

POLICY AND PROCEDURE PERTAINING TO MEDICATION ASSISTANCE AND ADMINISTRATION

PURPOSE

As a staff member supporting persons in their homes, we must agree that our primary responsibility is to provide the person with the best possible care and training. This means that it is our duty to become as knowledgeable and skillful in our field as possible in order to achieve this goal.

Administering medication is a serious responsibility. This policy is designed to provide you with the necessary information and background to acquire competency in administering medication; that is, to ensure quality care for the person and avoid errors. It is your task to learn and utilize this information if you are to assume this responsibility. Therefore, read this material *carefully*. Note any questions you may have regarding the material or note any portions of the material that does not seem clear. Any questions you have can be directed to your supervisor. **If working at an ICF site**, you will be scheduled for a review session with the LPN or RN prior to testing for certification.

The study of this policy should help you meet the following objectives:

1. To know and understand the proper methods of drug administration.
2. To become familiar with abbreviations and terminology commonly used in the directions for administering medications.
3. To properly document (chart) administration and follow-up.
4. To become aware of the areas of responsibility involved in medication administration.
5. To skillfully use available reference materials such as a Drug Handbook and/or pharmacy medication information sheets.

POLICY

The goal of the Medication Management System is to establish the six rights that will decrease the likelihood of medication errors. Those rights include: The “Right Dose”, “The Right Drug”, “The Right Patient”, “The Right Route”, “The Right Time”, and “The Right Charting”.

All staff will read the registered nurse (RN) developed and Department of Health Approved Medication Administration Manual, pass the accompanying test, and the return demonstrations to the supervisor prior to administering any medications. Annually, staff will complete a return demonstration with their supervisor. In the absence of the house supervisor, the return demonstrations may be done with a manager, LPN or RN. Any staff working with a person with overriding health care needs will have additional training and/or the Medication Administration Training Course taught by the RN.

ICF SITES: All staff will complete the Medication Administration Certification/Training taught by the LPN or RN to meet the federal requirements for an ICF. This includes reading the RN developed and Department of Health Approved Medication Administration Manual, passing the accompanying test, and the return demonstrations to the LPN or RN prior to administering any medications. Procedures and practices referenced in the manual will be adhered to.

Supervisors of each site are responsible for coordinating necessary periodic & company required trainings and ongoing quality monitoring to assure that our medication system is

effective. In the event of an error, the supervisor will complete an evaluation and advise the EON, Inc. CSD of that outcome. Management review will be focused on eliminating any future similar errors. As necessary, appropriate health care professionals will be consulted to assure the proper procuring of medication, storage, dispensing, administering, and monitoring.

PROCEDURE

I. Related Terms

Below you will note a list of terms, many of which you will encounter in the course of administering medication. It is essential for you to understand the meaning of these terms if you are to know the nature of the drugs which you administer.

A. Drug: The term drug may be used interchangeably with the term medication.

Each drug is known by two names: the generic name and the brand (or trade) name. These names are again referred to in the section describing the use of the Drug Handbook or medication information sheets.

1. Brand (or Trade) Name: A specific drug name assigned by and registered to the drug manufacturer, also called the trade name, e.g., Valium.
2. Generic Name: A general name given to a class of drugs based on the chemical nature and action, e.g., Diazepam.

There are three basic forms of medication:

1. Liquids: Some examples of liquid preparations are as follows: for internal use, examples would be Kaopectate, which is used for diarrhea; or a syrup such as Robitussin, used in the treatment of cold symptoms; for external use, examples would be Dermassage lotion for skin conditions or an antiseptic spray which is applied to the skin.
2. Solid forms: Examples would be capsules, pills, and tablets for internal use.
3. Semi-solid preparations: Examples of this form of medication would be suppositories, ointments, and creams which are generally used externally only.

B. Dose: Quantity of a drug given at one time which is determined by the doctor or pharmacist.

C. Adverse Reactions: Can result from administering too high a dose. These results are unexpected reactions.

1. Check Drug Handbook or medication information sheets for adverse reaction.
2. Call nurse in event of unexpected reactions.

D. Side Effects: Any effect of a drug either desirable or undesirable, and an effect other than which it was administered for. Side effects are different from adverse effects because side effects are documented reactions from drug trials.

E. Allergic Reaction: An allergic response may vary in severity from a slight rash to shock or death. Fortunately, such severe reactions are not common. Example: Penicillin may cause a reaction such as a rash initially, however, the next time it is taken, it could produce a reaction as severe as death.

II. Other Terms to Be Familiar With

- Analgesic: A pain relieving remedy, e.g., Darvon.
- Antacid: An agent which reduces or eliminates acids in the stomach, e.g., Maalox.
- Antianxiety: Medication or other intervention that inhibits anxiety, e.g., Ativan.
- Antiarrhythmic: A group of pharmaceuticals used to suppress abnormal rhythms of the heart such as atrial fibrillation, e.g., Metoprolol, Digoxin.
- Antibiotic: Slows the growth of microorganisms, derived from a mold or bacterial growth, or is made synthetically, e.g., Ampicillin.
- Anticholinergic: Drug used to block neurotransmitter acetylcholine in central and peripheral nervous system used for gastrointestinal, genitourinary, respiratory and other disorders, e.g., Levodopa.
- Anticoagulant: An agent which slows blood clotting, e.g., Coumadin.
- Anticonvulsant: Antiepileptic or antiseizure drug used to treat epileptic seizures, e.g., Zarontin, Dilantin.
- Antidepressant: Drug used to treat major depressive disorder and other conditions, e.g., Zoloft, Paxil.
- Antidiarrheal: Used to treat diarrhea, e.g., Kaopectate.
- Antiemetic: Drug used for nausea and vomiting, also used to treat motion sickness, e.g., Dramamine.
- Antihypertensive: A drug which tends to lower the blood pressure, e.g., Lisinopril.
- Anti-infective: Acts against infection by inhibiting the spread of an infectious agent or kills agent outright, e.g., Penicillin, Tetracycline.
- Anti-inflammatory: Used to reduce inflammation, e.g., Ibuprofen, Celebrex.
- Antipsychotic: Also known as neuroleptic or major tranquilizer, used to manage psychosis (schizophrenia), behavioral symptoms in dementia and other severe mental disorders, e.g., Haldol.
- Antipyretic: Substance used to reduce fever, e.g., Tylenol.
- Antiseptic: A substance which slows the growth of susceptible germs but does not necessarily kill them, e.g., Hydrogen Peroxide.
- Antispasmodic: A drug used to relieve muscle spasms, e.g., Bentyl.
- Antiulcer: Used to treat ulcers in stomach and upper part of small intestine, e.g., Pepcid, Zantac, Carafate.
- Brand Name: A specific drug name assigned by and registered to the drug manufacturer, also called the trade name, e.g., Valium.
- Bronchial: Relating to air passages of lungs, e.g., Theophylline.
- Buccal: Placed in the mouth between the cheek and gums.

- Cathartic: A compound used to induce bowel movement, e.g., Epsom salt.
- Coagulant: A drug which promotes blood clotting, e.g., Vitamin K.
- Contraindication: A symptom, condition or indication in which a remedy or method of treatment is not advisable.
- Controlled Substance: Any substance included under the federal classification system in which drugs known to be habit forming are assigned a level of classification from 1-5, depending upon their potential for abuse.
- Decongestant: Drug used to relieve nasal congestion in the upper respiratory tract, e.g., Psuedophedrine.
- Diuretic: A drug used to stimulate formation of urine, e.g., Lasix.
- Emetic: A drug used to induce vomiting, e.g., Ipecac.
- Expectorant: A substance used to induce coughing and spitting, e.g., Mucinex.
- Generic Name: A general name given to a class of drugs based on the chemical nature and action, e.g., Diazepam.
- Hypnotic: Drug to induce sleep, e.g., Lunesta.
- Indication: Any symptom caused or occurrence in a disease which points out a course of treatment.
- Laxative: An agent which loosens the bowels, e.g., Metamucil, Milk of Magnesia.
- Legend Drug: A drug for which a prescription is required.
- Muscle Relaxant: Drug that affects skeletal muscle function and decreases muscle tone to alleviate spasms and pain, e.g., Flexeril, Diazepam.
- Sedative: An agent which quiets activity, calms or tranquilizes, e.g., Phenobarbital.
- Stimulant: Medication used for Attention Deficit Hyperactivity Disorder, e.g., Amphetamine.
- Stop Order: A policy whereby a person's medication is automatically discontinued after a certain period of time, if the physician has not ordered it discontinued at a specific time.
- Sublingual: Placed under the tongue.
- Suppressant: Agent used to suppress or reduce intensity such as a cough, e.g., Robitussin DM.
- Trade Name: Same as the brand name.
- Vasodilator: Drug used to widen blood vessels to treat a variety of conditions including high blood pressure, e.g., Nitroglycerin.
- Vitamin: A compound which has no calories but is essential to life and growth, e.g., Vitamin K is essential to blood clotting.

III. Common Over-the-Counter Medications for Common Ailments

Each person may have their own PRN (pro re nata e.g., as the circumstances arise or use when necessary) medications for symptoms they commonly display. These medications will be listed on their Medication/Treatment Record (hereafter referred to as med/tx sheet) or Therap Medication Administration Record (hereafter referred to as MAR). Use these medications as symptoms indicate.

For other symptoms, use the Standing Orders sheet. Follow label directions for dosage and frequency of administration. These Standing Orders will be approved by the person's physician at annual physical (see Standing Orders list referenced in documents). These will need to be added to their med/tx sheet or MAR when they are used.

A. Upset Stomach

1. Digel: For indigestion and gas.
2. Kaopectate: For diarrhea. Do not use in the presence of a high fever.
3. Milk of Magnesia: For constipation and upset stomach (antacid).

B. Pain/Fever

1. Tylenol: For headache.
2. Aspirin: For pain, elevated temperature (unless ulcer diagnosis).

C. Colds

There are many products for many symptoms. Read labels and use the product that treats only the symptom/s the person has. Some common ones are:

1. Sudafed: For nasal congestion.
2. Robitussin: For dry, non-productive cough.
3. Chloraseptic Lozenges: For sore throat.

D. Minor Injuries or Bites

1. Mycitracin/Bacitracin: Skin wounds.
2. Caladryl lotion: For relief of itching due to mild poison ivy or oak, insect bites or other minor skin irritations, soothing relief for sunburn.
3. Silvadine cream: For minor burns.
4. Solarcaine spray: For relief of pain due to minor burns and wounds, sunburn and abrasions, relieves itching of non-poisonous insect bites and poison ivy.

E. Athletes Foot

1. Tinactin
2. Desenex powder/ointment

IV. Medical Abbreviations

Medical abbreviations are a brief, shorthand way of effectively communicating medical orders. It is important that you become familiar with the abbreviations listed below if you are to effectively interpret orders from the physician and pharmacist. It will not be expected that you use these abbreviations when communicating with your fellow staff or in charting. It is suggested that you write out in long hand exactly what you are stating as opposed to using the abbreviations when charting in Health T-Logs or progress notes. However, at the end of this procedure, you should be able to recognize most of these abbreviations without referring to the list.

A. Time/Frequency

bid = twice per day (in 24 hours)

d = day

h = hour

hs = hour of sleep

pm = between noon and midnight

qd = every day

qh = every hour

q2h = every two hours

qid = four times per day

qod = every other day

tid = three times per day

am = midnight to noon

B. Route/Location of Administration

(o) = oral route

po = by mouth

(R) = rectal route

C. Forms of Medication

cap = capsule

gtt = drop

gtts = drops

supp = suppository

tab = tablet

D. Amount

cc = cubic centimeter (same as ml)

dr = dram

gm = gram

gr = grain

IU = International Unit

l = liter

mcg = microgram

mEq = milliequivalents

mg = milligram

ml = milliliter (same as cc)

oz = ounces

u = unit

E. Numbers

i = one

ii = two

iii = three

F. Other

ac = before a meal

ADLs = activities of daily living

amt = amount

approx = approximately

B & B = bowel and bladder

BM = bowel movement

B/P = blood pressure

\bar{c} = with

c/o = complains of

CVA = cerebral vascular accident

Disc = discontinued

d/c = discontinued

DNI = do not intubate

DNR = do not resuscitate

H₂O = water

HOB = head of bed

I & O = intake and output

med = medication

MI = myocardial infarction

npo = nothing by mouth

O₂ = oxygen

OD = right eye

OS = left eye

OU = both eyes

pc = after meals

PRN = as needed, when required

\bar{s} = without

SOB = shortness of breath

Stat = immediately

TIA = transient ischemic attack

VS = vital signs

\bar{p} = after

E = error, draw a line through the error and print "E" or the word error above it

H = out of facility, home visit/hospital etc.

W = work

Initials = (your initials circled) med refused by person or not received for any reason

G. Measurement

When giving oral medications such as liquids, it is desirable to be able to compare measurement equivalents such as:

tsp = teaspoon

TBSP or T = tablespoon

3 teaspoons = 1 tablespoons

V. Overview of Body Systems and Drug Classifications

A. Central Nervous System: Contains billions of interconnecting nerve cells that receive and transmit messages to and from the peripheral nerves.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Analgesic	Aspirin Tylenol Codeine	Pain Anti-inflammatory Antipyretic (fever)	Stomach upset Ringing in the ears	Do not use with blood thinner
Sedative	Diazepam Lunesta	Sleeplessness	Hang-over effect	Not to be used with alcohol
Antianxiety	Ativan Librium Valium	Anxiety	Drowsiness Dry mouth Blurred vision	Avoid use of alcohol; may be habit forming
Antidepressant	Doxepin Elavil	Depression	Drowsiness Dry mouth Blurred vision	Cheese, meat, and wine may affect blood pressure
Antipsychotic	Lithium Haldol Thioridazine	Psychotic disorder Agitation	Tremors Dizziness Dry mouth	Risk of developing Tardive Dyskinesia
Anticonvulsant	Tegretol Klonopin Mysoline Zarontin	Seizures	Poor memory Inability to concentrate Lethargy Lack of coordination	Avoid alcohol, carry identification
Anticholinergic	Benzotropine Levodopa Amantadine	Shakiness Expressionless Inability to control movements Muscular stiffness Tremors	Nausea Vomiting Headache Muscle weakness Mental confusion	Will not cure Parkinson's, but will help relieve symptoms
Stimulants	Caffeine Amphetamine	Excessive drowsiness Obesity	Addiction Sleeplessness Anxiety	Risk of addictions
Antiemetic	Scopolamine Dramamine Zofran	Vomiting Motion sickness	Drowsiness	May produce uncontrolled movements of tongue. Use with caution with Parkinson's sufferers.

- B. Circulatory System: Blood transports oxygen, nutrients, and heat; contains chemical messages in the form of drugs and hormones and carries away waste products. Pumped by the heart and carried in blood vessels (veins, arteries, and capillaries); blood circulates continuously around the body.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Antiarrhythmic	Digoxin Inderal	Irregular heartbeat Heart fibrillation Weak heartbeat	Excessive tiredness Confusion Loss of appetite Nausea, vomiting	Potassium supplements may be required
Vasodilator	Nitroglycerin	Chest pain	Headaches Dizziness	Route is placing tablet under tongue
Diuretic	Furosemide Bumex Hydrochlorothiazide	Heart failure Cirrhosis of liver	Weakness Confusion	May cause chemical imbalance
Anti-hypertensive	Tenormin Capoten	High blood pressure	Dizziness Fainting Drowsiness	Do not cure and may have to be taken indefinitely
Lipid lowering	Clofibrate Niacin Lopid	High cholesterol	Nausea Constipation Diarrhea Blurred vision	Will not correct underlying cause – may be necessary to continue drug treatment indefinitely
Anticoagulant	Coumadin Heparin	High risk of embolism	Bleeding from nose, gum or urinary tract	Anticoagulant drugs are easily affected by other drugs.

- C. Endocrine System: Collection of glands located throughout the body that produce hormones and release them into the blood stream.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Drugs used for diabetes	Glimepiride Glucophage Insulin Actos	Diabetes	Sweating Dizziness Faintness	Do not use alcohol; carry glucose tablets or candy.
Drugs for thyroid disorders	Hypo-thyroidism: Levothy-roxine	Tiredness Slowing of mental processes Dry skin Hair loss	Normally no adverse effects unless dosage is too high	Regular blood tests

	Hyper-thyroidism: Methimazole	Nervous, moody Warm/hot, red, itchy skin Weight loss Hair loss		
Drugs for pituitary disorders	Somatropin Vasopressin	Dwarfism Diabetes Insipidus Decreased breast milk production Infertility	Overproduction of hormones	Constant medical supervision
Contraceptives	Estradiol Ortho-Novum Tri-Norinyl Depo-Provera	Prevent pregnancy	Headache Depression Lethargy Hypertension	Increased risks associated with simultaneous use of cigarettes and oral contraceptives.

D. Gastro-Intestinal System: Fuels the body through ingestion, digestion, absorption and removes body wastes through process of elimination.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Antacids	Calcium Carbonate	Indigestion	Diarrhea Constipation	May interfere with absorption of other drugs.
Antiulcer	Cimetidine Sucralfate Zantac	Ulcers *peptic *duodenal	Constipation Drowsiness Dizziness	May interfere with absorption of vitamins A, D, E, and K.
Antidiarrheal	Kaopectate Pepto-Bismol	Frequent watery BMs	Constipation	All antidiarrheals should be taken with plenty of water.
Laxatives	Bisacodyl Mineral oil Metamucil	Constipation	Diarrhea	May cause diarrhea if taken in overdose and constipation if overused.
Drugs for inflammatory bowel disease	Hydrocortisone Sulfasalazine Budesonide	Pain Bloody diarrhea	Nausea Vomiting Fatigue	Immune suppressant and corticosteroid drugs are only prescribed when benefits outweigh risk.
Drugs for rectal and anal disorders	Bismuth Hydrocortisone Anusol Tucks	Hemorrhoids Fissure Pruritus Itching	No adverse effects	Treatment may delay diagnosis of a more serious disorder.
Drugs for treatment of gallstones	Pancreatin Viokase	Pain Jaundice	Diarrhea	May interfere with normal liver function.

E. Urinary System: Urine is produced by kidneys and stored in the bladder and discharged via urethra out of the body.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Diuretic	Lasix Diamox	Hypertension Edema Glaucoma	Dizziness Gastrointestinal (GI) upset Skin rashes Muscle cramps	Frequent urination
Antibiotic Anti-infective	Penicillin Amoxicillin Tetracycline	Infection	GI upset Skin rashes Diarrhea	Be mindful of allergies

F. Muscles, Bones, and Joints: Architecture of human body relies on bones, muscles, ligaments, tendons, and cartilage that enable the body to function with remarkable efficiency.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Anti-inflammatory: a) Non-steroidal	Celebrex Ibuprofen Indocin	Swelling of joints Pain Headache	Stomach bleeding	Not recommended during pregnancy or nursing mothers.
b) Corticosteroid	Hydrocortisone Prednisone Cortisone	Arthritis Bursitis Tendinitis	Acne Kidney damage Moon face	Usually produce dramatic relief from symptoms when injected into a joint.
Muscle relaxant	Baclofen Diazepam Flexeril	Muscle spasms	Weakness Liver damage	Dosage must be carefully adjusted to control symptoms and maintain sufficient muscle strength.

G. Respiratory System: Upper airway includes nose, mouth, pharynx, larynx. Lower airway includes trachea, bronchi, and lungs.

Major Drug Group	Example	Indication	Side Effects	Special Considerations
Bronchial	Epinephrine Atropine Theophylline	Difficulty breathing Breathless-ness Asthma Allergies	Dry mouth Blurred vision Difficulty passing urine	Usually given via inhalers or nebulizers
Decongestant	Ephedrine Pseudoephedrine Oxymetazoline	Common cold Congestion	Increased heart rate Trembling	Used too long, may do more harm than good; causing "rebound congestion".

Drugs to treat coughs: a) Expectorants b) Suppressants	Mucinex Robitussin DM Tessalon	Productive cough Non-productive cough	Drowsiness Confusion Headache Headache Dizziness	Diabetics may need to select sugar-free product Does not have any analgesic effect.
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VI. Legal Requirements

A. Minnesota State Board of Health

1. Persons' health record (medical cover sheet, permanent file)
 - a. Identifying information such as name, date of admission, etc.
 - b. Physician responsible for person's medical care.
 - c. Instructions for care.
 - d. Allergies.
 - e. Special services such as therapy, diet, etc.
2. Medication Handling Procedures
 - a. Controlled substances must be kept locked. Schedule II controlled substances in the facility must be stored in a locked storage area permitting access only by persons and staff authorized to administer the medications. In addition, **ICF SITES**: All medications (prescription and non-prescription) in the facility must be stored in a locked storage area permitting access only by persons and staff authorized to administer the medications.
 - i. Internally and externally taken drugs are to be stored separately.
 - ii. Refrigerated meds must be stored in a container on a shelf in refrigerator.
 - b. All medications will be kept in original containers (bottles, cards or packages) stating name of drug, strength and quantity of drug, expiration dates and direction for use. In addition, a prescription medication will include prescription number, person's name, physician's name, date of original issue or refill, name and address of the licensed pharmacy which issued the medications.
 - i. Any drug container having detached, or damaged label shall be destroyed or returned to pharmacy for relabeling.
 - c. Individuals who self-administer medications will do so from original pill bottles, bubble packs or automatic pill dispenser systems that alarm/unlock at med time.
3. Administration of medication is recorded on medication/treatment sheet or MAR in Therap.

B. Federal Regulations

1. Controlled Substances Act – 1970
 - a. Federal law prohibits transfer of this drug to any person other than the one for whom it was prescribed.

- b. Controlled drugs may not be disposed of except in the manner prescribed by the Drug Enforcement Agency (DEA). Medications must be disposed of according to the Environmental Protection Agency recommendations.
2. Food and Drug Act
 - a. Drug container labels must state contents in understandable words.
 - b. Labels must include clear directions for use of medication.
 - c. All non-prescription medications must have the name of medication, strength, quantity, and directions for use on the label.
3. Federal Register
 - a. Medications administered to a person are ordered either in writing or orally by a physician.
 - i. Oral orders are given only to a licensed pharmacist or nurse.
 - b. **ICF SITES:** Medications are reviewed quarterly by the physician.
 - c. **ICF SITES:** All personnel administering medication must complete a state approved training program.

VII-A. Administration of Medication – General Information

1. Medications can be administered only upon the order from a physician or from his/her standing orders for PRN (as needed) medications. Therefore, when you come on duty, begin by checking:
 - a. The house communication book and/or Therap Scomms.
 - b. Check the Medication/Treatment Record (hereafter referred to as med/tx sheet) or Therap Medication Administration Record (hereafter referred to as MAR) to see that you are aware of any PRN or new medications which have been initiated.
 - c. Read the High and Medium Therap Health T-Logs since the last time you worked or two most recent Progress Notes for each person to ensure that you have an update on the present condition of each person. Read earlier Health T-Logs or Progress Notes as needed, until you feel comfortable that you are aware of all the needed information regarding that person to proceed with your shift.
Contact the LPN or RN or pharmacy prior to administering any medication about which you may have a question.
2. Only one person's medication/s will be set up at a time. Administer the medication/s immediately after setting them up. The medication administration process is one complete process without any interruption.
3. Each person has a med/tx sheet or MAR. On this record is listed each medication to be administered (the name of the medication; the dose to be given; the times it is to be given). The route of administration is assumed to be oral unless otherwise indicated. Example: (R) will tell you that a medication is to be administered rectally. If it is a topical, the med/tx sheet will indicate how the medication is to be applied,

i.e., apply ointment to burn area.

4. If the information on the prescription label of the container and the med/tx sheet or MAR differ, wait to administer the medication until you can clarify the questions with the LPN, RN, physician or pharmacy. If a dosage has changed, have the pharmacy create a new label to reflect the change.
5. The person administering the medication has the responsibility to know why the medication is being given and what side effects may occur and under what conditions the medication should not be administered. This information is available in the Medication Information/Side Effects binder, on the medication information sheet from pharmacy, or in the drug handbook.
6. It is also the responsibility of the person administering the medication to be familiar with any conditions of the person such as difficulty swallowing or chewing which may impede his/her ability to receive the medication and take the appropriate action.
7. The six items which you must remember in administering a medication are as follows:
 - a. the correct person is being given the medication.
 - b. the correct medicine is being given.
 - c. the correct dose is measured.
 - d. the medication is being given at the correct time and date.
 - e. the medication is administered by the correct route.
 - f. the medication is charted correctly.
8. Administer medications that only you have set up and chart only medications that you have given.
9. Chart medications on the med/tx sheet or MAR only after you have administered them. That means, for example, in the case of administering an oral medication, note that you have seen the person take the medication, put it in his/her mouth, and swallowed it.
10. If med/tx sheets are used, sign your full name at the bottom of each med/tx sheet at the beginning of each month or on the Authorization to Administer Medications Form at hire and annually. Include your initials and also the abbreviation of your position. Example: LS – Lisa Smith, DSP. This does not apply if Therap MAR is being used.
11. If a label is missing or difficult to read, do not administer the medication until you can clarify the contents with the pharmacist and have the label changed. If you are in a situation where it is imperative that the person receive the medication, and you are unable to contact the pharmacist for a label change, contact the LPN or RN. If it is a PRN medication, and you have questions concerning the contents of the container, do not administer until label is changed by the pharmacist. If necessary, purchase a new container of the PRN medication such as Tylenol, etc.
12. Keep all medication containers tightly closed to prevent any changes in strength

- from occurring. Any odor or change of color should be reported and do not administer.
13. Never have a person carry or administer medications to another person.
 14. Give the drug within one hour before or after the scheduled time and remain with the person to make sure he/she has swallowed it.
 15. Remember to read the label on the medication container carefully, checking to see that the label, and order on the med/tx sheet or MAR read the same. The label should be read three times.
 - a. when the container is taken from the person's box.
 - b. when the medication is removed from the container.
 - c. when the container is returned to the person's box.
 16. Following the administration of the medication, return the tightly closed container to the individual person's box in the med cabinet area. The cabinet should remain closed at all times unless you are present. **ICF SITES:** The cabinet should remain locked at all times unless you are present and in the process of administering medications. Do not leave the area if the cabinet is open. After locking the cabinet, return the key to the designated place. Refrain from leaving the key lay on the cupboard or remain in the lock.
 17. In the event of an error, either in charting or administration, it must be recorded. See Section X – Medication Error – Reporting Procedure.
 18. A prn medication is administered on an as needed basis, as opposed to those medications which are given on a regularly scheduled basis. Each person has a list of medications which have been approved by the physician and may be found listed on the Standing Orders sheet in the med book. Only give those medications which have been prescribed by the physician and are on the Standing Orders sheet. Examples of situations which would require a PRN medication would be: cold or congestion, diarrhea, headache, flu symptoms, etc.
 19. If a person is involved in self-administration of medications, follow the procedures outlined in Section XV – Self-Administering Medications.
 20. Notify the LPN or RN (if there is one for the site) or supervisor for:
 - a. Person illness/symptoms
 - b. Person accident/injury
 - c. Medication error
 - d. Questions about medication
 - e. Any questions or concerns relating to person's health
 21. If medications are carded/bubble packed by the pharmacy, all of the above requirements apply. In addition:

- a. Mark the bubble packs in the top corner with a permanent marker, the time that the pack is for (am, pm, 8a, 12n, 4p, 8p, etc.) The cards can then be lined up in a basket/box/tray according to the time of day they are to be given.
- b. If four-week bubble packs/cards are used, they should be numbered when they arrive from the pharmacy with the dates they are to cover.
- c. No matter when the cards arrive or are started, punch out the pill from the number on the card that corresponds to the current day of the month. The exception to this would be any PRN medications. PRN medications are started from the 31st and working backwards.
- d. When removing the pill from the card/pack, initial and date near where the pill was punched out. This does not replace initialing on the med/tx sheet or MAR!

Working with the Pharmacy

1. When medications are received from the pharmacy, compare the label to the med/tx sheet or MAR to make sure everything is accurate (name of medication, dose of medication, frequency and how much of the medication is to be given). If there are any discrepancies, contact the pharmacy.
2. Pharmacies will make an extra bottle or card with matching label directions for work, if you ask them to do this.
3. Pharmacies will make a new label or re-card if a medication dosage changes, if you ask them to do this. The pharmacy will ask you to bring in the current bottle/card.

VII-B. Procedure for Administration of Oral Medication

1. Get out the Med Book or log onto the MAR on Therap to review the information on the med/tx sheet or MAR. Also, review any information in the person's Health T-Logs or progress notes. Only one person's medications are to be set up at a time.
2. Wash your hands prior to administering any medication.
3. Obtain the medication and check the ENTIRE label (person name, med name, dose, number tabs to give and times to give) and compare with med/tx sheet or MAR three times before administering to the person:
 - a. when container/card taken from the person's individual box;
 - b. when medication is removed from the container/card, and;
 - c. when container/card is returned to the person's supply.
4. Use the top of the container, a med cup or small bowl to pour the medication into for the person in the prescribed amount. Do not touch medication with hands. (See next page for how to measure liquid medications.)
5. Once all medications are removed from the containers/cards, return the containers/cards to the person's box in the medication storage area before administering the medications.
6. Have the person come to the medication administration area and obtain a glass of water. If the person is bedridden or unable to come, take a glass of water and the medication to the person.

7. Before administering an oral medication, make sure you are aware of any special considerations that the person has for swallowing/taking the medication. In the event that you notice difficulty, contact the LPN, RN or supervisor and document in the Health T-Logs or progress notes.
8. Provide food as needed when administering medication and follow with beverage unless sublingual medication
9. In the event the person is unable to keep the medication down due to vomiting, contact the emergency room (ER) for instructions.
10. Chart the medication on the med/tx sheet or MAR by signing your initials in the appropriate box under the date administered and across from the time to be administered after observing the person swallowing the medication. In the event of a prn, you should list the time in the box immediately above your initials on med/tx sheet or record date, time and reason for PRN on the MAR.
11. If you are giving a PRN or if follow-up charting is required for a prescribed medication, chart in the Health T-Logs, progress notes or in detail mode on MAR, observations that you have made and/or reasons for giving the PRN medication, what medication was administered, how much was administered, the time it was administered and any instructions for staff that may be assuming direct care responsibilities in the next few hours when they would be responsible for follow-up charting. Following an initiation of a PRN medication, reaction to drug and/or status of the person should be charted within an hour to a few hours after the medication is given. If a PRN medication was given for immediate relief of symptoms, such as a headache, check with the person in one-half to one hour to see if the desired relief has been achieved, chart in Health T-Logs or progress notes, or as follow-up on MAR.
12. Chart the medication administered on the person's med/tx sheet or MAR or in Health T-Logs or progress notes only after a medication has been administered and swallowed by the person.
13. It is your responsibility to be familiar with the possible side effects/adverse reactions of any medication you are administering. Observe the person following administration and note any unexpected or unusual symptoms in the Health T-Logs or progress notes and contact the LPN, RN, doctor, or ER, as needed.
14. All administrations are assumed to be given orally unless otherwise indicated. See the abbreviations for alternate routes of administration: rectal, topical, drops, etc.
15. Report any errors in administration as directed in Section X – Medication Error – Reporting Procedure.

Procedure for Measuring Liquid Medications

Follow steps 1-3 on previous page.

- 4a. Read the label directions to determine if shaking or rotating is needed. If so, make sure that the cap of the bottle is on securely before doing so. After shaking or rotating, remove the cap, placing it upside down on the counter and pour the medication with the label facing your palm to prevent dripping on the label. Wipe the lip of the bottle with a damp paper towel before recapping.

- 4b. If amount of medication prescribed matches the dosing marks on a plastic dosing cup, place the dosing cup on a level surface, get down to eye level with the cup to assure accurate dose and pour the prescribed amount into the dosing cup. For example, if 5cc of medication is ordered, pour the medication to the 5cc mark on the cup.
- 4c. If amount of medication prescribed does not match the dosing marks on a plastic dosing cup, a syringe should be used.
- i. With the cap on the end of a syringe and the plunger out, hold the syringe on a level surface. Pour the prescribed amount of medication into the syringe. For example, if 11 cc of medication is ordered, pour medication to the 11cc mark on the syringe. Pour the measured medication into a plastic dosing cup.
 - ii. If no cap is available, press syringe firmly onto bottom of plastic dosing cup. Pour the prescribed amount of medication into the syringe. Lift syringe so medication pours into dosing cup. If medication is thick, plunger may be used to push medication through syringe.
 - iii. If syringe is very small, insert CLEAN syringe into bottle and draw up the prescribed amount of medication by pulling back on the plunger. Squirt the medication into a plastic dosing cup.
 - iv. Fill the syringe with water to rinse any remaining medication from the syringe and pour this water into the dosing cup with the medication.
 - v. When finished giving medication, remove cap, rinsing cap and syringe thoroughly. Allow syringe to dry thoroughly so water does not pool in syringe.

Continue with administering as stated in steps 5-15 in previous section.

Some oral medications may be given sublingually or buccally.

Sublingual – Administer the medication by placing under the tongue.

Buccal – Administer the medication by placing in the person's mouth along the inner cheek (between the back gums and cheek) to dissolve.

VII-C. Procedure for Administration of Topical Medication

Any topical medication which requires sterile procedure will be administered by an EON nurse.

1. Get out the Med Book or log onto the MAR on Therap to review the information on the med/tx sheet or MAR. Also, review any information in the person's Health T-Logs or progress notes.
2. Wash your hands prior to applying any topical medication.
3. Obtain the medication and check the ENTIRE label (person name, med name, dose, amount to give and times to give) and compare with med/tx sheet or MAR when container is taken from the person's individual box.
4. Review any directions for administering the medication carefully. If you have any questions regarding how to apply the medication ordered, contact the LPN or RN (if there is one for the site), supervisor, or pharmacist.

5. If the medication must be given in a location other than the medication administration area, gather all necessary materials (including med/tx sheets or MAR) and proceed with the person to the appropriate area.
6. Identify the person to ensure that you are administering the right drug to the right person.
7. Explain to the person what you are going to do and how you are going to do it. Position the person according to directions.
8. Check the medication a second time to see that the entire label on the medication corresponds with the medication ordered on the med/tx sheet or MAR.
9. Note any significant observation or complaints concerning the affected area of the body prior to applying the medication.
10. When uncapping the medication, check the entire label for the third time to see that the medication corresponds with the medication ordered on the med/tx sheet or MAR.
11. Administer the medication according to directions. Apply gloves if needed. Ointments/creams are applied by smearing a piece of gauze with the medication or using a Q-tip or a gloved finger. Dip into container only one time. If additional ointment/cream is needed use a clean glove or Q-tip.
12. After applying the medication, leave the person in a comfortable position.
13. Remove and dispose of gloves, if used. Wash your hands. Clean and replace the equipment.
14. Chart the medication administered on the person's med/tx sheet or MAR only after a medication has been administered.
15. Describe the appearance (including any drainage) of the area treated, any complaints from the person and any unusual reactions or symptoms following the medication application in the Health T-Logs or progress notes and contact the LPN, RN, doctor, or ER, as needed.
16. If the medication has been applied or administered for a specific purpose (to relieve itching, pain, etc.), check with the person in one-half to one hour to see if the desired results have been achieved and chart these results in the Health T-Logs, progress notes or follow up on MAR.

VII-D. Procedure for Administration of Eye Drops

1. Get out the Med Book or log onto the MAR on Therap to review the information on the med/tx sheet or MAR. Also, review any information in the person's Health T-Logs or progress notes.
2. Wash your hands. Put on gloves if being treated for an infection.
3. Obtain the medication and check the ENTIRE label (person name, med name, dose, number of drops to give and times to give) and compare with med/tx sheet or MAR when container is taken from the person's individual box.

4. If the medication must be given in a location other than the medication administration area, gather all necessary materials (including med/tx sheets or MAR) and proceed with the person to the appropriate area.
5. Identify the person to ensure that you are administering the right drug to the right person.
6. Ask the person to come to a chair, couch or bed. Explain to the person what you are going to do and how you are going to do it. Have the person tilt their head back or lie down.
7. Check the medication a second time to see that the entire label on the medication corresponds with the medication ordered on the med/tx sheet or MAR.
8. Note any significant observations or complaints regarding the affected eye/s prior to instilling the medication.
9. Cleanse the eye with a cotton ball, gauze, or clean washcloth. Wipe from the inner corner outward once. If drops are to be instilled into both eyes, use a clean cotton ball, gauze, or clean section of washcloth for each eye.
10. Draw up the ordered amount of medication into the dropper, checking the entire label for the third time to see that the medication corresponds with the medication ordered on the med/tx sheet or MAR.
11. Position the person with head back and looking upward. Separate the lid by raising the upper lid with your index finger or forefinger and the lower lid with your thumb. Approach the eye with the dropper from below and outside the person's field of vision with due care to avoid contact with the eye. The drop is applied gently near the center of the lower lid, and is not allowed to fall more than one inch before it strikes the eye.
12. Allow the eye to close gently. Ask the person to keep eyes closed for a few minutes.
13. Wipe excess medication from the eye with a clean cotton ball or tissue using a separate cotton ball or tissue for each eye.
14. Leave the person in a comfortable position.
15. Remove and dispose of gloves, if used. Wash your hands. Clean and replace the equipment.
16. Chart the medication administered on the person's med/tx sheet or MAR only after a medication has been administered.
17. Describe the appearance (including any drainage) of the eye/s, any complaints from the person and any unusual reactions or symptoms following the medication application in the Health T-Logs or progress notes and contact the LPN, RN, doctor, or ER, as needed.
18. If the eye drops have been instilled for a specific purpose, check with the person in one-half to one hour to see that the desired results have been achieved and chart the results in the person's Health T-Logs, progress notes or follow up on MAR.

VII-E. Procedure for Administration of Eye Ointment

1. Get out the Med Book or log onto the MAR on Therap to review the information on the med/tx sheet or MAR. Also, review any information in the person's Health T-Logs or progress notes.
2. Wash your hands. Put on gloves if being treated for an infection.
3. Obtain the medication and check the ENTIRE label (person name, med name, dose, amount to give and times to give) and compare with med/tx sheet or MAR when container is taken from the person's individual box.
4. If the medication must be given in a location other than the medication administration area, gather all necessary materials (including med/tx sheets or MAR) and proceed with the person to the appropriate area.
5. Identify the person to ensure that you are administering the right drug to the right person.
6. Ask the person to come to a chair, couch or bed. Explain to the person what you are going to do and how you are going to do it. Have the person tilt their head back or lie down.
7. Check the medication a second time to see that the entire label on the medication corresponds with the medication ordered on the med/tx X sheet or MAR.
8. Note any significant observations or complaints regarding the affected eye/s prior to instilling the medication.
9. Cleanse the eye with a cotton ball, gauze or clean washcloth. Wipe from the inner corner outward once. If ointment is to be instilled into both eyes, use a clean cotton ball, gauze or clean section of washcloth for each eye.
10. Remove the cover from the ointment, checking the entire label for the third time to see that the medication corresponds with the medication ordered on the med/tx sheet or MAR.
11. Position the person with head back and looking upward. Retract the lower lid. Approach the eye from below and outside the person's field of vision with due care to avoid contact with the eye. Apply the ointment in a thin layer inside the lower lid from inner to outer corner by squeezing the tube. Do not use your fingers.
12. Hold the lid open for a few seconds. Allow the eye to close gently and then ask the person to blink to distribute the ointment.
13. Wipe excess medication from the eye with a clean cotton ball or tissue using a separate cotton ball or tissue for each eye.
14. Leave the person in a comfortable position.
15. Remove and dispose of gloves, if used. Wash your hands. Clean and replace the equipment.
16. Chart the medication administered on the person's med/tx sheet or MAR only after a medication has been administered.

17. Describe the appearance (including any drainage) of the eye/s, any complaints from the person and any unusual reactions or symptoms following the medication application in the Health T-Logs or progress notes and contact the LPN, RN, doctor, or ER, as needed.
18. If the medication has been instilled for a specific purpose, check with the person in one-half to one hour to see that the desired results have been achieved and chart the results in the person's Health T-Logs, progress notes or follow up on MAR.

VII-F. Procedure for Administration of Ear Drops

1. Get out the Med Book or log onto the MAR on Therap to review the information on the med/tx sheet or MAR. Also, review any information in the person's Health T-Logs or progress notes.
2. Wash your hands. Put on gloves if being treated for an infection.
3. Obtain the medication and check the ENTIRE label (person name, med name, dose, number of drops to give and times to give) and compare with med/tx sheet or MAR when container is taken from the person's individual box.
4. If the medication must be given in a location other than the medication administration area, gather all necessary materials (including med/tx sheets or MAR) and proceed with the person to the appropriate area.
5. Identify the person to ensure that you are administering the right drug to the right person.
6. Ask the person to come to a chair, couch or bed. Explain to the person what you are going to do and how you are going to do it.
7. Position the person in bed, having the bed flat and turn the head to the opposite side OR sitting in a chair with the head lying on a flat surface, such as the arm of the chair or a tabletop, tilting the head sideways until the ear is as horizontal as possible.
8. Check the medication a second time to see that the entire label on the medication corresponds with the medication ordered on the med/tx sheet or MAR.
9. Note any significant observations or complaints regarding the affected ear(s) prior to instilling the medication.
10. Clean the entry to the ear canal with a cotton ball, gauze, or clean washcloth.
11. Remove the cover from the container, checking the entire label for the third time to see that the medication corresponds with the medication ordered on the med/tx sheet or MAR.
12. Administer the eardrops by pulling the upper, outer part of the ear gently backward and upward, then instill the number of drops ordered into the ear canal. Do not touch any part of the ear canal with the dropper, to prevent contamination of the dropper.
13. Place a clean rolled up cotton ball in the ear.

14. Have the person maintain this position for two or three minutes to give the eardrops time to enter down into the ear. If drops are to be instilled in both ears, wait at least five minutes before putting drops in the second ear and then repeat the procedure as instructed. Leave the person in a comfortable position.
15. Remove and dispose of gloves, if used. Wash your hands. Clean and replace the equipment.
16. Chart the medication administered on the person's med/tx sheet or MAR only after a medication has been administered.
17. Describe the appearance (including any drainage) of the ear/s, any complaints from the person and any unusual reactions or symptoms following the medication application in the Health T-Logs or progress notes and contact the LPN, RN, doctor, or ER, as needed.
18. If the ear drops have been instilled for a specific purpose, check with the person in one-half to one hour to see that the desired results have been achieved and chart the results in the person's Health T-Logs, progress notes or follow up on MAR.

VII-G. Procedure for Administration of Rectal Medication

1. Get out the Med Book or log onto the MAR on Therap to review the information on the med/tx sheet or MAR. Also, review any information in the person's Health T-Logs or progress notes.
2. Wash your hands.
3. Obtain the medication and check the ENTIRE label (person name, med name, dose, amount to give and times to give) and compare with med/tx sheet or MAR when container is taken from the person's individual box.
4. Obtain the items you will need (including med/tx sheets or MAR), e.g., the suppository, gloves, a water-soluble lubrication to lubricate the suppository (KY), some tissues.
5. Identify the person to ensure that you are administering the right drug to the right person.
6. Take the materials and go with the person to a private location where administration of the suppository may be completed.
7. Discuss with the person what you are going to do and how it is going to be done.
8. Have the person lie down on the bed and turn to his/her side.
9. Check the medication a second time to see that the entire label on the medication corresponds with the medication ordered on the med/tx or MAR.
10. Put on gloves.
11. Remove the suppository from the wrapper or foil, checking the entire label for the third time to see that the medication corresponds with the medication ordered on the med/tx sheet or MAR.

12. Lubricate the whole suppository with the lubricant on a tissue, paper towel, chux, or in a med cup.
13. Insert the suppository into the rectum well beyond the sphincter, pushing it in gently with your gloved index finger or forefinger. Encourage the person to relax by breathing through his/her mouth. Talk to the person about general subjects to take their mind off the discomfort.
14. After slowly withdrawing your finger, press the tissue against the anus until the urge to expel subsides. Encourage person to remain lying down at least 15 – 20 minutes.
15. Remove and discard gloves and wash your hands.
16. Leave the person in a comfortable position.
17. Clean and replace the equipment.
18. Chart the medication administered on the med/tx sheet or MAR only after a medication has been administered.
19. Note any complaints from the person, unusual reactions or symptoms following the insertion of the suppository in the Health T-Logs or progress notes and contact the LPN, RN, doctor, or ER, as needed.
20. If the suppository has been administered for a specific purpose, check with the person in one-half to one hour to see if desired results have been achieved and chart the results in the person's Health T-Logs, progress notes or follow up on MAR.

VII-H. Procedure for Administration of Subcutaneous Injection

Only an RN or LPN will provide intramuscular or intravenous injections when ordered by physician.

1. Non-licensed staff may administer subcutaneous injections (for example, insulin injections for diabetes) **ONLY** after training of the following criteria have been met.
 - a. information on disease (e.g., diabetes)
 - b. information on medication (e.g., insulin)
 - c. session with RN
 - i. demonstration of injections by RN.
 - ii. return demonstration to RN.
 - iii. checklist signed by RN.
2. Unless staff have completed the training listed above, they will not be able to administer subcutaneous injections. If there is not a trained staff present, staff will need to call an EON RN or LPN and ask them to give the injection.
3. Disposing of needles. Do not recap needles. Needles are to be disposed of in a sharps container.

Subcutaneous Injection Steps

1. Obtain the medication and check the ENTIRE label (person name, med name, dose, route and times to give) and compare with med/tx sheet or MAR three times before administering.
2. Get supplies (including sharps container, med, alcohol swab, syringe with needle or pen needle, band aid). Wash hands and put on gloves.
3. Roll vial/pen between hands to mix up white residue so solution is cloudy or prepare medication as directed on package insert.
4. Wipe top of vial or end of medication pen with alcohol swab.
5. Withdraw plunger about ½ inch allowing air into syringe. (N/A if using pen with needle attachment.)
6. Push needle into top of vial, injecting air into the vial. (N/A if using pen with needle attachment.)
7. Withdraw medication until correct dose is reached. (N/A if using pen with needle attachment.)
8. Remove air bubbles by tapping syringe with finger and expel air with plunger. (N/A if using pen with needle attachment.)
9. If using pen with needle attachment, wipe end of pen with alcohol swab and put needle on pen. New pen from refrigerator should have small amount of air expelled so that solution comes out (about 2-5 units). Prime pen by expelling 2 units of solution from pen prior to dialing up dose for injection.
10. Dial up correct dose for client according to physician orders.
11. Clean skin with alcohol swab.
12. Hold syringe at 45° angle. Pinch skin. (Heavier client does not require this.)
13. Push needle through skin.
14. Inject medication by pushing plunger in slowly. If using pen with needle attachment, keep in place for ten seconds or not all medication will be released. Other medication may require longer time to keep in place to absorb solution, follow package insert for medication.
15. Withdraw needle, press down on site with alcohol swab. Apply band aid if necessary or desired.
16. Dispose of needle into sharps container immediately after using. Do not recap needle. If using pen with needle attachment, dispose of needle attachment in the special container or sharps container to discard.
17. Return supplies. Remove gloves and wash hands.
18. Document medication, dose, time, route, site of injection, any reactions.
19. Note: Change site of injection with every injection. Use Body Diagram Record.
If subcutaneous injections are required, refer to detailed training information, including employee and RN signatures. A copy of this detailed training document will be maintained in the employee's personnel file.

VIII. General Rules for Charting

- A. All entries not made in the company computer program, that are part of the person's medical chart must be made **ONLY** in blue or black, non-erasable ink. Never chart in pencil, with pens with ink that bleeds (felt tip markers, gel pens) or in any other color.
- B. Entries should be printed or handwritten in a legible fashion if not using company computer program. If you are not sure about the spelling of a word, use the dictionary to look it up.
- C. If you should make a mistake when charting the medication, such as placing your initials in the incorrect box, recording the incorrect item, or charting on the incorrect chart, draw a single line through the mistake and print the letter "E" or the word "error" above the mistake and explain the error in Health T-Logs or med progress notes.
- D. Document **AFTER** completing each task for the person and sign your name completely after each entry. Initials are only acceptable on the med/tx sheet or MAR. All other signatures must include a minimum of your first name initial, full last name and the abbreviation of your position at the facility. Be exact in your charting, i.e., the time, the effect, the results of all treatments and procedures.
- E. Record the person's complaints and specific symptoms or behavior. Describe your observations clearly and accurately in your charting. When describing pain, it is: a) sharp or dull; b) constant or occasional; c) where the pain is located. Be specific (including right or left) in describing the part of the body affected. Example: "Person was observed rubbing the left side of head; when asked if she had pain in her head, she nodded her head yes (person is non-verbal)."
- F. If you are initiating a medication, note the specific symptom/s or behavior you have observed or the complaints you have heard that gave reason for its initiation. Note any physical signs and symptoms as described above. Example: cut on left index fingertip, approximately 1/4" in length; very little bleeding; area washed; band-aid applied.
- G. Information on the med/tx sheet (see sample included in referenced documents) or Therap MAR should include the name of each medication being given, the dose of medication, the time it is given and/or frequency. In the second column of small squares should be noted the time, if specified, that the medication is to be administered. Example: 8:00 am. If the times are not specified and it is simply indicated to give the medication two (or three, four, etc.) times per day as needed, then in a small square, indicate one line for time and immediately under that, one line for initial. Allow enough space for two rows for each time the medication is to be given.
- H. Use the following method of charting on the med/tx sheet or MAR and/or detail mode for each circumstance below:
 1. Your Initials = medication or treatment administered as directed.
 2. H = person on home visit or in hospital and responsibility for medications has been assumed by another person, e.g., parent or sibling, etc.
 3. W = work.
 4. Your Initials Circled = person did not get the medication or treatment as directed.
- I. Some of these circumstances should also be documented in the Health T-Logs or med

progress notes in greater detail. Specify the time the person left for a home visit and returned from a home visit. Reason that the medication was not administered as directed (person refused, medication not available, etc.)

- J. If charting is done in the med progress notes, begin with the date and time you are doing the charting, followed by your observations or information required on the chart. Draw a line filling in any remaining blank space on the last line on which you charted. Charting is done correctly only when it contains your signature and abbreviated job title on the med progress notes. (N/A for Health T-Logs.) Be sure that the person's name, month and year appears on the top of all pages (splint records, PT/OT sheets, positioning, fluid intake sheets, etc.) added to the chart.

K. Remember the Six Rights:

1. Right patient.
2. Right medicine.
3. Right dose.
4. Right time and date.
5. Right route.
6. Right charting.

If Rights #1 – 6 are violated, a Therap (GER) General Event Report - Medication Error must be completed. See Section X – Medication Error – Reporting Procedure.

If you are not comfortable administering medications, please report to your supervisor. Every possible effort will be made to make you feel comfortable and confident, so you will be able to give medications carefully and safely.

IX. Missed Medications

If a dose of a medication is missed:

- A. Follow any established protocol ordered by physician regarding missed doses of a particular medication, for a particular individual.
- B. If no existing protocol, refer to the medication information sheet accompanying the medication from the pharmacy and follow those instructions.
- C. If neither of the above (1 or 2) are available, contact pharmacy, LPN, RN, or ER for instructions.

X. Medication Error – Reporting Procedure

- A. There are two forms of errors that you may encounter when administering medication:
1. **Charting/documentation error:** When a medication or treatment has been given or done, but is not signed off. A violation of the right documentation/charting.
 2. **Administration error:** A violation of any of the five rights with medication administration, i.e., right patient, right time, right medicine, right dose, or right route of administration.

- B. Document any and all errors and the action taken in Health T-Logs or med progress notes and complete a Therap General Event Report (GER) – Medication Error.
 - C. For an error in administration involving a missed med, an incorrect dosage or meds given to the wrong person, contact the LPN or RN. If the LPN or RN is unavailable, contact the person's physician, the pharmacy, the ER, or Poison Control. Follow their instructions. Document in Health T-Logs or med progress notes who you spoke to and what you were instructed to do.
 - D. If the medication error is of a serious enough nature for the person to be SEEN by a medical or mental health professional, everything in the above paragraph applies. Notify the supervisor as soon as possible. In addition, a GER (Accident Incident Report in hourly sites) must be completed and passed to the supervisor within 24 hours of the incident. The supervisor will follow up with reporting any possible Vulnerable Adult maltreatment issue to the Common Entry Point.
- Notify the LPN, RN, supervisor and, as requested, the legal representative, case manager, and prescribing physician that a medication error has occurred.
- E. **ICF SITES:** All GERs – Medication Error are faxed to the person's physician when error is discovered.
 - F. All medication errors will be reviewed for patterns by the RN for any subsequent action (additional training, clarification of information on med/tx sheet or regarding doctor's orders, etc.).
 - G. The GER – Medication Error is printed by the supervisor when the Quarterly Medication Administration Review is made out and attached to that Review and placed with the individual's records.

XI. Dispensing Medication When Leaving Home

When medications are to be released to a non-staff person for supervision and administration, they are prepared so that all medications to be given at a specific time and day are "packaged" together. This minimizes the risk of error for non-trained individuals. Each individual "package" of medications must be clearly labeled with the person's name, the date of administration, the time of administration, name and dose of medications to be administered and the initials of the person preparing the medications.

- A. If the pharmacy dispenses medications as described above, simply tear off the days and times that correspond to the days and times the individual will be gone.
- B. If the pharmacy dispenses medications in bottles or bubble packs, the packages will need to be prepared as described above. Obtain the necessary materials:
 1. The med/tx sheet or Therap MAR
 2. All medication that will be dispensed for the person
 3. Small (coin) envelopes

Set up the medications in the envelopes according to the day, date and time of administration and doses. For example, if a person was receiving two different medications, both of which are administered twice per day, once at 8:00 a.m. and once at 10:00 pm, the procedure would be as follows:

1. In the first envelope, you would note on the outside of the envelope the person's name, the date of administration, the time of administration, which medications were contained in the envelope, and your initials in the corner. You would therefore have two envelopes per day sent with the person – one for the 8:00 a.m. administration and one for the 10:00 p.m. administration. Below you will see the two example envelopes prepared:

JOHN SMITH
FRIDAY 1/1/10 8:00 AM
Aspirin – 10gr – 2 tablets
Dilantin – 100 mg – 1 tablet
AB

JOHN SMITH
FRIDAY 1/1/10 10:00 PM
Aspirin – 10gr – 2 tablets
Dilantin – 100 mg – 1 tablet
AB

You can see by looking at the two envelopes that if they become mixed up you will be able to see who is receiving the medication, which administrations are due, and when and what exactly is to be given to the person. It will help eliminate confusion in what is to be given and when to administer it. One envelope should be set up for each anticipated administration time that the person will be absent from their home.

2. When there is a possibility that the person may not return to their home as scheduled, prepare an additional one to two doses. This will assure the person's medication schedule could be continued as indicated even though the person was not able to return to the house as soon as planned.
 3. If a person will be gone for an extended period, whole bottles of pills or an entire bubble pack may be sent along with the person and a COPY of their med/tx sheet or Therap MAR printout will be included.
- C. If you are sending a medication such as a cream or ointment, ensure that it is packaged appropriately and that instructions are clearly stated on the label as to the time and method of administration. Include with the medication any items that might be needed (such as Q-tips, cotton balls or dressings) in a clean plastic bag to ensure that the medication will be administered properly. Any special instructions should be noted in writing to be sent with the person and explained to the person accompanying the person prior to their leaving.
- D. **ICF SITES:** After the administration packets are prepared, complete a Release of Medication form (see sample in Forms). List the medications that are being released and how many doses of each are being sent. Using the example listed above, if the person was leaving on Friday afternoon and returning Sunday by 7:00 pm, there are four doses or times of administration – Friday 10:00 pm, Saturday 8:00 am, Saturday

10:00 pm, and Sunday 8:00 am. Therefore, the medication release form would list Aspirin, eight tablets and Dilantin, four tablets. The medication release form is initialed by the person setting up the medications. When the medications are released to the person assuming responsibility for the medication, that person signs the release as well as the staff witnessing the release. The medications would then be given to the person responsible.

- E. Complete the 245D Medication Setup and Release Sections on the MAR as directed. Make an entry in Health T-Logs or med progress notes indicating the time the person left, with whom and their anticipated return.
- F. While the person is gone, put the letter "H" in the appropriate spaces on the med/tx sheet indicating that those medications were administered at a location outside of the house by a non-staff person. If using Therap MAR, indicate LOA and describe in detail mode where the client is (i.e., home).
- G. Upon returning from the visit, check with the responsible person accompanying the person served, to see that all administrations of medications were given as scheduled and/or if there were any extra medications to be returned. **ICF SITES:** Indicate this on the Release of Medication form, along with staff initials.
- H. If it is noted that any medication was not administered or if there seemed to be a problem with the administration, that should be noted in Health T-Logs or med progress notes. Also, make an entry in Health T-Logs or med progress notes indicating the time the person returned.

XII. Disposition of Controlled Medication Upon Person's Discharge

As per a July 2004 Minnesota Department of Health established standard licensing waiver process from Supervised Living Facility Rule 4665.4600, persons may take their controlled drugs with them when discharged as long as the following criteria are met:

- A. Medication must be in a child resistant container, unless the person or responsible party requests otherwise.
- B. There must be an order from the person's physician (licensed to practice in Minnesota) authorizing the release of the medication upon discharge.
- C. If the medication is released to a responsible party who has the authority to make decisions about the person's care, that responsible party must be identified in the person's medical record.
- D. A notation of the medication released must indicate the
 1. Date released
 2. Quantity, name, strength, and dosage form of the medication
 3. Prescription number, name, address, and telephone number of the dispensing pharmacy
 4. Name and signature of person releasing the medication
 5. Name and signature of person receiving the medication

Upon the death of an individual, unused portions of controlled medications must be disposed of as described in section XIV. They are not to be released to the individual's responsible person.

XIII. Destruction of Medication

- A. Discontinued, unused or expired medications (except for controlled substances, see section XIV) must be destroyed by a med trained staff and witnessed by a second med trained staff. The destruction must be documented and consist of the name of the medication, dose of the medication, number of pills or amount of liquid. Documentation is as follows, depending on the site:
1. In 24-hour sites, two Therap Health T-Logs for the person whose medication is being destroyed, one by the person destroying the medication and a second by the person witnessing the medication destruction.
 2. In hourly sites, one med progress note, signed by the person destroying the medication and the person witnessing the destruction.
 3. If the site uses the Medication Destruction Record (**INCLUDING ICF SITES**), document the destruction there, no Health T-Log or med progress note is required. One Medication Destruction Record (see sample in Forms) per person per year, this becomes part of that person's permanent record.
- B. Remove the label from the medication container and tear it up. If the label can't be removed, black out the person's name and prescription number on the label with a permanent marker.
- C. Medications are disposed of according to the Environmental Protection Agency recommendations, which are the same as the consumer guidelines developed by the U.S. Food and Drug Administration in conjunction with the White House Office of National Drug Control Policy:
1. Take the medication out of its original container and put it in a "zip lock" type bag to prevent it from leaking or breaking out of a garbage bag.
 2. Mix the medication with coffee grounds or kitty litter moistened with hot water. Rub the bag between fingers to break down the medications. (The medication will be less appealing to children and pets, and unrecognizable to people who may intentionally go through the trash.)
- D. If the pharmacy where the prescription was filled has a "take back" program, this is the preferred method of disposal. Follow the pharmacy's instructions for doing so and document the return of the medication(s) in one of the manners as listed above, depending on the site.
- E. An RN or an LPN and a Director will handle the destruction of unused portions of controlled substances by following the procedure outlined under "Destruction of Controlled Substances" in section XIV.

Any questions regarding medication destruction should be referred to an EON RN.

XIV. Destruction of Controlled Substances

The Drug Enforcement Administration has allowed an optional method for the disposition of controlled substances in long-term care facilities in Minnesota employing a consultant pharmacist. Drugs in Schedules II through V may be destroyed in the facility in accordance with the following conditions.

Schedule II Controlled Substances (examples include: Adderall, Ritalin, Demerol, Concerta, Percocet, Oxycontin, this is NOT a complete list) may be destroyed in the facility in accordance with the following conditions:

- A. **ICF SITES:** All controlled substances destroyed must be destroyed in the presence of the administrator or licensed nurse (RN) and either the consulting or vendor pharmacist or licensed nurse.
- B. **Other sites:** All controlled substances destroyed must be destroyed in the presence of an LPN or RN and one other staff person.
- C. The destruction with signatures will be recorded on the client drug destruction record to be filed in the client health care archive records.
- D. A copy of the certificate of destruction with signatures shall be retained in the facility for at least two years from the date of destruction.

NOTE: Controlled drugs should not be returned to the pharmacy for destruction or for re-use.

XV. Self-Administering Medications

- A. We will not be using any pill caddies in any of our EON, Inc. houses, this includes persons that are self-administering medications.
- B. Individuals who self-administer medications will do so from original pill bottles, bubble packs or automatic pill dispenser systems that alarm/unlock at med time.
- C. Requirements for self-administering medications:
 - 1. Must have a doctor sign that this person can self-administer medications. This is done annually at the person's physical exam on the Physical Exam form or Approval for Self-Administration of Medication form.
 - 2. Person must know what times they need to take their medications and ask for them.
 - 3. Person must be able to read the label on the bottles or bubble packs (if using) and the medication record sheet and compare everything for accuracy. The medication, the dose, the number of tabs to be given, and the frequency.
 - 4. Person must be able to open the bottle and/or punch out the medication from the bubble packs (if using) or open the automatic pill dispenser system and assure that all of their medications are there before putting them in their mouth.
 - 5. Person should be able to initial a paper med/tx sheet for taking their medications, if this is required by team.
 - 6. Staff should be observing that all the correct medications are being dished up and the medications are being taken and signed for. Staff must be present in location the

person is getting their medications ready and when the medications are being taken. Staff cannot be observing from across the room. Even though the person is self-administering their medications, staff must still be present and observe that they are being taken. Staff must still sign on the med/tx sheet or MAR for meds taken.

7. If using paper med/tx sheets, print out two sets of med/tx sheets for that person, one for the staff to sign on for observing the person taking medications and one for the person to sign on for taking the medications. The medication sheets should be labeled that way on the top of the medication sheet. At the end of the month the two sheets (person and staff) should be stapled together so they are put in the permanent record together. When using Therap MAR, staff initial on the MAR and person initials on printed med/tx sheets, (if client signing for meds as required by team). Those printed sheets are then filed in person's medical archives.
 8. If the medications are kept in a bin at the house, the staff can get out the bin for the person to take their medications, but the person must be able to pull the correct bottles and/or bubble packs without staff assist.
 9. If staff are doing any part of this process, this is NOT self-administration of medications. If staff pull bottles/cards for the person this is NOT self-administration. If staff tell the person that it is time for their medications or which ones they need to take this is NOT self-administration.
- D. If you feel that the person has the ability to self-administer medications, the option is to make a program and teach/train on the steps to see their level of independence prior to requesting the consent from the doctor for the person to self-administer medications on their annual Physical Exam form or Approval for Self-Administration of Medication form.
- E. If a person does self-administer medications, the house supervisor would have to evaluate this on an ongoing basis and have the staff monitor for the person's continued ability to correctly perform this function independently. This information would be included in client semi-annual & annual reports.
- F. Coin envelopes can be used when a person is going out with family or on outings (camp, vacations, etc.), or if they are self-administering their own medications at work. They are not to be used day to day to set up medications for a person to take at home (if there are staff present at the house) or for another staff person to give to a person.

XVI. Use of Drug Handbook or Medication Information Sheets

Each medication a person takes should have a readily available medication information sheet. These are typically printouts from the pharmacy, but may also be given to a person by the prescribing physician. These information sheets are maintained in the Medication Information/Side Effects binder. If a medication is discontinued, that side effect sheet is placed in the person's medical archives.

Another good source of information about medications is a drug handbook. The Nursing Drug Handbook and Mosby's Nursing Drug Reference are two common ones.

A. How is a Drug Handbook Used?

As with any reference book, a drug handbook is not intended to be memorized. Rather it should be immediately available for your use when confronted with an unfamiliar drug or

to refresh your memory. Remember... you should never administer any medication with which you are not familiar. If in doubt, look it up.

As an example, for use of a drug handbook, let us consider the drug, Valium. You would like to know more about this medication, so you use the drug handbook to get some information. You would refer to the alphabetical listing until you came upon the word Valium to find the page number the information is on. You will find that the information about Valium is divided into sections, each section addressing a different aspect of the medication.

1. The brand name and the generic name: Most drugs can be known by at least two names, the brand name and the generic name. Before each drug is marketed, the manufacturer gives it a brand (also called trade) name. Drugs are also classified on the basis of their composition and action. The more general classification gives rise to the generic name.
It will also list the pharmacological class and the therapeutic class.
2. Available forms the medication comes in: tablets, liquids, injections, etc. (how it is supplied).
3. Indications and Dosages: This refers to various conditions which may be present in the person for whom the physician prescribes the drug. It says what dosage the medication would be ordered in. It will also describe the average dose in relation to the various reasons for use of the medication.
4. Administration: It will specify ways or cautions about taking the medications (take with or without food, avoid certain foods, certain time of day, etc.) and handling the medication (do not crush, storage temperature requirements, shake before use, etc.)
5. Action: This is how the medication works, what it does to the system/s of the body it impacts.
6. Adverse Reactions: You will find a variety of side effects which have been noted in people who use the medication. You will be alerted to possible reactions which the person may experience from this drug. In the event you noted any of these reactions or other reactions that may be associated but not listed in the handbook, you would report these conditions immediately to the LPN or RN (if there is one for the site) or physician.
7. Interactions: This section discusses interactions the medication has with other medications and/or foods, that could alter how the medication works.
8. Effects on Lab Test Results.
9. Contraindications and Cautions: This area refers to predisposing conditions which would caution the physician in prescribing the drug even though the person would otherwise qualify under the Indications. It warns the physician that the conditions listed there are not compatible with the use of the associated medication.
10. Nursing Considerations: This section specifies any special monitoring (lab work, more frequent preventative screenings, vital sign checks, etc.) related to possible side effects/adverse reactions and what to do if any of those occur.

11. Patient Teaching: Things the patient should be aware of (activities to avoid, signs and symptoms to monitor, possible changes in mood, etc.) when taking the medication and things to report to the prescriber.
12. Black Box Warnings: May be included in several sections. Black box warnings alert the health care provider or person taking the medication of possible conditions, complications, interactions or situations which may need further attention.
13. The drug handbook is a resource to find out information concerning any medication that you may be dealing with and how to administer the drug with a relatively high degree of safety.
14. If you have any questions concerning the usage of medication information sheets or the drug handbook, please contact an EON, Inc. LPN or RN.

XVII. Psychotropic Medication Use and Monitoring (All Sites Other Than ICFs)

- A. Any medication given to influence behavior or stabilize mood is considered a psychotropic medication as defined by the MN Department of Human Services. This may differ from a medical professional's definition of a psychotropic medication, which may be based on the chemical classification of the drug.
 1. When EON, Inc. is assigned responsibility for administration of medication in the person's Support Plan (SP) or Support Plan Addendum (SPA) and the person is prescribed a psychotropic medication, EON, Inc. will assure that the following requirements are met.
 - a. All applicable rules governing medication administration will be adhered to.
 - b. A description of the target symptoms that the psychotropic medication is to alleviate is to be developed. Target symptoms refers to any perceptible diagnostic criteria for person's diagnosed mental disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-R) or successive editions, that has been identified for alleviation.
 - c. If the prescriber requires it, documentation methods to monitor and measure changes in target symptoms will be developed. This medication and symptom related data must be collected and reported to the prescriber as instructed. This monitoring data must be provided to the person's support team for review every three months, or as otherwise requested by the person or their legal representative, if any.
 - d. Psychotropic medication may be used in conjunction with positive behavioral programming as an integral part of an individual's plan that is designed by the support team to lead to a less restrictive way of managing a behavior or condition for which a psychotropic drug is prescribed.
 - e. The medical professional prescribing the medication shall be notified in the event of any adverse side effects.
 - f. If the person and/or legal representative, if any, refuses to authorize the administration of a psychotropic medication as ordered by the prescriber, the

medication must not be administered. The refusal to authorize medication administration must be reported to the prescriber as expeditiously as possible. After reporting the refusal to the prescriber, any directives or orders given by the prescriber must be followed. A court order must be obtained to override the refusal. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must be reached in compliance with the service termination policy.

B. For the ICF/DDs Only: (1407 Tenth North & 1131 Raymond)

1. If it is determined that a psychotropic medication will be used, prior to the medication being administered, written **informed consent** must be obtained by the person or their legal representative, if any. In the event of an emergency, EON, Inc. may obtain a verbal informed consent, which must be authenticated in writing as soon as possible (within 30 days). Informed consent means the person giving consent is fully aware of the: specific treatment; reason for treatment or procedure; the risks vs. benefits; alternatives; right to refuse; and the consequences associated with consent or refusal of the program or medication. The “Informed Consent Form for Psychotropic Medications” should be used for individuals served in the ICF/DD homes.

For those individuals on a psychotropic medication (or any other medication that may cause TD), it is recommended that a baseline for Monitoring of Side Effects (MOSES) be completed. If the psychotropic medication is a neuroleptic or otherwise has Tardive Dyskinesia (TD) as a side effect, a Dyskinesia Identification System: Condensed User Scale (DISCUS) will be completed. The individual’s physician should be consulted with to determine a schedule of side effects monitoring and who should complete that monitoring.

2. Use of Pre-Medical/Dental Procedure Sedation (**For ICF’s/DD Only**)

- a. When a physician or dentist orders a pre-procedure sedative such as Ativan (lorazepam) or Valium (diazepam), this is considered a “chemical restraint” and requires guardian consent PRIOR to administration of the medication.
- b. In addition, the reason for the use of the medication must be assessed and this assessment documented. Some sedatives (e.g., Valium) also act as muscle relaxants and may be given solely to reduce spasticity related to a physical condition such as cerebral palsy.
- c. If the sedative is to reduce a person’s fear, apprehension or anxiety about a medical or dental appointment, formal or informal programming must be developed in attempts to decrease the person’s anxiety and potentially reduce the need to use sedation. Those attempts to desensitize the person must be documented.
- d. The nurse or community supports supervisor will need to do the following whenever a new medication is proposed, a dosage is changed or a new procedure requiring pre-procedure sedation is added.
 - i. Obtain physician’s or dentist’s order for medication.

- ii. Assess the reason for the medication and document that assessment. If related to person's anxiety about appointment(s), develop a plan to attempt to reduce that fear.
- iii. Prepare a consent form for the medication that includes the name of drug, dose, route, reason and side effects.
- iv. Obtain guardian consent for use of the medication.
- v. Pass copy of signed consent to Human Rights Committee for review, along with the plan to attempt to reduce the need for the sedative. This is required by our rules and regulations.
- vi. Place signed consent in the medical file under "consents".
- vii. If it is determined that the use of a sedative prior to medical and/or dental procedures is needed on an ongoing basis until programming helps the person reduce their anxiety, it will be added to the person's Individual Abuse Prevention Plan (IAPP) and/or Support Plan Addendum (SPA) and/or Self-Management Assessment (SMA) at their next Progress Review meeting.

REFERENCED POLICIES

REFERENCED FORMS

Sample Medication/Treatment Sheets
Authorization to Administer Medication
Release of Medication
Medication Destruction Record
Medical Progress Notes
Medication Administration Procedure Sheets
Standing Orders
RN Review of Medication Management Policies and Procedures
Return Demo Checklists-Waiver
ICF Medication Administration Certificate
ICF Drug Handbook Assignment
Return Demo Checklists-ICF
Psychotropic Physician Letter and Monitoring Record
Psychotropic PRN Protocol Sample – Template