all antidotes
#10	Eliminate 1,000 mL bags of sterile water (for injection, irrigation, inhalation) from all areas outside the pharmacy	5	21	74	Purchased outside of pharmacy; still found in dialysis, NICU, procedural areas; shortages of 2,000 mL bags
#11	Independently verify the ingredient(s) and amount/volume *prior* to its addition to the final container of compounded sterile preparations	14	50	36	Only for certain drugs/pediatrics; cost/staff resources; bypassing IV workflow systems; verifying images afterward
#12	Eliminate the prescribing of fenta**NYL** patches for opioid-naïve patients and patients with acute pain (incorporated into new Best Practice #15 for 2020)	13	34	53	Exception for end of life palliative care; pharmacy monitoring all fenta**NYL** patch prescriptions but prescribers are resistant to changing orders
#13	Eliminate injectable promethazine from the hospital	38	30	32	IV minibag/IM use; nonformulary drug, still available; shortages of alternatives
#14	Seek out and use information about medication risks and errors that have occurred in other external organizations and take action	4	38	58	Insufficient staff resources; lack of a formal process; no sharing between facilities per legal

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Careful where you place those stickers!

To reconstitute **REVATIO** (sildenafil) suspension and generic equivalents, you need to loosen the powder, add 60 mL of water, shake, then add another 30 mL of water and shake again for a final volume of 112 mL. Unfortunately, in a recent report, it was mentioned that placement of pharmacy auxiliary labels on the outer carton of the product obscured part of the reconstitution directions—specifically, the part about adding another 30 mL of water (**Figure 1**). As a result, a pharmacy technician mistakenly reconstituted the product with only 60 mL of water instead of 90 mL total. The technician discovered the error the next day while reconstituting another Revatio oral suspension. The patient received one dose of the incorrectly reconstituted suspension before being notified. No adverse effects occurred.

The problem of pharmacy labels obscuring critical information on manufacturer product labels is important and something we have brought up before. For example, in one report, ropivacaine was ordered for epidural infusion, but it was infused intravenously (IV). A pharmacy label had been placed over a portion of the infusion bottle label that stated, "Not for intravenous administration," and the nurse infused it IV because it looked like other IV piggyback infusions. Pharmacists and pharmacy technicians must not obscure important information when auxiliary labels, price stickers, or other labels are affixed to medication containers.

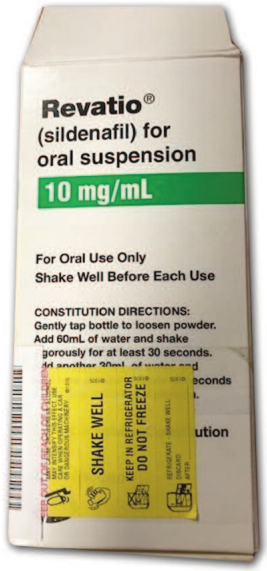

Figure 1. Auxiliary pharmacy labels obscured a portion of the reconstitution directions for Revatio oral suspension.

Methadone overdose linked to scanning the wrong barcode

Problem: An elderly patient received an accidental overdose of methadone. The patient was admitted to the hospital for pain management and was supposed to continue her home regimen of methadone oral solution 2.5 mg twice daily. During order entry, the physician was presented with a selection of methadone products including 10 mg tablets, 1 mg/mL oral solution, and 10 mg/mL concentrated oral solution. The physician did not see the 1 mg/mL oral solution choice and selected the 10 mg/mL oral solution. This required a volume of 0.25 mL per dose, which is hard to measure. A pharmacist verified the order but did not think to call the prescriber to change the concentration of methadone to 1 mg/mL.

For methadone maintenance, the pharmacy prepared batches of oral syringes (10 mg/mL), each containing 6 mL (60 mg of methadone total per syringe) to meet the needs of patients requiring higher doses. A barcoded label was attached to all batched oral syringes which, when scanned, alerts the nurse to administer the volume intended for the patient. When dispensed, the batched syringe is placed in a bag with an attached label stating the patient's dose and volume. An erroneous dispense code allowed a barcode to be printed on this patient-specific label. The process was for nurses to scan the barcode on the oral syringe (not on the patient-specific label affixed to the bag). The barcode system would then alert the nurse to administer the correct volume and dose from the batched oral syringe and to waste the remainder, if needed.

In this case, the nurse received the batched oral syringe, but instead of scanning the barcode on the syringe label, she scanned the barcode on the patient-specific label on the outer bag, which indicated the correct patient dose of 2.5 mg. Thus, the nurse was not alerted to administer just 0.25 mL of the syringe. Also, the syringe itself did not have a label on it to warn the nurse to administer only 0.25 mL (which would have been difficult to measure accurately using a 10 mL syringe). The nurse administered the full 6 mL (60 mg) of the concentrated oral solution.

The evening nurse, who was undergoing orientation, also administered a full 6 mL syringe for the second dose of the day. Instead of the intended 5 mg total daily dose, the patient received 120 mg of methadone that day—a 24-fold overdose. When a nurse preceptor asked about wasting the remainder of the oral methadone, the orientee said she had administered the entire syringe of medication. After realization of the error, the patient was transferred to the intensive care unit, started on a naloxone drip, and was monitored for the next 24 hours.

Safe Practice Recommendations: When prescribing methadone oral solution, the order entry system, not the prescriber, should automatically select the most appropriate concentration of the product based on the patient's dose. For example, if the dose is 10 mg or less, the system would default to a 1 mg/mL oral solution; if the dose is greater than 10 mg, the system would default to a 10 mg/mL concentration.

Particularly for an infrequently prescribed, high-alert medication like methadone oral solution, pharmacy-prepared oral syringes in patient-specific doses should be dispensed for inpatients, as nurses are often accustomed to believing that one syringe equals one dose. This would also reduce the amount of waste and the risk of diversion. The same is true for other oral high-alert medications in cups, oral syringes, and bottles of tablets. Whenever possible, one package should equal one dose.

If products must be batched, the barcode on the batched product should be the only available barcode for nurses to scan at the bedside. Thus, if the patient's dose is different than the amount in the batched container, the barcode system should alert the nurse to administer a partial dose. Also, be sure the standard dose of the batched product is as close as possible to commonly prescribed doses in your facility.

Special Announcements

ECRI-ISMP podcast: Stronger Together

ISMP President **Michael Cohen** and ECRI Institute CEO and President **Marcus Schabacker** recently recorded a podcast discussing the new affiliation between the two organizations and the impact they can have together to improve quality and safety. Both leaders are passionate about the opportunities that lie ahead and are excited about the potential to make an even bigger difference in patient safety worldwide. As they work on integration planning, the leaders are focused on bringing their Patient Safety Organizations together, expanding membership offerings, and enhancing educational programs to increase patient safety. To listen to the podcast, ***ECRI and ISMP–Stronger Together***, visit: www.ismp.org/ext/351.

Practitioner in Residence mentorship

Spend a week, **March 30** to **April 3**, being mentored by national medication safety experts as a **Practitioner in Residence** at ISMP's office in Horsham, PA. Participants will leave with resources to support ongoing safety efforts. To learn more, call 215-947-7797 or visit: www.ismp.org/node/13263.

FREE FDA webinar series

The US Food and Drug Administration's (FDA) Division of Drug Information is presenting a **FREE** webinar on **March 17**, ***FDA Drug Topics: Role of FDA and ISMP in Preventing Medication Errors***. For details, visit: www.ismp.org/ext/30, and to register, visit: www.ismp.org/ext/31.

To subscribe: www.ismp.org/node/10

ISMP Medication *Safety Alert!* Acute Care (ISSN 1550-6312)

Report medication and vaccine errors to ISMP: Call 1-800-FAIL-SAF(E), or visit www.ismp.org/MERP or www.ismp.org/VERP. ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

ISMP Survey on the Two NEW *2020-2021 Targeted Medication Safety Best Practices for Hospitals*

ISMP is conducting a short survey to get a general sense of the current level of implementation of the two new ***2020-2021 Targeted Medication Safety Best Practices for Hospitals*** (#15 and #16). We would appreciate your participation in this survey regardless of whether you have implemented the new Best Practices. Please complete this survey online by **April 17, 2020,** by visiting: www.ismp.org/ext/350. The survey questions are provided below for your review prior to taking the online survey. For a detailed description and exact wording of the two new Best Practices, visit: www.ismp.org/node/160.

General Demographics

1 Please select the one category that best describes the number of inpatient beds in your hospital, based on average daily census.
☐ Up to 25 beds ☐ 26-99 beds ☐ 100-299 beds ☐ 300-499 beds ☐ 500 beds and over

2 Please select where your facility is located.
☐ US/US territory ☐ US military foreign country/territory ☐ Other foreign country/territory

3 Does your organization employ one or more full-time or part-time medication safety officer(s)?
☐ Yes ☐ No

Survey

4 Please select the best option that reflects the status of the two new 2020-2021 Best Practices in your hospital using the KEY that follows. For None or Partial implementation of the Best Practices, please also provide comments about any barriers to implementation that you have encountered.

Key

None: This Best Practice has not been implemented
Partial: This Best Practice has been partially implemented (i.e., not all components have been implemented and/or have not been implemented in all areas and/or for all applicable patients or orders)
Full: This Best Practice is fully implemented in all areas and for all applicable patients or orders

New Best Practice 15 (2020-2021)	None	Partial	Full	Comments or Barriers to Implementation
Verify and document a patient's opioid status (naïve versus tolerant) and type of pain (acute versus chronic) before prescribing and dispensing extended-release and long-acting opioids.				
■ Default order entry systems to the lowest initial starting dose and frequency when initiating orders for extended-release and long-acting opioids.				
■ Alert practitioners when extended-release and long-acting opioid dose adjustments are required due to age, renal or liver impairment, or when patients are prescribed other sedating medications.				
■ Eliminate the prescribing of fenta**NY**L patches for opioid-naïve patients and/or patients with acute pain.				
■ Eliminate the storage of fenta**NY**L patches in automated dispensing cabinets or as unit stock in clinical locations where acute pain is primarily treated (e.g., in the emergency department, operating room, postanesthesia care unit, procedural areas).				

New Best Practice 16 (2020-2021) (Select NA [not applicable] ONLY if ADCs are not used at all in your facility)	NA	None	Partial	Full	Comments or Barriers to Implementation
Limit the variety of medications that can be removed from an automated dispensing cabinet (ADC) using the override function.					
Require a medication order (e.g., electronic, written, telephone, verbal) prior to removing any medication from an ADC, including those removed using the override function.					
Monitor ADC overrides to verify appropriateness, transcription of orders, and documentation of administration.					
Periodically review for appropriateness the list of medications available using the override function.					
■ Restrict medications available using override to those that would be needed emergently (organization-defined) such as antidotes, rescue/reversal agents, life-sustaining drugs, and comfort measure medications (e.g., for acute pain, intractable nausea/vomiting).					