CEDAR VALLEY SERVICES, INC.
MEDICATION ADMINISTRATION POLICY

Albert Lea Division
2205 Myers Road
Albert Lea, MN 56007

Alpha Program
1839 SE Broadway Ave.
Albert Lea, MN 56007

Austin Division
2111 4th St. NW
Austin, MN 55912

Top Flight Program
102 1st St. NW
Austin, MN 55912

Owatonna Division
415 North Grove Ave.
Owatonna, MN 55060

RESIDENTIAL FACILITIES
October Home
1370 18th St. SE
Owatonna, MN 55060

Murray Home
2096 Harbour Oak Drive
Owatonna, MN 55060

CONTENTS

I. GENERAL INFORMATION

A. The administration of medications is offered to persons participating in DHS licensed programs, CADI funded programs and other non-E/E programs. Extended Employees are expected to:
   1. Be independent with meds
   2. Or schedule around work hours
   3. Or arrange for other supports for med administration.

B. Staff 18 years of age or under can administer medications.

C. Prior to administering medication to the person served, CVS will obtain written authorization from the person served and/or legal representative to administer medications or treatments, including psychotropic medications.

D. Prior to administering medications, all staff will receive Medication Administration Training from a curriculum developed and approved by a Registered Nurse. Annual Medication Administration Updates are required.

E. Staff passing medications need to demonstrate competency to the consulting R.N. prior to actual medication administration, utilizing the agency medication administration procedures.

F. Medication administration includes substances:
   1. Ingested
   2. Lozenges
   3. Sublingual (under the tongue)
   4. Buccal (in the cheek)
   5. Inhaled
   6. External/Topical
   7. Eye Drops
   8. Eye Ointments
   9. Ear Drops
   10. Epinephrine Pen
   11. Accu-Check (Chemstick)
   12. Subcutaneous Insulin Injection (pre-dialed pen)
   13. Rectal Insertion
   14. Gastrostomy/PEG Tube
   15. Nasal Spray

G. If more than one medication is to be given to the person served the staff will repeat the Medication Pass Procedure for each medication.

H. CVS Designated Coordinators will make every attempt to obtain on-going information regarding any person served medication changes. Information received from the residence, through Medication Review, physician orders, etc. will be immediately shared with the TMA/Lead CMA (Trained Medical Assistant/ Certified Medical Assistant) on site to ensure any changes in our responsibilities are updated on the Medication Administration Record (MAR). Designated Coordinators will assure that medication changes are documented in the persons' served legal file.

I. Any exceptions to the CVS Medication Administration Policies must have prior approval by the R.N. Consultant. The exception must be clearly documented in

the persons' served legal file, including a description of the circumstances, the date the R.N. was consulted, and the recommendations of the R.N. The R.N. will in turn give verbal recommendation followed by written or faxed Nurse's Notes for insertion in the persons' served legal file.

J. Records must be maintained to record each dose of medication given to an individual. Medication Administration Record (MAR) (Attachment #1) will be used for this purpose. These forms will be kept/maintained in the individual's medication file for 7 years, including those who have been terminated/ discharged.

K. Medications received:

1. Residential services – medications must be labeled by a pharmacist, including the name of the drug, strength and quantity of drug, directions for use, individual's name, and prescription number.
2. Day Program services – medications must be clearly labeled (may be labeled by residence), including the name of the drug, strength and quantity of drug, directions for use, individual's name, and time for dosage.

L. All medications will be stored appropriately in a locked storage/supply cabinet. The location of stored medications will be site specific. All Schedule II control medications when received, will be double locked and counted daily by staff to ensure accountability of CII medication. This locked process can be in a locked cupboard, then within a locked box in that cupboard.

M. If a re-useable item (such as a spoon) has been used for medication administration, wash it with soap and warm water.

N. TMA/CMA will check in medications upon arrival using inventory sheet (Attachment #2).

II. STAFF EXPECTATIONS

A. Practice infection control and universal precautions.

B. Give medications accurately and safely. Knowledge that no drug is harmless.

C. Check expiration date of medications prior to administering, and knowledge that expired medication may not be as effective. Staff will make contact with person served medical staff for recommendations if expired.

D. All medications must be ordered by a physician. This could include: medical doctors, doctors of osteopathy, dentists, podiatrists, dermatologists, ophthalmologists, psychiatrists, surgeons, nurse practitioners, physician assistants, etc.

E. The TMA or Lead CMA onsite will be responsible for obtaining the required orders on a yearly basis. Notice will be sent out to residential providers approximately one month prior to the expiration date of the current orders, requesting their assistance in obtaining these (Attachment #3).

F. In the event the TMA or Lead CMA is unable to obtain the new orders by the expiration date and the person served requires medication(s) to be administered at work, they will inform the manager before administering the medication(s). The manager will contact the residence to work out an alternative. If the problem is not resolved, the residential provider will be responsible for the medication administration.

G. A copy of only current orders (including standing orders) will be kept in the person served medication file to prevent confusion (old copies will be ripped in half and placed in recycling bin for shredding).

H. The original of all orders will be maintained in the person served legal file for seven years.

I. Knowledge about the medication(s) to be administered, including the medications intended use, any reactions or side effects which might occur, and any warning or specific considerations with the drug. A summary of this information will be placed behind the MAR for each person served (usually from the Nursing Drug Handbook or other resource, occasionally a medication not found in the handbook will require information from the internet or the pharmacy for inclusion behind the MAR as a reference).

J. A copy of the doctor's order indicating the reason for the medication (and the expected changes) will be placed behind the MAR if the medication is for an unlisted or nontraditional reason.

K. Will have completed training and shown competency to actually administer and document the medication(s).

L. The CVS line of responsibility related to medication administration will be followed:

1. Lead TMA/CMA
2. Designated Manager/Designated Coordinator
3. R.N. Consultant

M. Medications will be given in accordance with the times per day and specific hours of the day as prescribed.

N. Medications will be given within one hour before scheduled time to one hour after scheduled time unless the prescriber has indicated by writing in the order that the time parameters can be altered/extended (this order will be placed behind the MAR). Any outlying medication administration will be noted as a medication error unless the person served is off premises.

O. The person served general health and condition that is being treated with medication will be noted to the residence.

P. Observations about any individual's unusual response to the medication will be reported to the residence.

Q. Medications will be administered by the route and dose ordered.

R. Medications will be stored in a safe, clean and proper manner as indicated on the package (refrigerate, avoid light, etc.).

S. Medication is to be administered in the designated setting (by facility).

T. Person served privacy is paramount. HIPAA compliance will be in effect at all times. Staff will be trained in HIPAA on a yearly basis.

U. Create a calm environment, free from distraction, to administer drugs safely.

V. Medications are to be set up immediately before administration. Medication must be in constant view until given.

W. Gently clean any area with warm water before administration of medication if area has drainage or is dirty (follow specifics if written in MAR).

X. The staff person who set up the medication is responsible for administering and documenting the medication.

Y. Do not give a medication that you did not set up (unless properly packaged and labeled from the persons' served residence).

Z. Knowledge of the 7 rights of Medication Administration and is responsible to follow the rights:

1. Right person
2. Right medication (Rx number)
3. Right day/date
4. Right time
5. Right route
6. Right dose (includes # of pills)
7. Right documentation

AA. It is important to document the persons' served response to any medication, especially PRN medications.

BB. Knowledge of procedure for medication or treatment

CC. All medication errors will be reported to:

1. Designated Coordinator/Designated Manager
2. Residential facility
3. Family/Guardian
4. Case Manager

DD. A notation will be made in the individual's chart. A copy of all error reports will also be sent to the R.N. Consultant for review and monitoring at minimum on a monthly basis.

EE. A copy of the medication error report will be placed in the persons' served medication file, and the original report will be placed in the Manager's central file.

FF. In no case shall a prescription medication of one individual be used or saved for the use of other individuals.

GG. Any medication not given (ex: individual refused or dropped on the floor) will be disposed of using the Medication/Treatment Destruction and Documentation Procedure.

HH. A copy of all Medication/Treatment Destruction records will be sent to the residence involved to notify them of disposal and possible inventory change. A copy of the record will be placed in the persons' served medication file, and the original record will be placed in the Manager's central file.

II. Every individual person has the right to refuse medications.

JJ. A licensed and knowledgeable person will be available for consultation about any procedure or directions. Unlicensed personnel administering medications recognize their limitations and ALWAYS seek professional assistance when in doubt.

III. PSYCHOTROPIC MEDICATION USE - GENERAL GUIDELINES

A. Psychotropic medication shall be used only as an integral part of a Support Plan Addendum. The goal in use of psychotropic medication is a less restrictive way of managing, and ultimately controlling/eliminating the behavior or disorder/condition for which the medication is prescribed.

B. Current procedures for the monitoring and evaluation for use of psychotropic medications do not discriminate between the use of these medications for behavior control and use of these medications for the treatment of a diagnosed mental illness which may accompany the diagnosis of mental retardation.

C. While the evaluation for use and effectiveness of these medications may remain the same for individuals with a dual diagnosis or for those individuals taking medication for behavior management, frequently the expectations for progress differ.

D. It is strongly recommended that person served receiving or being considered as candidates for psychotropic medication receive a psychiatric evaluation to determine if a diagnosable mental illness is present.

E. Under no circumstance shall psychotropic medications be used:
   1. As punishment
   2. For staff convenience or as a substitute for adequate numbers or specific types of staff
   3. As a substitute for behavior, developmental, educational and/or therapeutic program
   4. Excessively or in quantities that interfere with an individual's rehabilitation.
   5. In the absence of a systematic data collection method with which to evaluate drug efficiency.

F. Recognition of both the benefits of psychotropic medications and possible risks inherent in the administration of these medications requires specific evaluation procedures to be followed to ensure administration which is appropriate and effective.

G. In all cases in which psychotropic is prescribed for the purpose of behavior control, staff will follow the guidelines outlined in the Psychotropic Med Use Checklist (PMUC) (Attachment #4).

IV. PROCEDURE FOR MEDICATION OR TREATMENT ERRORS/MEDICATION REFUSALS

A. It is a medication or treatment error if any of the following has occurred:
   1. A medication or treatment is not given
   2. An incorrect dose of medication is given or a treatment is given incorrectly
   3. A medication or treatment is given to the wrong person served
   4. A medication or treatment is given via the wrong route
   5. A medication or treatment is given on the wrong date
   6. A medication is given at the wrong time
   7. A medication is not documented
   8. A medication is refused by person served.

B. When a Medication/Treatment Error has been discovered or a Medication Refusal, the Designated Coordinator/ Designated Manager is to be notified immediately by the staff.

C. Designated Coordinator, Designated Manager, or designated staff will complete the following:
   1. Call the RN Consultant or Medical Professional for residence.
   2. Follow their instructions/recommendations
   3. Contact the residential facility/family/guardian/case manager to notify.
   4. Document the medication error and instructions or that the person refused their medication(s) in the persons' served file.
   5. Complete the medication error/ medication refusal form (Attachment #5) and give to supervisor. The supervisor will assure a copy is sent to the R.N.

Consultant, a copy is placed in the persons' served medication file, and the original is placed in the manager's central file.

V. PROCEDURE FOR MEDICATION/TREATMENT DESTRUCTION AND DOCUMENTATION

A. Day Programs

1. Option 1: Staff will return the medication/treatment to the persons' served residence for proper destruction.
   a. The CMA will fill in the following on the persons' served "medication/ treatment destruction record" (Attachment #6)
      1) Date
      2) Name and dose of medication/treatment
      3) Amount of medication/treatment
      4) Reason for being destroyed
      5) Prescription number
   b. The CMA will bag the medication/treatment in its original form (do not crush pills or open capsules), seal with duct tape, and label for destruction. The label will clearly state "DESTROY", and list the following information:
      1) Person served name
      2) Date
      3) Name and dose of medication/treatment
      4) Reason being destroyed
      5) Prescription number
2. Option 2: If a medication/treatment is found at a Day Program and it is unknown who it belongs to, a CMA will attempt to identify whether or not it is a controlled substance or psychotropic. It will then be destroyed using the proper procedure outlined below for residential programs. A "medication/ treatment destruction record" will be kept for the facility to record the destruction of all unknown medications/treatments.
3. Option 3: Permanent Collection Sites: Because of concerns of drug abuse and that some medications are highly regulated controlled substances, drug take-back programs are managed through law enforcement agencies.
   Austin Law Enforcement Center, 201 1st St. NE, Austin MN 55912 (507) 437-9400
   Albert Lea City Hall, 221 E. Clark St., Albert Lea MN 56007 (507) 377-5209
   Owatonna Law Enforcement Center, 204 E. Pearl St, Owatonna MN 55060 (507) 444-3800

B. Residential Programs - Medications/treatments that are not controlled substances or psychotropic:

1. Option 1-General Medication
   a. Facility staff that is certified in Medication Administration (CMA) may destroy any medication or treatment which is NOT a controlled substance or psychotropic medication, but only in the presence of another staff (witness).
   b. Immediately before the medication/treatment is destroyed, the CMA that is doing the destruction will fill in the following on the persons' served "medication/treatment destruction record":

1) Date
2) Name and dose of medication/treatment
3) Reason being destroyed
4) Prescription number

c. Take the medication/treatment to be destroyed, destruction record, and witness to the medication administration area.
d. Prepare medication if it is a pill or capsule, by crushing or braking open and emptying capsules. Leave other medication/treatments in their natural state (liquids, ointments, creams, powders, drops, suppositories).
e. Put at least ½ to 1 cup of kitty litter into a plastic bag and mix in prepared medication/treatment to be disposed of. Be sure to smash into the kitty litter.
f. Seal the bag thoroughly with duct tape and throw into garbage.
g. If medication/treatment container is to be thrown away also, remove all identifying personal information from the container before doing so.
h. Fill in the time the medication/treatment was destroyed on the destruction record.
i. Sign the destruction record and have the witness sign.
j. Place Medication/Destruction Record in facilities central file.

2. Option 2- Controlled substance or psychotropic medications/treatments:
   a. Facility staff that are certified in Medication Administration (CMA/TMA) may with a medical professional destroy any controlled substance or psychotropic medication or treatment
   b. If/when a controlled substance or psychotropic medication needs to be destroyed, the CMA will bag it in its original form (do not crush pills or open capsules, no kitty litter), seal with duct tape, and label for destruction. The label will clearly state "DESTROY", and list the following information:
      1) Person served name
      2) Date
      3) Name and dose of medication/treatment
      4) Amount of medication/treatment
      5) Reason being destroyed
      6) Prescription number
   c. Controlled Substances and Psychotropic Medications/Treatments – These medications/treatments must be destroyed by a nurse with a facility staff as witness, using the procedure outlined in number (1) above.
3. Option 3-Permanent Collection Sites: Because of concerns of drug abuse and that some medications are highly regulated controlled substances, drug take-back programs are managed through law enforcement agencies.
   Austin Law Enforcement Center, 201 1st St. NE, Austin MN 55912 (507) 437-9400
   Albert Lea City Hall, 221 E. Clark St., Albert Lea MN 56007 (507) 377-5209
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VI. PROCEDURES FOR ADMINISTERING PRN MEDICATIONS/STANDING ORDERS/ AND OFF-SITE MEDICATIONS

A. Administering PRN Medications

1. Check the list of person served allergies.
2. Check the list of standing orders; if the medication is not listed it may not be administered at the day program (only if residing in a licensed facility).
3. If possible, check with residential facility or family, to confirm if medication was administered prior to arrival to day program and has the recommended time span between doses lapsed.
4. Administer the medication using the appropriate procedures, according to the manufacturer's directions stated on the medication container.
5. Enter the order on the Monthly Medication sheet as listed on the standing order.
6. Record the persons' served name, reason for administering the medication, dosage, route, date, time the medication was administered and signature.
7. Check with the person served in ½ hour to ensure desired effect of the medication has been achieved. Document this in the persons' served file.
8. Communicate this information to residential facility or family.

B. Standing Orders

1. Standing orders are a list of medications available for use by the person served.
2. Standing order medications are used to treat minor issues on a temporary basis (no more than 3 days before contacting the prescriber to evaluate for a regular order).
3. Each residence may have a list of standing orders available for the prescriber to review and sign off on for the persons' served use on a yearly basis.
4. Medication Administration will be in compliance with Cedar Valley Services Medication Policy.
5. When a medication from a person served list of standing orders is given, a MAR will be filled out if they do not already have one for routine meds, and it will be documented in the PRN section.

C. Off-Site Medications

1. All medications will be stored in a locked cupboard at the specific work site.
2. Off site medications refers to administration or self administration of a person served away from their main work site.
3. When needing to take medication(s) out of a person served main work site due to another job, the staff person who packages the medication is responsible for administering and documenting the medication. The staff person will keep the packaged medication on one's person until administered to the person served unless it is written in the persons served *Support Plan and/or Support Plan Addendum* that they can keep the medication on one's person.
4. Staff will label the medication envelope: a.) Person's served first and last name, b.) Name of the Medication, c). Dosage, d.) Route to be taken, e.) Time to be taken, f.) Number of pills
5. Staff, when packaging the medication envelope, will compare the MAR to the medication(s) and complete the 3 medication checks: taking the medication out of the cupboard and comparing it to the MAR, when putting the medication

in the paper envelope, and when putting the remaining medication back into the cupboard.

6. Staff will upon returning to the main work site, staff will document in the MAR that the person served medication was administered.

VII. PROCEDURE FOR MEDICATION ASSISTANCE

A. There may be an occasion when CVS or the Residential Program is assigned the responsibly of solely for medication assistance to enable a person served to self-administer medication or treatments when the person is capable of directing their own care or when the persons served legal guardian is present and is able to direct the care for the person.

B. If medication assistance is assigned in the *Support Plan and/or the Support Plan Addendum*, staff may:

1. Bring to the person an open container of previously set up medication, empty the container into the person's served hand, or open and give the medication in the original container to the person under the direction of the person served.
2. Bring the person served food or liquids to accompany the medication.
3. Provide reminders, in person, remotely, or through programming devices such as telephones, alarms, or medication boxes, to regularly take scheduled medication or perform regularly scheduled treatments and exercises.

VIII. ADMINISTERING SPECIFIC FORMS OF MEDICATIONS

A. ORAL MEDICATIONS

1. Verify Medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (Medication must be delivered within one hour before or after designated medication time).
3. If any parameters are required check before medication delivery (i.e. BP/Pulse/Temp).
4. Assess person served for any concerns (possible issue or need for PRN meds).
5. Person served has the right to refuse all or part of these medications (follow refusal procedure for any medication not accepted).
6. Gather needed supplies.
7. Remove person served medications from locked medication storage/supply area.
8. Wash hands.
9. Put on gloves, if necessary.
10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time
    d. Medication (including Rx #)
    e. Dose
    f. Route
11. If medication is not available, notify lead TMA/CMA.

12. Obtain any food, drink, or other necessary items needed to deliver the medication (check volume/amount ordered).
13. Remove the correct medication verifying the person served, medication, time, route, and dose.
14. See #18 below for specifics on dosing.
15. Return medication container(s) to locked storage/supply again verifying the person served, medication, time, route and dose.
16. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, etc.
17. Identify yourself and explain the procedure.
18. **SPECIFICS FOR DOSING AND ADMINISTERING DIFFERENT FORMS OF ORAL MEDICATIONS:**

a. PILLS/CAPSULES

1) Bottle-pour pill or capsule into the cap of container, then put into medication cup
2) Bubble pack-punch pill or capsule directly into the medication cup
3) Pre-set up medications from persons' served residence-open appropriate day/date and pour into medication cup
4) Note the total number of pills/capsules to be delivered and compare to number in medication cup
5) Crush medication if indicated on MAR and administer mixed as per person served care plan
6) Administer the medication with water or other liquid according to person served care plan
7) Watch the person served swallow the medication

b. LIQUIDS

1) Medication cup-place on a flat surface to pour (view liquid medication in the med cup on a flat surface at eye level)
2) Dropper-hold at eye level and draw up the correct amount of medication in correct syringe or dropper (using a different syringe or dropper may deliver the wrong dose)
3) Note the total number of liquids to be delivered and deliver to person served in individual medication cups or one combined cup as indicated on the MAR
4) Administer the medication with water or other liquid according to their care plan
5) Watch the person served swallow the medication

c. POWDERED

1) Measure or pour into medication cup
2) Combine for delivery as indicated on the MAR (i.e. mix liquid or soft food such as applesauce)
3) Administer the medication immediately after mixing well
4) Watch the person served swallow the medication

d. **BUCCAL**
   1) Bottle-pour pill into cap of bottle then into medication cup or draw up the medication in dropper if liquid
   2) Place the prescribed amount of medication in the inside of the cheek
   3) Wait 5 minutes before giving person served any liquids

e. **LOZENGES**
   1) Check the label and unwrap the lozenge if necessary, and put it in a medication cup
   2) Ask the person to place the lozenge on their tongue, or using gloves place the lozenge on their tongue
   3) Wait 10 minutes before giving person served any liquids

f. **SUBLINGUAL TABLETS**
   1) Put tablet into cap of bottle then into medication cup
   2) Using a glove, place or allow the person served to place the tablet under the person's tongue to dissolve
   3) Tell the person not to chew the tablet
   4) Wait 10 minutes before giving person served any liquids.

19. Discard the medication cup(s)
20. Remove gloves if used and discard
21. Wash hands
22. Chart the medication(s) as given on the MAR
23. Fill in the PRN or optional dose medication on the back of the MAR if given
24. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

B. TOPICAL MEDICATIONS (ON SKIN)

1. Verify medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (medications must be delivered within one hour before or after designated medication time)
3. If any parameters are required, check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Gather needed supplies
7. Remove person served medications form locked medication storage/supply area
8. Wash hands
9. Put on gloves
10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time

d. Medication (including Rx#)
e. Dose
f. Route

11. Note the names of the medications due at this time and the dose, including the number of topical medication(s) and site(s) for administration
12. Remove the correct medication verifying the person served, medication, time, route, and dose
13. If medication as ordered is not available notify TMA/CMA
14. Remove the correct amount of medication
    a. Bottle: Pour/drip slowly into the medication cup
    b. Tube: Squeeze into medication cup
15. Note the number of topical medications to be delivered and compare to number in medication cups
16. Return medication container(s) to locked storage/supply again verifying the person served, medication, time, route, and dose
17. Approach the person served and identify them by methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, tec.
18. Identify yourself and explain the procedure
19. Administer the medication with Q-tip or gloved finger
20. Inform the person served not to touch the area after the medication administration
21. Discard the medication cup
22. Remove gloves and discard
23. Wash hands
24. Chart the medication(s) as given on the MAR
25. Fill in the PRN or optional dose medication on the back of the MAR
26. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

D. EYE MEDICATIONS

1. Verify medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (medication must be delivered within one hour before or after designated medication time)
3. If parameters are required check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Gather needed supplies
7. Remove the person served medications from locked storage/supply area
8. Wash hands
9. Put on gloves
10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time

d. Medication (including Rx#)
e. Dose
f. Route

11. If medication as ordered is not available notify TMA/CMA
12. Note the names of the medications due at this time and the dose
13. Remove the correct medication verifying the person served, medication, time, route, and dose.
14. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, etc.
15. Identify yourself and explain the procedure.
16. Ask the person served to tip head back, assist if needed
17. **SPECIFICS FOR DOSING AND ADMINISTERING DIFFERENT FORMS OF EYE MEDICATIONS**

a. **DROPS (gtts)**
   1) Note the number of eye drops and which eye(s)
   2) Open the eyelids by placing the palm to the side of the face and gently opening the eyelids with the thumb and first finger
   3) Hold the medication approximately 1 inch above the eye where the eyeball and lower lid meet
   4) Administer the medication without touching the eye
   5) Make sure the medication goes into the eye. Reapply if the person served blinks or the medication does not go into the eye
   6) Wait approximately 1 minute between drops of the same medication to the same eye
   7) Wait at least 5 minutes between types of eye drops to the same eye

b. **OINTMENT**
   1) Note the number of eye ointments and which eye(s)
   2) Make person served aware there may be a slight blurring of vision immediately after ointment administration and that blurring will gradually resolve
   3) Open the eyelids by placing the palm to the side of the face and gently opening the lower eyelid with the thumb or first finger
   4) Hold the medication immediately above the eye where the eyeball and lower eyelid meet
   5) Administer the medication in a continuous line starting at one edge and ending at the other edge without touching the eye with the dispenser
   6) Ask person served to close the eye for 1-2 minutes
   7) Notify the person served when the eye can be opened

18. Provide the person served with w tissue or assist in wiping away any overrun of the medication on the face
19. Instruct the person served not to wipe the eye
20. Return medication container(s) to locked storage
21. Remove gloves and discard

22. Wash hands
23. Chart the medication(s) as given on the MAR
24. Fill in the PRN or optional dose medication on the back of the MAR if given
25. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

E. ADMINISTERING EAR DROPS (gtts)

1. Verify medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (medication must be delivered within one hour before or after designated medication time)
3. If any parameters are required check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Gather needed supplies
7. Remove person served medications from locked medication storage/supply area
8. Wash hands
9. Put gloves on
10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time
    d. Medication (including Rx #)
    e. Dose
    f. Route
11. Note the names of the medications due at this time and the dose, including the number of ear drops and which ear(s)
12. If medication as ordered is not available notify TMA/CMA
13. Remove the correct medication verifying the person served, medication, time, route, and dose
14. Draw up the medication in dropper
15. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, etc.
16. Identify yourself and explain the procedure
17. Ask the person served to tip head to the side assist if needed (can lay head on table or be lying in bed)
18. Grasp the ear lobe (pinna) gently and pull gently toward back of head and then slightly upward toward top of the head (for adults)
19. Hold the medication immediately above the ear canal
20. Administer the medication one drop at a time without touching the ear with the dispenser
21. Ask person served to remain in side position for 2-3 minutes
22. Provide the person served with a tissue or assist in wiping any overrun of the medication

23. Instruct the person served not to wipe or rub the ear
24. Notify the person served when the head can be returned to the upright position
25. If both ears require drops, wait 5 minutes between administering
26. Make person served aware there may be a slight feeling of fullness in the ear
27. Return medication container(s) to locked storage
28. Remove gloves and discard
29. Wash hands
30. Chart the medication(s) as given on the MAR
31. Fill in the PRN or optional dose medication on the back of the MAR if given
32. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

F. ADMINISTERING INHALED MEDICATION

1. Verify medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (medication must be delivered within one hour before or after designated medication time)
3. If any parameters are required check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Gather needed supplies
7. Remove person served medications from locked medication storage/supply area
8. Wash hands
9. Put gloves on
10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time
    d. Medication (including Rx #)
    e. Dose
    f. Route
11. Note the names of the medications due at this time and the dose, including the number of medications to be dispensed
12. If medication as ordered is not available notify TMA/CMA
13. Place a clean barrier device on the surface you are working on (such as a paper towel)
14. Remove the correct medication verifying the person served, medication, time, route and dose
15. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR verbal confirmation from additional staff, etc.
16. Identify yourself and explain the procedure
17. Ask the person served to relax

18. SPECIFICS FOR DOSING AND ADMINISTERING DIFFERENT FORMS OF INHALED MEDICATIONS:

a. NEBULIZED

1) Note if medications are to be combined (together) or consecutive (one following the other)
2) Assemble the nebulizer tubing
3) Place the medications in the nebulizer receptacle
4) Add diluting solution such as saline if ordered
5) Hold the medication immediately in front of the person served and turn on the nebulizer verifying that the mist appears
6) Assist the person served in placing on the mask or holding the medication dispenser between lips as needed
7) Encourage person served to breathe slowly and deeply until medication mist disappears
8) Notify the person served when the medication treatment is completed
9) Rinse out the nebulizer equipment parts including tubing with warm water and allow to air dry, hanging tubing so it can drip

b. INHALERS WITH AND WITHOUT SPACERS

1) Shake the medication container to activate medication
2) Assemble inhaler(s) and extender if used
3) Hold the medication immediately in front of the person served
4) Ask the person served to pull in a breath and exhale deeply
5) Assist the person served is placing on the mask or holding the medication dispenser between lips, as needed
6) Deploy inhaler
7) Ask person served to breathe slowly and deeply for approximately 10 seconds
8) Notify person served when 10 seconds is over
9) Wait one minute (or time ordered) before repeating (if ordered)
10) Rinse out the extender (if used) with warm water and allow to air dry.

c. NASAL SPRAY

1) Shake the bottle
2) Ask individual to gently blow their nose
3) Have individual tilt head slightly forward if using a pump bottle and head upright if using a nasal spray
4) Have individual pinch closed one nostril with finger
5) While keeping the bottle upright, carefully insert the nasal applicator into the other nostril
6) Advise individual to start to breathe in thorough the nose
7) WHILE BREATHING IN, press down, firmly and quickly, once on the applicator to release the spray

8) Have the individual breathe in through the nostril and breath out through purse lips or through the nose
9) Repeat in other nostril per instructions
10) Wipe the nasal applicator with a clean tissue and replace the dust cover
11) Most nasal sprays should be stored upright
12) **If a different type of nasal spray is prescribed for a person served, Designated Coordinator's or Designated Manager's will develop a protocol, per medication guidelines for administering the specific nasal spray, and staff will be trained on the protocol before administering the nasal spray medication**

19. Discard the barrier device
20. Return medication container(s) to locked storage
21. Remove gloves and discard
22. Wash hands
23. Chart the medication(s) as given on the MAR
24. Fill in the PRN or optional dose medication on the back of the MAR if given
25. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

G. ADMINISTERING BLOOD GLUCOSE MONITORING SYSTEMS (ACCU CHECKS/CHEMSTICKS)

1. Verify that this person served has Accu Checks ordered
2. Verify Accu Check due at this time per Medication Administration Record (MAR) or that person served is showing altered behavior and Accu Check is needed to verify blood sugar stability (testing must be done within one hour before or after designated testing time)
3. Assess person served for any concerns (possible issue or need for PRN meds)
4. Person served has the right to refuse all or part of this treatment (follow refusal procedure for any treatment not accepted)
5. Gather needed supplies
6. Remove person served Accu Check device from locked medication storage/supply area
7. Wash hands
8. Put on gloves
9. Recheck the MAR for:
   a. Person
   b. Day/Date
   c. Time
10. Note the names of any medication(s) due in conjunction with Accu Check and any parameters for administration (i.e. Accu Check above or below a certain value)
11. Place a clean barrier device on the surface you are working on (such as a paper towel)

12. Verify that the Accu Check machine is for this person served rechecking the MAR for:
    a. Person
    b. Day/Date
    c. Time
13. If Accu Check machine for this person served is not available notify TMA/CMA
14. Verify the Accu Check device and lancet are ready for use
    a. Accu Check device has a test strip in place (you also have a second test strip available if needed)
    b. Clean lancet is available and inserted in delivery system (you also have a second lancet if needed)
    c. Set depth on lancet delivery device
15. A sharps container is available and ready for use
16. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from staff, etc.
17. Identify yourself and explain the procedure
18. Ask the person served to relax
19. Identify which finger and what area of finger will be used for testing
20. Clean or assist the person served in cleaning the area with alcohol and allow to air dry or have person served wash and dry hands
21. Place or assist the person served in placing the lancet device against the identified and cleaned area of the finger and draw blood
22. Place or direct the person served to place used lancet on barrier device stabbing sharp into cover or place in sharps container
23. Blot or assist the person served in blotting first drop of blood with tissue or cotton
24. Squeeze or assist person served in squeezing finger until fresh drop of blood appears
25. Place or assist the person served in placing the test strip beside the drop of blood and slowly sliding it into the drop of blood
26. Set Accu Check on barrier device during countdown
27. Blot or allow person served to blot the lancet entry site to remove any blood, applying mild pressure if needed, apply band-aid
28. Read test strip, share results with person served (if appropriate)
29. Proceed to insulin if ordered for indicated Accu Check results
30. Place all contaminated items except sharps in one gloved hand and pull glove over palmed items including barrier device then pull second glove over first glove and discard per policy
31. Wash hands
32. Chart the Accu Check results on the MAR
33. Fill in the PRN or optional treatment on the back of the MAR given

H. ADMINISTERING INSULIN INJECTION (PEN)

1. Verify medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what insulin(s) are due at this time (medication must be delivered within one hour before or after designated medication time)

3. If any parameters are required check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Look specifically for any sliding scale insulin to be given dependent on Accu Check results
7. Gather needed supplies
8. Remove person served medications from locked storage/supply area
9. Wash hands
10. Put on gloves
11. Compare the insulin pen label to the MAR for:
    a. Person
    b. Day/Date
    c. Time
    d. Medication (including Rx #)
    e. Dose
    f. Route
12. Note the names of the medications due at this time and the dose, including the amounts of insulin and number of different insulin
13. If medication as ordered is not available notify TMA/CMA
14. Note: The pen can either be reusable, using a cartridge that needs to be replaced when empty, or disposable, pre-filled with insulin and then disposed of when empty
15. Remove the correct medication verifying the person served, medication, time, route, and dose
16. Note that insulin does not have to be refrigerated
17. Check the insulin solution for clarity (not cloudy)
18. Rolling is not required for insulin pens (the medication is a solution not a suspension). If you chose to rotate insulin do so between palms in a rolling motion (do not shake)
19. Screw on a disposable needle to the end of the insulin pen
20. Hold insulin pen upright and check for bubbles. If found rotate delivery to #2 and expel the bubble(s)
21. Note the total amount of insulin to be delivered, adding standing dose of insulin and any sliding scale insulin to be given based on the Accu Check results and rotate pen delivery to # indicated
22. Recheck total amount to be given against MAR
23. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, etc.
24. Ask the person served to relax
25. Identify which site the person served would like to use for the injection.
26. Clean or assist the person served in cleaning the area with alcohol and allow to air dry or have person served wash and dry area
27. In a suitable area take a fold of skin between the thumb, index and middle finger. Only lift the skin NOT the muscle below it.

28. Place or assist the person served in placing the needle tip on the identified area at a 90-degree angle.
29. With your prepared pen, push or assist the client to push the needle all the way into the skin at the peak of the fold at a 90 degree angle
30. Inject insulin
31. Keep the needle in for at least 10 seconds after the dial has returned to zero to make sure to deliver full dose
32. The grip on the skin should be maintained throughout the injection
33. Take the needle out slowly, releasing the skin at the same time
34. Place used insulin syringe in sharps container
35. Blot or allow person served to blot the needle entry site to remove any blood, applying mild pressure if needed, apply band-aid if indicated
36. Give or assist the person served in giving second subcutaneous injection if indicated, repeating the previous steps for each
37. Recap the needle with the large cover (not the small needle guard) and place it in a sharps collector immediately
38. Place all contaminated items except sharps in one gloved hand and pull glove over palmed items including barrier device then pull second glove over first glove and discard per policy
39. Wash hands
40. Chart the insulin administration including the amount of insulin and site of delivery on the MAR for each dose
41. Fill in the PRN or optional dose medication on the back of the MAR if given
42. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

I. ADMINISTERING EPINEPHRINE PEN (2 STYLES)

****NOTE THIS IS AN EMERGENCY PROCEDURE, 911 MUST ALWAYS BE CALLED****

1. Verify medication administration Record (MAR) if available
2. Assess person served and identify what type of reaction person served is having
3. This procedure is for Respiratory Distress as a known allergic reaction
4. Encourage the person served to sit down
5. Ask the person served if they have an Epinephrine Pen and where it is
6. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
7. Yell for assistance and be prepared to initiate CPR if needed
   a. Have someone call 911, get first aid kit and AED
   b. Caller is to inform 911 dispatcher there is an allergy emergency involving breathing and an Epinephrine Pen is being used
8. Remove person served Epinephrine Pen from fanny pack/lunch bag or locked medical supply cabinet
9. Compare the pen label to the MAR for:
   a. Person
   b. Day/Date
   c. Time

d. Medication (including Rx#)
e. Dose
f. Route

10. Remove Epinephrine cover
11. Use opposite hand to keep persons' served arm out of the way
12. Note time of delivery for documentation and for emergency personnel
13. Hold Epinephrine Pen (standard, style #1) in firm palm grip or
14. Hold Talking Epinephrine Pen (Auvi-Q by SANOFI, style #2) in hand and follow verbal prompts resuming this procedure starting at step #21.
15. Give injection in outer thigh, midway between the hip and knee (may be given in bare skin or through clothing along the seam of the slacks if wearing pants)
16. Place or assist the person served in placing the needle tip on the identified area at a 90-degree angle
17. Firmly push the needle all the way in using a jabbing motion a t a 90 degree angle
18. Keep the needle in for at least 10 seconds after the needle is inserted to make sure full dose is delivered
19. Take the needle straight out (90 degree angle maintained)
20. Put on gloves (if not already wearing)
21. Wearing gloves rub or allow the person served to rub the needle entry site to assist in absorption
22. If available place syringe in a sharps collector immediately (alternatively give to rescue team for disposal)
23. Place all contaminated items except sharps in one gloved hand and pull glove over palmed items then pull second glove over first glove and discard per policy
24. Wash hands
25. Chart the Epinephrine administration including the time of the incident if known and the Epinephrine administration time.
26. Fill in the PRN or optional dose medication section on the back of the MAR
27. Notify your manager of the incident as soon as 911 arrives for follow-up

J. ADMINISTERING RECTAL MEDICATION

1. Verify Medication Delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (medication must be delivered within one hour before or after designated time)
3. If any parameters are required check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Gather needed supplies
7. Remove person served medication from locked medication storage/supply area
8. Wash hands
9. Put on gloves

10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time
    d. Medication (including Rx#)
    e. Dose
    f. Route
11. Place a clean barrier device on the surface you are working on (such as a paper towel)
12. Remove the correct medication verifying the person served, medication, time, route and dose
13. See #21 below for specifics on dosing
14. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, etc.
15. Identify yourself and explain the procedure
16. Assist person served to private area such as med room
17. Assist person served as needed in removing or lowering clothing to expose buttocks
18. Ask the person served to lay on their side with lower leg straight and top leg is bent at the knee
19. Have the person served roll slightly forward onto bent knee
20. Grasp and spread the buttocks with one gloved hand
21. **SPECIFICS FOR DOSING AND ADMINISTERING DIFFERENT FORMS OF RECTAL MEDICATIONS:**

    a. **SUPPOSITORY**
        1) Place opened suppository in med cup with water soluble lubricant (dime size) in medication cup with rounded tip down
        2) Hold the suppository in the opposite gloved hand
        3) Administer the medication be inserting the rounded lubricated end of the suppository into the rectum slowly to the first finger joint.

    b. **BOTTLED LIQUID ENEMA OR LIQUID SUPPOSITORY**
        1) Place syringe tip with water soluble lubricant (pre-applied or place a dime size) in medication cup
        2) Hold the syringe or container tip in the opposite gloved hand
        3) Administer the medication by inserting the end of the syringe or container tip into the rectum slowly approximately 1 ½ inches or until the length of the catheter tip of the syringe is inserted
        4) Do not JAM the tip into the rectum
        5) Include details on seizure report form in appropriate.

22. Hold the buttocks firmly together for 5 minutes to delay expulsion
23. Ask person served to remain in side position for 10-15 minutes
24. Provide the person served with a tissue or assist in wiping away any overrun of the lubricant

25. Instruct the person served not to wipe or rub his or her rectum as this may stimulate expulsion
26. Notify the person served when the time has elapsed and it is acceptable to return to the sitting position
27. Make person served aware there may be a slight feeling of fullness
28. Assist person served in returning clothing to original position, as appropriate
29. Discard the barrier device
30. Remove gloves and discard
31. Wash hands
32. Chart the medication(s) as given on the MAR
33. Fill in the PRN or optional dose medication on the back of the MAR if given
34. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR

K. ADMINISTERING GASTROSTOMY OR PEG TUBE MEDICATIONS

1. Verify Medication delivery due at this time per Medication Administration Record (MAR)
2. Identify what medications are due at this time (medication must be delivered within one hour before or after designated medication time)
3. If any parameters are required check before medication delivery (i.e. BP/pulse/temp)
4. Assess person served for any concerns (possible issue or need for PRN meds)
5. Person served has the right to refuse all or part of this medication(s) (follow refusal procedure for any medications not accepted)
6. Gather needed supplies
7. Remove person served medication from locked medication storage/supply area
8. Wash hands
9. Put on gloves
10. Compare the medication container label to the MAR for:
    a. Person
    b. Day/Date
    c. Time
    d. Medication (including Rx #)
    e. Dose
    f. Route
11. Note the names of the medications due at this time and the dose, including liquids, pills or powders for each medication is present
12. If medication as ordered is not available notify TMA/CMA
13. Medications must be given separately if more than one
14. Place a clean barrier device on the surface you are working on (such as a paper towel)
15. Remove the correct medication verifying the person served, medication, time, route, and dose

16. Place the medication cup on a flat surface. Pour or draw up the correct amount of medication (viewing liquid medication in the med cup on a flat surface and at eye level or the dropper held at eye level)
17. Crushed medications will be placed in a pill crusher and be finely ground. Pill crusher to be cleaned after each use.
18. Crushed or powdered medication will be reconstituted into a suspension
19. Note the total number of liquids to be delivered and deliver to person served in individual medication cups as indicated on the MAR
20. Note any fluid restrictions and abide by them
21. Obtain liquid in predetermined amount ordered for tube flush in a large cup
22. Return medication container(s) to locked storage/supply area again verifying the person served, medication, time, route, and dose
23. Approach the person served and identify them by 2 methods: 1-photo; 2-med tag, MAR, verbal confirmation from additional staff, etc.
24. Identify yourself and explain the procedure
25. All staff to be trained to follow procedure for type of tube each individual has to administer medication(s) through. See individual procedure.
26. Discard the medication cup(s) and barrier device
27. Remove gloves if used and discard
28. Wash hands
29. Chart the medication(s) as given on the MAR
30. Fill in the PRN or optional dose medication on the back of the MAR if given
31. Re-evaluate 30 minutes after PRN medication for effectiveness and chart in MAR