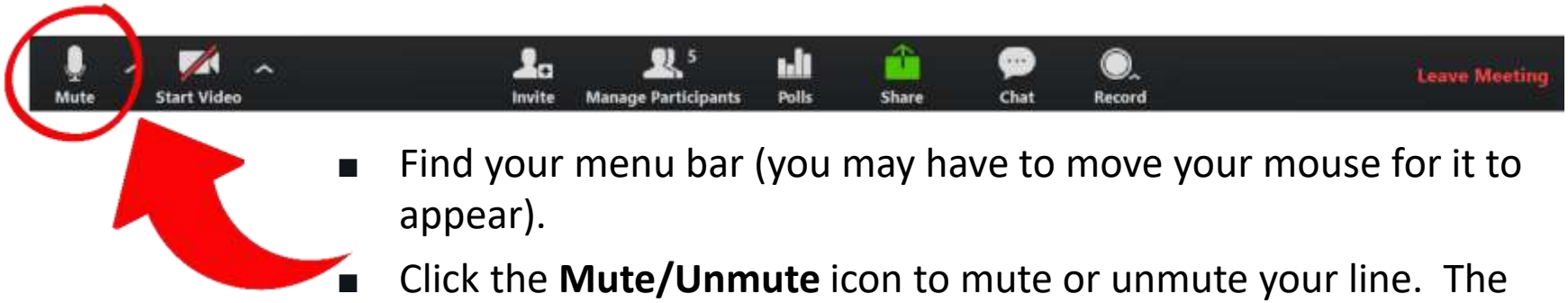
Medication Administration Training

For TBHS Staff and Provider Staff

TECHNOLOGY CONTROLS



- Find your menu bar (you may have to move your mouse for it to appear).
- Click the **Mute/Unmute** icon to mute or unmute your line. The **Start Video** icon next to it works the same way.
- To write in the chat box, click the chat icon and a window will pop up. I would like to test this function by having everyone chat their role in the community.

Welcome to Medication Training

After the completion of this course, you will be assigned the Medication Administration Test through the Relias Learning platform.

You will need to pass the test by 80% or higher to receive credit for taking this training.

Must complete Medication skills check off with a TBHS Nurse and complete the Medication Observation Form with your Supervisor/Home Manager.

Additional Trainings

- Additional training may be required that is not provided in this course.
- All home staff will need additional training if the individual served is in need of procedures such as:
  - Glucometer Testing
  - Subcutaneous Injections
  - Peg Tube Placement with Tube feedings
  - Special Diet Changes
  - Simple Wound Care

Things to Know Before Administering Medications

- Michigan Department of Health & Human Services (MDHHS) Governs Medication Administration.
- TBHS requires newly Medication Administration trained staff to pass medications with Home Manager a certain number of times before staff may pass medications independently.
- Home Manager needs to submit staff's completed Medication Observation Guide to TBHS Training Services.
- Prior to passing medications, staff must know the purpose of each medication and side effects of medication.
    - Approved resources for medication information:
        - Registered Nurse
        - Medical Provider
        - Pharmacy
        - Medication Book
        - Poison Control (800-222-1222)

Medications

- Medication can have significant impact on a person's overall state of health, behavior, and the ability to prevent, combat, or control disease.
- This training focuses on the information you need to safely and accurately perform the critical tasks of administering medication to an individual.

Use of Medications

- Prevent Disease
- Diagnosis of Disease
- Treatment of Disease/Most common use of medications
- Relief of Pain
- Maintenance of Function

Medications

- **Non-Prescriptions** or Over-The-Counter (OTC)
  - Needs licensed physician's order
- **Prescriptions**
  - Regular prescription medications
  - Prescribed by a licensed to do so by the Department of Licensing and Regulation (licensed physician, dentist, CNS or psychiatrist)
  - Dispensed by licensed pharmacies
- **Controlled Medication** or Narcotics (Examples: Ativan, Valium, Ritalin)
  - High potential for abuse
  - Require special storage in double lock system
  - Must be counted in and out when handling on a Count Sheet
  - Disposal & Counts need a witness

All drugs given are considered to be prescription medication. All medications administered must be prescribe by a person licensed to do so by the Department of Licensing and Regulation (i.e., doctor, dentist).

E-Prescribing

- The electronic transmission of a drug prescription directly to a pharmacy.
- Always ask prior to leaving an appointment if there are any new orders being sent to the pharmacy and make sure they are instructing you on these changes.

Non-Emergent Standing Orders

TUSCOLA BEHAVIORAL HEALTH SYSTEMS

A Michigan Community Mental Health Authority serving Tuscola County

NON-EMERGENT STANDING ORDERS

Consumer: _____ Case No: _____

Allergies: _____ Home: _____

BURNS & ABRASIONS (NOTIFY R.N.)	APPLY COOL COMPRESS TO AFFECTED AREA FOR 20 MINUTES 4 TIMES A DAY PRN. IF SKIN REMAINS INTACT, APPLY ALOE VERA GEL 4 TIMES A DAY FOR 3 DAYS. DERMAPLAST – USE ACCORDING TO MANUFACTURER'S DIRECTIONS.
COLD SYMPTOMS	DIMETAPP EVERY 4 HOURS PRN (OR) Administer as directed on label – Adult Dosage CLARITIN – 10 MG DAILY (1 TAB) PRN CONTACT R.N. IF COLD SYMPTOMS CONTINUE LONGER THAN 5 DAYS
COLD SORES	CARMEX apply according to label directions as needed.
CONSTIPATION	PRUNE JUICE, GIVE AS DIRECTED ___ OUNCES PER DAY MILK OF MAGNESIA 30 ml, IF NO BM IN _____ NO. OF DAYS DULCOLAX SUPPOSITORY, GIVE 1 SUPPOSITORY, IF NO BM IN _____ NO. OF DAYS FLEETS ENEMA, GIVE 1 ENEMA, IF NO BM IN _____ NO. OF DAYS
COUGH	ROBITUSSIN 10 ml, GIVE EVERY 6 HOURS PRN. CONTACT R.N. IF COUGH CONTINUES LONGER THAN 3 DAYS
CUTS	TRIPLE ANTIBIOTIC OINTMENT, USE AS DIRECTED ON THE LABEL PRN. A&D OINTMENT, 3 TIMES A DAY PRN. COVER AREA IF DRAINAGE IS PRESENT – IF AREA IS COVERED, RECHECK AREA DAILY FOR SIGNS OF INFECTION RECOVER AREA IF NEEDED
DIARRHEA (NOTIFY R.N. PRIOR TO GIVING)	IF CONSUMER HAS THREE LOOSE STOOLS IN 24 HOURS, CONTACT RN. **DO NOT BEGIN KAOPECTATE UNTIL CONTACT WITH RN.** KAOPECTATE 30 ml, GIVE EVERY 4 HOURS PRN. NOT TO EXCEED 6 DOSES IN 24 HOURS PRN DO NOT CONTINUE LONGER THAN 3 DAYS.
DRY LIPS	CHAPSTICK - APPLY TO LIPS PRN FOR DRY OR CHAPPED LIPS.
DRY SKIN	HAND LOTION - APPLY TO DRY SKIN PRN.
EAR WAX	MINERAL OIL - 2 DROPS PER EAR THE FIRST FIVE DAYS OF THE MONTH TO PREVENT EAR WAX IMPACTION PRN. DEBROX WAX SOFTENER - USE AS DIRECTED IF IMPACTION IS IDENTIFIED & ORDERED BY R.N.
FEVER (NOTIFY RN PRIOR TO GIVING)	IBUPROFEN 200 mg tablets, GIVE 2 TABLETS EVERY 6 HOURS PRN FOR A TEMPERATURE (OR) ACETAMINOPHEN 500 mg tablets, GIVE 2 EVERY 6 HOURS PRN FOR FEVER GREATER THAN . **NOTIFY R.N. IF FEVER CONTINUES LONGER THAN 24 HOURS.**
HEADACHE	IBUPROFEN, 200 mg tablets, GIVE 1 OR 2 TABLETS EVERY 6 HOURS PRN. (OR) ACETAMINOPHEN 500 mg tablets, GIVE 2 TABLETS EVERY 6 HOURS PRN **NOTIFY R.N. IF USED MORE THAN 3 DAYS.**
HEART ATTACK PROTOCOL (If signs of a heart attack are shown – CALL 911 IMMEDIATELY)	ASPIRIN 325 mg 1tablet (OR) 81 mg 2 tablets (162mg), (MUST BE NON-ENTERIC COATED) GIVE TABLET(S) ORALLY, HAVE CONSUMER CHEW THE TABLET(S) AND THEN SWALLOW WITH A SMALL AMOUNT OF WATER FOR ANY CONSUMER SHOWING EARLY SIGNS OF A HEART ATTACK , SUCH AS PERSISTENT CHEST PAIN OR PRESSURE THAT LAST LONGER THAN 3-5 MINS OR COMES AND GOES, SHORTNESS OF BREATH, DIZZINESS, SWEATING, NAUSEA, OR VOMITING. **(Before giving aspirin check for the following: allergies to aspirin, a history of stomach ulcers or stomach disease, are they using any blood thinners such as Warfarin or Coumadin. If the answer is No to these questions, aspirin may be given as outlined above.)**
ITCHING/RASH (NOTIFY R.N. PRIOR TO USING)	CALAMINE LOTION - USE AS DIRECTED ON LABEL PRN FOR INSECT BITES. HYDROCORTISONE OINTMENT – APPLY TO AFFECTED AREA AS DIRECTED ON LABEL PRN. BENADRYL OINTMENT - APPLY TO AFFECTED AREA AS DIRECTED ON LABEL PRN.
MENSTRUAL CRAMPS	IBUPROFEN 200 mg tablets, GIVE 1 OR 2 TABLETS EVERY 6 HOURS PRN.
MINOR PAIN/ DISCOMFORT	IBUPROFEN 200 mg tablets, GIVE 1 OR 2 TABLETS EVERY 6 HOURS PRN. (OR) ACETAMINOPHEN, 500 mg tablets, GIVE 2 TABLETS EVERY 6 HOURS PRN **NOTIFY R.N. IF COMPLAINTS CONTINUE LONGER THAN 2 DAYS.**
SUNSCREEN	SPF-30 OR GREATER. Apply at least 15 minutes prior to sun exposure. Re-apply frequently per label directions.
UPSET STOMACH	PEPTO BISMOL 30 ml, GIVE EVERY 30-60 MINUTES PRN. NOT TO EXCEED 8 DOSES IN 24 HOURS. **(MAY NOT BE GIVEN ALONG WITH KAOPECTATE** (OR) MAALOX 10 ml, GIVE 4 TIMES A DAY PRN. TUMS 1 OR 2 TABLETS. GIVE AS DIRECTED ON LABEL PRN. NOTIFY R.N. IF UPSET STOMACH LAST LONGER THAN 3 DAYS.
SKIN BREAKDOWN	TRIPLE ANTIBIOTIC OINTMENT – APPLY TO AFFECTED AREA(S) TID AVOID EXCESSIVE PRESSURE TO AREA AND TURN CONSUMER EVERY 1-2 HOURS.
IRRITATED SKIN (CALL RN PRIOR TO GIVING)	ANTI-MONKEY BUTT POWDER – USE AS DIRECTED LOTRIMINE SPRAY – USE AS DIRECTED BAG BALM – USE AS DIRECTED
HEMORRHOIDS	PREPARATION-H – USE AS DIRECTED TUCKS MEDICATED PADS – USE AS DIRECTED
Note:	FOR SPECIALIZED RESIDENTIAL CONSUMERS THESE ORDERS WILL BE RENEWED EVERY 90 DAYS WITH THE FORWARDING OF ROUTINE PHYSICAN'S ORDERS. For all other consumer's these orders will be renewed annually. **MAY USE GENERIC EQUIVALENT**.

Physician's Signature: _____ **Date:** _____

White Copy–Retain in Pharmacy Yellow Copy–Retain in Home Pink Copy –Retain in TBHS–PIC/Records Gold Copy–Retain by Nurse

Medical Service Notes

When taking a consumer to an appointment, you will most likely take a medical service note with you. The doctor may fill this out. If the doctor writes any instructions on this form, it is now considered an order and must contain the doctor's signature.

When taking a consumer to an appointment always get a script from the doctor for any scheduled medications, treatments, or diet changes.

You are able to ask questions regarding care they are providing, treatments the consumer is receiving during appointments.

Drug Abuse

- Refers to using a medication in a manner other than that for which it was intended.

Effects of Drug Abuse

Physical Dependence (Addiction):

- Without the drug, the person experiences withdrawal symptoms. When the drug is re-administered, the withdrawal symptoms disappear.

Effects of Drug Abuse

Psychological Dependence (Habituation):

- Is an emotional dependence upon a drug. The dependence may range from a mild desire for a drug to a compulsive use. The person prefers the drug-induced feelings.

Effects of Drug Abuse

Functional impairment:

- Is when the body can no longer function normally without the drug.

Effects of Drug Abuse

- Drugs which have a beneficial medical effects also have the potential for abuse. These drugs are often abused because they alter one's state of mind.
- The major categories of drugs that have the potential of drug abuse are:
  - Narcotics (heroin, morphine, Demerol)
  - General central nervous system depressants (barbiturates, alcohol)
  - Center nervous system stimulants (cocaine, amphetamines)
  - Mind-altering drugs (LSD and marijuana)

Effects of Drug Abuse

- Our attitudes regarding the importance of taking medications depends on our culture, community, family, and friends.
- No matter what your personal values are regarding taking medications, you are responsible, as a direct care staff person, to assist the person in using medications as ordered.

  Note: Portions of this content adapted from Bergersen, Betty S. Pharmacology in Nursing, 14th Edition, St Louis: C.V. Mosby Co., 1979.

LEGAL AND ETHICAL IMPLICATION OF MEDICATION ADMINSTRATION

Direct Care Staff are legally responsible for the safe administration of prescribed medication.

Legal and Ethical Implications of Medication Administration

- There are laws governing every aspect of drug therapy. The Department of Mental Health (DMH) has issued specific guidelines regarding medications used to decrease some thoughts, feelings and behaviors (psychotropics) and medications use to decrease seizures (anticonvulsants.)
- All medication including over-the-counter medication must be prescribed by a person licensed to do so by the Department of Licensing and Regulation (i.e. doctor, dentist).

Legal and Ethical Implications of Medication Administration

- In order to administer medication, there must be a consent signed by the parent or guardian stating that residential community staff may administer medications.
- Staff must have taken and passed a medication training program approved by your agency.
- You should only administer medication using procedures for which you have been trained in class.
- You should refuse to carry out procedures unless properly trained.

Legal and Ethical Implications of Medication Administration

- As a direct care staff, you must know the policies and procedures.
- Most errors in administering medication can be traced to failure to follow these policies and procedures.
- Information about each drug must be obtained before administering the medication.
- There are many responsibilities which come with administering medications.
- As a direct care staff, you must convey a positive attitude about medications.
- Questions asked should be answered honestly and accurately.

Legal and Ethical Implications of Medication Administration

- Any person has the right to refuse medication.
- A person should never be forced to take a medication.
- The refusal must be reported appropriately.
- Rarely, a decision to force medications is made by the physician, and provisions for this are included in the Michigan Mental Health Code.

Never force a person to take medications

He/she has the right to refuse medications

Legal and Ethical Implications of Medication Administration

Safety is the prime concern when administering medications.

- This includes strictly adhering to the “six rights,” (right person, right medication, right time, right dose, right route, right documentation).
- You must observe, record and report the person’s responses to drug therapy.
- Every medication is potentially dangerous if not administered properly.
- If you have any questions about administering medications, be sure to confer with the nurse consultant/ pharmacist before proceeding.

Ethical and Legal Implications

- All Direct Care Staff must have taken and passed a Medication Administration Program approved by the facility before passing medications and must only administer medication using the procedures for which you have been trained. (Following the six rights, triple check, use of identifiers, and witnessing.)
- Staff can be held legally responsible for failure to follow these procedures in the event of medication error.
- Must Demonstrate Competency - checklist completed by supervisor.
- State and Federal Laws regulating the administration of medication.

Ethical & Legal Implications

WILLFUL AND WANTON

- Willful and wanton conduct means a course of action showing an actual or deliberate intention to injure or, if not intentional, shows an utter indifference to or conscious disregard for the safety of others.

GROSS NEGLIGENCE

- Failure to use even the slightest amount of care in a way that shows recklessness or willful disregard for the safety of others.
- Gross negligence means conduct or a failure to act that is so reckless that it demonstrates a substantial lack of concern for whether an injury will result.

Effects of Drugs

Drugs are administered for their site and systemic (general) effects.

How Medications Work in the Body

Local Action

- Targets a specific area of the body

Systemic Action

- Can potentially affect the whole body systems.

Can you think of examples for each?

Response of Medication

- Therapeutic Effects – Desired Response
- Side Effects – Unintended Response
- Adverse Effects – Harmful Response
- Contraindication – Inadvisable for Use

The effect of a drug may vary from person to person at different times.

POP QUIZ!

Terms to pick from:

Local Action	Therapeutic	Side Effect
Contraindication	Systemic Action	Adverse Effect

1. Motrin caused a mild stomach ache
2. A pregnant woman must stop taking her birth control pills, because this is a _____.
3. Tylenol relieved a fever
4. Zyprexa caused anaphylactic shock
5. Benadryl ointment resolved an itchy bee sting
6. Benadryl capsule resolved swelling and itchiness, it also caused drowsiness (hint: think of 3 terms)

Common Drug Routes and Dosage Forms

- Drugs are manufactured in a variety of forms. Each form is intended to be administered by a specific route.
- The form of the drug and the route determines the amount of drug that reaches the bloodstream or other body system.

Common Drug Routes

- The major routes of medication administration include:
  1. Oral (by mouth)
  2. Injectable
  3. Topical (apply directly to tissue or organ; example: eye, ear, nose, skin)
  4. Rectal
  5. Vaginal

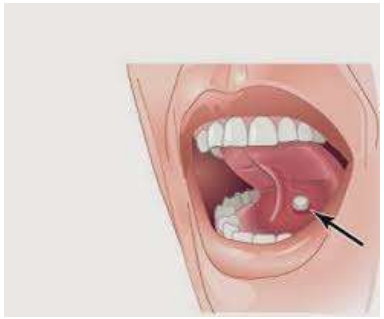
Oral Route

- The oral route is the most convenient and most common route of medication administration.
- The oral route is the method by which you will be administering most medications.

Sublingual and Buccal

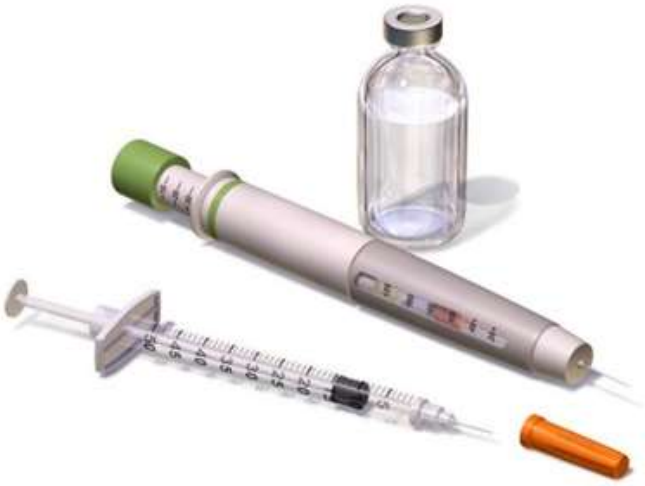
- **Sublingual** administration involves placing a drug under the tongue to dissolve and absorb into the blood through the tissue there.
- **Buccal** administration involves placing a drug between the gums and cheek, where it also dissolves and is absorbed into the blood.

https://www.healthline.com/health/sublingual-and-buccal-medication-administration#:~:text=Sublingual%20administration%20involves%20placing%20a,is%20absorbed%20into%20your%20blood.



Injectable

- Intramuscular (into a muscle)
  - Given by RN only (example is Haldol, Risperdal)
- Subcutaneous “Sub Q” (underneath the skin)
  - Given by staff (example is Insulin)



Remember: This training program does not qualify you to administer medication by injection or perform other procedures not covered.

Additional training and approval by licensed health care provider or his/her designee is required.

Common Dosage Forms

Drugs are manufactured in several forms. Some of the common forms are:

1. Capsules
2. Tablets
3. Ointment/Creams
4. Suppositories
5. Elixirs
6. Patches

Occasionally, you will encounter a dosage form that is not covered here and that you are not familiar with. Consent your pharmacist or nurse consultant for safe administration techniques

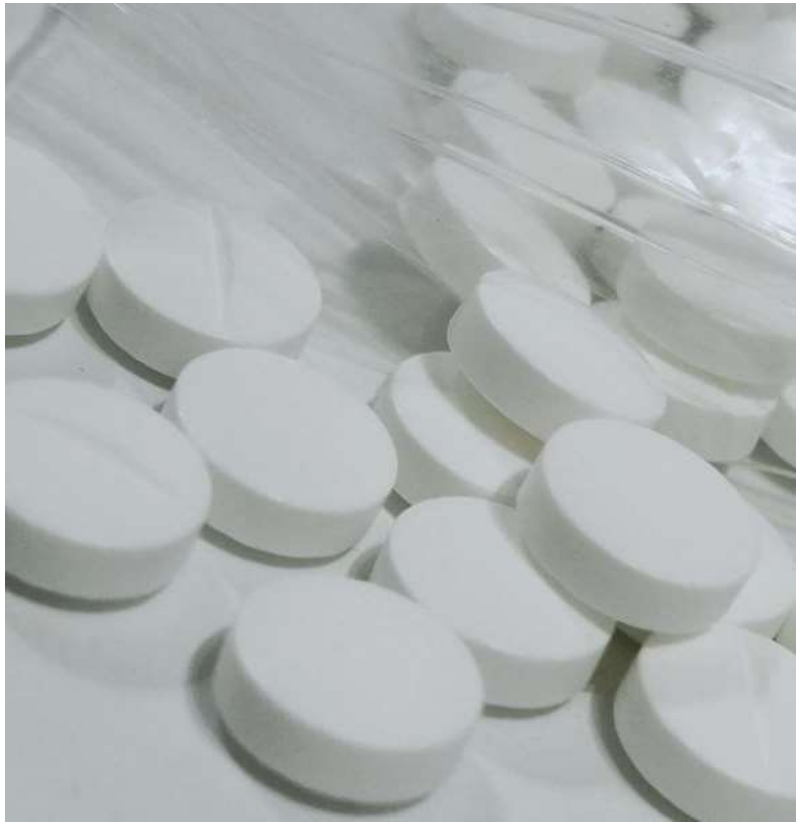
Don't crush tablets or open any capsules without first consulting a pharmacist.

Capsules

- Are small containers made from gelatin. The medicine is placed in the capsule which readily dissolves in the stomach.
- Should be taken whole unless the physician order states that it should be sprinkled into food.

Tablets

- Are pressed or molded preparations of powdered drugs. When exposed to liquid, they expand and break apart. The tablet may have a coating.



Tablets

- Enteric Coated

- Cannot Crush

True or False – Reply in Chat

The medication below is enteric coated?

Scored Tablets

Which tablet is scored? – Answer in Chat

A.

B.

C.

Dissolvable Tablets

- Keep in original package

Ointments and Creams

- Are intended for external applications to the skin or mucus membranes.

Suppositories

- Drugs for insertion into the vagina or rectum.
- The suppository will dissolve or melt at body temperature releasing the drug for absorption through the mucus membrane.

Syrups

Suspensions

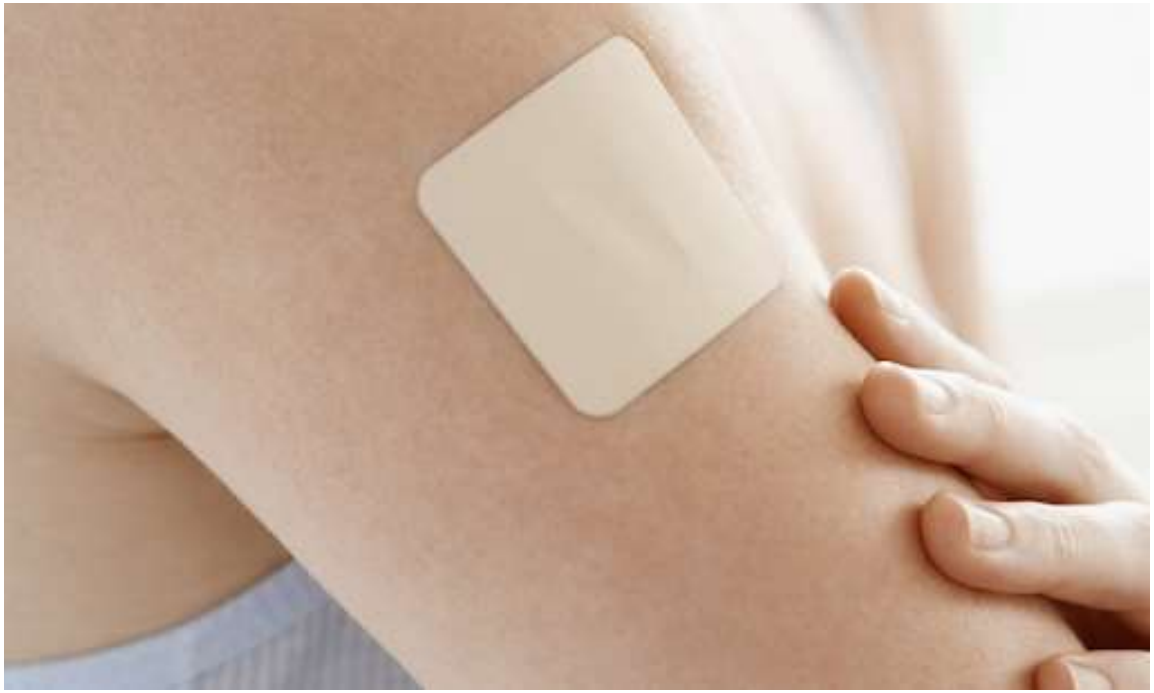
Elixirs

Liquids

- **Syrups:** Distribution of drug within the solution is even.
- **Suspensions:** drug particles do not fully dissolve into the solution (have to shake prior to administering).
- **Elixirs:** Distribution of drug within the solution is even. Clear, thinner than syrups

Patch

- Placed on the skin to deliver medication into the body by controlled release of medication.



Scenario

Molly has been asked to administer an antibiotic to Louise, one of the older residents. Molly feels pretty comfortable with this, since she has administered medications to Louise many times. Yesterday when Molly administered this medication to Louise, she noticed that she had difficulty swallowing it. Louise gagged and coughed, making Molly concerned that she could choke on it, since it is a fairly large pill.

Scenario

What should Molly do?

1. Crush the pill to make it easier for Louise to swallow it.
2. Administer the pill anyway, but be sure to have extra water nearby for Louise.
3. Ask Louise if she would rather take a liquid form and if so, administer that form of the medication.
4. Communicate the concerns about Louise's swallowing difficulty with the nurse.

Scenario

What should Molly do?

4. Communicate the concerns about Louise's swallowing difficulty with the nurse.

Molly has noticed a change in Louise's condition. She should therefore speak with the nurse before giving her the medication.

Understanding Pharmacy Labels and Physician Orders

Written Medication Orders

In order for the physician to prescribe the best treatment and medication, the following types of information should be provided:

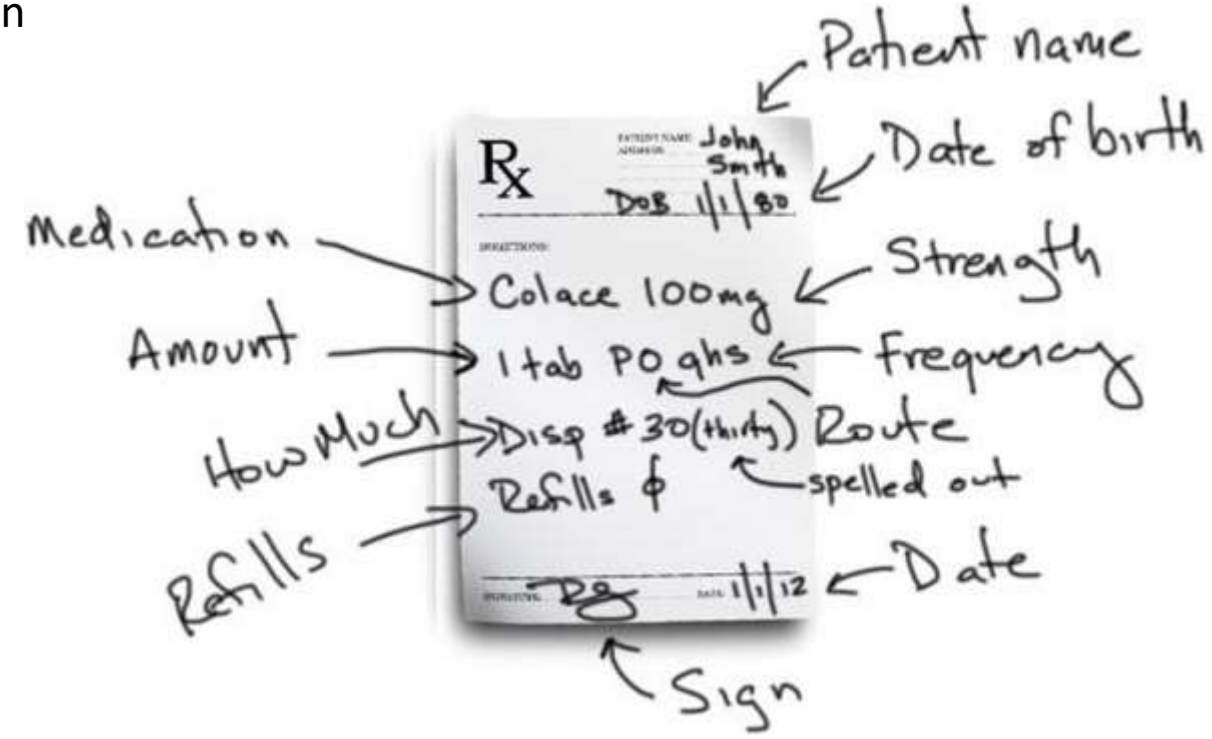
1. The person's complete medical record.
2. History of any drug allergies.
3. Current medications being administered and for what purpose.
4. Medical and dental conditions.
5. Written observations of recent physical or behavioral changes.

Written Medication Orders

When the physician decides that a person requires treatment with a medication, the physician writes the prescription to be taken to the pharmacy. A copy of the prescription is necessary for each site where the medications will be given.

Prescription Copies

- A copy of the prescription from the most recent:
  - Must Doctor's Appointment
  - Hospital Discharge
  - Other Appointments
- Must be kept on site to reference when passing medications.
- This applies to <u>ALL</u> Prescription Medication and Over-the-Counter Medication.



Written Medication Orders

The following information about each medication must be obtained before it is given:

1. Purpose of the medication and therapeutic effect.
2. When should the desired effects be expected to occur?
3. Are there any unwanted side effects? What actions should be taken if they occur?
4. Are there any known drug interactions with drugs the person is currently taking?
5. Are there special administration or storage instructions?

NOTE: The above information and additional information may be obtained from the pharmacist, nurse consultant, or from a current drug book. IF YOU HAVE DOUBTS, CHECK THEM OUT!!

Telephone Medication Orders

Occasionally in emergency situations a physician may need to give an order for medication without seeing the person. Since only persons licensed to do so can receive telephone orders for medication, the procedure is as follows:

1. Ask the physician to call the medication order in to the pharmacist. (The pharmacist records the order, dispenses the medication and then files the order for future reference.)
2. Carefully document in the person's record:
   a) Time and date of emergency
   b) Detailed description of the emergency
   c) Name of physician contacted and any instructions given.
3. Obtain the medication from the pharmacy
4. Ask the pharmacist for a copy of the prescription for the person's record.
5. After obtaining the medication from the pharmacy, record in the person's record all the information on the prescription pharmacy label.

At times, a physician may forget you are unlicensed and proceed to give you a medication order over the phone or in person.

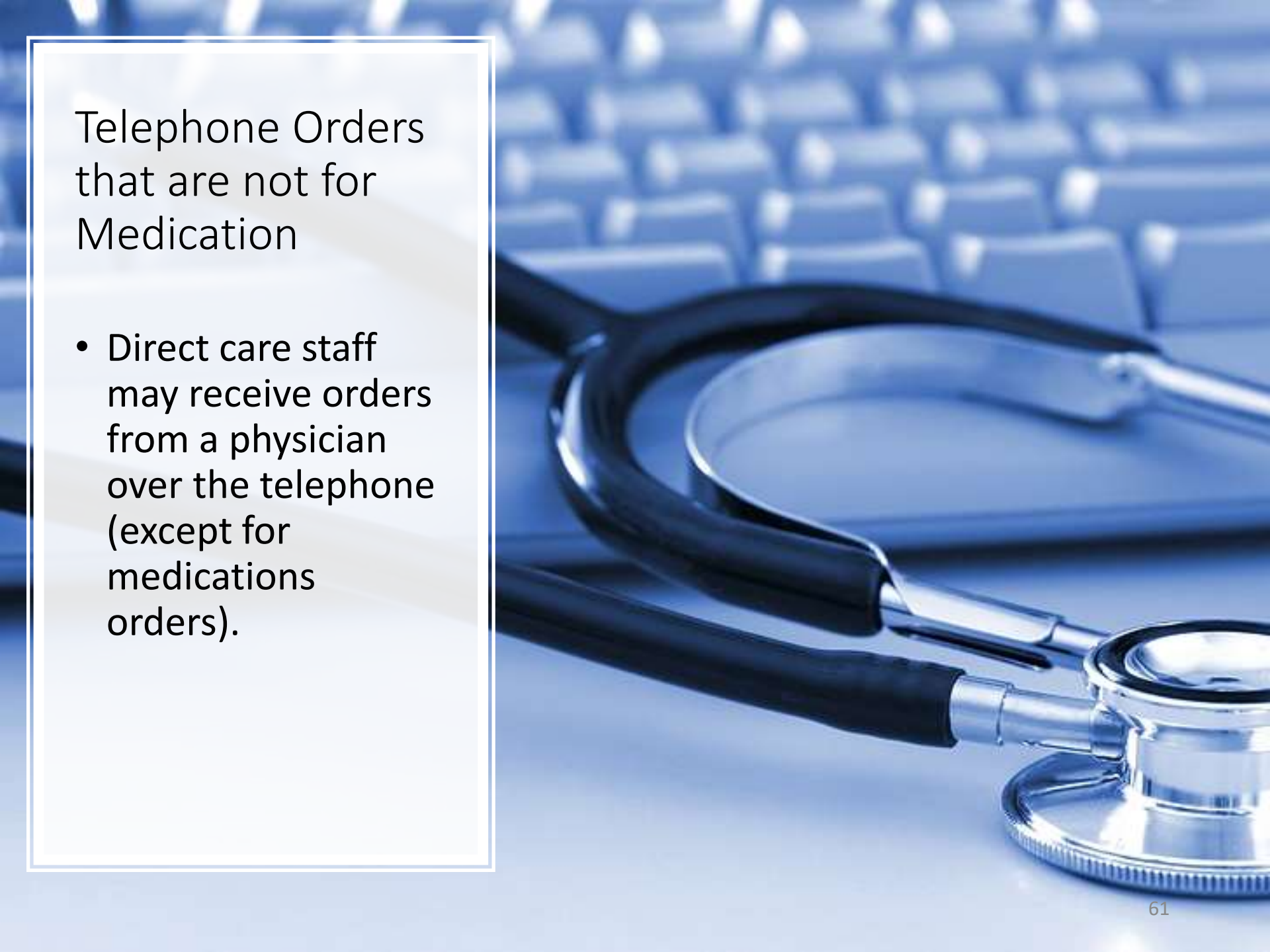
You must remind him/her to call the order to the pharmacist.

Holding or Discontinuing Medications

You may be instructed by a physician to discontinue or “hold” a medication. You may hold the medication and must contact your nurse.

Telephone Orders that are not for Medication

- Direct care staff may receive orders from a physician over the telephone (except for medications orders).



Telephone Orders that are not for Medication

When you receive a telephone order from a physician, that is not for medication, the procedure to follow is:

1. Repeat the order back to the physician for confirmation.
2. Be sure to understand what you are instructed to do. Ask any necessary questions to be sure.
3. Immediately write down in the person's record. Write down the name of the doctor you talked to, date, time, order (what was said) and your signature.
4. Notify supervisor and nurse consultant.

Prescription Pharmacy Label

- The information from the prescription is put on the pharmacy label by the pharmacist.
- The pharmacy label contains the important information from the prescription that you must have to correctly and safely give the medications.
- The pharmacy label should give at least as much information as the prescription gives.
- The medication container frequently have small labels attached giving special directions regarding the administration and storage of the medications.
    - An example of these directions might read “take with a full glass of water”, or “do not take dairy products, antacids, or iron preparations with in one hour of this medication.”

Prescription Pharmacy Label

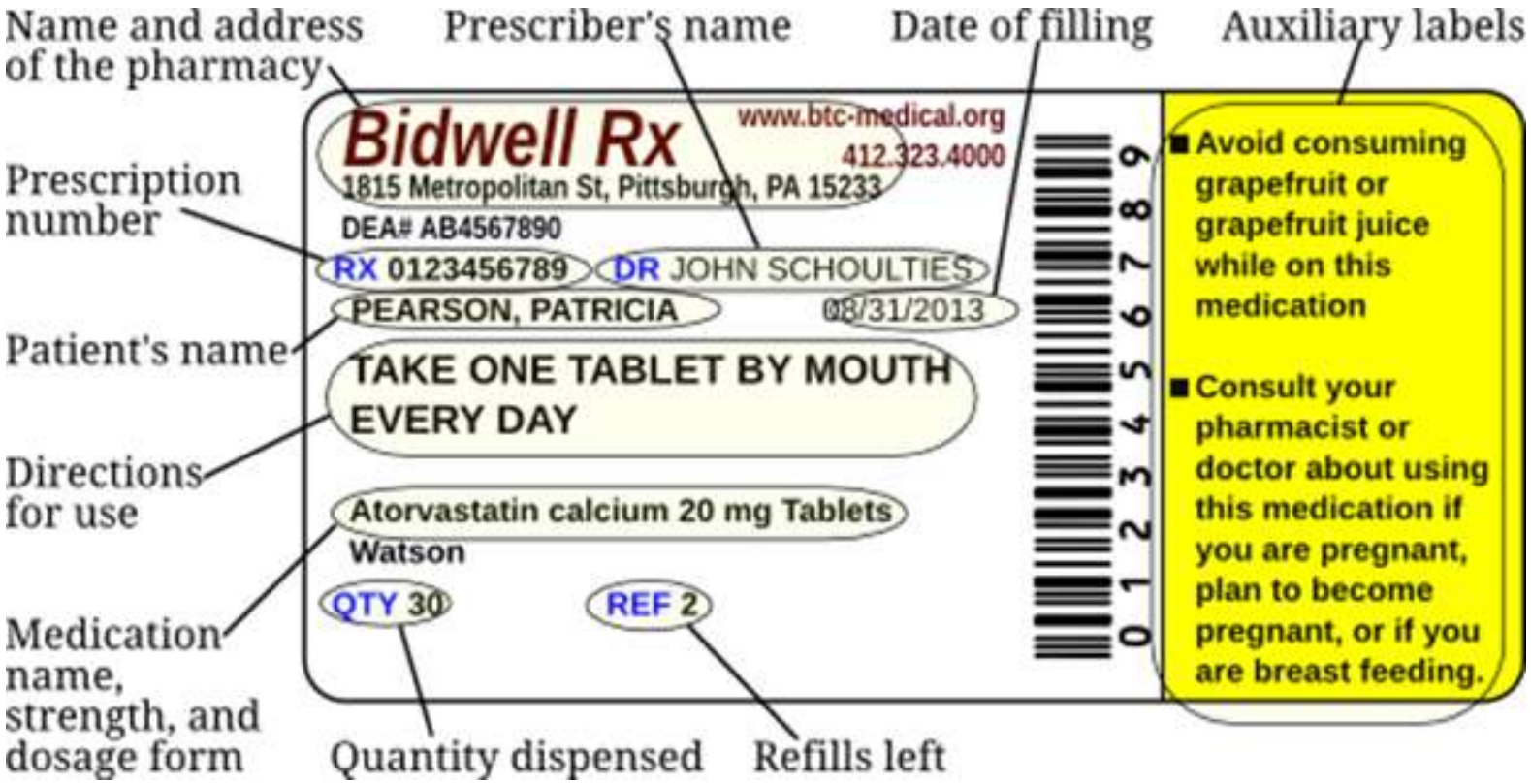
All containers in which prescription medication is dispensed must bear a label which contains, at a minimum, all the following information:

1. Pharmacy name and address.
2. Prescription number.
3. Person's name.
4. Date the prescription was most recently dispensed.
5. Prescriber's name.
6. Directions for use.
7. The name of the medication.
8. Amount dispensed.
9. Strength of medication.
10. Dosage of medication.

Prescription Pharmacy Label

- Frequently, additional information is also included on the pharmacy label, such as:

1. Pharmacy phone number
2. Refill instructions
3. Initials of pharmacist filling prescription
4. Special instructions for storage/handling.

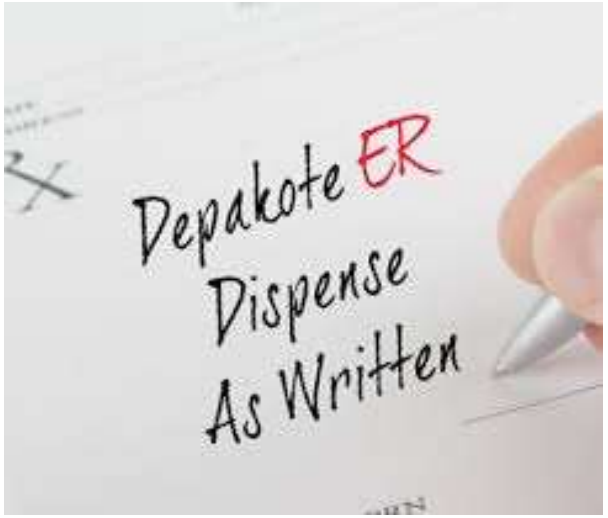

Name and address of the pharmacy
Prescriber's name
Date of filling
Auxiliary labels
Bidwell Rx
www.btc-medical.org
412.323.4000
1815 Metropolitan St, Pittsburgh, PA 15233
DEA# AB4567890
Prescription number
RX 0123456789
DR JOHN SCHOULTIES
Patient's name
PEARSON, PATRICIA
08/31/2013
TAKE ONE TABLET BY MOUTH EVERY DAY
Directions for use
Atorvastatin calcium 20 mg Tablets
Watson
Medication name, strength, and dosage form
QTY 30
REF 2
Quantity dispensed
Refills left
0 1 2 3 4 5 6 7 8 9
Avoid consuming grapefruit or grapefruit juice while on this medication
Consult your pharmacist or doctor about using this medication if you are pregnant, plan to become pregnant, or if you are breast feeding.

Prescription Pharmacy Label

- Two or more manufacturing companies may choose to use the same formula and chemicals to make a medication.
- Both products would have the same generic name.
- Each company could give the product their own brand name.
  - For example: The generic name of the antibiotic is tetracycline. It is also manufactured under a number of brand names (e.g., Achromycin, Panmycin, Tetracyn and Steclin).

Prescription Pharmacy Label

- Usually the pharmacist will substitute a generic product for the brand name. In that case, the prescription label should list both names or state “GEQ” (generic equivalent).
- State of Michigan pharmacists are required to substitute unless “DAW” (dispense as written) is written on the prescription.



Prescription Pharmacy Label

- The community pharmacist is an excellent person to ask for specific information about the medication prescribed.
- The pharmacist maintains a list of all (including over-the-counter) medication prescribed for the person.
- The direct care staff is responsible for updating (informing) the pharmacist on all prescription and over-the-counter drugs the person is currently receiving.
- This information should be given from the individual's record.

Storage of Medications

Locking Medication Boxes

- All medications must be in original containers with pharmacy labels in a locked med box.
- Medications requiring refrigeration need their own med box.
- External medications such as ointments & creams, drops, shampoo, need own med box (stored separately from oral medication).

Practices to be Followed in Storing Medications

Medication Cabinets

- Shall not be located over heated areas (heat can change the chemical properties).
- Shall be used only for medication storage.
- Shall be kept clean and orderly.
- Shall have sufficient storage space and adequate lighting.
- Shall be kept locked except when putting in or taking out medications.
- Double Lock System for Controlled meds

Key(s) to the locked medication storage cabinet must be kept on the person assigned to medication administration on each shift.

Medication Preparation, Administration and Documentation

Transcribing Medications

Once you have obtained the necessary medication(s) from the pharmacist you must write down certain information on the appropriate forms. This is known as transcribing. You will be using the information received from the physician and pharmacist for the important transcribing process.

Transcribing is an important part of administering medication safely.

Abbreviations and Symbols

Abbreviations and symbols are shortened form of words. Some of the common abbreviations and symbols use in transcribing follow:

- q. (Q) = Every
- D. = Day
- H. = Hour
- Q.3 h. = Every three hours
- b.i.d. = Twice a day
- t.i.d. = Three times a day
- q.i.d = Four time a day
- h.s. (HS) = Hour of sleep (bedtime)
- prn = When necessary, or as needed
- A.M. = Morning
- X = Times
- oz. = Ounce
- STAT = At once (now)
- (o) = Orally
- ASA – Aspirin
- MOM = Milk of Magnesia
- tsp. = Teaspoon
- Tbsp. = Tablespoon
- gr. = grains
- mg. = milligrams
- GM, gm. = grams
- P.M. = Afternoon
- ml = milliliter (same as cubic centime)
- cc – cubic centimeter

Transcribing

When you return from the pharmacy, you should have:

1. The medication in the container supplied by the pharmacist.
2. A correct and legible (able to read) label on the container.
3. A written physician's order for the medication.
4. Any additional instructions the physician or pharmacist has given you.

Transcription Guidelines

1. Definition: Transcription means copying information from the pharmacy label to the Medication Record and the HCC. The purpose of transcription is to set up the Medication Record form so that staff can perform the Three Checks before administering a medication and can accurately document the medications that have been given.
2. On the job, you will also transcribe from the pharmacy label to the Health Care Chronological. In class, we will not have the time to do this.
3. The physicians order must be transcribed exactly as written on the pharmacy label.
4. Transcription is done before the medication is given. Documenting is done after the medication is given. To document a medication while transcribing is a serious error. In classroom practices, you will have to error out that medication order and re-transcribe it. During the return demonstration, documenting when you are transcribing will result in failure of the return demonstration. On the job, making this mistake may result in your termination.

Transcription Guidelines

5. The month and year are written at the top (not the date of the month), underneath the words, Medication Record.
6. Allergies are written in red at the top left corner of the page. If the person has no known allergies, write "**NKA**" in red.
7. This is a legal document. You must use permanent blue or black ink. You may not use correction fluid or other means of covering up errors. You may not error out individual mistakes – the entire order must be re-transcribed.
8. Errors must be corrected properly (no matter how small the mistake). Write the word "ERROR" in large letters across the dose blocks, the date, and your initials. Draw three or four diagonal lines through the medication order and re-transcribe the order completely.
9. When the medication is ordered for a specific number of days, you must calculate the date and time of the last dose. To do this, multiply the number of times the medication is given each day by the number of days for which it is prescribed. That gives you the total number of doses that the person will receive. Count the doses, starting from the first time the medication is given to determine the date and time of the last dose.

Transcription Guidelines

10. After calculating the last dose and drawing your lines accurately, indicate a discontinuation by writing: “D/C on (date) after (time) dose.” Write your initials or number next to this note. Also write “DC (date)” after the last words of the medication order.
11. Months with 30 days are April, June, September, and November. All the rest have 31 days except February, which has either 28 or 29 days.
12. 12:00 PM = Noon; 12:00 AM = Midnight; midnight is the last dose of the day.
13. Neatness counts. If your handwriting is not easily read, you need to print the information that you are transcribing.

BLANK MAR

TUSCOLA BEHAVIORAL HEALTH SYSTEMS
MEDICATION / TREATMENT RECORD
WITH DATES

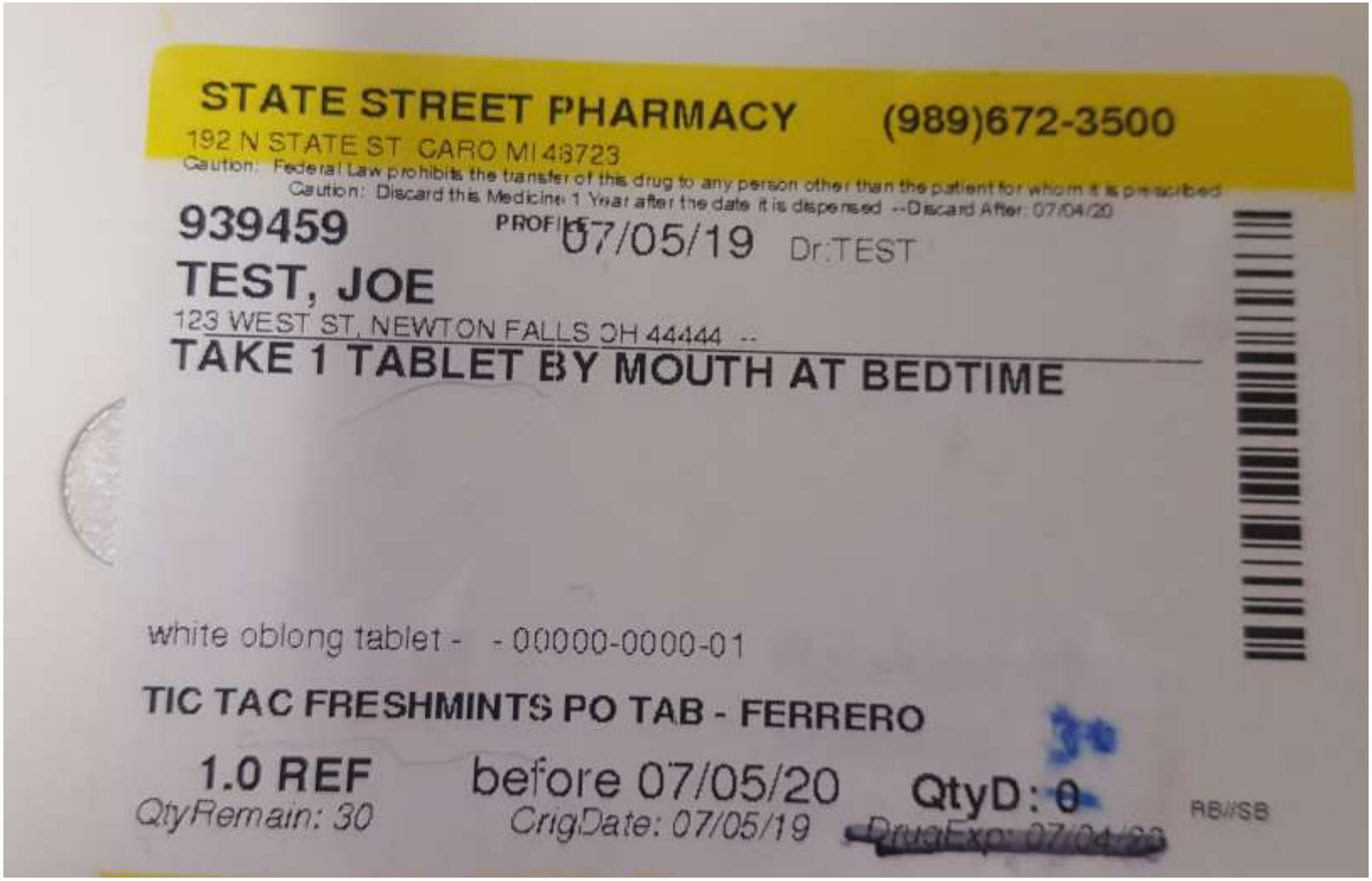
ALLERGIES	NAME	CASE#	MONTH	YEAR

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 Identifiers verified																															

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 Identifiers verified																															

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 Identifiers verified																															

Initials	Name	Title	Initials	Name	Title	Initials	Name	Title


STATE STREET PHARMACY (989)672-3500
192 N STATE ST CARO MI 48723
Caution: Federal Law prohibits the transfer of this drug to any person other than the patient for whom it is prescribed
Caution: Discard this Medicine 1 Year after the date it is dispensed --Discard After: 07/04/20
939459
PROFILE
07/05/19 Dr:TEST
TEST, JOE
123 WEST ST, NEWTON FALLS OH 44444 --
TAKE 1 TABLET BY MOUTH AT BEDTIME
white oblong tablet - - 00000-0000-01
TIC TAC FRESHMINTS PO TAB - FERRERO
1.0 REF
QtyRemain: 30
before 07/05/20
CrigDate: 07/05/19
QtyD: 0
RB/SB

TUSCOLA BEHAVIORAL HEALTH SYSTEMS
MEDICATION / TREATMENT RECORD
WITH DATES

NKA (ALLERGIES) | Test, Joe (NAME) | 1234 (CASE#) | July (MONTH) | 2019 (YEAR)

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Tic Tac Freshmints Take 1 tablet by mouth at bedtime	7/5/19		1 TAB	8 PM																															
				COUNT																															
				2 Identifiers verified																															

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 identifiers verified																															

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 identifiers verified																															

Initials	Name	Title	Initials	Name	Title	Initials	Name	Title

TBHS

PIC
SEC 15

11-17-05

TUSCOLA BEHAVIORAL HEALTH SYSTEMS
MEDICATION / TREATMENT RECORD
WITH DATES

NKA (ALLERGIES) | Test, Joe (NAME) | 1234 (CASE#) | July (MONTH) | 2019 (YEAR)

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Tic Tac Freshmints Take 1 tablet by mouth at bedtime	7/5/19		1 TAB	8 pm					JD																										
				COUNT																															
				2 Identifiers verified																															

Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 Identifiers verified																															

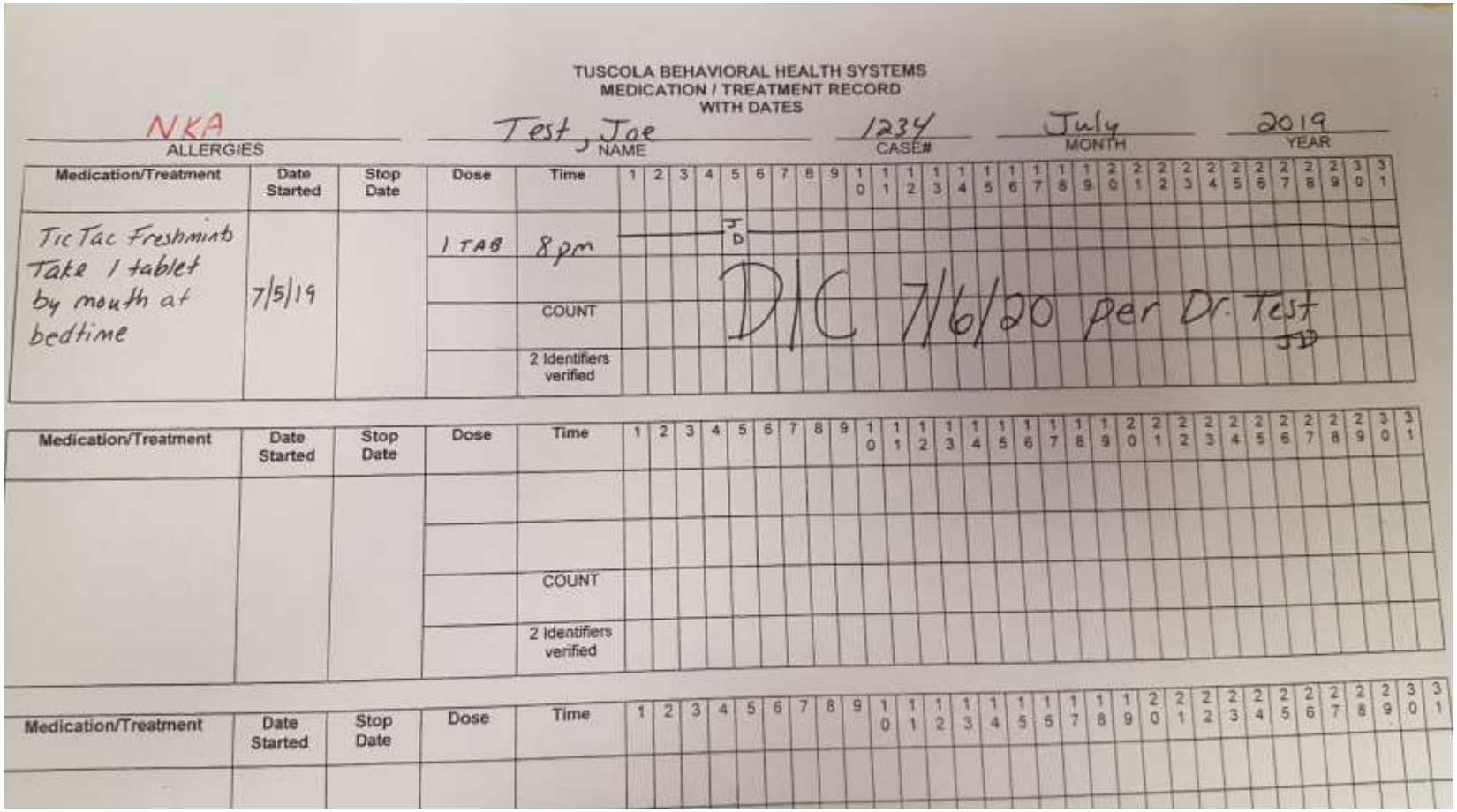
Medication/Treatment	Date Started	Stop Date	Dose	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
				COUNT																															
				2 Identifiers verified																															

Initials	Name	Title	Initials	Name	Title	Initials	Name	Title
JD	Jane Doe	DCW						

TBHS

PIC
SEC 13

11-17-05



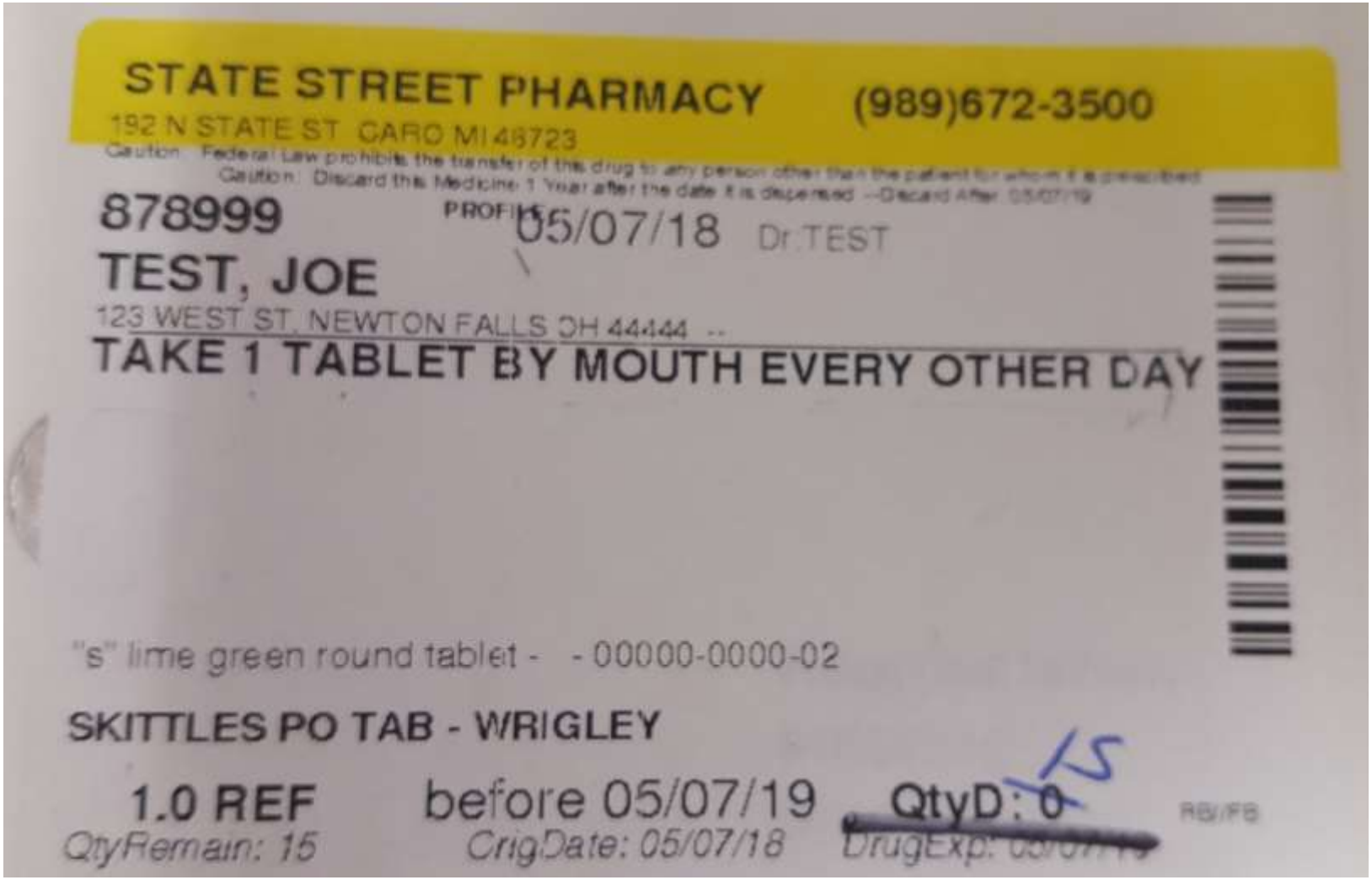
TUSCOLA BEHAVIORAL HEALTH SYSTEMS
MEDICATION / TREATMENT RECORD
WITH DATES

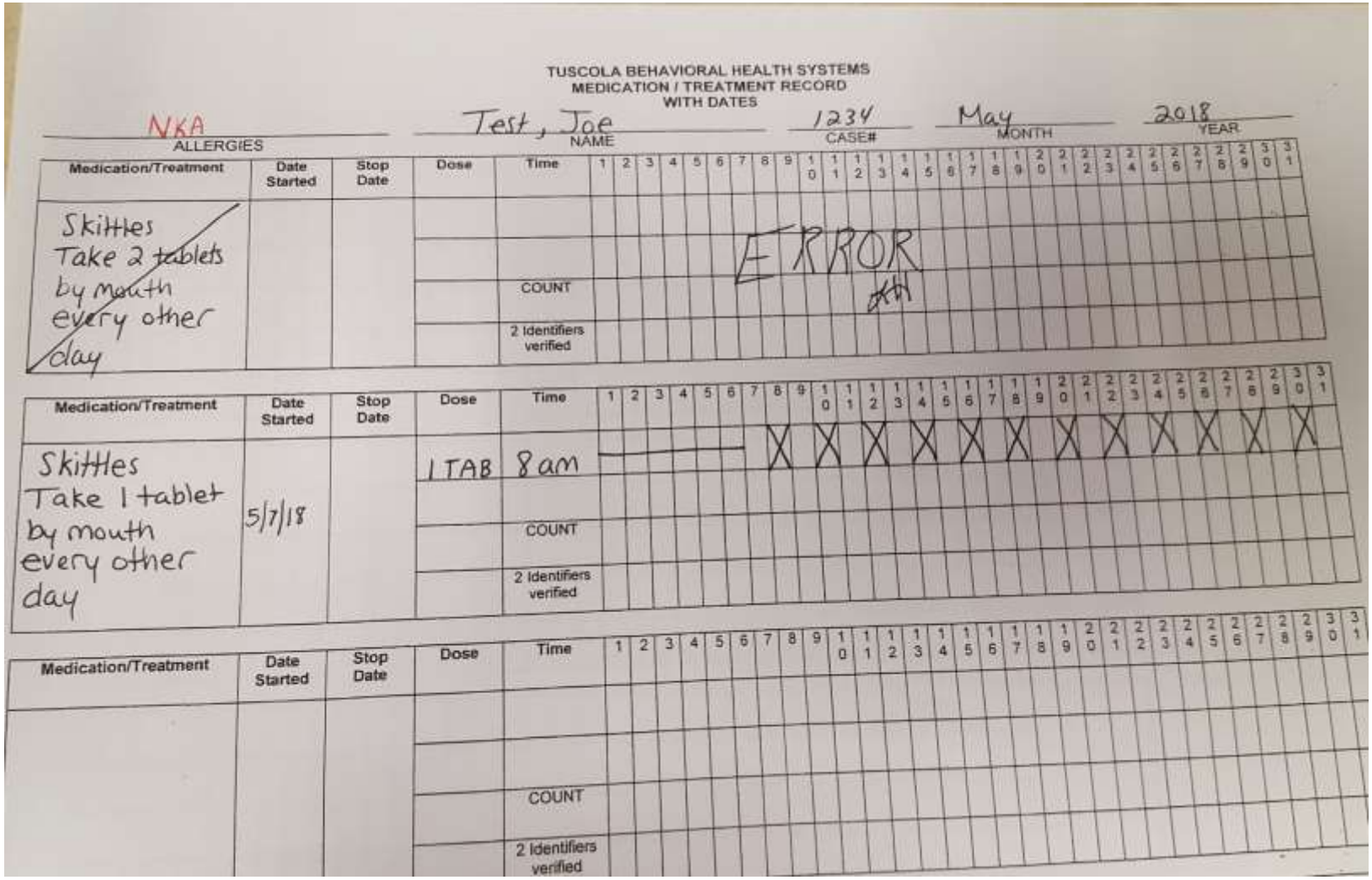
NKA (ALLERGIES) | Test, Jae (NAME) | 1234 (CASE#) | July (MONTH) | 2019 (YEAR)

Medication/Treatment	Date Started	Stop Date	Dose	Time	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Tic Tac Freshmints Take 1 tablet by mouth at bedtime	7/5/19		1 TAB	8pm	JD
				COUNT	D/C 7/6/20 per Dr. Test JD
				2 Identifiers verified	

Medication/Treatment	Date Started	Stop Date	Dose	Time	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
				COUNT	
				2 Identifiers verified	

Medication/Treatment	Date Started	Stop Date	Dose	Time	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31


STATE STREET PHARMACY (989)672-3500
192 N STATE ST CARO MI 48723
Caution: Federal Law prohibits the transfer of this drug to any person other than the patient for whom it is prescribed
Caution: Discard this Medicine 1 Year after the date it is dispensed --Discard After 05/07/19
878999
PROFILE
05/07/18 Dr.TEST
TEST, JOE
123 WEST ST, NEWTON FALLS OH 44444 --
TAKE 1 TABLET BY MOUTH EVERY OTHER DAY
"s" lime green round tablet - - 00000-0000-02
SKITTLES PO TAB - WRIGLEY
1.0 REF
before 05/07/19
QtyD: 0
15
RB/FB
QtyRemain: 15
CrigDate: 05/07/18
DrugExp:



TUSCOLA BEHAVIORAL HEALTH SYSTEMS
MEDICATION / TREATMENT RECORD
WITH DATES

NKA (ALLERGIES) | Test, Joe (NAME) | 1234 (CASE#) | May (MONTH) | 2018 (YEAR)

Medication/Treatment	Date Started	Stop Date	Dose	Time
Skittles Take 2 ~~tablets~~ by mouth every other day				COUNT / 2 Identifiers verified
Skittles Take 1 tablet by mouth every other day	5/7/18		1 TAB	8 am / COUNT / 2 Identifiers verified
				COUNT / 2 Identifiers verified

ERROR

Administration of Medications

There must be a written, approved program/treatment plan for individuals to be taught to administer their own medications.

Know the Goals from the Individual Plan of Service (IPOS)

The people who are receiving services have a wide range of needs from staffing regarding medications.

The IPOS will help determine your role.

The needs could range from:

Assisting with Self-Medication	Monitoring Self-Medication	Administering Medications (Full support)

Assisting with Self-Medication

- Ask if medications were taken
- Prompt to take medication
- Check if medications were taken
- Know the medication side effects
- Make sure enough medication is available
- Document any side effects or other items identified in the IPOS

Monitoring Self-Medication

- Perform medication counts to ensure they are taken properly.
- Know the medication effects and side effects.
- Observe for any side effects.
- Make sure all supplies or equipment are available.
- Document effects and or other items identified in the IPOS.

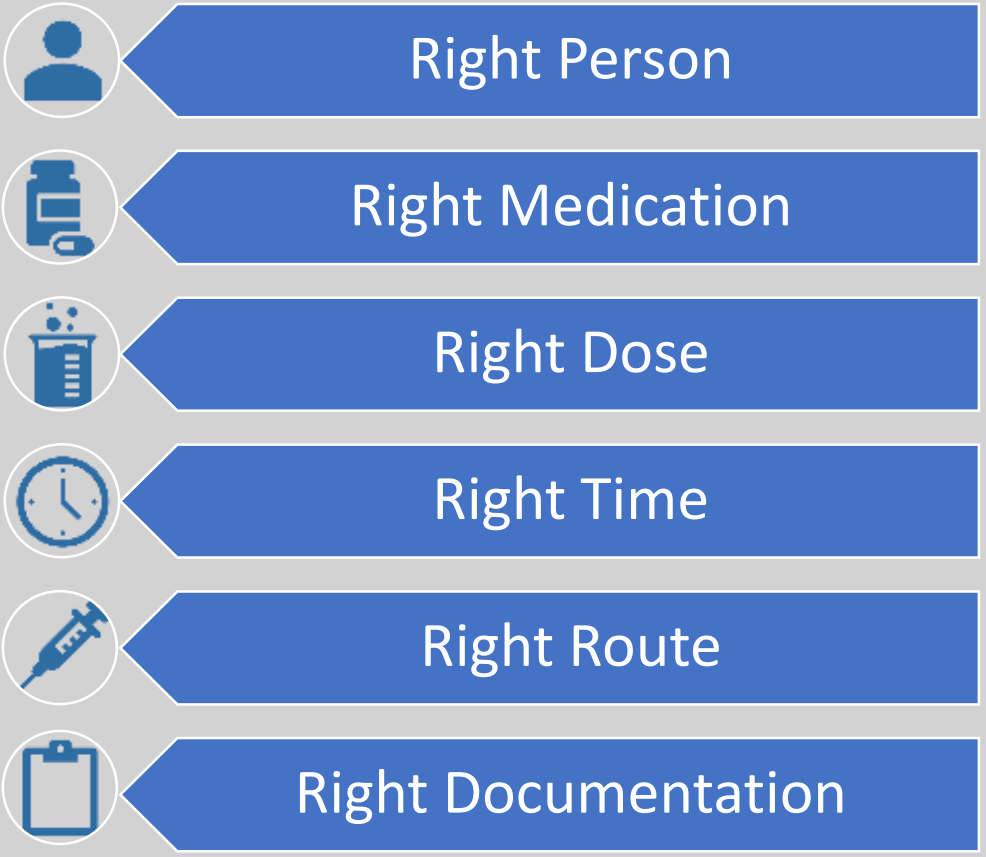
Providing Full Support

- Know the medication effects and side effects.
- Know how to set up medications accurately and safely.
- Observe for any side effects.
- Make sure all supplies or equipment are available.
- Document effects and or other items identified in the IPOS.

If a client expresses an interest in learning more about their medications or becoming more independent, contact the Case manager or the assigned R.N.

Six Rights of Administration

Each time you administer a medication, you need to be sure to have the:



Right Person

- Use at least two (2) identifiers
  - State ID
  - Photo
  - Consumer stating their own name.
  - Ask a staff member, “Who is this?”

Right Medication

To make sure you administer the right medication, there is a specific procedure to follow:

1. Compare the medication record sheet and the pharmacy label.
2. Triple check them. MAKE SURE THAT THEY AGREE.
3. If they do not agree, immediately consult with the nurse consultant or the pharmacist for clarification.

Right Dose

- Be sure you give the right dose by comparing the medication record sheet and the pharmacy label to make sure they agree.

Right Time

- When a physician prescribes a medication, he or she will specify how often the medication is to be taken.
- Some medications must be administered only at very specific times of the day; for instance, before meals, one hour after meals, at bedtime, etc.
- It is very important that medications be administered as prescribed.
- One hour total (half hour before to half hour after)
- Check the MAR at the beginning of each shift to know when medications are due.

Right Route

- The pharmacy label should state the route by which the drug should be administered if other than oral.
- If you have any doubt as to whether the medication is in the correct form as ordered, or can be administered as specified, consult with your nurse consultant or pharmacist before you administer the medication.
- Watch your orders for peg tubes.

Six Right of Administration

The nursing profession has long referred to these as the “six rights” of medication administration.

Each time a medication is given you must systematically and conscientiously check your procedure against these six rights.

You must be certain you are administering the right medication, in the right amount, to the right person, at the right time, using the right route, and documenting right away.

Six Rights of Administration

This procedure is a “must” each time you administer any medication – including those which a person has been taking for a long time and will probably continue to take for a long time.

Right Documentation

- Document immediately after administering the medication by initialing the Medication Administration Record (MAR).
- It should NOT be recorded ahead of time or at a later time.
- The person administering the medication must be the person who documents on the MAR.
- Failure to document correctly is a medication error which could result in a Recipient Rights violation.
- If the medication is not given, circle the box on the MAR and fill out an Incident Report (IR)– this is a requirement for your job.

Know the Six Rights

NEVER administer a medication if one of the six rights is missing from the MAR and/or pharmacy label.

When Not to Give Medications

There may be occasions when it is the appropriate time to administer medications, BUT unusual circumstances require that you do NOT proceed.

1. <u>If any one or more of the following required items are missing</u>:
   - Your agency's medication record form
   - Legible pharmacy label

   If you do not have, or cannot find either one of these for the medication you are going to administer, STOP! Contact your supervisor for assistance/direction.

When Not to Give Medications

2. Person exhibits a dramatic change in status.
   - If the person is showing signs of seizures, unconsciousness, difficulty breathing or other change which appears to be life threatening, do not administer the medication.
   - Follow the instructions give for reporting an emergency or life threatening situation.

When Not to Give Medication.

3. If you have any doubt that you have the right person, right drug, right dosage, right time, or right route, get assistance from your supervisor and/or nurse consultant before giving the person the medication.
4. Person refuses to take medication. Explain to the person why it is important to take the medications as prescribed by the physician and encourage the person to cooperate.
   - If the person still refuses, do not force him/her to take the medication.
   - Notify your supervisor and nurse consultant for instructions.
   - Immediately document the incident.

Medication Administration Guidelines

1. Observe the six right:
   - Right person
   - Right time
   - Right rout
   - Right dosage
   - Right medication
   - Right documentation
2. Work with adequate light.
3. Provide a clean environment for preparing medications.
4. While preparing or administering medications, concentrate on this alone.

Medication Administration Guidelines

5. Be knowledgeable about the medications you give:
   - Why and how it is being given
   - How soon it should act
   - Possible side effects and adverse reactions and what to do if they occur.
6. Always wash your hands before preparing medications and use a clean technique while preparing and administering medications.
7. Administer only medications that you have prepared personally.
8. Give medications as prescribed and on time.
9. Persons with known drug allergies must have charts and medication record labeled with red “allergic” labels.

Medication Administration Guidelines

10. If there is anything unusual about the appearance or smell, do not give the medication until you check with the pharmacist. If the medication must be withheld, the nurse must be notified.
11. Have prescription refilled several days before medication runs out.
12. If you find any discrepancy between the medication record or pharmacy label, consult with the nurse consultant or pharmacist for clarification.
13. If an error is made on the medication sheet, circle it.
14. Only approved abbreviations can be used. Abbreviations should be posted.

Medication Administration Guidelines

15. All pertinent information must be documented! If it is not documented, it didn't happen!
16. Document medications immediately after you pass the medication(s).
17. Avoid interruptions or distractions while preparing or administering medications. Be attentive.
18. All medications must be kept in locked compartments under proper temperature control.

Medication Administration Guidelines

a) **Never** give a person any medication that has not been prescribed by a person licensed to prescribe.

b) **Never** use a medication ordered for one person to treat another.

c) **Never** give a medication to one person from another person's prescription bottle.

d) **Never** pour medication from one bottle to another or relabel bottle.

e) **Never** force a medication.

f) **Never** give a medication without an order.

g) **Never** give out a medication you did not "set up".

h) **Never** change a pharmacy label.

i) **Never** mix medications together unless directed to do so by the prescriber.

j) **Never** return an unused dose of medication to the bottle.

k) **Never** cut an unscored tablet.

l) **Never** leave medication cabinets unlocked or medications unattended.

m) **Never** call medications "candy".

n) **Never** take a telephone medication order from a physician/dentist.

General Procedure for Preparing Medication

1. Check each person's medication record to see if he/she is scheduled to received medications
2. Select medication record according to time and day medications are to be given.
3. If you are unfamiliar with a medication you are giving check with the nurse consultant/pharmacist/current drug book.
4. Clean off work area.
5. Wash hands.

General Procedure for Preparing Medication

6. Compare label to the medication container with the medication record three (3) times to ensure accuracy as follows:
   - Before the container is taken from the storage area.
   - Before the medication is removed from the container.
   - Before the container is returned to the storage area (if using topicals or eye/ear drops, make third check before administering).

General Procedure for Preparing Medication

7. Prepare the right medication in the right dose at the right time by the right route for the right person.
8. Follow special instructions written on label or attached to container (i.e., shake, warm, do not take with milk).
9. If using a bottle of medication, pour capsule, tablets, or pills into the lid. From lid, pour into medicine cup.

General Procedure for Preparing Medication

10. Pour liquids from unlabeled side of bottle, wipe off excess medication with paper towel.
11. Measure liquid medication in measuring spoons or measuring glass/cup.
12. Pour liquid medication at eye level.
13. Prepare one person's medications at a time.

General Procedure for Administering Medication

1. Positively identify the person prior to administration of medication.
2. Do not “force” a person to take medications.
3. Explain to the person why the physician ordered the medication (even if the person is non-verbal) and what the procedure will be. It is important that someone understand why they must take medicine.
4. Provide privacy if appropriate.

General Procedure for Administering Medication

5. Assist person in taking his/her medication.
   - Positioning the head correctly will aid in the swallowing process.
   - Give adequate water to aid in swallowing tablets, capsules or liquids.
   - If a person has difficulties swallowing the tablet, capsule or liquid, notify the nurse consultant.

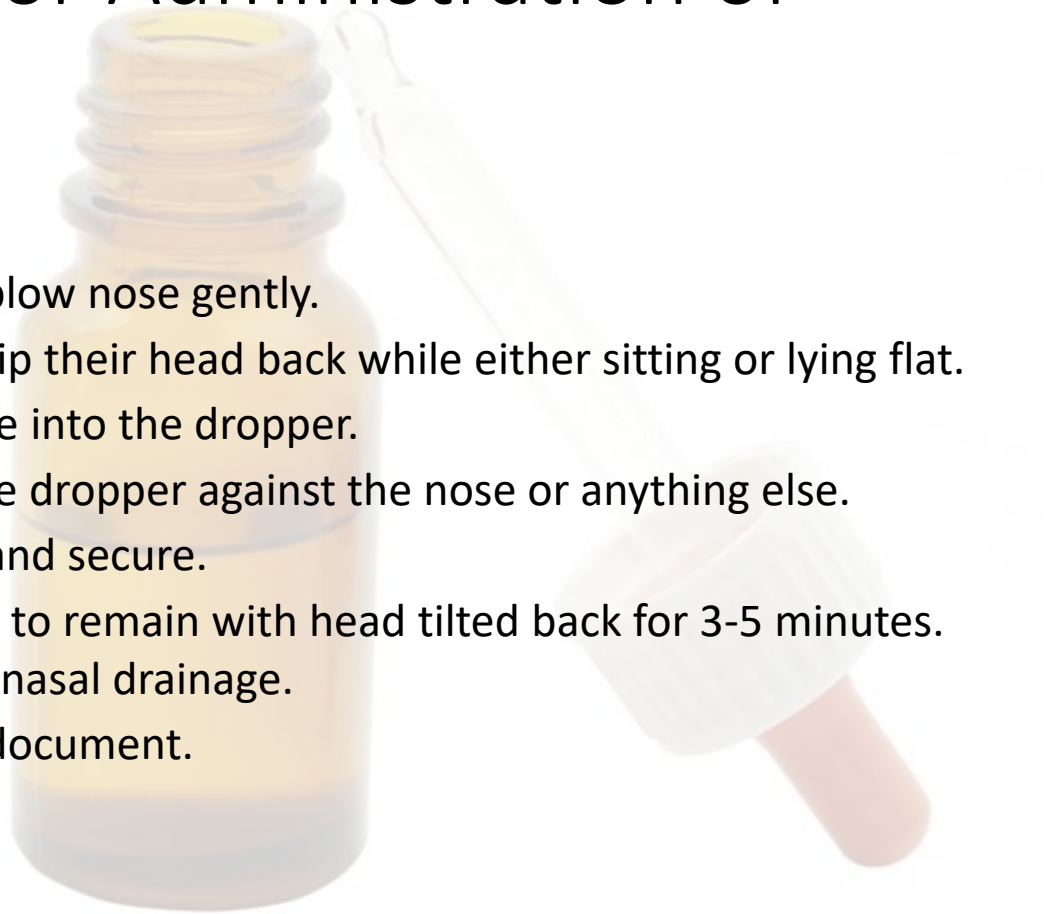
General Procedure for Administering Medication

6. Remain with the person until he/she swallows the medication.
7. Some medication is not to be swallowed (i.e., lozenges, nitroglycerin).
8. Administer only medication that you prepare.
9. Observe, record, and report person's response to the medication.

Procedure for Administration of Topical Medications

Wash	Wash hands.
Remove	Remove medication from jars with tongue blade or cotton tipped applications. DO NOT USE YOUR FINGERS.
Insert	Insert applicator or tongue blade into container only once, NEVER RE-INSERT.
Use	Use cotton tipped applicators, sterile gauze, or gloved had to apply topical medications unless otherwise directed.
Wash	Wash hands and document.

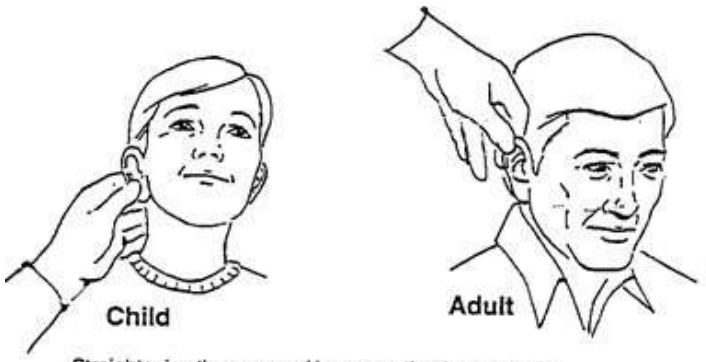
Procedure for Administration of Nose Drops



1. **Wash hands.**
2. Have the person blow nose gently.
3. Have the person tip their head back while either sitting or lying flat.
4. Draw the medicine into the dropper.
5. Avoid touching the dropper against the nose or anything else.
6. Replace dropper and secure.
7. Encourage person to remain with head tilted back for 3-5 minutes. Provide tissue for nasal drainage.
8. Wash hands and document.

Procedure for Administration of Ear Drops

1. **Wash hands.**
2. Rub medication bottle between the palms of your hands to warm drops.
3. Have consumer lie down with affected ear facing up.
4. Consumer **older than three years old**, hold upper part of ear lobe and pull up and back.
5. A consumer older than five may sit in a chair and tilt head with affected ear facing up.
6. Avoid touching the dropper against the ear or anything else to reduce the chance of contamination or ear injury.
7. Allow the drops to run in
8. Clean external ear with cotton and discard.
9. Keep the ear tilted up for 3-5 minutes.
10. Wash hands and document.



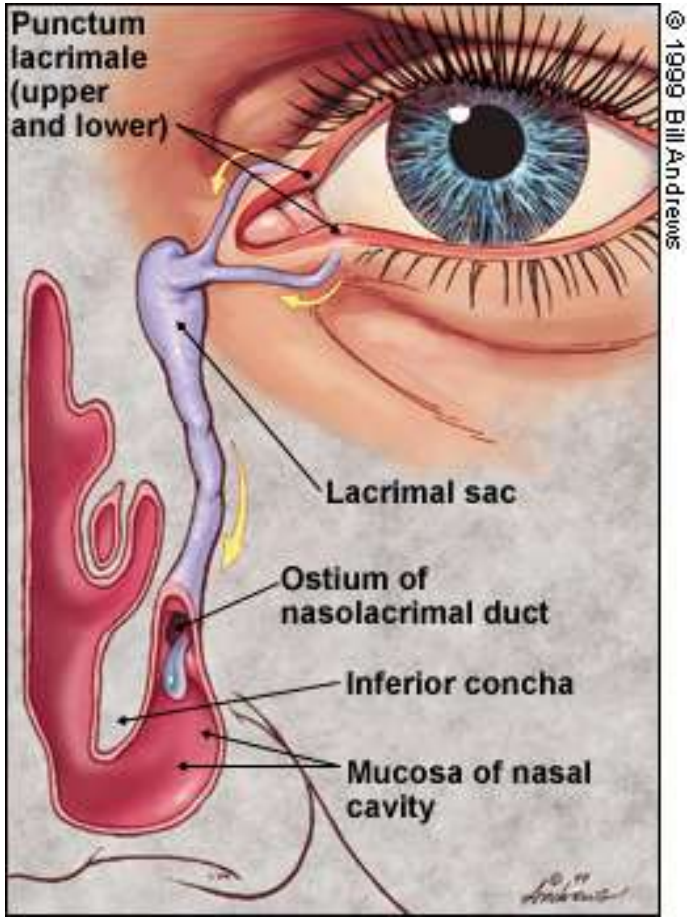
Straightening the ear canal in preparation for ear drops.

Procedure for Administration of Eye Drops

- **Wash hands.**
- Rub the medicine bottle between the palms of your hands to help warm the drops. Check the label to see if drops need to be shaken.
- Clean the eye by wiping each eye once from the inside to the outside. Use a clean tissue for each eye.
- If older than five, the individual may be seated.
- Ask consumer to look up. Gently open eye; pull down the lower lid to make a pocket.

Procedure for Administration of Eye Drops

- Bring the medication toward the eye outside of the consumers field of vision.
- Do not touch the eye or anything else with the bottle or dropper.
- With the bottle no more than an inch above the eye, drop one drop into the lower lid.
- Close the eye, apply pressure on the inside corner of the eye for 10-20 seconds.
- Wipe away any excess medication or tearing with clean tissue.
- Wash hands and document.



Procedure for Administration of Eye Ointment

- Follow instructions for eye drops.
- Apply along the inside of lower eyelid. Do not touch tip of tube to the eyes.
- Rotate the tube when you reach the edge of the outer eye, this will help detach the ointment from the tube.
- After applying, hold the eye open for a few seconds, then have the consumer keep it closed for about 1 minute.
- Wipe away any excess medication or tearing with clean tissue.
- Wash hands and document.

Procedure for Administration of Rectal Suppositories

- Wash hands. Remove suppository from storage. Store suppositories in a cool place to avoid melting. Refrigerate them if so labeled.
- Explain to the person why the physician ordered the medication and the procedure.
- Provide privacy.
- Have the client remove their undergarments and lie on their left side with the lower leg straightened out and the upper leg bent forward toward the stomach. Cover exposed area with a towel or sheet. Do not give in a sitting position.
- Remove wrapper if present. Put on disposable gloves. Lubricate suppository, finger, and rectal opening with water-soluble lubricant (e.g. K-Y Jelly).
- Lift upper buttock to expose rectal area. Encourage the client to take several deep breaths to help relax.
- Insert suppository with finger until it passes the muscular sphincter of the rectum, about ½ to 1 inch in infants and 1 inch in adults. If not inserted past this sphincter, the suppository may pop back out.
- Hold buttocks together for a few seconds.
- Have the person remain lying down for about 15 minutes to avoid having the suppository come back out.
- Remove gloves, wash hands and document.
- Document.

Procedure for the Administration of Vaginal Suppository

- Wash hands and remove suppository from storage. Store suppository in a cool place to avoid melting. Refrigerate them if so labeled.
- Explain to the person why the physician ordered the medication and the procedure.
- Select a private location with adequate lighting.
- Have the person remove undergarments, cover with a sheet or towel. Have the consumer lie on back with knees bent.
- Remove the wrapper if present.
- Put on disposable gloves.
- Identify vaginal opening.
- Insert medication approximately two inches into vaginal canal, following the instructions on the pharmacy label.
- Ask the person to remain lying down for 15 minutes.
- Remove gloves, wash hands and document.

General Procedure for Documenting Medication Administration

1. Observe the rules and general documentation (i.e., write in ink, never erase or use white-out).
2. All forms must have the name of the person receiving the medicine on them. Medicines must be used only for the people they are prescribed for.
3. All medication administered, prescription and over-the-counter, must be documented.
4. Medications must be documented by the person administering them.

Record immediately after administering the medication, NOT before.

Procedure for Documenting Medication Administration on the Medication Record

1. The first time you document the administration of a medication on the medication record, sign your name, title and initials once at the bottom of the page.
2. Any code used must be explained at the bottom of the medication record (e.g., LOA for leave of absence).
3. Stat and single dose medications must be recorded on medication record.

Documenting Effects of Medications

- Physical and behavioral changes that are due to the effect of a medication are often difficult to sort out from those that are not due to medication.
- There may be many different reasons for the same sign or symptom.
- A change in behavior may be due to a medication change or a change in the person's environment.
- A sore throat may be one the first symptoms of a cold or may be an adverse effect of a medication.

Documenting Effects of Medications

- Interpretation (deciding the meaning) of a sign or symptom is the responsibility of a physician.
- Your responsibility is to consistently and accurately observe, report and record any change in physical conditions or behavior.
- It is also your responsibility to give the appropriate care to a person in the meantime if it is an emergency or potentially health threatening condition.

Procedure for Administration of Medications for School, Day Program or Leave of Absence

If the person will be taking medication at more than one location (for example, in the home, at work or school or day program) follow these procedures.

1. Explain to the pharmacist that the person will be taking the medication in two different locations.
   - The person will need two pharmacy-labeled containers, one for each locations.
   - Be prepared to give the pharmacist the information needed for putting the correct dosage in each container. (The number of days per week or month that a person would need the medication at a job setting, for example.)
   - Ask the pharmacist to type SCHOOL, WORKSHOP, or DAY PROGRAM on the container.

Procedure for Administration of Medications for School, Day Program or Leave of Absence

2. Hand deliver the medication containers to the appropriate facilities along with a copy of the physician's order.
3. Share any information that the physician, pharmacist, or nurse consultant has given you about the medication and potential response or the person.

Procedure for Administration of Medications for School, Day Program or Leave of Absence

Be sure that:

1. You do not dispense medication, that is, transfer medication from the medication container to another container for someone else to administer it. PHARMACISTS DISPENSE MEDICATIONS.
2. Consumers are not to transport medications to school/day program unless it has been approved by the interdisciplinary team and written in the program/treatment plan (PCP).
3. Register the correct code on the medical record.

Procedure for Administration of Medications for School, Day Program or Leave of Absence

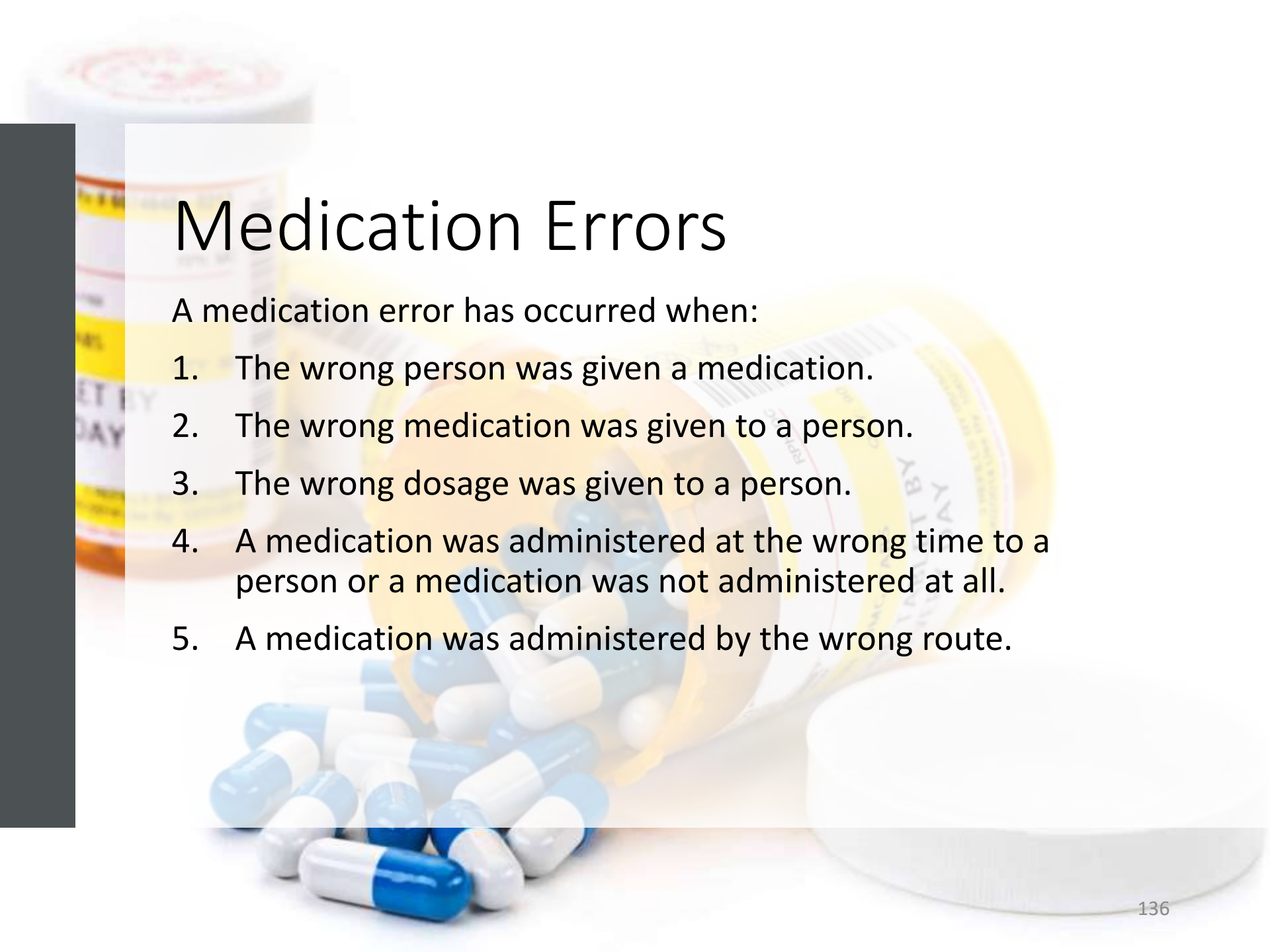
- If the person takes a leave of absence, the pharmacist should dispense medications to be given while on leave.
- If this is not possible, all medications must be sent in the original pharmacy container.
- Be sure to share any information with the family/guardian that the physician/pharmacist/ nurse consultant has given about the medication and potential response of the person.
- When the person returns, ask the family or guardian whether the medication was administered and the response of the person.
- **Register the correct code on the medication record when the person is to received that medication on a leave of absence.**

Medication Errors

Medication Errors

A medication error has occurred when:

1. The wrong person was given a medication.
2. The wrong medication was given to a person.
3. The wrong dosage was given to a person.
4. A medication was administered at the wrong time to a person or a medication was not administered at all.
5. A medication was administered by the wrong route.



Every medication error is potentially serious and could be life-threatening.

The error should be reported immediately.

Medication Errors

Ways to prevent errors include:

1. Stay alert and always observe the “Six Rights” of medication administration.
2. Avoid distractions when preparing, administering, and documenting medication.
3. Be knowledgeable about the medications you administer.
4. Ask for help from your licensed health providers if you are unsure about any step in preparing, administering, and documenting medications.

If an error does occur, it must be reported immediately, and necessary action taken. The error must be recorded and your agency’s policies followed.

Safety When Administering Medications

- Policies and Procedures
  - Staff need to know and follow relevant policy
- Medication Errors
  - Is a serious matter and MUST be reported.
    - Notify Nurse Consultant immediately.
    - Notify Home Manager/Supervisor
    - Follow Procedure
    - Write up Incident Report

TUSCOLA BEHAVIORAL HEALTH SYSTEMS
Medication Error Review Record

INITIATOR

Consumer Name: | Sex : | Primary Physician:

Case #: | Program: | DOB: | Residence: | Allergies:

Date and Time Error Occurred: | Location of Error: | Error Reported By: | Date and Time Error Discovered: | Date and Time Nurse Notified: | Date and Time Consumer Notified:

Name of Physician Notified: | Date and Time Physician Notified:

Guardian Name: | Date and Time Guardian Notified (if applicable)

Type of Order: | Prescribing Physician: | Date Prescribed:

- ☐ Verbal Order
- ☐ Written Order
- ☐ Other (Explain)

- ☐ TBHS Psychiatrist
- ☐ Primary Physician
- ☐ Other:

Type of Incident:

Transcribing:	Preparing/Dispensing:	Administration
☐ MAR Recorded incorrectly	☐ Incorrect pharmacy/label	☐ Incorrect Consumer
☐ No initials on MAR	☐ Order filled incorrectly	☐ Incorrect Time
☐ Other	☐ Failure to process medication order	☐ Incorrect Medication
	☐ Failure to verify two identifiers	☐ Incorrect Route
	☐ Other	☐ Incorrect Dose

☐ Omission
☐ Other

Brief Description of Incident:

Initiators Name:
Initiators Signature:
Date: | Time:

Medication Error Index: A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐
If > E refer to physician immediately.

PHYSICIAN

Physician Recommendations:

Physician's Printed Name:
Physician's Signature:
Date: | Time:

SUPERVISION

Nursing Supervisor Review of Error:

Could this error have been avoided? Yes ☐ No ☐

Nursing Supervisor Recommendations:

Consumer Final Outcome: Death ☐ Disability ☐ On-Going Non-disabling Medical Condition: ☐ No-Medical Condition: ☐

Describe Consumers Final Outcome in a Narrative:

Nursing Supervisors Printed Name:
Signature:
Date:

MEDICATION ERROR INDEX

CATEGORY	RESULT
NO ERROR A	Circumstance or events that have the capacity to cause error. (These events are not reviewed by the treating physician.)
ERROR, NO HARM B	An error occurred but the medication did not reach the patient. (These events are not reviewed by the treating physician.)
C	An error occurred that reached the patient but did not cause the patient harm.
D	An error occurred that resulted in the need for increased patient monitoring but no patient harm.
ERROR, HARM E	An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm.
F	An error occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm.
G	An error occurred that resulted in permanent patient harm.
H	An error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest).
ERROR, DEATH	An error occurred that resulted patient death.

Molly's Mistake

- Molly works as an unlicensed assistive personnel (UAP) at Boothbay Community Residence, a local residential care facility for individuals with serious and persistent mental illness. One of the unit nurses has asked Molly to administer a dose of Seroquel to David, one of their new residents. Most of the residents were in the day room for activity, and another UAP pointed out which resident was David.

Molly's Mistake

- Molly approached him and asked, "Hi there! You are David, right?" When he confirmed his name was David, she administered the medication. Within twenty minutes, David was experiencing a severe allergic reaction to the medication, despite the fact that his record indicates that he has been taking this medication for over a month. Molly later learned that in the past week, Boothbay admitted two new residents, both named David. She unfortunately administered the medication to the wrong peron.

Review

Molly was not responsible for the medication error with David, since another staff had pointed out the wrong person, and the prescribing provider never alerted her to the fact that there were two new residents with the same first name.

- ☐ True
- ☐ False

Review

- False – It was ultimately Molly's responsibility as the person administering the medication to verify the resident's first and last name along with at least one additional identifier before administering the medication.

Discontinuation and Disposal of Medication

There are several acceptable ways to dispose of medications. It is your responsibility to inform yourself of the method used at your work site:

1. Medications should be returned to the pharmacy when the pharmacy agrees to accept them.
   - In this case, medication to be disposed of is segregated and kept locked in a box clearly marked for disposal.
   - Staff will follow the written policy for documenting medication that is collected for return to the pharmacy.

Discontinuation and Disposal of Medication

- Medications may be disposed of by the nurse consultant and a witness when the contracting pharmacy will not accept the medication.
  - In this case, the medication is segregated and held until the next consultant home visit.
  - It is kept locked in a box clearly marked for disposal.
  - Staff need to follow the written policy for documenting medication that is disposed of.
- Medications may be disposed of by two staff, with one acting as a witness.

Discontinuation and Disposal of Medication

Procedures to follow when contaminated medication, deteriorated medication and medication whose shelf life has expired needs to be disposed of are:

a. Two direct care staff, one acting as a witness, should destroy the medications beyond possible reclamation as outlined in the procedure for discontinued medications.

b. Documentation of the disposal of the medications should be done on the person's record/log/journal.

c. Other staff should be made aware of the disposal of the medication.

d. The nurse consultant should be contacted for instructions regarding replacement.

Discontinuation and Disposal of Medication

- If a medication is prescribed for a specific number of days or doses, the medication is administered until all the medication is gone.
- If the physician decides to increase, decrease, or discontinue the medication before it has all been taken, the remaining medication must be discarded in a safe and thorough manner, or returned to the pharmacy.
- A new prescription must be written by the physician.

Discontinuation and Disposal of Medication

When a medication is discontinued certain procedures must be followed:

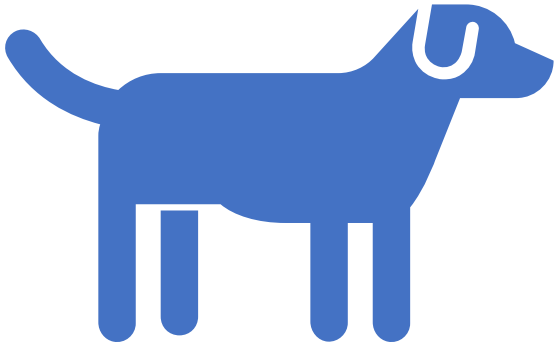
1. A physician's order authorizing discontinuation should be on file in the person's record.
2. Two direct care staff, one acting as a witness, should:
    a. Compare the pharmacy label with the physician's order to make sure the right medication is being discarded.
    b. Destroy the medications beyond possible reclamation.

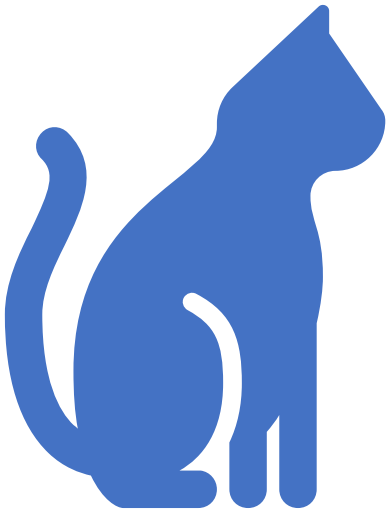
NOTE: Your agency may require that an Incident Report or Medication Disposal Form be completed.

Discontinuation and Disposal of Medication

3. Document the disposal of the medications on the person's record/log/journal, including both person's signatures.
4. Write discontinued or D/C in bold letters on the medication record starting where the next dose would have been recorded.
5. Make other staff aware of the discontinuation of the medications.

Never dispose of medications where humans or animals have access.





MEDICATION DISPOSAL RECORD

Month/Year: _____

Date	Consumer #	Medication/Strength	Amt	Reason for Disposal	Init	Init

Notes: _____

Init	Signature	Title	Init	Signature	Title

Recognizing and Reporting Changes in Health Circumstances

153

Emergency Conditions

- Emergency conditions may arise from a great number of different causes: Injuries, illnesses, and complications, including unwanted effects of medications. There is no rule to follow in deciding what is and what is not an emergency situation. The most common conditions involve:
  - Excessive bleeding which you are unable to control
  - Accidents involving severe injury
  - Failure of obstruction (as in choking) of the respiratory system (breathing)
  - Failure of the circulatory system (heartbeat)
  - Behavior which is a danger to self or others and is not controllable
  - Loss of consciousness unrelated to predictable seizure activity

Emergency Conditions

- Your job is to react swiftly to any emergency condition, using your skills in first aid and CPR for temporary life support. Emergency conditions are those thought to be of an immediate life threatening nature. You must report them immediately to persons who can help you support the life of the recipient.
- Phone 911 immediately. Talk calmly, slowly, and clearly. Answer any additional questions the emergency operator may ask. Be sure to give the exact address and location of the emergency. Do not hang up the phone until the emergency operator hangs up or tells you to hang up.

Emergency Conditions

- It is the caregiver's responsibility to support the physical well being of the recipient while securing the appropriate medical assistance. When more than one staff person is involved, one person must take charge of the situation. This person is responsible for telling others what to do and for providing immediate emergency assistance. Other staff members should call 911, help administer first aid or CPR if necessary, and gather the Medicaid care, permission for treatment form, medical records, and blank forms so that the doctor who treats the person will have complete information.
- If you are the only staff person involved, you will have to deal with the emergency on your own unless bystanders or other consumers are able to help. Remember your primary responsibility is to see that 911 is called and to provide emergency assistance to the person until help arrives. Accompany the person in the ambulance to the hospital with all the necessary information and forms.

Emergency Conditions

- If an ambulance is not available, you may have to transport the person to the emergency room on your own. Be sure to notify the hospital that you are on your way and explain the nature of the emergency and about how long it will take you to arrive at the emergency room.
- Stay with the person in the hospital until relieved by other staff or released by your supervisor. Return to the group home with the person if he or she is not admitted to the hospital. Be sure to document all of the details of the emergency, including medications and orders received and follow-up treatments required.
- After the emergency is under control, call your supervisor if he or she has not been notified earlier. Inform the person's doctor and the nurse consultant for the home. Be sure to communicate all of the necessary information to other staff.

Recognizing and Reporting Changes in Health Circumstances

157

Non-Emergency Health-Threatening Condtions

- Non-emergency health-threatening conditions are those conditions, which lead you to believe that the health or safety of the recipient or others is endangered. This definition is very broad and vague. Common sense is important here. Examples of such situations are:
  - A fever that is not reduced by normal procedures, such as aspirin.
  - Repeated episodes of angry or aggressive behavior, which while controllable, are not typical of the person.
  - Diarrhea, which is not affected by the medication that has been ordered.
  - A rash which lasts for several days or which appears to be getting worse.
  - A persistent sore throat.
  - A severe seizure for a person who has a history of mild seizures.
  - An increase in seizure activity.
  - Unusually withdrawn behavior on the part of a person who ordinarily is not withdrawn

Non-Emergency Health Threatening Conditions

- Call the nurse or designated person to report your observations. Follow the instructions of the nurse. If you cannot contact the nurse or other designated person, call the doctor, report your observations, and follow any directions given. Record your observations. Continue to observe the person for further changes and report to your supervisor.
- When reporting a health-threatening condition, include the following information: the nature of the problem; other signs of trouble (bleeding, swelling, weakness, coughing, diarrhea, vomiting, etc.); when the signs were first noticed; and what, if anything, you have done already for the condition.

Recognizing and Reporting Changes in Health Circumstances

159

Other Changes in Health Condition:

- Any changes other than those already covered are included in this category. Any significant changes in a person's general health or behavior could be important signs. Examples of such conditions are:
  - Changes in sleeping, eating, or activity levels.
  - Minor problems such as colds, low fevers, mild diarrhea, etc.
  - Unexplained minor bruises.
  - Reddened areas.

Other Changes in Health Condition

- As soon as possible, write a written description of the condition you have observed. Check for any standing medical orders for that specific condition. Continue to observe the person for further changes. Be sure to notify the nurse, your supervisor, and other staff of your observations and any actions you have already taken to relieve the condition.
- Sometimes you may not be sure if a situation is an emergency condition or not, or whether a situation is health threatening or simply a minor change in a person's status. When you are not sure, take the actions appropriate for the more serious of the categories, just to be on the safe side. Then, even if you are incorrect, no further harm will have been done.

QUESTIONS

This concludes to Medication Administration Training. Please remember to login to Relias and completed the Medication Administration Test in order to be marked complete.