InformRx

Clinical & Regulatory News By PharMerica

Long Term Care
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PharMerica®

Medication care, cost, and compliance at long-term care facilities are crucial to providing better patient outcomes. That's why the pharmacy experts at PharMerica offer InformRx, sharing the latest clinical and regulatory news, to help you focus on the health and quality of life of your long-term care patients.

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# Anticoagulant Safety in the Elderly

By Heather Hoyda, Consultant Pharmacist

A 74-year-old woman with a body weight of 55kg, CrCl of 24mL/min, and a history of atrial fibrillation and frequent falls is on an anticoagulant. This is a scenario often encountered in long-term care, where it is important to evaluate the resident's past medical history, current medications and diagnosis to determine risk versus benefit of anticoagulant use.

**Anticoagulant Use and Risks**

Anticoagulants are approved for use for post-surgical blood clot prevention, atrial fibrillation, acute myocardial infarction, cardiomyopathy, current or history of an embolism, mechanical prosthetic heart valve and valvular heart disease[1]. In the elderly population, there is increased risk of bleeding with use of anticoagulants due to co-morbidities, drug interactions and age[2].

Different classes of anticoagulants present with different risks, monitoring and dosing adjustments. When evaluating anticoagulant use, facilities should assess for risks including: bleeding/hemorrhage, age >65, frequent falls, cerebrovascular disease, history of GI bleed, hypertension, changes in dietary Vitamin K, malignancy, other anti-thrombic medications, interacting medications (ex. NSAID's, antibiotics, amiodarone) renal impairment, liver impairment, heart disease, mobility, recent surgeries, prior venous thromboembolic events and trauma.

Common signs and symptoms of bleeding may include elevated INR level, platelets <150,000, bruising, nose and/or gum bleeding, excessive bleeding from a wound, blood in urine, blood in feces, vomiting blood and hypotension[1]. On the other hand, common signs and symptoms of a blood clot include pain or tenderness of a lower or upper extremity, increased warmth and edema to an extremity, shortness of breath, chest pain, coughing, hemoptysis and anxiety[1]. It is important that residents and family members are educated on the signs and symptoms of bleeding and hemorrhaging.

**A Plan for Bleeding**

Facilities should plan for potential bleeding and hemorrhaging by evaluating, monitoring and having a process in place for how to handle these situations.

- *Warfarin:* While effective, Warfarin (Coumadin), a vitamin K antagonist, requires frequent INR monitoring to evaluate for appropriate dosing. INR levels should range from 2-3, except when treating an artificial valve levels should range from 2.5-3.5. Monitoring may be done as often as multiple times weekly to a minimum of monthly once stable.

Dose adjustments due to impaired renal or hepatic function are not necessary with Warfarin. However, since Warfarin interacts with many other medications and can be impacted by diet change, it is important to monitor closely when adding, adjusting or discontinuing medications.

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# Anticoagulant Safety in the Elderly

By Heather Hoyda, Consultant Pharmacist

When a new medication is initiated that can cause an interaction (e.g. antibiotic, amiodarone, or NSAID), it is vital to obtain an INR level. An elevated INR level means an increased risk for bleeding and may require additional monitoring, holding warfarin and/or administering a reversal agent ***(see chart below)[1].***

Vitamin K is an effective reversal agent for Warfarin and can be administered orally, subcutaneously or IV depending on severity. Facilities should have a system in place to ensure lab values, including panic values, are communicated to prescribers and acted on appropriately.

| INR | Symptoms | Recommendations |
|---|---|---|
| INR ≤0.5 over therapeutic range | No Bleeding | Continue current dose and check INR within 1-2 weeks |
| Above therapeutic but < 4.5 | No Bleeding | Reduce or skip dose. Monitor INR and resume warfarin at a lower dose if neede when INR is therpeudic |
| INR 4.5 - 10 | No Bleeding | If the patient has no other risk factors for bleeding, hold 1 or 2 doses. Monitor INR and resumer warfarin at a lower dose when INR is therapeudic. |
| INR > 10 | No Bleeding | Hold warfarin and give PO Vitamin K 2.5-5mg. INR should change within 24-48 hours. Continue to monitor INR frequently and give Vitamin K again if necessary. Resume warfarin at an adjusted dose when INR is therapeudic. |
| Elevated INR | Minor Bleeding | Hold warfarin. May give PO Vitamin K 2.5-5mg. Continue to monitor INR frequently. If INR is not therapeudic after 24 hours, repeat Vitamin K dose. |
| Elevated INR | Major Bleeding | Notify physician. Give four factor prothrombin complex concentrate and IV Vitamin K 5-10mg by slow infusion as necessary. |

*Chart 1*

- *Direct oral anticoagulants (DOACs):* This type of anticoagulant requires less monitoring, have a quicker onset and are more predictable than Warfarin, but reversal is less predictable. These medications include: the thrombin inhibitor dabigatran (Pradaxa) and the factor Xa inhibitors rivaroxaban (Xarelto), apixaban (Eliquis), betrixaban (Bevyxxa) and edoxaban (Savaysa).

Monitoring renal function is important when dosing DOACs, especially in the elderly population who are at higher risk of a bleed. DOACs commonly require dose adjustments based on indication, age, weight and renal function[3]. Bleeding is a risk when using DOACs, but reversal agents are available for certain DOACs in cases of severe bleeding or when emergency surgery is required ***(see chart below)[2].*** Idarucizumab (Praxbind) reverses the effects of dabigatran and andexanet alfa (Andexxa) reverses the effects of apixaban and rivaroxaban. Other off-label options to reverse DOACs include prothrombin complex concentrate (PTT) and activated prothrombin complex concentrate (aPTT), but these are unpredictable and may not be appropriate in emergency situations.

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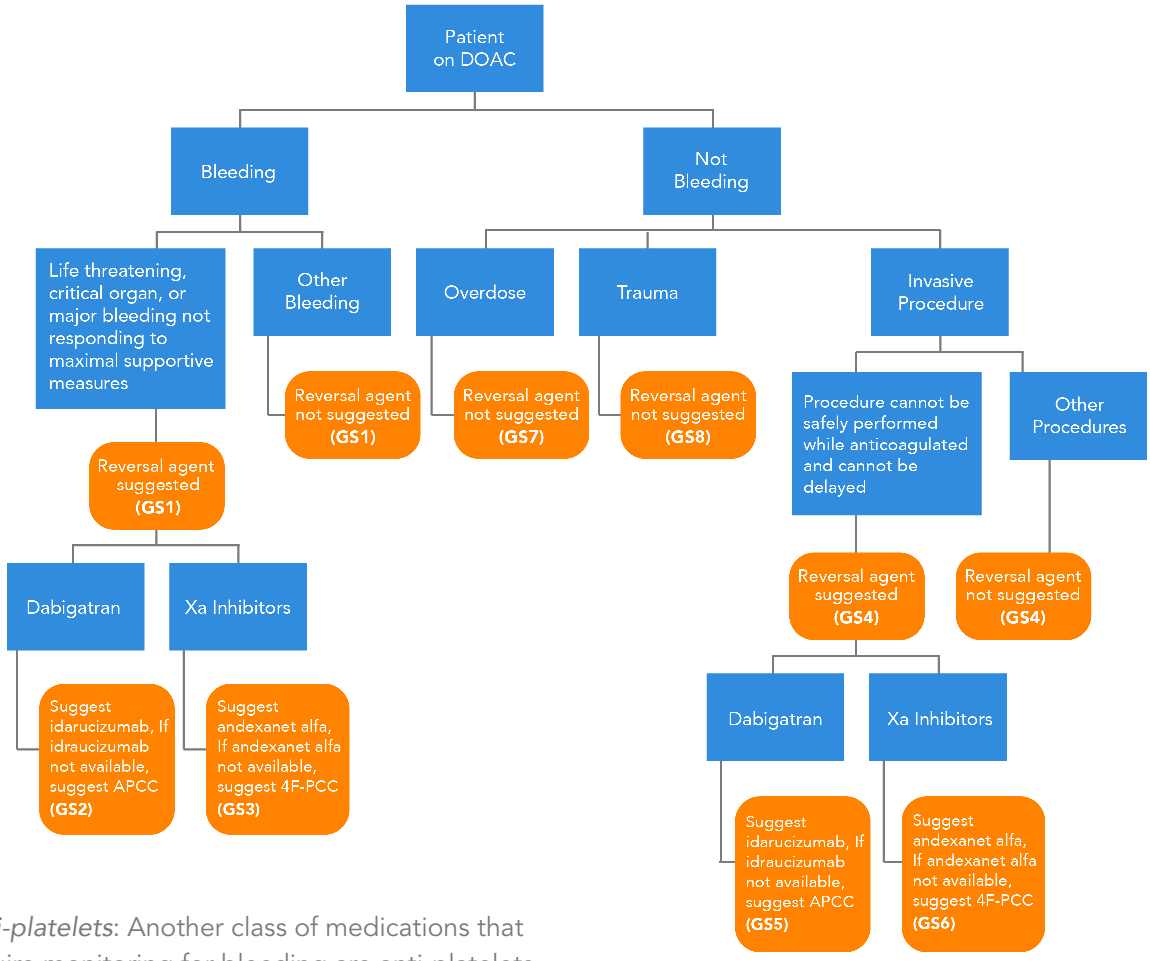
*Chart 2*




- *Anti-platelets*: Another class of medications that require monitoring for bleeding are anti-platelets. Anti-platelets, such as aspirin and clopidogrel (Plavix), are used to prevent platelet aggregation, decreasing the risk of blood clots. Indications for anti-platelets include: acute coronary syndrome, myocardial infarction, ischemic stroke and peripheral atherosclerotic disease[4]. Anti-platelets can be used in combination with an anticoagulant, although this increases the risk of bleeding. Monitoring for signs and symptoms of bleeding in the elderly is important when using anti-platelets, whether in combination with an anticoagulant or alone. Overall, anticoagulants are an effective treatment to many disease states. There are different options with different mechanisms of action, dose adjustments and ways to reverse effects. Due to the increased risk of bleeding in the elderly, it is important to monitor for signs and symptoms of bleeding and consider risk versus benefit of anticoagulant use.

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# F-756 and How It Can Ruin Your Survey

**Don Harrington, MS, RPh, *Consultant Pharmacist,* PharMerica**

During an annual survey, a facility can receive an F-756 (Drug Regimen Review[1]) citation if the recommendations from your Consultant Pharmacist have not been addressed appropriately. Unfortunately, if the irregularity noted by the pharmacist was related to a Gradual Dose Reduction (GDR) for a psychoactive medication, failure to appropriately address the recommendation could also lead to additional citations (F-757, F-758).

***"Irregularity"*** refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services.

According to the State Operations Manual, an irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy. (See reference to F757 Unnecessary Drugs which defines unnecessary drugs in opening regulatory language.)

**3 New Requirements**

The Phase I changes to the CMS regulations that took effect in November 2016 stated three new requirements for the review of psychoactive medications.

- *Psychoactive Medications Defined:* First, it defined psychoactive medications as, but not limited to, antipsychotics, antidepressants, anxiolytics and sedative-hypnotics. "Mood stabilizers," such as anticonvulsants, are usually considered psychoactives by the surveyors and, therefore, should be considered for GDRs when appropriate.
- *MRR Policies:* The second change was to develop specific policies and procedures for the monthly Medication Regimen Review. The main change was that irregularities found by the pharmacist are reported to the Attending Physician, Medical Director and Director of Nursing.
- *Review Timing:* The third new requirement addressed the time frame for review and appropriate filing of the completed review. The new rule states that the recommendations must be addressed by the attending physician, or their additional caregiver such as a CNP or PA, within a timeframe defined by facility policy. For example, the PharMerica policy and procedure manual states that recommendation response must be completed within 30 days while urgent,

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# F-756 and How It Can Ruin Your Survey

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high-priority recommendations must be addressed by midnight the following calendar day. Moreover, the completed recommendation must be kept in the physical chart or resident's electronic medical record, not just in a binder in the Director of Nursing's office. This type of binder can be used to store copies of the recommendations, but cannot not be the only storage method.

**Additional Citation Risks**

Further reading of the regulations reveal some other requirements that can lead to citations. An important example is the requirement that documentation be provided when the pharmacist's recommendation is not accepted. Specifically, the prescriber must supply appropriate clinical rationale for not accepting the recommendation; simply checking the "Disagree" box and signing the form without further documentation will, in most cases, lead to survey citation. Staff can support prescribers by reviewing responses to ensure a rationale is included and prompting them for additional information if it is not. This step will also help the timeliness of responses.

**Reasons Behind F-Tags**

In the three years since the Phase I changes were implemented, we have seen facilities receive F-756 citations for these reasons:

- recommendations were not addressed within 30 days
- recommendations were not filed in the resident's medical record after addressed
- prescribers did not provide adequate clinical rationale for not accepting the recommendation

In some cases, physicians only visit the facility once a month and refuse to address anything non-urgent before their next visit. Facilities may need to educate prescribers on the requirement and work with them to come up with a viable solution that still meets the intent of the regulation. Alternatively, the medical director can help resolve outstanding recommendations until the primary prescriber is able to review.

Another citation scenario to be aware of occurs when nursing documentation does not agree and shows few or no behavior events.

**Facility Best Practices**

We looked at facilities that have not received F-756 citations to try to find what they do differently than buildings with these citations. A few common themes were found:

- *Detailed Procedures:* Successful facilities have developed a detailed procedure based on the PharMerica Policy and Procedure manual with specific additions to fit their organization. The MRR process has many steps – simply printing the reports and putting them in the physician's folders is not a good plan. GDR requests require the clinical staff to discuss the resident and check the documentation in the chart. Notes can be added to the recommendation sheet. Ideally, someone meets with the physician to discuss the request and how a GDR could affect the resident. If the current dose is to be continued, the reason(s) why need to be documented, either on the recommendation sheet or in the physician Progress Note section.
- *Physician Reminders:* To address the physician who will not address anything non-urgent until the next visit, a brief note or phone call from the Medical Director or the facility Administrator may be required to remind the physician that caring for nursing home residents has additional regulatory requirements. These can sometime be considered urgent matters, even if the resident is not immediately clinically compromised.

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- *Medical Record Filing:* Once the recommendations have been addressed, make sure they are filed in the medical record as soon as possible. Remember, if a surveyor can find what they are looking for quickly, they often move on to something else. But, if they have to dig a little for what they need, they often find something else. If you are scanning documents into your electronic medical record (MRRs, labs, other outside documents, etc.), have a process to do it quickly and routinely. A stack of documents sitting in your Medical Records department waiting to be scanned is a disaster waiting to happen, and makes effective chart review difficult for all caregivers.

**A Checklist for a Successful MRR Process:**

- Make sure your Consultant Pharmacist communicates with you to schedule their monthly visit date(s). If possible, schedule the visit shortly before the physician's "usual" visit date(s).
- Establish a method to receive recommendations and reports (emailed to the DON, paper copies printed at the visit, etc.). All reports should be at the facility within 48 hours of the pharmacist's visit completion.
- Determine a point person to handle all the MRRs until they have been completely addressed. This individual does not have to be the DON. The Unit Managers are often good to lead this effort for the residents on their units.
- Discuss any recommendation request with the nurses who care for the residents every day to get good clinical data for the prescriber to consider.
- The point person (above) will discuss the recommendation and the resident's condition with the prescriber and help make the decision to accept the recommendation or continue the current regimen.
- If a medication change is indicated (recommendation accepted), the point person facilitates getting the new order written and transcribed that day.
- If a medication change is not indicated (recommendation not accepted), the point person makes sure the prescriber documents appropriate clinical rationale to justify continuing the current regimen.
- If a prescriber has not addressed the recommendation and the 30-day limit is near, the point person contacts the prescriber. The recommendation can often be addressed via telephone. If the prescriber refuses, the Medical Director and/or Administrator may need to get involved to ensure that the recommendation is addressed within 30 days.
- After the recommendation has been addressed, it must be filed in the physical chart or EMR. An additional copy can be kept in a pharmacy binder, but this cannot be the primary storage method.

A few easy steps can mean the difference between a successful survey and unnecessary frustration over an F-756 citation, which could lead to additional citations (F-757; F-758). Good luck!

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***F756***

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.45(c) Drug Regimen Review.

§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

1. Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
2. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
3. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

# To Crush or Not to Crush?

## By Jill Powers, RPh, PharMerica

Crushing medication has been a hot topic lately. And one of the biggest reasons is the rise in recent survey deficiencies related to F759/760 medication errors.

**Why crush?**

Why do we need to crush medications? The practice may be due to patient preference or need. Patients with an enteral feeding tube or who are physical unable to swallow medications whole require an alternative dosage form or modification of tablets and capsules. *The most common reason for this is a condition known as dysphagia.*

People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Dysphagia occurs most frequently when there is a problem with the neural control or the structures involved in any part of the swallowing process. The issue may be caused by a stroke or other nervous system disorder, cancer, surgery, injury or disorders of the esophagus. It can even be drug induced.

**Common Medications that Contribute to Dysphagia**

- Opioid Analgesics
- Antibiotics: Tetracyclines,
- Clindamycin, Sulfamethoxazole/TMP
- Ferrous Sulfate
- Potassium Chloride
- Bisphosphonates – ex. Alendronate
- Aspirin
- NSAIDS
- Steroids
- Antipsychotics
- Chemotherapeutic Agents
- Anticholinergic Agents

**When Not to Crush**

Although there are numerous reasons to crush medications, there are also many products that should not be altered *in any way.* Instead, consider changing to a liquid alternative if appropriate and available.

*Some common medications that should never be crushed are:*

*Extended Release Products:*

These medications are in a slow or modified released formulation. Usually, this is to slow the release of the drug so that the medicine is given less frequently. The other benefit of modified release products is that the concentration of the drug in the body goes up slowly and, therefore, reduces the chance of side effects. Since these products usually have a higher than normal amount of the drug within them, crushing destroys the delayed released mechanism and the whole dose will be released very quickly. This can cause unintended bolus dose delivery and potentially dangerous adverse effects. Any medication with ER, DR, XL, XR, SR, XT, XT, CD, LA, 24hr, or Slo- as part of its name should never be crushed. Instead, some of these products are

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capsules and they can be opened and contents sprinkled on soft food, but not chewed. Others can be cut in half (if they are scored), like Toprol XL. Check with your pharmacist if you are not sure.

*Mucous Membrane Irritation:*

Mucous membrane irritation is another reason a medication may be listed as "do not crush." The most common examples of this type of medication are Alendronate (Fosamax) and Risedronate (Actonel). Rarely will the benefits outweigh the risk of crushing these medications.

*Film Coated:*

Film coated tablets are other formulations that are on do not crush lists. A film coating is a very thin layer placed around the tablet often to protect the tongue from the flavor of the ingredients and also to protect the tablet from moisture and light. The film will break down with saliva and does not significantly affect the way in which the drug is absorbed in the body. While crushing these tablets may not seriously affect how the drug is released, it may cause the resultant mixture to be unpleasant to taste. Examples of this type of medication are Cardizem (diltiazem), Paxil (Paroxitene) and some Ferrous Sulfate preparations.

*Enteric Coated:*

Unlike film coating, enteric coated tablets should never be crushed. They have a polymer coating on it that is designed to hold the tablet together in acid conditions (through the stomach) and break down in the alkaline conditions of the intestines. These medications often begin with EC- or EN-. Omeprazole and EC ASA are the most popular medications in this class.

*Lozenges and Effervescents:*

Sublingual, buccal, lozenges and effervescent medications should not be crushed because it will decrease the medication's effectiveness.

*Manufacturer Recommended:*

For this last category, there is no particular reason; however, the manufacturer recommends in their package insert that it not be crushed. Vesicare (Solifenacin) is an example.

**Overriding Crushing Recommendations**

While some medications "should not" be crushed, depending on the situation, it may be determined that it is in the resident's best interest to have the medication crushed. If a medication is listed on the Institute for Safe Medication Practices (ISMP) list at https://www.ismp.org/recommendations/do-not-crush, PharMerica's Do Not Crush List, the National Institute for Occupational Safety and Health's (NIOSH's) list, or if the manufacturer recommends not crushing a medication, then it needs to be reviewed if it is not being given whole.

If, after discussing the benefits versus risks of crushing the particular medication with the pharmacist and physician, it is determined that the resident will receive the medication crushed, documentation is essential. A progress note should be entered in the medical record with the reason to crush and additional information added to the medication order's instructions: "crush per MD – see supporting note."

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There should be a system in place to easily identify who received medications crushed by having the prescriber and/or consultant pharmacist note that resident cannot swallow medications whole and medications were reviewed for appropriateness of crushing.

**Other Considerations When Crushing**

In addition to do not crush lists, there are other situations in which special care must be taken. These include:

- *Hazardous Drugs:* Hazardous drug, as defined by NIOSH, need special care if they are being crushed in order to protect staff from exposure. USP 800, updated in December 2019, offers ways to protect staff from hazardous drugs. In addition, PharMerica has provided information to help you develop policies regarding safe handling of hazardous medication. Surveyors are being trained on USP 800 and the need to have appropriate PPE (personal protective equipment) when crushing hazardous medications so it is important to have procedures in place.
- *Crushing Multiple Medications:* If a resident is receiving multiple medications crushed together, there should be documentation in the care plan to support this practice, which should be updated as resident's condition changes. According to CMS regulations, "best practice would be to separately crush each medication and separately administer each medication..." They continue with their guidance to surveyors stating, "However, separating crushed medications may not be appropriate for all residents and is generally not counted as a medication error unless there are instructions not to crush the medication(s). Facilities should use a person-centered, individualized approach to administering all medications. If a surveyor identifies concerns related to crushing and combining oral medications, the surveyor should evaluate whether facility staff have worked with the resident/representative and appropriate clinicians (e.g., the consultant pharmacist, attending physician, medical director) to determine the most appropriate method for administering crushed medications which considers each resident's safety, needs, medication schedule, preferences, and functional ability." Based on this, the days of having standing orders of "may crush medications if not against pharmacy guidelines" are over.
- *Medications with a Narrow Therapeutic Index:* Drug loss is frequently observed when tablets are crushed, such as powder spilled or left behind in the plastic bag. Therefore, medications with a narrow therapeutic index, as well as critical dose drugs, should be noted if they are being crushed. Although the manufacturers do not state medication cannot be crushed, the prescriber should be aware if it is not being given whole since the difference of how much medication is left on plastic pouch or cup could be significant. In a 2018 study comparing crushing devices with disposable bags, between 2.1% and 13.3% (average 6.6%) of the drug was lost. Digoxin, Synthroid and Coumadin are common medications in this category. If possible, consider giving these medications whole in pudding/applesauce or commercially available products like Assure Slide.

*As a reminder, F-Tags F759 and F760 require medications to be administered according to "accepted professional standards and principles … include the various practice regulations in each state, and current commonly accepted health standards established by national organizations, boards, and councils." Inappropriate crushing of medication can result in either of these deficiencies during survey. Your consultant pharmacist is a valuable resource in guiding you through these regulations.*

***Sources***


- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-FAQs.pdf
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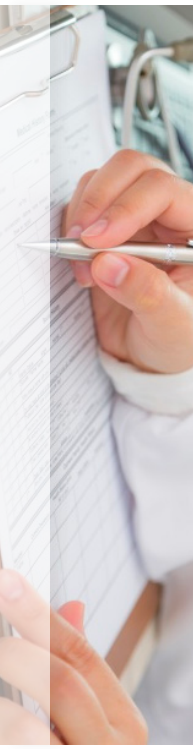
- http://ispub.com/IJORL/1/2/13059
- https://www.ismp.org/recommendations/do-not-crush
- https://www.the-hospitalist.org
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5832315/


# Reducing Transcription Errors

By Madonna Neumann, Consultant Pharmacist, PharMerica

The accuracy of medical transcription is a leading priority in pharmacy today. Transcribing medication orders includes taking a physician's prescription order and transferring it to a medication administration record. In order to maintain accuracy — **there is a simple** two-step **transfer process:**

1. The licensed practitioner writes the medication order.
2. The person transcribing the order must make sure it is complete, with all the information needed:



- the date
- name of resident
- name of medication
- dosage form of medication
- how to take it
- how much to take
- how often
- the stop date
- reason for use
- practitioner signature

**Common Transcription Errors**

Despite this established transfer process, sometimes medication errors related to transcription occur. These fall into four major areas:

## 1 *Illegible handwriting*

Illegible handwriting can originate from the physician or nursing staff. Common errors involve words that seem similar, but have different meanings such as drug names like Lovenox instead of lovastatin. Grammar or spelling mistakes can also be misinterpreted in transcription of the order. Homophones, or words that sound alike, can also cause errors. Simple words like "can," "and," or "an" could be mistaken for each other, causing inaccurate transcription.

## 2 *Decimal errors*

To minimize decimal errors during transcription, always use a leading zero for dosages less than one. For dosages greater than one, do not use a trailing zero.

## 3 *Misused abbreviations:*

To avoid errors, use abbreviations as little as possible. Frequency of doses should be written out. Avoid using some abbreviations like "cc" which could be "mL" or mistaken for "u" (units). The use of "H.S." could be half strength or at bedtime, so it should be completely written out. Lab order abbreviations also need to be monitored. A request for "BMP" could easily be mistaken for "BNP."

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# Reducing Transcription Errors

By Madonna Neumann, Consultant Pharmacist, PharMerica

## 4 *Incorrect dosages:*

Incorrect dosage of medication errors also need to be monitored. Be alert to large dosages, which are doses more than 1,000. Use commas like that in "1,000," or words for doses over 1,000.

### Minimizing Risk

To avoid transcription errors, there are several steps providers can take.

- *Staff education:* Nurses need to have adequate information about the drug being administered. Several preliminary questions should be asked, including:
  - Along with name of the drug, what are its indications and normal dosages?
  - What are the drug precautions and contradictions?
  - What are drug/food and drug/drug interactions?
  - How should medication be administered?
- *A policy for high-alert medications:* Staff needs to be proficient on which medications are considered high risk and be aware of the facility's policies and checklists that need to be followed. Commonly used high-risk medications in long-term care include anticoagulants, insulin, opioids, antibiotics, and medications used for chemotherapy.
- *Setting considerations:* Transcription of orders should be done in a well-lit quiet area, if possible, away from the distractions of the nurses' desk. Be sure to clarify orders with the practitioner before they leave the nursing unit and also check that they are complete or require any monitoring.
- *Review process:* Make sure there is a system in place to check the transcribed orders, especially one that involves a fresh set of eyes. Active orders need to be checked against the medication administration record then a double check should be done by a second person. High-risk medications should get extra attention. In addition, when administering medication, nursing should read the entire order multiple times to make sure it is correct and appropriate for the resident. Question orders that do not seem right to you and get clarification to ensure everything is correct. When order and medication changes occur, be sure to discontinue the old order and transcribe new one and transfer it to the MAR.

***Improper transcription accounts for about half of the adverse reactions in patients. The ability to transcribe medication orders correctly is of the utmost importance, so your work and effort should reflect that.***

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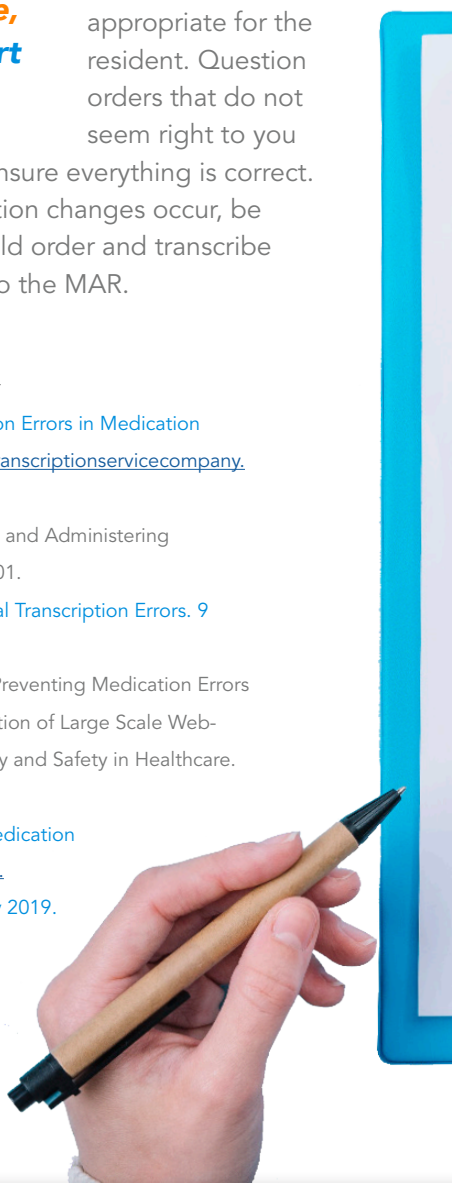
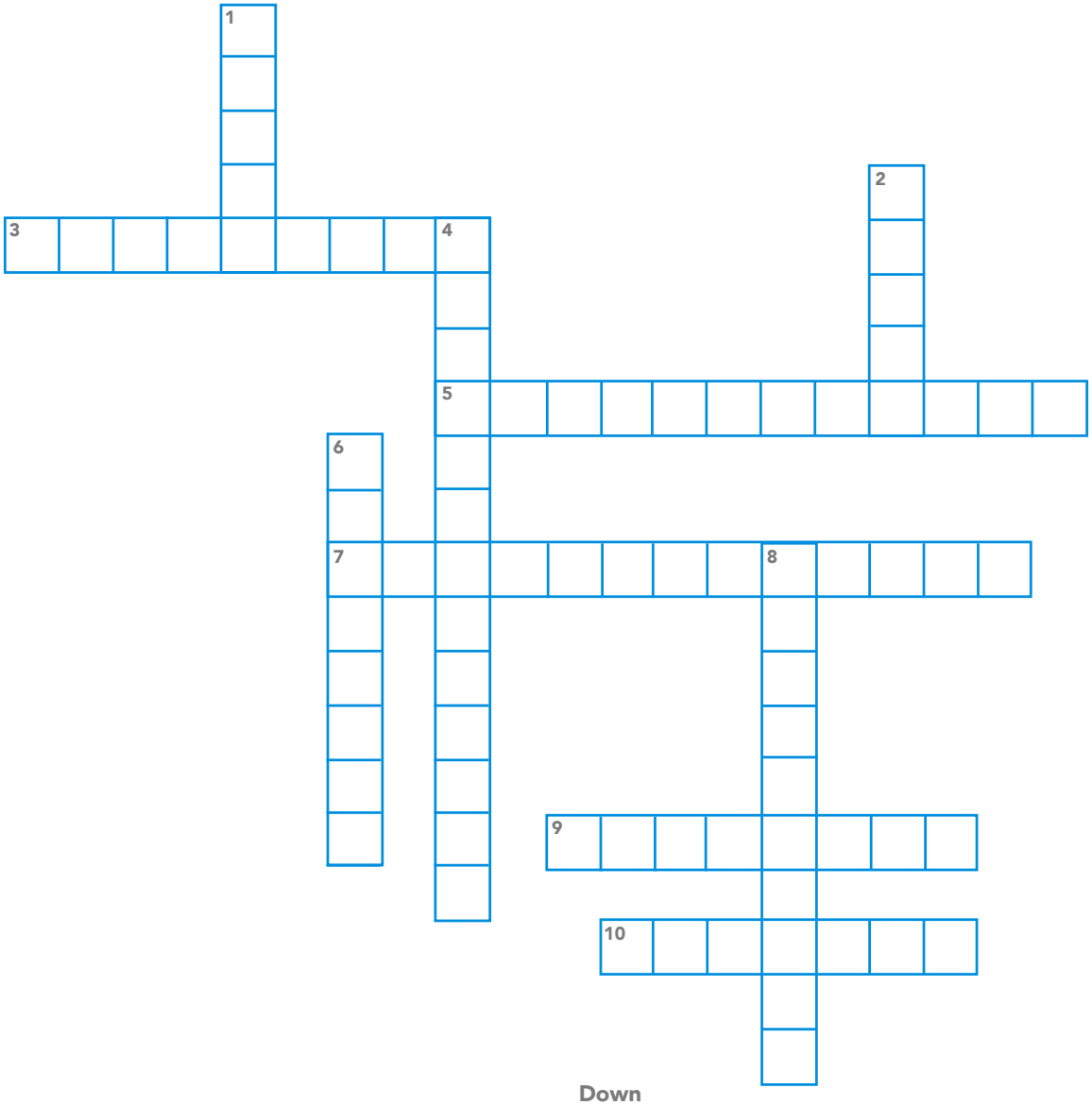


# Complete the Crossword Puzzle Below




## Across

**3.** The condition that is the most common reason for crushing medication
**5.** A use of medication inconsistent with accepted standards of practice for providing pharmaceutical services
**7.** Transferring a physician's prescription order to a medication administration record
**9.** A comprehensive medication management program for senior living communities
**10.** A type of anti-platelet medication

## Down

**1.** Each resident's drug regimen must be reviewed at least once a _____ by a licensed pharmacist
**2.** A web-based tool that combines e-Ordering and an e-MAR system for nursing facilities
**4.** A medication approved for use for blood clot prevention
**6.** An effective reversal agent for Warfarin ***(2 words)***
**8.** Pharmacy experts with 30 years of experience in long-term care

Across: 3. DYSPHAGIA, 5. IRREGULARITY, 7. TRANSCRIPTION, 9. VALUEMED, 10. ASPIRIN | Down: 1. MONTH, 2. EZMAR, 4. ANTICOAGULANT, 6. VITAMINK, 8. PHARMERICA