POLICY AND PROCEDURE PERTAINING TO MEDICATION ADMINISTRATION

PURPOSE

Delegation of Medication Administration

- Before the RN delegates the task of assistance with self-administration of medications or the task of medication administration, treatment and therapy the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks.
- After the unlicensed personnel have met the qualifications for orientation, the RN will instruct, and competency test the unlicensed personnel on the following topics and tasks before delegating to them the task of medication administration, treatment and therapy.
    - The 6 RIGHTS of administration
    - Infection control techniques that must be followed when administering medications, treatment and therapy including hand washing and the use of gloves when appropriate.
    - The complete procedure for checking a client's record and the nurse's written procedures specific to the client for the administration of any delegated tasks. This includes procedures for administration of any over-the-counter medications, PRN medications or dietary supplements, treatment and therapy, our agency has agreed to provide for the client.
    - Procedures for the proper methods to administer medications, treatment and therapy to the client.
    - How to document services provided for the client consistent with our agency's MAR documentation procedure.
    - The type of information reportable to a nurse regarding assistance or administration of medications, treatment and therapy including side effects, effectiveness, refused or held medications and medication errors and provision of treatment and therapy.
- The RN must have communicated with unlicensed personnel about the individual needs of the client prior to the delegation of nursing or therapy tasks to the unlicensed personnel. This communication will be orally, in person or in writing.
- The RN will document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record.

Medication Administration

- Unlicensed personnel that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the RN, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of inhalant or nebulizer, gastric tube, insulin injection or topically by following the RN's written instructions for administering the medications to the client.

- Unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and competency tested by the RN on the following:
    - The complete procedures for checking the client's medication administration record and medication profile, treatment and therapy profile and any additional information.
    - Infection control precautions that must be followed when administering medications, treatment and therapy.
    - Preparation of the medication for the client when necessary;
    - Administration of the medication, treatment and therapy to the client (or assistance with self-administration);
    - Documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our agency's procedures for documenting the MAR.
    - The procedure for staff to notify the RN of any medications or dietary supplements that are being used by the client and that are not included in the assessment for med management services.
- Medications, treatment and therapy always need to be administered according to the "6 Rights"
    - Right person
    - Right medication, treatment or therapy
    - Right time
    - Right route (by mouth, eye drops, to the skin, etc.)
    - Right dose (how many milligrams, drops, etc)
    - Right chart/record to document that the medication, treatment and therapy was taken

- The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements listed above if:
    - Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedures;
    - The RN has developed written, specific instruction for each client
    - The RN has communicated with the unlicensed personnel about the individual needs of the client; and
    - The RN has documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures.

Medication, treatment, and exercise reminders

- Prior to providing any medication, treatment and therapy reminders, a RN will conduct a nursing assessment of a client's functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services and

develop an individualized medication management plan and/or treatment and therapy individualized plan for the client based on the client's needs and preferences. The RN will describe how the reminder will be provided, for example, visual or verbal reminder over the telephone or in person, and whether other tasks will be provided in conjunction with the reminder, such as bringing the client water or juice.

- Medication, treatment and therapy reminders will be provided only when the RN decides that a reminder is sufficient to give a reasonable assurance that the client will comply with the medication regimen based on the nursing assessment.
- Staff will provide medication, treatment and therapy reminders as appropriate according to the assessed needs of the client and consistent with the MAR/TAR and the assignment sheet for the unlicensed personnel.

- Unlicensed staff will chart in each client's medication administration record any problems with medication, treatment and therapy reminders and will notify the nurse about the problem. Staff will document any notification of problems with medication reminders to the nurse.
- The nurse who sets up the medications in the dosage box will monitor the medication reminder documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up.

Documentation of Medication Administration

- Staff will document each task immediately after that task has been performed.
- Documentation will follow professional standards for documentation, including the requirement that entries must be:
    - Legible;
    - Permanently recorded in black/blue ink or in electronic form;
    - Dated with the time of entry;
    - Authenticated with the name and title of the person making the entry. When initials are used by persons making entries in the client record, the person will authenticate initials with a full signature and title. The signature and title may be included on the same document or on the EMR.
    - Entries in the client record will never be redacted. If there is an error in an entry in paper documentation, draw one line through the erroneous entry, making sure that the inaccurate information is still legible. Initial and date the entry. State the reason for the error (i.e. in the margin or above the note if room) and document the correct information.
    - Staff will use only approved health care abbreviations identified by the RN and agency.
- Documentation of PRN Medications.
- The RN will provide specific instructions for administering PRN medications, treatment and therapy consistent with the prescriber's prescription for the reason/circumstances under which the PRN's may be administered.
- The RN will provide detailed instructions on the use of a PRN medication, treatment or therapy as per the prescriber's order.

- The PRN instructions will include the need and interval to monitor and report effectiveness to the RN.
- Receiving and Requesting Prescriptions and Refills. The nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for clients, including communications with the prescriber, pharmacy, client and/or client's representative or family.

Medication management for clients who will be away from home

EON, Inc. Assisted Living/ the comprehensive home provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

- for planned time away, the medications must be obtained from the pharmacy or set up by a licensed nurse according to appropriate state and federal laws and nursing standards of practice
- for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days
- the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances
- the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled
- the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.
- For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
    - the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients
    - the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:
        - the type of container or containers to be used for the medications appropriate to the provider's medication system
        - how the container or containers must be labeled
        - the written information about the medications to be given to the client or client's representative
        - how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person

who gave the medications to the client, the number of medications that were given to the client, and other required information;
- how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative
- a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel
- how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication.

Medication Orders

A written or electronically recorded prescriber's order will be obtained for all medications for which medication management services are provided, including over-the-counter medication and dietary supplements. Medications may be ordered by a physician, dentist, advanced practice registered nurse, or other health professional licensed to prescribe.

The client or the client's representative will be informed that the provider requires a prescriber's order for all medications needing medication management services prior to providing the services. All orders will be dated and signed by the prescriber and will contain the name of the individual, the name of the drug, dosage, indication, frequency, and directions for use.

All medication orders will be renewed by the prescriber at least 12 months or more frequently as indicated by prescribing requirements or client condition. Prescriptions for controlled substances must comply with chapter 152.

Orders received must:
- be kept confidential,
- be communicated to the supervising nurse as soon as possible; and
- implemented within 24 hours

Verbal Orders

Only a nurse or a pharmacist may receive a verbal order. Upon receiving a verbal order from a prescriber, the nurse must:
- Record and sign the order; and
- Forward the written order to the prescriber for the prescriber's signature

Storage of Medications

- A registered nurse must conduct a face to face nursing assessment of a client's need for medication management services, including the appropriate method to store the client's medications and whether secured storage is appropriate given the client's functional and

cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the RN will develop an individualized medication management plan for the client that will address storage of the client's medications.

- Proper Storage of Medications
    - The RN will recommend where medications should be stored understanding that our agency may not be able to control where and how a client stores his/her medications in their room. The RN will provide education to the client/client's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the client's room and the nursing office.
    - Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications.
    - An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer.
    - A sample of medication provided to the client by an authorized prescriber must be kept in its original container bearing the original label with legible directions for use.

- In the client's individualized medication management plan, the RN may identify the need for secured storage of the medications within the client's private living space because of the client's cognitive status, concerns about medication diversion or other concerns, When secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications.
- The RN will also identify in the client's individualized medication management plan a process for monitoring or tracking a client's controlled or other medications that might be at risk of diversion.
- When clients are living in a congregate setting or similar senior housing setting, the RN will develop a procedure to secure medications when they are delivered to the building rather than delivered directly to the client in the client's living space.
- The RN will establish a system that addresses the storage and handling of medications, including:
    - How medications will be received and secured when delivered by the pharmacy
    - Where medications will be stored
    - How medications will be secured if in the client's private living space or if centrally stored
    - Who is authorized to access the medications?
    - How refills and prescription renewals will be monitored.
    - Controls and procedures to identify or prevent diversion of medications.

- For private setting, the RN will establish a process that addresses the storage and handling of medications including:
    - How the medications will be delivered and to what location (i.e., the client's home, agency office, or client's representative)
    - Where and how the medications will be stored
    - How medications are secured if applicable
    - Who is authorized to access the medications?
    - How refills and renewals are monitored
    - Controls and procedures to identify or prevent medications.

Security of Medications

All medications are always kept locked except when being prepared for administration. Only the person authorized to administer medications will have access to the medications. All controlled substances will be kept under a double lock system. Controlled substances are counted by two staff at each shift change and the count is maintained for each controlled substance administered. Medications requiring refrigeration will be kept in the medication fridge. Staff are required to obtain and record the temperature of the fridge daily to ensure proper storage. Prescription medications are the property of the client and will only be used for the person who is named on the pharmacy label

Disposition of Medications

Any current medications being managed by EON, Inc. assisted living/ comprehensive home care provider must be given to the client or the client's representative when the client's service plan ends, or medication management services are no longer a part of the service plan.

EON, Inc. assisted living/ comprehensive home care provider will dispose of any medications remaining with the provider that are discontinued, expired or upon termination of the service contract or the client's death according to the state and federal regulations for disposition of medications and controlled substances.

Upon disposition the licensed nurse and a witness must document in the client's record the disposition of the medication including:

- the medication's name,
- strength,
- prescription number as applicable,
- quantity,
- to whom the medications were given/how they were disposed,
- date of disposition,
- and names of the nurse and the witness involved in the disposition.

Loss or spillage of a controlled substance

- When loss or a spillage of any medication occurs, and notation must be made in the client's medication record explaining the spillage and the actions taken. The notation must be

signed by the person responsible for the loss or spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.

- A medication that is dropped or spilled will be routinely disposed of unless the client refuses. If the medication is to be discarded, it must be treated as hazardous waste and must discarded consisted with the agency's disposal policy.
- If the loss or spillage is of a controlled medication, the notation about the loss or spillage must be signed by the person responsible and one witness.
- A Medication error form must be completed, and the nurse notified so that the required medication can be replaced and administered to the client on a timely basis. The designated RN will review the medication error reports on a timely basis.
- The agency is required to take appropriate action under federal or state regulations for any lost or unaccounted prescription drugs when theft or diversion is suspected. If theft or diversion is suspected, documentation will include the investigation and findings. If theft or diversion of prescription drugs is suspected, it must be reported to local law enforcement and may require a report to the MAARC.

Medications Administration Procedures

I. Related Terms

Below you will note a list of terms, many of which you will encounter while 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 <u>generic</u> name and the <u>brand</u> (or <u>trade</u>) name. These names are again referred to in the section describing the use of the Drug Handbook.

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 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. 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

c̄ = with

c/o = complains of

CVA = cerebral vascular accident

Disc = discontinued

d/c = discontinued

DNI = do not intubate

DNR = do not resuscitate

H_2O = water

HOB = head of bed

I & O = intake and output

med = medication

MI = myocardial infarction

npo = nothing by mouth

O_2 = oxygen

OD = right eye

OS = left eye

OU = both eyes

pc = after meals

PRN = as needed, when required

s̄ = without

SOB = shortness of breath

Stat = immediately

TIA = transient ischemic attack

TBI = traumatic brain injury

VS = vital signs

p̄ = 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, medication was set up for unplanned time away or not received per prescribers' orders

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

III. Administration of Medication – General Information

A. 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:

1. The house communication book and/or Therap Scomms.
2. 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.
3. 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 Nurse prior to administering any medication about which you may have a question.

B. 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.
C. 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 and the reason it is being given). The route of administration will be listed on the med sheet or MAR. 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.
D. If the information on the prescription label of the container and the med/tx sheet or MAR differ, staff are to follow the MAR and contact the site nurse with the discrepancy. If a dosage has changed, the nurse will have the pharmacy create a new label to reflect the change. Call the nurse on call to verify after hours or the house nurse Mon-Friday 8a-5pm.
E. 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 Individualized medication assessment, and/or in the drug handbook.
F. 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.
G. Remember the "Six Rights" to check with each medication administered:
   1. Right Person
   2. Right Medication
   3. Right Dose
   4. Right Time
   5. Right Route
   6. Right Documentation
H. The medications container/prescription label should be checked against the med sheet or MAR to verify the 6 rights prior to punching out the medication from the bubble pack. If the medications are set up in a Caddy by the Nurse, staff are to check the description of

the pill on the med sheet/MAR. The med sheet/MAR will indicate if the medications is set up in the caddy and the description will include the color, shape and any marking on the pill.

I. Administer medications that only you have set up and chart only medications that you have given.

J. 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 observed the person take the medication, put it in his/her mouth, and swallowed it.

K. 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 the abbreviation of your position. Example: LS – Lisa Smith, DSP. This does not apply if Therap MAR is being used.

L. 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 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.

M. Keep all medication containers tightly closed to prevent any changes in strength from occurring. Any odor or change of color should be reported to the nurse and do not administer.

N. Never have a person carry or administer medications to another person.

O. 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, unless otherwise indicated in the client's medication assessment.

P. 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.
   1. when the container is taken from the person's box.
   2. when the medication is removed from the container.
   3. when the container is returned to the person's box.

Q. Following the administration of the medication, return the tightly closed container to the individual person's box in the med cabinet/cart area. The cabinet/cart should always remain closed unless you are present. Do not leave the area if the cabinet/cart is open. Refrain from leaving the key lay on the cupboard/cart or remain in the lock.

R. In the event of an error, either in charting or administration, it must be recorded. See Section VII – Medication Error – Reporting Procedure.

S. 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 med sheet/MAR. Only give those medications which have been prescribed by the physician and are on the med sheet/MAR. Examples of situations which would require a PRN medication would be old or congestion, diarrhea, headache, flu symptoms, etc.

T. Notify the Nurse or supervisor for:
   1. Person illness/symptoms
   2. Person accident/injury
   3. Medication error
   4. Questions about medication
   5. Any questions or concerns relating to person's health

U. If medications are carded/bubble packed by the pharmacy, all the above requirements apply. In addition:
   1. 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.
   2. 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.
   3. 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

IV. Procedures for Medication, treatment, or exercise reminders

A. Get out the Med Book or log onto the MAR on Therap to review the information on the med/Tx sheet or MAR for scheduled time of medication, treatment, or exercise reminders
B. Verbally or visually remind the client to take their medications or do their treatment, or exercise
C. Staff may look at the pill caddy to ensure that the medications were taken, but do not physically give them to the client
D. If the client is frequently forgetting medications, treatments/ exercises or is remind then does not take/do them the staff should notify the house nurse to re-evaluate the medication management plan/ treatment or therapy plan
E. Chart the medication, treatment or exercise reminder on the person's med/Tx sheet or MAR only after a medication, treatment, or exercise reminder has been given.

V. Working with the Pharmacy

F. 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 nurse.
   1. Pharmacies will make an extra bottle or card with matching label directions for work if you ask them to do this.
   2. 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.

VI. 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 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.

H. Use the following method of charting on the med/tx sheet or MAR for each circumstance below:

    1. Your Initials = medication or treatment administered as directed

    2. H = person is on a home visit or in the hospital and the responsibility for medications has been assumed by another person, e.g. parent or sibling, etc. H could also indicate that the medication should be held per prescriber’s orders. This should be documented

in the client's T-logs.

3. W = work

4. Your Initials Circled = person did not get the medication or treatment as directed. Initials circled could also indicated that staff set up medications and sent them out with the client per the unplanned time away procedures. This should be documented in the client's T-logs.

I. Each of the above 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.) and the nurse that was contacted.

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.

VII. Missed Medications

If a dose of a medication is missed:

A. Contact the site nurse immediately or the nurse on call and follow instructions given.

B. Follow any established protocol ordered by physician regarding missed doses of a medication, for a particular individual.

C. If neither of the above options are available, contact pharmacy or ER for instructions.

VIII. 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 site nurse. If the site nurse is unavailable, follow the nurse on call procedure. 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 RN, supervisor and, as requested, the legal representative, case manager, and prescribing physician that a medication error has occurred.

E. 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.).

F. 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.

IX. Procedures for Counting and Tracking a Controlled Substances

A Controlled Substance is defined as a drug or other substance that has been restricted by federal or states law and illegal for sale unless, depending on the substance, prescribed by a physician. Government control has been deemed necessary due to the potentially dangerous, addictive or other potentially harmful nature of the substance.

A. When controlled substances are delivered from the pharmacy, they are to be immediately counted in on the controlled substance count sheet.
   1. Controlled Substance count sheet must include:
      a. Name of the client
      b. Year medication was prescribed
      c. Rx # (this is usually different for each delivery. If Rx number is the same new count can just be added to current sheets).
      d. Prescribing Doctor (Found on Pharmacy Label)
      e. Drug Name and Strength
      f. Date/time the initial count was done
      g. Under the current count column staff will put "+ (the number of tabs received)

h. Signature of staff counting in medication

i. If a second person is on site, they should also count and sign in medication

B. Controlled Substance count is to be updated each time a medication is given to a client and at each shift change
   1. When administering medications, a second signature is not required to perform an updated count
   2. At shift change the person going off shift and the person coming on shift are required to perform a controlled substance count together prior to any staff leaving

      a. If there is a discrepancy with the controlled substance count staff will compare the card, to the med sheet/MAR to try and determine where the count is off

         b. The House nurse should be contacted and informed

X. Destruction of Medication/controlled substances

- Discontinued, unused or expired medications must be destroyed by a nurse and witnessed by a second med trained staff. The destruction must be documented and consist of: the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given/how they were disposed, date of disposition, and names of the nurse and the witness involved in the disposition.

A. The Medication Destruction Record should be used for all disposition of medications, no Health T-Log or med progress note is required. One Medication Destruction Record (see refenced documentation) per person, 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.)
   3. RX destroyer is also another way to destroy medications. This is done by placing the medications into the RX destroyer then putting the lid back on and gently shaking the bottle to ensure that all the medications are in the liquid. Continue to add medications

to RX destroyer as needed until the fill mark is reached. Then discard the bottle in the garbage.

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.

XVI. Use of Drug Handbook

A 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 the 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 does in relation to the various reasons for use of the medication.
4. Administration: It will specify any 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: Here, you will find listed a variety of side effects which have been

noted in people who use the medication. You will then be alerted to possible reactions which the person may experience from this drug. In the event that you were to note 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 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 the 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.) about 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. RN.

References: MN Rule 144A.4792 Subdivisions 1 through 23