

STANDARDIZING DOCUMENTATION OF SCHEDULE II PRESCRIPTION IN A  
PRIMARY CARE CLINIC

by

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## DEDICATION

This paper is dedicated to my understanding husband and daughter for encouraging me to continue my education. This paper is also dedicated to my mother for encouraging me to pursue a career in nursing as well as being my role model, and to my father who taught me perseverance. Thank you also to the many friends and family members who encouraged me to towards nursing excellence, I could not have done it without your help.

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## ABSTRACT

Standardization of processes and documentation in healthcare has continually been linked to quality of care. Implementation of new electronic health records (EHR), inadequate training, and lack of processes in place can all effect nursing documentation. The purpose of this project is to standardize documentation of charting the destruction of schedule II prescriptions in an Internal Medicine Clinic. Prior to the implementation of this project there was no standardized workflow for how or where to document the destruction of schedule II prescriptions. Lack of standardization and protocol contributed to prolonged time to complete refills, increased risk of duplicates, increased risk of harm to patients, and high nurse utilization. A pre and post-test was utilized to evaluate the nurse practice on documenting the destruction of controlled prescriptions. The pre-intervention results demonstrated inconsistent documentation which included: documenting in a communication encounter, documenting in the medication tab, a mixture of both documenting in the communication encounter and medication tab, or just not documenting. A standardized workflow was developed, presented to nursing staff, and competency assessment completed. The post-test demonstrated 100% compliance in documentation and made locating the documentation in the chart faster and easier reducing nurse workload.

## INTRODUCTION

Quality nursing documentation promotes effective communication with other healthcare providers as well as facilitates continuity of care. According to Mykkanen, Miettinen, & Saranto, “The use of an electronic patient record (EPR) and nursing documentation have been shown to lead to higher quality, more comprehensive, and more patient-oriented documentation than paper-based nursing documentation” (2016). Continued improvement, learning, and deeper insights occur through standardizing and stabilizing processes. (Nelson, Batalden, & Godfrey, 2007).

Accurate, standardized documentation is necessary to document prescription destruction in an acute care facility as well as in the primary care clinics, especially in the wake of America’s current ‘opioid epidemic’. In 2016, a total of 64,070 people in the United States died from illicit and prescribed opioid overdoses (National Institute on Drug Abuse, 2017). Through the current electronic health system, schedule II prescriptions cannot be faxed directly to the pharmacy but must be printed, signed by a provider, and taken to the pharmacy. Tracking these prescriptions can be difficult since there is no expiration for a schedule II prescription under federal law, although many states have established time restrictions (Gershman, 2017). Routinely, patients may get three separate prescriptions from their provider that are post dated but can hold on to these schedule II prescriptions for an indefinite amount of time. Insurance companies only cover one thirty-day supply and will alert the pharmacy if the patient attempts to fill another script through insurance before that thirty-day has expired. Difficulty in

monitoring refills comes when a patient utilizes two different pharmacies, paying with cash at one pharmacy, using insurance to receive a prescription at a separate pharmacy.

A majority of states have started to monitor controlled substances with the use of a Prescription Drug Monitoring Program (PDMP). The PDMP is a statewide electronic database that collects data on controlled substances that have been dispensed, patient information, the quantity, date dispensed, the date the script was written, and the prescriber (US Department of Justice, 2016). Pharmacists and providers may sign up to have access to this information after completing an online training course. If a provider would like their nurse to have access the PDMP, they can appoint a nurse in proxy to gain the ability to print a prescription drug registry report on a patient.

At the local Internal Medicine Clinic pharmacists are available through clinical pharmacy services to print off the drug registry for providers and nurses without the provider having to complete the registration and training. Only a few nurses in the clinic have access to print the PDMP. The PDMP can have a lag of one to two weeks from when it is first printed to when the database is updated with controlled substances that have been dispensed and cannot be a reliable indicator in the short term.

The nursing staff frequently manages the controlled prescription refills. These nurses take time to research when the last prescription was printed, verifying when scripts were filled at the pharmacy, have PDMP's printed, post-dating scripts, and then printing the prescriptions for the provider to review and sign prior to being handed to the patient. It slows down the refill process if, during the review of the electronic health record (EHR), it appears the patient still has a remaining post-dated prescription, multiple scripts

dated for the same month, or there is inconsistent documentation. Frequently prescriptions are destroyed if they are printed with errors like an incorrect date, quantity, or directions. Documentation of script destruction should be placed in the patient's chart; however, inconsistencies in documentation make it difficult for the nurse to locate this information.

The EHR, EPIC is utilized at the local Internal Medicine Clinic and throughout Sanford Health. Sanford Health has hospitals in Fargo, North Dakota, Sioux Falls, South Dakota, Bemidji, Minnesota, and Bismarck, North Dakota (Sanford Health, 2016). Different organizations and multiple specialties utilize this system. There are numerous methods for documenting, with no established workflow created in regards to standardizing documentation of prescription destruction. At the local clinic, script destruction historically has not been documented in a standard location or not documented at all. Of the locations used, the most prevalent documentation location was in a telephone encounter, the second being in the medication record. The inconsistent documentation of prescription destruction can lead to delays in refills, inaccurate refill dates, and the frustration of both patient and nurse.

During medication management visits patients are often given three post-dated scripts to last until their next appointment. If a script was printed and destroyed due to inaccuracies it was frequently not documented. Future refill dates are based from the last refill date in the electronic health record. If the last script that was printed was destroyed due to inaccuracies, it could lead to errors in future scripts. It takes a considerable amount of time to research last fill dates, try to locate documentation, print a PDMP, and call the

pharmacy when trying to fill a prescription for a patient. PDMP's are useful for verifying refill dates over the last six months, reviewing patient usage, and pharmacies used but are not always accurate and can take one to two weeks to reflect a recent fill.

Delays in refills can extend and postpone appointments for medication management. Longer wait times negatively affect patient satisfaction scores and the results indicate that such delays affect every aspect of the patient experience. These delays can even affect the confidence in the care provider and perceived quality of care (Quality of Care, 2014). One study found that visits associated with brief waits of under fifteen minutes and longer visit time with the provider had a physician care satisfaction score of 92.7 (Balkrishnan, Camacho, & Anderson, 2007). Physician satisfaction scores range from 0 to 100%, high scores positively reflect patient satisfaction with their healthcare and are used as a measure of quality. A delay during an appointment does not only affect the current patient waiting for a prescription, but these delays often cause a cascade effect for the rest of the scheduled appointments for the day and may negatively affect the patient satisfaction score.

Once a medication prescription is printed in the EHR the program documents it with a time and date. Unless documentation is present to note that the prescription has been destroyed in the chart, providers are unable to track where the prescription is located. Scripts that have been destroyed but lack documentation create confusion in the EHR as to when the next refill date should fall and may lead to inaccurate future fills: either too early or too late. Of the documented medication errors, prescription errors

account for 70% that could potentially result in adverse effects (Velo & Minuz, 2009).

Frequent early refills may contribute to the overuse of these controlled substances.

EPIC, the current electronic health record in the facility, is hosted through Sanford Health and has high utilization and specialty diversity. In having this flexibility for other specialties and other organizations it also has three locations where one can document information. Recurrent frustration with persistently inaccurate or nonexistent documentation forced the author to consult other nurses to find how, if, and where they were documenting this information. A survey was conducted prior to starting the project incorporating all the nursing staff and a few providers to assess need for standardization (See Appendix A).

Results of the survey showed that documentation in a telephone encounter was the most prevalent method of documentation. However, this consumed a lot of research time for the nurses preparing future refills due to these documentation inconsistencies. The second method used to document involves adding a note to the medication record. The medication record has two areas where a script can be charted as discontinued and a reason for why it was discontinued. Documentation in the medication record can be problematic in that if they chart in the wrong box the documentation will apply to all past and future scripts for that singular medication with no way to delete the note. If the second box is used the note is only applied to that specific medication for that specific fill date. The EHR support staff was consulted to find out how other organizations that utilize EPIC were documenting this information and if there was a workflow developed. It was discovered that other organizations did not have a standardized workflow for reference.

Standardizing is not a new concept and serves to decrease guesswork and improve quality by decreasing ambiguity in workflow. Lean Six Sigma is a great example of an improvement methodology developed in the 1980's that focused on identifying and eliminating three types of waste: non-value added work, unpredictable variation, and overburdening resources (Go Skills, 2019). Initially utilized in production industries Lean Six Sigma has been harnessed in other industries to improve processes by eliminating waste. As an example, one study conducted by Hynes et al (2019) utilized and demonstrated the use of Lean Six Sigma to significantly improve turnaround time from  $3.74 \pm 3.28$  days to  $1.89 \pm 1.82$  for placement of inpatient peripherally inserted central catheters (PICC).

One study published by the *Engineering Management Journal* noted that inadequate data quality is widespread in healthcare leading to increased cost due to pricing errors, wasted time for managers dealing with suppliers resolving debates, and can result in delays in treatment if those supplies are not available (Smith, Nachtmann, & Pohl, 2012). This study discusses the benefits of standardizing data quality and supply chain for coding and barriers to standardizing and these concepts can also be applied to this project. Data was obtained by sending out two separate online surveys to supply chain professionals working for healthcare provider organizations. The studies obtained data unanimously; the first study was conducted in November 2008 and consisted of 1,056 healthcare organizations. The second study was conducted in June of 2010 and obtained data from 399 healthcare organizations. The results indicated the belief that by adopting data standards it will lower costs and improve quality within the organization (Smith, Nachtmann, & Pohl, 2012). The study goes on to note that incorporating data

standards in a consistent format enhances the organizations ability to monitor the credibility, fidelity, and reduce confusion between all who utilize the information.

### Specific Aims

The purpose of this project is to introduce a standardized documentation procedure in a primary care clinic and in doing so allow healthcare team members to access prior prescription history that is accurate and easy to locate. This project utilizes the Continuous Quality Improvement (CQI) model Plan-Do-Check-Act to track progress (See Appendix B).

## METHODS

### Context

The data from the pre and post-test were collected from nurses at a rural Montana Primary Care Clinic from 2017-2018 (See Appendix A). This clinic manages patient care for patient ages eighteen and older, with the majority of the patient population over 65yrs. The clinical site staff is composed of twenty providers, thirty-one nurses, four patient care technicians (PCT), and numerous clerical staff. The Clinic is made up of four pods of providers, nurses, and PCTs. Each pod is staffed with four to six providers, five to eight nurses, and one PCT. In each pod there are four to six nurse provider teams consisting of a provider paired with a designated nurse. The designated nurse is in charge of rooming the provider's patients, answering phone calls, administering treatments and medications, and assisting during procedures. On any given day there are one to two helper nurses in each pod assigned to manage the walk-in patients, answer phone calls, and assist the nurse/provider teams. The pre and post data was analyzed for compliance with the intervention.

### Intervention

Plan-Do-Check-Act (PDCA) is a tool utilized for continuous improvement that encompasses four steps: plan, do, check, and act. The first step (Plan) focuses on identifying an opportunity and planning for a change. Step two (Do) tests a planned change by conducting a small-scale study with planned change. Step three (Check)

reviews and analyzes the results from the small-scale study. The final step (Act) is where an action is selected based on results of the small-scale study (American Society for Quality, 2019). A cycle is the completion of steps one through four and may be repeated multiple times throughout a study or project to guide the continuous improvement project. This project completed three cycles and each step is detailed below.

**Cycle 1:** Create a list of nurses employed in the clinic and then decide the quickest way to collect the data. For this project the quickest way to collect the data was to conduct a one-on-one survey with each nurse. Develop questions that are quick and easy to answer, to decrease nurse inconvenience. Conduct verbal one-on-one survey with nurses to collect the following data: if the nurse is charting the destruction of a controlled prescription, where this information is charted, and any comments they want to share (Table 1).

Table 1. Sample of Data Collected

Name	Document in Communication Log	Document in the Medication Tab Under Left Side Navigation	Other
Nurse 1	X		Not documented if not signed

Review the data and note inconsistencies in charting. Contact Information Technology (IT) to discover if there is already a workflow available through the current Electronic Health Record (EHR). If IT has an available workflow, obtain it, if not develop one. Share the results with the nursing supervisor and obtain approval for a project improvement. Contact the Quality Department and schedule a meeting to discuss

performance improvement project. Follow a Plan-Do-Check-Act outline throughout the project (See Appendix A).

**Cycle 2:**

Gain approval from the nursing supervisor to conduct a meeting evaluating workflow with other nursing staff. Identify key nurses in each pod to invite to the workflow meeting and schedule a time to evaluate workflow interventions. Evaluate workflows with the key nurses and determine best practice. Create a template for step-by-step instructions. Present the selected workflow to Unit Based Council and gain approval.

**Cycle 3:**

Disseminate the approved workflow to the nursing staff during a nurse meeting with leader demonstration. Have nurses demonstrate understanding and skill with an approved evaluator to complete competency. Place an approved evaluator in each of the four pods to facilitate nursing sign-off of competency, expedite the process, and promote retention of the new workflow.

If new nurses are hired during the time of intervention, educate and complete competency sign-off with them, but do not include them in the pre-test. Have the nurse mentor disseminate prescription destruction workflow during the four-week new hire nurse orientation. Continue monitoring post intervention: for each controlled medication renewal request that is received, prescription history is reviewed. If any inconsistencies or duplicates are found then nursing will review for workflow adherence. If script destruction documentation is discovered under a telephone encounter and not in the

medication record that nurse will be asked to review workflow and complete a return demonstration with an approved validator.

Compare the data collected from the pre-test with the data of the post-test to assess quantitatively if the intervention was effective and it will be presented as a percentage of change. Use the comments collected from the pre and post-test to qualify the data and evaluate the effectiveness of the intervention from the nursing perspective.

Study of the Intervention

Initially a survey was conducted to assess the current nursing workflow and assess need. A pre and post-test assessment was completed without collecting ongoing data, time is not a variable in understanding variation within the data.

The initial nursing survey indicated there was a need for further education and protocol that needed to be developed to make documenting the destruction of schedule II prescriptions in one key area the standard (See Appendix A). Team members were selected from each of the four nursing pods in the clinic. The team leader scheduled the computer training room to work discuss pros and cons and different workflows of charting (See Table 2).

Table 2. Documentation Location Pros and Cons

<b>Location to document script destruction</b>	<b>Pros</b>	<b>Cons</b>
Telephone Encounter	<ul style="list-style-type: none"> <li>• Documentation is time stamped.</li> <li>• Does not require further EPIC training.</li> </ul>	<ul style="list-style-type: none"> <li>• Have to search each encounter for documentation.</li> <li>• Takes time to locate data.</li> </ul>
	<ul style="list-style-type: none"> <li>• Documentation for</li> </ul>	<ul style="list-style-type: none"> <li>• Would require a</li> </ul>

Medication Record-selected one script	medication is centralized. <ul style="list-style-type: none"> <li>• Documentation can be attached to a single dated prescription.</li> </ul>	nursing in-service to educate nurses on workflow. <ul style="list-style-type: none"> <li>• The attached documentation has to be selected to view.</li> </ul>
Medication Record- Multi script	<ul style="list-style-type: none"> <li>• Documentation for medication is centralized.</li> <li>• Documentation is attached to all future and past schedule II scripts and cannot be deleted.</li> </ul>	<ul style="list-style-type: none"> <li>• Would require a nursing in-service to educate nurses.</li> <li>• The attached documentation has to be selected to view.</li> <li>• Notes from past scripts that were destroyed still remain on all future scripts.</li> </ul>

The team decided that having the documentation attached to the individual prescription that was destroyed in the medication record was the most efficient. Working with the information systems team, a step-by-step workflow with picture screenshot instructions was developed (see appendix C). This workflow was disseminated to the team members with instructions to test this workflow on a small scale prior to rolling it out to the rest of the clinic. A plan, do, study, act (PDSA) was initiated with minimal changes made to the constructed workflow (See Appendix B).

The workflow was presented to the unit-based council for approval (See Appendix C). Once approved, the workflow was presented to nursing staff during a nurse meeting. During the meeting discussion was focused on promoting the change and explaining the benefits of use: easier tracking possibly leading to a decreased wait time for patients and quicker refills. These explanations increased motivation to comply with change. Each nurse was provided a step-by-step color copy of the workflow (See Appendix D), and a mandatory competency was accomplished by having each nurse

complete a verbal or actual employment of the steps for documenting the destruction of schedule II prescriptions.

Providers who were interested in learning how to document this information were given the workflow handout and the opportunity for demonstration using the EHR. The workflow was not presented in a staff meeting that included providers due to the overwhelming response from providers that nursing mainly handled medication refills. If a provider did make a mistake and needed the prescription destroyed, they were instructed to write void on the prescription and give it to the nurse to document.

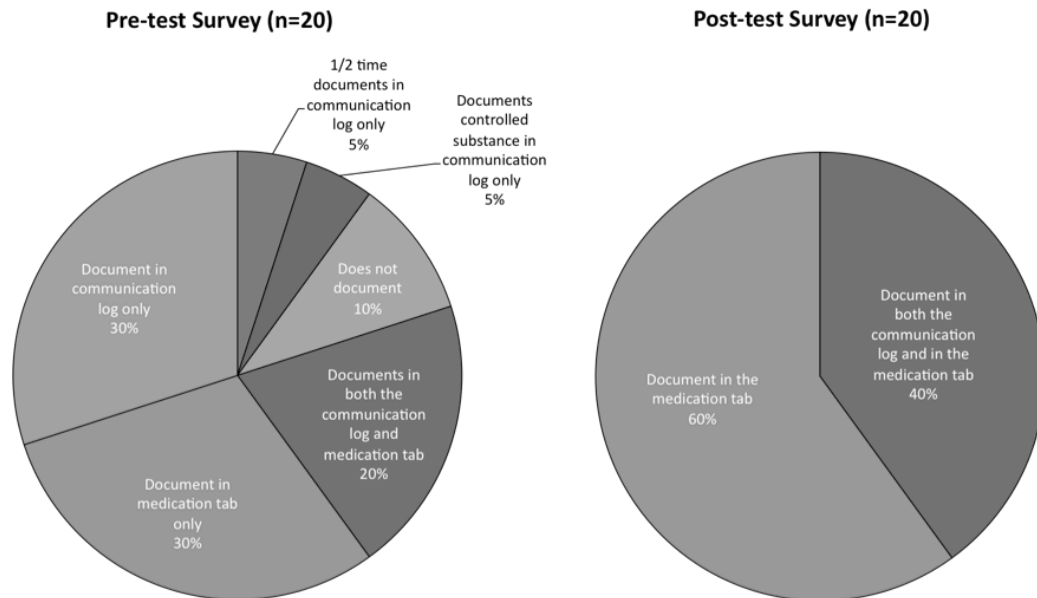
#### Ethical Considerations

Project approval was granted by the clinic manager and nursing supervisor prior to project initiation. No sensitive information was collected on patients or clinical staff and data was reported in aggregate. The survey method selected minimized nursing burden and on average only taking one minute to complete per nurse.

RESULTS

Of the 20 nurses that participated in the project, 100% were required to work in the current EHR. The aim of this project was to create a workflow to standardize documentation of prescription destruction in a primary care clinic. The design utilized for testing the intervention change was the pre/post test, see figure 1. In a pre and posttest, a comparison is made of the data before the change to the data after the change (Langley, 2009).

Figure 1. Pre and Post-Test Data Comparison (n=20).



The Pre intervention study showed that 50% (n=10) of nurses were documenting under the medication tab and/or the communication log, which improved to 100% (n=20) at post-test. Post intervention, some nurses (20%, n=4), still felt the need to also

document prescription destruction in a communication log as well as the medication tab. Of the 10% (n=2) of nurses that did not document the destruction of prescriptions in the pre-test, post intervention assessment demonstrates these nurses are now documenting when prescriptions are destroyed.

Upon reviewing the qualitative data three consistent comments were made: “Documentation is easier to follow, it is very helpful, and saves time since documentation is consistent.” The qualitative data was not substantiated with measurable variables, but since the nursing staff manages a majority of refills it is a positive indicator for the project on outcomes. The post intervention quantitative data collected indicates that the intervention was successful in creating a consistent workflow for documenting the prescription destruction in the medication tab.

## DISCUSSION

The purpose of this project was to standardize documentation of charting the destruction of schedule II prescriptions in a rural Montana Primary Care Clinic. An organizational leader's role is to strive to create a culture of quality and continuous improvement and the influence cannot be underestimated (Sullivan, 2006). Through the use of an organizational leader this project demonstrated that standardizing documentation is achievable by reviewing the current practice, discovering discrepancies, and reducing/eliminating waste.

This project's strength included: quick pre and post survey results, administration and nursing staff support, the intervention was straightforward, and it decreased confusion on the location for documenting; increasing incentive to continue once the project was completed. The potential benefits of this study may include reducing: prescribing errors, patient wait times, provider burden, and nurse compliance. Having a standardized location for reviewing past prescription history that is current and includes detailed information on a prescription that was destroyed has decreased confusion on refill due dates. The prior confusion associated with the inaccurate/inconsistent documentation was eliminated; making for a more consistent, accurate and timely workflow.

Further studies are needed to evaluate schedule II prescription fill-times. A future project might include evaluating how long it takes from first receiving a refill request to the time the prescription is filled and timing each step evaluating for waste/delay.

Continued monitoring for maintaining standardized documentation is completed during every schedule II refill by nursing evaluating the chart for the last refill. The

protocol is feasible and no extra staff is needed to complete the documentation.

According to comments made on the post survey, nurses felt preparing prescription refills was quicker and documentation easier to locate.

The cost associated with this project includes an hour of meeting time for a team of six nurses to develop the workflow, the price of paper to print the step-by-step guide (see Appendix D), and around twenty hours to complete the Plan-Do-Check-Act cycles.

### Limitations

Pre and Post-test data may be skewed by the fact that it was collected via one on one meeting with each nurse and not via an anonymous test questionnaire. To minimize this effect the pre and posttest was conducted in one-on-one meetings with each nurse in a secluded location and each nurse was assured that the data was confidential and would only be used to determine inconsistencies in workflow. Second were drawbacks to not presenting the information to providers. Since the providers did not participate initially in documenting the destruction of schedule II prescriptions, they did not have the motivation to document this information going forward. Providers were instructed to write void on the printed prescription and then give the prescription to their nurse to document.

Nursing continually audits charts when conducting refills monitoring for discrepancies. If it is discovered a prescription was not documented or destroyed in the medication tab the nurse that printed the prescription is re-educated on the workflow. Float pool nurses are utilized in the clinics in different areas. This workflow has not been

rolled out to the other affiliated clinics, so float pool nurses are often not aware of its existence and fail to follow the new workflow.

### Conclusions

The purpose of a Clinical Nurse Leader (CNL) is to be a leader within the healthcare delivery system. They function as a generalist that is accountable for healthcare environment outcomes, utilizing evidence-based practice to promote quality, and function as part of an interdisciplinary team working together to plan and implement care (American Association of Colleges of Nursing, 2019).

This project is a prime example of a CNL Capstone and successfully utilized several of CNL competencies, these include but are not limited to: member of a profession, team manager, systems analyst, outcomes manager, life long learner, and educator. Identifying a deficiency within the EHR and then leading a team of nurses to develop a viable solution is one of the responsibilities of an active member of the nursing profession. After new workflow approval, a meeting was held to educate the rest of the nursing staff as to what the changes would be and how to complete the processes appropriately.

The tool that helped streamline the process of supervising outcomes was the Plan-Do-Check-Act. It is specifically designed to assist in performance improvement projects such as this one. This tool in conjunction with the Lean Six Sigma method helped to identify and eliminate the added work of searching for script records in vain. All the extra time involved in the process of a potentially unfruitful search was an expensive burden on the nursing staff as a whole. The usefulness of this project goes beyond solving

one problem in day-to-day clinic workflow. The experience gained in the process of identifying areas of improvement and finding a restructured course of action will educate and guide future undertakings to improve the efficiency of clinical operations.

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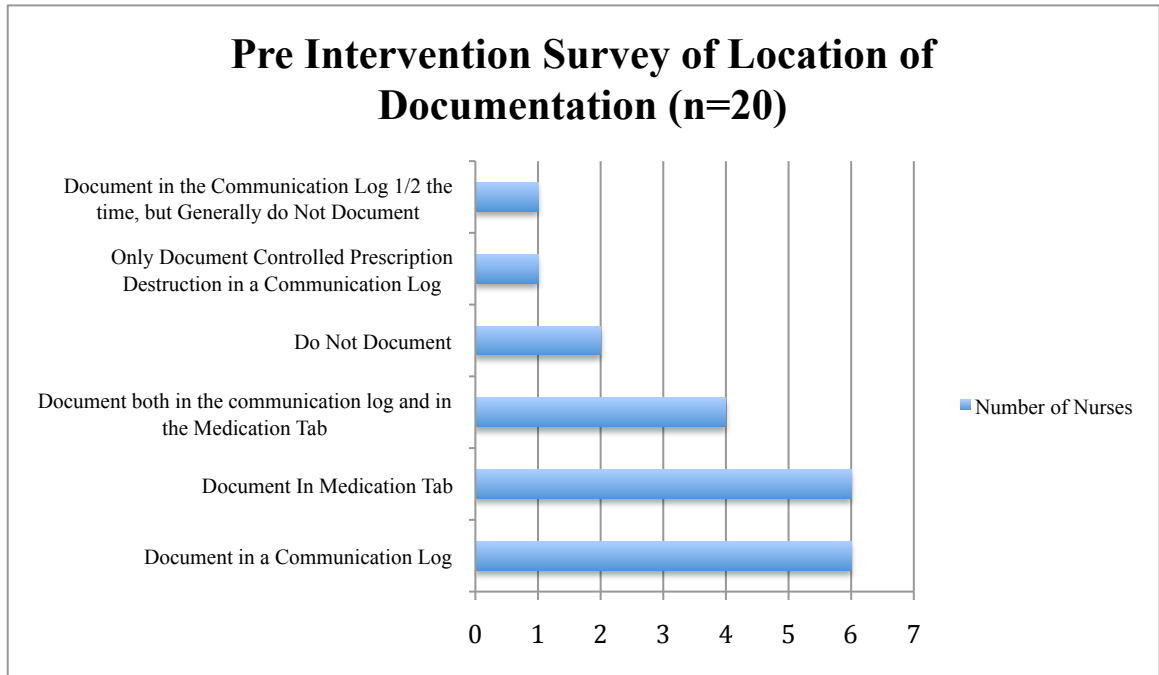
<http://doi.org/10.1111/j.1365-2125.2009.03425.x>

APPENDICES

APPENDIX A

PRE-INTERVENTION DATA

PRE-INTERVENTION DATA



APPENDIX B

PLAN-DO CHECK-ACT (PDCA) WRORKSHEET

PLAN-DO CHECK-ACT (PDCA) WRORKSHEET

**Project Title:** Improving the Documentation for Prescription Drug Tracking  
Cycle 1

Describe your first (or next) test of change:	Cycle #	Person responsible	When to be done	Where to be done
Gather Data on how clinical staff is documenting controlled script destruction	1	Lindsey Taylor	02/27/17	Internal Medicine

**Plan**

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Meeting with nurses 1:1 completed	Lindsey Taylor	02/27/17	Internal Medicine
What Data will need to be collected for each task listed above?	Person responsible	When to be done	Where to be done
Percentage of nursing staff documenting in medication record/history	Lindsey Taylor	02/27/17	Internal Medicine

Predict what will happen when the test is carried out	Describe the Measure that determines if test of change succeeds
NA	NA

**Do**

**Describe what actually happened when you ran the test:**

Discovered ambiguity in documentation for controlled scripts being destroyed. Standardized process had not been established.

**Chek**

**Describe the measured results & what was learned:**

Documentation for Script Destruction Process. In February there were only 30% of nursing staff documenting in the medication record/history.

**Act**

**Describe what modifications to the plan will be made for the next cycle from what you learned or plan for sustainability if no modifications are needed.**

After discovering that there is no standardized process our next step will be to create a workflow with nursing input.

**Project Title:** Improving the Documentation for Prescription Drug Tracking  
Cycle 2

Describe your first (or next) test of change:	Cycle #	Person responsible	When to be done	Where to be done
Documentation for Script Destruction	2	All	May 2017	Internal Medicine

**Plan**

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Nurse meeting to discuss possible workflow for documenting script destruction	All	March 2017	Internal Medicine
Draft and Finalization created	All	March 2017	Internal Medicine
Unit Based Council Approval	Lindsey T	April 2017	UBC
What Data will need to be collected for each task listed above?	Person responsible	When to be done	Where to be done
NA			

Predict what will happen when the test is carried out	Describe the Measure that determines if test of change succeeds
After this new standardized process is implemented we expect to see medication notes in all medication records/history if script was destroyed.	NA

**Do** Describe what actually happened when you ran the test:  
 After process was approved, the Internal Medicine Nursing staff began education.

**Check** Describe the measured results & what was learned:  
 No measurement for this PDCA.

**Act** Describe what modifications to the plan will be made for the next cycle from what you learned or plan for sustainability if no modifications are needed.  
 After approved workflow/flowchart, staff education and sign off will begin.

**Project Title:** Improving the Documentation for Prescription Drug Tracking  
Cycle 3

<b>Describe your first (or next) test of change:</b>	<b>Cycle #</b>	<b>Person responsible</b>	<b>When to be done</b>	<b>Where to be done</b>
Staff Education and Sign Off	3	Lindsey T	September 2017	Internal Medicine

### **Plan**

<b>List the tasks needed to set up this test of change</b>	<b>Person responsible</b>	<b>When to be done</b>	<b>Where to be done</b>
Nurse Meeting - Education	Lindsey T	May 2017	Internal Medicine
Sign off	Lindsey T	September 2017	Internal Medicine
<b>What Data will need to be collected for each task listed above?</b>	<b>Person responsible</b>	<b>When to be done</b>	<b>Where to be done</b>
Number of nurses attending the meeting and received education	Lindsey T	May 2017	Internal Medicine
Number of nurses able to demonstrate their ability to document RX destruction through new process	Lindsey T	September 2017	Internal Medicine

<b>Predict what will happen when the test is carried out</b>	<b>Describe the Measure that determines if test of change succeeds</b>
Staff will begin documenting in the Medication Record. This process standardization should improve our medication communication.	Numerator = Number of nurses that completed the education and sign off/Denominator = Number of total nurses

### **Do**

#### **Describe what actually happened when you ran the test:**

Standardized medication destruction documentation has begun. Nursing staff has begun documenting in Medication Record as new process directs.

### **Check**

#### **Describe the measured results & what was learned:**

35 out of 35 nursing staff have completed education and sign off. 100% of the nursing staff is able to speak to the new implemented standardized process.

### **Act**

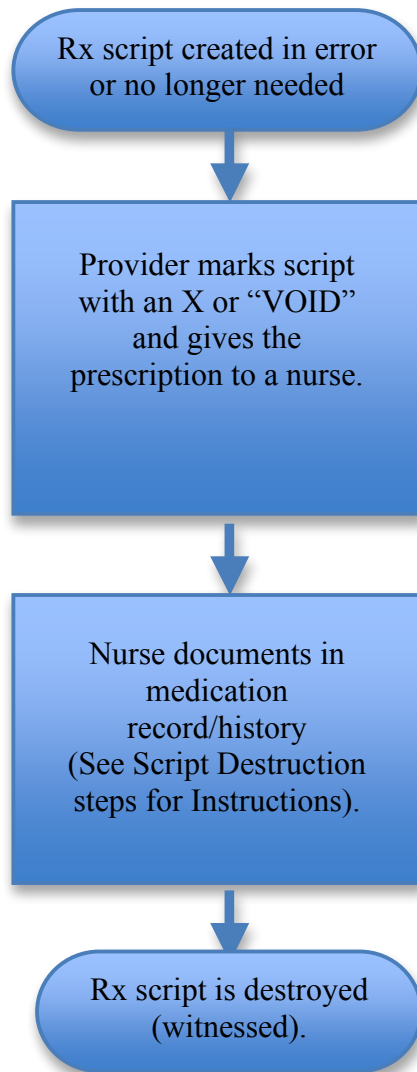
**Describe what modifications to the plan will be made for the next cycle from what you learned or plan for sustainability if no modifications are needed.** We plan

to continue audits and based on results make modifications if needed. If project continues to be successful, we do plan to share with other departments and clinics for a systems standardization.

APPENDIX C

FLOWCHART FOR PRESCRIPTION DESTRUCTION

## FLOWCHART FOR PRESCRIPTION DESTRUCTION



APPENDIX D

STEPS FOR SCRIPT DESTRUCTION

## STEPS FOR SCRIPT DESTRUCTION

1. Use left side navigation to select medication, if not listed go to more tab to locate.

The screenshot shows a medical software interface for patient **Viking, Larson Benjy**. The left sidebar navigation menu includes options like Chart Review, Results Review, Rooming, Medications, Notes, Plan, Wrap-Up, Synopsi, After Visit Sum..., Sign Visit, Advance Care, IPPE\_AWV, and Visit Navigator. A red arrow points to the **Medications** tab in this menu.

The main content area is divided into several sections:

- Specialty Comments:** No comments regarding specialty.
- Documents Filed to Patient:** Power of Attorney (Not on File), Living Will (Not on File), My Sanford Chart Status (Active).
- Allergies:** Penicillin Rash (Marked as Verified, Reviewed by RN on 4/21/2017).
- Medications:**
  - levothyroxine (SYNTHROID) 100 mcg tablet: Take 1 tablet (100 mcg total) by mouth 1 time per day.
  - cefuroxime (CEFTIN) 250 mg tablet: Take 1 tablet by mouth 2 times a day.
  - DILTiazem (CARDIZEM CD) 180 mg extended release capsule: Take 1 capsule by mouth 1 time per day.
  - simvastatin (ZOCOR) 40 mg tablet: Take 1 tablet by mouth every night at bedtime.
- Preferred Pharmacies:** E-Walgreens Drug Store 05745 SIOUX FALLS SD 3620 W 41ST ST 605-361-5600 (Phone) 57106-0726 605-361-0033 (Fax).
- Immunizations/Injections:**
  - FLU VACCINE TRIVALENT SINGLE DOSE (Fluvirin, Altuvia): 3/30/2009
  - TDAP: 5/31/2006
  - Tuberculin PPD: 2/13/2007
  - Zoster: 5/31/2007
- Significant History/Details:**
  - DOB: 2/13/1949
  - Smoking: Former Smoker (Quit Date: 11/11/1991), 1 ppd, 20 pack-years
  - Smokeless Tobacco: Never Used
  - Alcohol: 2.5 oz alcohol/week
  - 2 open orders: Hypertension - age 55, Hypothyroid - age 40, Hypercholesterolemia - age 60, Diabetes mellitus type 2 in nonobese - age 50, GERD (gastroesophageal reflux disease) - age 55, DVT (deep venous thrombosis) - age 55
- Health Maintenance:**

Topic	Due	Last Communication
Microalbumin	2/13/1949	
Hepatitis C Screening	2/13/1949	
Diabetic Foot Exam	2/13/1959	
Zoster Vaccine (1)	2/13/2009	
Hemoglobin A1C Every 6 Months	10/10/2013	
Pneumococcal 65yr+ Low/Med Risk (1 of 2 - PCV13)	2/13/2014	
Abdominal Aortic Aneurysm Screening	2/13/2014	
Lipid Screening	6/17/2014	
Colonoscopy	5/31/2016	
Tetanus Vaccine	5/31/2016	
Influenza Vaccine (1)	10/1/2016	
Ophthalmology Exam	10/10/2016	
- Reminders and Results:**

Sent	From	Type	Results	Done
4/21/2017	Interface, Collection Default	Results		<input type="checkbox"/>
- Surgical History:**

Procedure	Age	Side
TONSILLECTOMY & ADENOIDECTOMY	AGE 12+	Bilateral
APPENDECTOMY	age 25	

2. Select filter to filter for target medication

**Medications**

Prescription Summary for This Visit (4/26/2017) (4 listed)

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy	DAW	D/C Reason
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17	7 tablet	0 ordered	6/25/2017	7/25/2017			
levothyroxine (SYNTHROID) 100 mcg tablet	Take 1 tablet (100 mcg total) by mouth 1 time per day	30 tablet	0 ordered	9/26/2016			No	
cefuroxime (CEFTIN) 250 mg tablet	Take 1 tablet by mouth 2 times a day	28 tablet	0 ordered	11/11/2011				
DILTiazem (CARDIZEM CD) 180 mg extended release capsule	Take 1 capsule by mouth 1 time per day	30 capsule	0 ordered	11/11/2011				
simvastatin (ZOCOR) 40 mg tablet	Take 1 tablet by mouth every night at bedtime.	30 tablet	0 ordered	11/11/2011				

3. select medication to filter by

**Generic Drug Name**

- Cefuroxime Axetil
- Diltiazem HCl Coated Beads
- Enalapril Maleate
- Famotidine
- Hydrochlorothiazide
- Levothyroxine Sodium
- Losartan Potassium
- Naproxen
- Oseltamivir Phosphate
- Oxycodone HCl**
- Simvastatin
- Warfarin Sodium

Prescription Summary for This Visit (4/26/2017) (4 listed)

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy	DAW	D/C Reason
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17	7 tablet	0 ordered	6/25/2017	7/25/2017			

Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17

4. Select history to find scripts that have been discontinued (they could have been discontinued due to renewal).

The screenshot shows a medical software interface for a patient named Viking, Larson Benly. The 'Medications' section is active, displaying a list of prescriptions. A red arrow points to the 'Start Date' column header in the table below.

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy	DAW	D/C Reason
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17	7 tablet	0 ordered	6/25/2017	7/25/2017			

5. Hit start date twice so the arrow points down. This will order the start dates so most recent is at the top. Scroll the side bar up to make sure most recent is at the top. (Sometimes short supply scripts are renewed off of post-dated script and the post-dated script will show as discontinued).

The screenshot shows the same medical software interface, but with a red arrow pointing to the 'Start Date' column header, indicating it has been clicked. The table below shows the same data as the previous screenshot, but the rows are now ordered by their start dates in descending order.

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy	DAW	D/C Reason
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17	7 tablet	0 ordered	6/25/2017	7/25/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			

6. Right click and select the **Discontinue RX**

The screenshot shows the Epic Medications interface for patient Viking, Larson Benji. The 'Prescription History (3 listed)' table contains the following data:

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy	DAW	D/C Reason
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for Earliest Fill	7 tablet	0 ordered	6/25/2017	7/25/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tabl mouth ever needed for Earliest Fill	tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			

7. Select a discontinued reason.

The 'Discontinue Prescription' dialog box is open, showing details for the prescription: 'oxyCODONE (OXY-IR) 15 mg tablet'. The 'Discontinue reason' dropdown is highlighted with a red box and labeled '1.'. The dropdown menu is open, showing a list of reasons, with 'Data entry error' highlighted by a red arrow and labeled '2.'. The list of reasons includes:

- Administration route conversion
- Allergy
- Appointment cancelled
- Cost
- Data entry error**
- Discontinued by Physician
- Dose adjustment
- Drug shortage
- Duplicate
- Formulary change
- Home medication placed on hold per policy
- Incorrect provider
- Ineffective
- IV med discontinued and changed to oral med
- Order needs further clarification
- Order placed on hold
- Patient changed dose
- Patient declined
- Patient did not arrive
- Patient discharged
- Patient discontinued medication
- 33 categories loaded.

8. Chart reason, script destroyed, and who witnessed. Then hit accept.

Discontinue Prescription

Please enter the details for this discontinuation.

**To Be Discontinued**

oxyCODONE (OXY-IR) 15 mg tablet Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain 0 refills ordered  
Earliest Fill Date: 4/26/17  
From 4/26/2017 until 5/26/2017

Prevent dispenses by calling the pharmacy.  
E- Walgreens Drug Store 05745  
SIOUX FALLS SD 3620 W 41ST  
ST 57106-0726 (605-361-5600)

To stop the pharmacy from filling this prescription, you must call it directly at 605-361-5600.

OXYCODONE HCL

Discontinue reason: Data entry error Notes: incorrect start date. script destroyed witnessed by Lindsey Taylor F

End date: 4/26/2017 Cosigner:

1. 2.

Accept Cancel

9. You will be able to view the note if you double click on the medication.

**Viking, Larson Benjy** MRN: <E2544> Allergies: **Penicillin (Reaction...** POP: BARTH, RICHARD... Biobank Status: None My Sanford Chart: Active Last Weight: 81.6 kg (1...  
 Prefer: None Phone: 605-555-1212 Code: Not on file Attributed POP: None HM: **Health Maintenance** Adv Dir: None Last BMI: 24.38 kg/m<sup>2</sup>  
 Male, 02/13/1949, 68yr Pl Comm Pref: MyChart Patient Messages: Health Coach: None My Sticky Note: HIPAA: None  
 Language: English Active FYIs: None Case Manager: None INS: Click for more info Power of Attorney Flag...

**Order Report** [Close X]

Snapshot

**Medication** oxyCODONE (OXY-IR) 15 mg tablet (Order 709347)

**Releasing Order Information**

Date and Time	Department	User/Authorizing
4/26/2017 12:17 PM	Sanford Clinic Family Medicine 41st & Sertoma	Crunch, Pat

**Order Providers**

Prescribing Provider	Encounter Provider
Crunch, Pat	Crunch, Pat

**Order Info**

Order part of panel: OXY-IR 15 MG 90 DAY SUPPLY

Phase of Care

**Medication Notes**

Crunch, Pat 4/26/2017 12:23 PM  
 incorrect start date. script destroyed witnessed by Lindsey Taylor RN

**Associated Diagnoses**

Chronic left-sided low back pain with bilateral sciatica - Primary

**Pharmacy**

E- WALGREENS DRUG STORE 05745 SIOUX FALLS SD 3620 W 41ST ST 57106-0726

**Encounter**

[View Encounter](#)

**Warnings Override History for oxyCODONE (OXY-IR) 15 mg tablet [709347]**

Overridden by Crunch, Pat on 04/26/17 12:17

**Duplicate Therapy**

1. SHORT ACTING NARCOTIC ANALGESICS [Level: Abuse/Dependency Potential] [Reason: Previously tolerated without adverse effect]  
 Other Orders: oxyCODONE (OXY-IR) 15 mg tablet

**Print Trail**

Printed On	Printed By	Printed To	Report
4/26/17 12:24 PM	Crunch, Pat	NO WHERE	DUMMY REPORT

**Med Order Status**

Medication	Disp	Refills	Start	End
oxyCODONE (OXY-IR) 15 mg tablet (Discontinued) Sig - Route: Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17 - Oral Class: Med Print Reason for Discontinue: Data entry error Order: 709347 Date/Time Signed: 4/26/2017 12:17 PM	7 tablet	0	4/26/2017	4/26/2017
oxyCODONE (OXY-IR) 15 mg tablet Sig - Route: Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17 - Oral Class: Med Print Order: 709346 Date/Time Signed: 4/26/2017 12:17 PM	7 tablet	0	4/26/2017	5/26/2017
oxyCODONE (OXY-IR) 15 mg tablet Sig - Route: Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17 - Oral Class: Med Print Order: 709348 Date/Time Signed: 4/26/2017 12:17 PM	7 tablet	0	6/25/2017	7/25/2017

**Order Audit Trail**

# 1. Another way to do it is to go to notes instead of Discontinue Rx

The screenshot shows the Epic EMR interface for patient Viking, Larson Benjy. The top navigation bar includes various system tools. The patient's demographic and clinical information is displayed at the top, including MRN, allergies, and PCP. The main area is titled 'Medications' and contains a 'Prescription History' table with columns for Medication, Sig, Disp, Refills, Start Date, End Date, and Note to Pharmacy. A context menu is open over the 'oxyCODONE (Discontinued)' entry, with a red arrow pointing to the 'Notes' option.

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17	7 tablet	0 ordered	6/25/2017	7/25/2017	
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017	
oxyCODONE (Discontinued)	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	4/26/2017	

2. Type comment is second box as seen below, and hit accept.

Medication Notes

Notes applied to all OXYCODONE HCL medications

DO NOT TYPE IN THIS BOX!

[See all OXYCODONE HCL medications](#)

Notes for oxyCODONE (OXY-IR) 15 mg tablet

TYPE HERE

Accept Cancel

3. Either way will produce a yellow box to the left of the medication to alert the nurse that a comment has been placed.

If you use had selected note to document, it will not show a reason for why a script was discontinued: Listed under D/C reason to the right of the medication.

Medication	Sig	Disp	Refills	Start Date	End Date	Note to Pharmacy	DAW	D/C Reason
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 6/24/17	7 tablet	0 ordered	6/25/2017	7/25/2017			
oxyCODONE (OXY-IR) 15 mg tablet	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	5/26/2017			
oxyCODONE (OXY-IR) 15 mg tablet (Discontinued)	Take 1 tablet (15 mg) by mouth every 4 to 6 hours as needed for moderate pain Earliest Fill Date: 4/26/17	7 tablet	0 ordered	4/26/2017	4/26/2017			Data entry error