Section H: Medication Administration

MEDICATION ADMINISTRATION

ALL Procedures in this Section Apply to Community Living Programs

MEDICATION ADMINISTRATION - GENERAL

Medication will be administered to persons served as ordered from the prescribing physician by qualified employees only and within the training guidelines. Employees qualified to administer medications will have current Level One Medication Aide training completed the Community RN medical in-service and has completed required observations.

Administration of prescribed medication or treatment shall begin within 24 hours from when the prescription was issued any exceptions of this policy should result in a consult with the Community RN, in that absence the employee will contact the Director of Community Living.

When medication orders are received, and before medication is dispensed, the following information shall be entered on the Medication Administration Record, a.k.a. MAR.

- Medication name and strength (e.g. ibuprofen 200 mg)
- Route of administration (e.g., PO /orally)
- Dosage to be administered (e.g. 2 tablets)
- Frequency of administration (e.g. bid /twice a day)
- Diagnosis or reason for the medication
- Times of administration (e.g. 6 am, 5 pm)
- Date started and stop date if indicated
- Prescribing physician name and contact information
- Unless otherwise indicated, the dispensing pharmacy is Heartland Homecare and their contact information is indicated on each MAR sheet.
- In addition to the information noted on the MAR, potential side effects and drug interactions for each medication should also be kept with the MAR. Most frequently, these are obtained through the pharmacy filling the prescription.
- Note: for orders defined as “treatments” not all of the above information will be applicable. The Community RN should be contacted, however, to arrange for task delegation training.
- SEE ALSO “Receiving / Checking In Medications”

Rules for administration:

1. Wash hands with soap and water before handling medications.

2. Refer to the MAR. Compare prescription label(s) to the MAR before opening the bottle or blister-pack. When feasible, dates on bubble pack should match the MAR. in this review, the employee will ensure the “rights”: right person, right time, right medication, right dosage, right route.
    a. If there is a discrepancy, refer to the physician order for clarification and consult the supervisor (or assigned on-call manager) if needed.

b. The supervisor should contact the RN if further clarification is needed. If the discrepancy is not settled, dispense according to the bottle or bubble pack label and enter a note on the back of the MAR regarding the discrepancy. The supervisor shall take steps to remedy the discrepancy through contact with the pharmacy and/or physician within one business day. The supervisor should also take steps to make the respective Health Services Coordinator aware of the discrepancy and the action steps taken.

3. If that is not possible, employees should document on the back of the MAR and administer the appropriate medication from the last dose in the bubble pack (the date furthest away from the current date).

4. Set up and dispense medications for only one person served at a time, and make every reasonable effort to ensure that medication is consumed by the person served before dispensing the next individual's medication.

5. Transfer medication into a med cup. For medications packaged by Heartland Homecare pharmacy, the individual bubble pack itself can serve as the med cup.

6. Check dosage on the MAR again to be sure of the dosage transferred. When multiple medications are administered to a single person served, re-check the MAR and check and count the pills to ensure the correct medication and number are dispensed.

7. Correctly identify the person served who is to take the medication. Hand cup, envelope, or spoon to the person served and observe ingestion of the medication. For medications administered via a different route or for supports on the MAR indicated as "treatments," follow the instructions appropriate for that specific medication or treatment.

8. Enter initials on the MAR in prescribed space after administration (not after preparing it for administration.) (See also "Administration of Medications Outside the Home").

If medication is refused or cannot be given:

1. As a best practice if a medication is initially refused, employees should re-offer the medication at least two additional times within the medication administration window.

2. If after additional offers the person served continues to refuse a medication, write an "R" in the appropriate box(es) on the MAR. This indicates that you attempted but could not dispense – i.e., that the medications were not given;

3. On the back of the MAR, under "Medication Exception and Hold Notes," enter the date and time, medication(s) and dosage, and the reason for inability to give the medication and your initials.

4. Follow the instructions for Missed Medications in this procedure manual. Note the Results/Response on the back of the MAR. If warranted, complete a General Event Report and submit it to the home supervisor. For individuals who self-administer their medications, although Open Options employees are not administering the medication, the organization is still responsible for oversight. This would be documented on the MAR form and indicated as "forgot to give" (the individual forgot to take the medication).

If the refusal of a medication poses a potentially significant health risk, contact the Community RN for further instruction.

Vomiting – Never re-administer a dose of medication if a person served vomits following taking the medication unless advised to do so by the RN or physician. For individuals with Prader-Willi syndrome, refer to the PWS-specific protocol for vomiting.

For PRN (as needed) medications, employees will administer the medications when such a need is indicated by symptoms observed or reported by the person served. A specific time of administration will not be included on the MAR. The following steps shall be taken by employees:

1. Rules for Administration (above) shall be followed.

2. Immediately following the administration of a PRN medication, the employee who administered the medication will document the following on the back of the MAR:
    - Date and Hour of administration
    - Medication and Dosage administered
    - Reason medication was administered (e.g. symptoms present)
    - Initials of employee administering the medication

PRN Medications prescribed for behavior adjustment or psychiatric episodes will have specific criteria outlined by the prescribing physician and indicated in the Individual Support Plan. Employees must review and follow the protocol in the plan for administering these medications. Medications used for assisting in behavior support will have a doctor's order for that specific use. The plan for providing the PRN medication will have a specific protocol that may include other options to attempt prior to offering PRN or may have required authorizations of others before administering. The use of a PRN medication for behavior support will always produce an Event Report.

Following administration of a PRN medication, employees must also document the results of or response to the PRN medication. Examples:

- Temp is now ---------
- No further symptoms
- No c/o headache or pain
- Or
- Still c/o headache or pain
- Temp. is still ----------

When checking the MAR at the end of the shift, employees should check to ensure that PRN results are documented for any PRN medications administered during the shift.

MEDICATION ADMINISTRATION – MISSED MEDICATIONS OR CHARTING

All employees shall check the Medication Administration Record (MAR) at the beginning and end of each shift. When it is noticed that the medication sheet was not signed or the prepackaged dosage remains in the blister-pack card for a drug which was to be dispensed earlier, the following procedures shall apply:

a) If the MAR was not initialed for a specific dosage time(s), ask employee(s) on duty at that time if the medication was given. If the medication was given, the employee administering the medication must initial the MAR immediately.

1. If this necessitates the employee returning to the location to complete documentation, the MAR may be initialed later upon a return trip to the home but must be initialed within 24 hours of passing the medication. Note: if the medication(s) under question is a "loose" medication and the employee did not sign when they administered, it is a medication error whether they return to sign for it or not. Any "loose" medication not signed for should be documented as a medication error and an General Event Report completed.

2. If the employee responsible for passing the medications cannot be contacted or does not return within a reasonable timeframe to complete the documentation, the employee discovering the charting error shall make all reasonable efforts to determine if the medication was passed. This includes checking the blister/bubble pack to determine if the medication was punched out, and asking the person served and/or other employees on duty if the medication was passed.

3. If it is determined that the medication was administered and the employee who administered the medication fails to complete the documentation within 24 hours, the employee or the supervisor of the location shall initial the front of the MAR for each medication and circle his/her initials under the appropriate date and hour, and enter notes under "Medication Exception and Hold Notes" on the back of the MAR. The Medication Exception and Hold Notes shall include the date and time of the undocumented dosage, that it was determined to be a charting error and that it was verified the medications were administered. The employee making the correction shall enter their initials under the Medication Exception and Hold Notes.

4. Employees shall never attempt to correct a documentation error by entering another person's initials on the MAR. All corrections to the MAR shall be made by circling the initials on the respective entries and the specific information related to the correction shall be noted in the "Nurses Medication Notes" section on the back of the MAR.

b) If the medication was not given, and less than one hour has elapsed, dispense the medication. If more than one hour has elapsed, contact the RN and follow his/her instructions. Contact the home supervisor if the RN cannot be reached.

1. If the RN instructs you to dispense the dosage: Administer the medication and initial the MAR. On the back of the MAR enter a note under "Medication Exception and Hold Notes" indicating the exact time of late dosage, the reason the dosage was late, and the RN's instructions.

2. If the RN instructs you not to dispense or you were unable to reach him/her, and there is no established protocol for the specific person served and medication involved, do not dispense, code the MAR "O" (for omitted in error) and enter documentation under "Medication Exception and Hold Notes" on the back of the MAR. The entry includes date and time of dosage missed, reason dosage was missed, and the RN's

instructions. An Event Report must be completed any time that medications are not administered. If the employee omitting the medications has not completed a General Event Report, the person discovering the error must complete a report by the end of his/her shift.

3. If pre-packaged ("blister-pack") medications are used, leave the missed dosage in the card.

4. If a dosage of prescribed medication is not dispensed for any reason or if there is an error in time, route, dosage, or person, always complete a General Event Report. (If the medication was refused by the individual an event report is not required - complete an illness or injury report.)

MEDICATION ADMINISTRATION – OUTSIDE OF THE HOME OR PROGRAM

Administration of Medications outside of the home without employee presence - Medications which will be taken outside of the home without the presence of organization employees present special problems and issues of concern. Our responsibility for administration of the prescribed drug or treatment remains while our control diminishes. Extra care in the set-up of the dosage should be given:

a) Follow steps described in "Rules for Administration"

b) For the dates the individual is scheduled to be out of the home, remove the specific sealed medication bubble packs clearly marked with the person served's name, the name of the medication, and the date and time to be taken.

c) Place the removed bubble packs into a sealable Ziploc bag or similar container.

d) When a person is out of the home and their medications have been sent with them or with their family, employees should enter the code "M" only at each scheduled medication administration date and time. The code "M" should not be documented in advance (only in "real-time"). If medications were packed for a week, for example, employees working would only enter the code "M" at the actual date and time. This is to account for if a person served returns early and a code other than M would then be entered on the MAR.

e) When code "M" is used, on the back of the MAR, under "Medication Exception and Hold Notes," enter the date and time of the dosage(s) that were pre-packed, and the reason the medications were packaged (scheduled activity, day program, family visit, etc.) Initial the "Medication Exception and Hold Notes." If medications are given to a family member who will be responsible for administering the medications, the family member receiving the medications should sign the "Medication Exception and Hold Notes" indicating they have received the medications. If the family member refuses to sign, this should be documented by the employee in the same section.

f) If a person served returns home with the medication, or you learn otherwise that he/she did not take it as prescribed, follow steps outlined for Missed Dosage.

Administration of Medications outside of the home with employee presence – At times, employees may be asked to transport medications for administration outside of the home. This most typically occurs in the event of community

outings, appointments, or other commitments that result in the person served not being in their home at the time medications are to be administered. Extra care in the set-up of the dosage should be given:

a) Follow steps described in "Rules for Administration"

b) For the date(s) and time(s) the individual is scheduled to be out of the home, remove the specific sealed medication bubble packs clearly marked with the person served's name, the name of the medication, and the date and time to be taken. Under no circumstances should medications be removed from their respective sealed medication bubble packs prior to administration.

c) Place the removed bubble packs into a sealable Ziploc bag or similar container. Any medications that are being taken outside of the home for administration by employees must be kept on the employee's person in the sealable bag or similar container. This is done to ensure safety and that no unauthorized person accesses the medications. External and Internal medications should be placed in separate containers. Ointments or liquids shall be kept in the original carton or box. Bottled medications shall always be kept in the original bottle, prescription label affixed.

PERSON SERVED SELF-ADMINISTRATION OF MEDICATION

In keeping with training toward self-sufficiency, persons served in the community living program eighteen years of age or older may learn to self-administer medications and treatments with the following levels of approval:

- Primary care physician has provided a written "approval" statement.
- The self-administration program is included in the Individual Individual Support Plan with training objectives, charting methods, and frequency of employee monitoring specified in the written program. The program shall be individualized to accommodate reading, time-telling, and writing (charting) skills. After the training objective has been met, self-administration will be noted on the Physician Orders sheet.

Training toward self-administration typically occurs in phases which vary between individuals. Below are guidelines for the development of individualized training with the person served and his/her support team.

a) Evaluation – Persons served who express a desire to learn to self-administer their medications will first be evaluated using the Medication Administration Assessment to assess their ability to complete the program. An administration procedure and an action plan for self-administration of medications will be designed and approved by the support team and attending physician. The training will be designed to progress from learning information about specific medications (purpose/side effects) and schedules, to administration with gradually fading levels of supervision. The person served may at any time discontinue this progression in training.

b) Criteria for Self-Administration – Before an individual can self-administer his/her medications, the following criteria must be met:
   - The person's interdisciplinary team has pre-approved the self-administration of medication and this is documented in the person's Individual Support Plan.

- The individual has been provided training in administering his or her own medications and recording the medications administered and demonstrates responsibility in taking prescribed medications and recording them appropriately.
- The individual knows how to call or get support if a dosage is missed, extra medication is taken or an adverse reaction is experienced.
- The individual has been educated and knows how to utilize the pharmacy and/or physician, or knows how to get supports to access their medical records, report problems with prescriptions, etc.
- A system is put into place for employees to monitor self-administration. This will most frequently consist of reviewing the bubble packs and (if applicable) MAR on a frequency determined by the individual's support team. Ongoing documentation may not be necessary if the individual has been provided with the necessary information and can manage his/her own medication administration without difficulty.

c) Lockbox Storage - Once the criteria for self-administration have been met, the person served and employee will purchase a lockbox in which to store all training medications. The lockbox will be kept secure in the designated medication closet or cabinet. Employees will write "Self Administers" beside those medications on the treatment MAR approved for the person served to train on. Employees will complete a sign-off sheet listing the training medications, and the person served and employees will sign off only on the person served's sign-off sheet each time training medications are administered.

d) Training Process Documentation - Medications shall never be administered incorrectly due to person served error during the training process, as employees should intervene. However, the need for a prompt or guidance will indicate less than independent performance and will be marked as a "negative" on the Medication Administration Assessment. Any employee errors are not counted as person served errors. Errors in self administration will be documented by employees by circling his/her initials under the date of the error and writing the time, medication name and amount, the reason for the error, and his/her signature on the back of the medication sign-off sheet.

e) Training Process Suspensions - A refusal of a medication, occurrence of suicidal behaviors, or upon physician recommendations the program may be interrupted so the support team may re-evaluate for appropriateness and to ensure the safety of the person served. Attempted use of the wrong dosage, incorrect method, or administration at the incorrect time (beyond the usual one-hour parameter) will result in an automatic re-evaluation of the training process, and may be cause for delaying or suspending the self-administration program.

The support team may choose to suspend the training program for an indefinite period if there are interruptions in the program as described above.

f) Independent Administration - After successful completion of the medication self-administration with employee sign-off phase, the person served's overall performance and the administration method will be reviewed by employees and Division Directors shall sign off on the monthly PCP review acknowledging completion of the objective and concurrence with the independent administration method.

At this time the person served will begin independent administration of the medications upon which he/she was trained. Charting methods and the amount of medication supply maintained by the person served is individualized. Employees shall review person served self-charting per the individual program but not less than monthly. Subsequent problems in self-administration will be handled in consultation with the RN and support team. However, refusal of medications, physician recommendations or demonstration of inappropriate administration methods will require

immediate interruption of self-administration to evaluate the need for further training. Self-administration will be reviewed annually and documented in the Individual Support Plan.

MEDICATION ADMINISTRATION - RECORDS

Prescription medications shall be recorded per physician' orders on the Medication Administration Record, (MAR) including

- Medication name and strength (e.g. ibuprophen 200 mg)
- Route of administration (e.g., PO /orally)
- Dosage to be administered (e.g. 2 tablets)
- Frequency of administration (e.g. bid /twice a day)
- Diagnosis or reason for the medication
- Times of administration (e.g. 6 am, 5 pm) (does not apply to PRN medications)
- Date started and stop date if indicated

The Medication Administration Record (MAR) is the standard chart used to document the administration of the medication, unless the person served self-administers all medications. The following procedures shall apply:

a) There shall be a MAR prepared for every person served for whom we provide medication administration every month. When applicable, MARs will be pre-printed by the pharmacy providing the medication. In these cases, the MAR shall be checked for accuracy by comparing with previous month and ensuring any needed changes have been made. The Manager is responsible for checking and ensuring the accuracy of the MAR at the beginning of the charting period. The MAR will designate the month or charting period. If no entries are necessary, the word "none" shall be written at the end of the month.

b) Any medication or treatment administered - Prescription or over the counter medications, internal or external, vitamin / mineral supplements - shall be entered on the MAR with full data as the MAR requires.

c) "Discontinued" or revised dosages shall be recorded as "D/C" with the date of the order under the date column for the date it is discontinued. If dosage has changed, the previous order (now discontinued) shall be recorded as "D/C" and re-enter full information with new dosage as a separate entry on the MAR. A new sheet may be instigated if there is no space to list new medications; in these cases a note directing employees to the new entry shall be included in the "DC" entry. The employee recording the discontinuation should also indicate their initials next to the "D/C." If the pharmacy has provided a new MAR for the new medication, this serves as the new entry.

d) Other treatments, as prescribed or recommended by a physician or registered nurse, shall be entered on the MAR. This includes topical applications, dressing changes, soaks, exercises, etc.

e) Employee initials shall be used to denote administration of medication or treatment. The full name and initials to be used shall be entered in the appropriate space on the back of the MAR.

f) When medications are packaged for administration outside of the program, employees shall code the MAR with a

written explanation on the back of the MAR. See also procedures for administration of medications "Outside of the Home or Program".

g) For PRN (as needed) medications, dosage times will not be listed on the MAR. Whenever a PRN medication is administered, the employee administering will document the following on the back of the MAR:

- Date and Hour of administration
- Medication and Dosage administered
- Reason medication was administered (e.g., symptoms present)
- Initials of employee administering the medication

Following administration of a PRN medication, employees must also document the results of or response to the PRN medication.

When checking the MAR at the end of the shift, employees should check to ensure that PRN results are documented for any PRN medications administered during the shift.

h) Orders for prescription medications or treatments received shall be noted on the MAR at the time that the hard copy of the written order/script is received in the home. (Note: an employee may never take a verbal order, from a physician or otherwise. All orders must be documented in writing in order to be followed.) The date of the order shall be recorded on the MAR. When new orders are received during a charting period, the days passed prior to the receipt of the new order shall be marked though with a single line leading up to the date of the first administration. When new orders necessitate the use of additional MAR pages, the employee noting the order on the MAR should also make a notation on the first page of the MAR directing employees to the back page(s). (Example: New order received). Stickers provided by the pharmacy may also be used to direct employees to changes in orders.

The Health Services Coordinator will be responsible for updating any needed changes to physician orders and forwarding them to the pharmacy prior to each cycle of medications. This will help to ensure the accuracy of the MARs when they are printed by the pharmacy. The Health Services Coordinator will ensure:

- All orders are accurate, reflecting any recent changes
- All orders include a diagnosis or reasons for the medication/treatment
- All current diagnoses are listed
- All allergies are listed

i) For purposes of documentation on the MARs, the following codes will be used:

- **M** - Med Sent. The person served is on scheduled activity out of the home and their medications have been prepackaged and sent with them and/or a responsible party.

- **A -** Absent. The person served is out of the facility or home and their medications were not sent or prepackaged (They are in the hospital, for example).

- **H** – Held. The medication was held with a doctor's order (for example, they're going in for a medical procedure and the doctor instructs us to not pass their morning meds) [Document on the back of the MAR the reason for the hold and who authorized].

- **O** – Omitted. The medication was omitted/ not administered in error. An event report should also be completed.

- **R** – Refused. The person served has refused their medication. Refer to specific protocol indicated in MEDICATION ADMINISTRATION – GENERAL Section D.

j) If a circumstance arises for which there is not an appropriate code, employees should initial the front side, circle their initial, and write a note on the back of the MAR explaining the circumstance. Any unusual occurrence in the administration and documentation of medications shall be noted on the back of the MAR under "Medication Exception and Hold Notes," including the date and time, medication and dosage, the reason for the occurrence, and the initials of the employee making the note.

ORDERING MEDICATIONS

PROCEDURE – Community Living

Physician Appointments

During appointments with the physician, the employee accompanying the person served will take the following steps:

- Ask the doctor to complete the physician sections of the Physician Appointment Form.
- Request the physician e-scribes any medication (s) so the medication order is sent electronically to the pharmacy.
- Obtain written orders for any medication prescribed, even if the physician is calling it in to the pharmacy. If possible, ask the doctor to write orders on the Physician Orders Sheet in the medical record. If this is not possible, regular prescription forms are acceptable, but these must be secured to a full-sized paper for faxing and filing in the Medical Record.
- Document the visit and any verbal information shared in the individual record in Therap.

The Health Services Coordinator is responsible for ensuring that the following takes place:

- A designated employee (if not the Health Services Coordinator) will review the appointment form, physician order sheet, and any prescription forms received.
- Changes in medications will be faxed to the pharmacy prior to the end of the shift (or if the pharmacy is closed and not accepting faxes, at the beginning of the next shift.) Unless there are special circumstances and the RN is advised, orders must be implemented within 24 hours.
- At the time the order is received in the home, a designated employee will update the MAR with any medication changes (including new meds, discontinued meds, or changes in dosage) and any prescribed treatments.
- Any lab work that was ordered will be scheduled within the week unless otherwise noted.
- Physician order sheet and appointment forms/reports will be filed in the Medical Record by the designated employee (most typically the Health Services Coordinator).

In the event that a medication cannot be obtained due to lack of insurance coverage, the following steps must be taken:

- The Health Services Coordinator will contact the pharmacy to determine the needed course of action.
- The Health Services Coordinator will contact the prescribing physician to seek prior authorization or an alternative medication.
- If an alternative medication is prescribed, the employee involved will request a written order for the alternative medication and a discontinue order for the medication being replaced. The physician may fax the written orders to the home or the applicable office, and then the order must be filed in the person served's Medical Record.
- Contacts with physician and pharmacy must be documented in Therap in the ISP Data under "Health."
- If the steps above do not resolve the issue and medications still cannot be obtained, employees must notify the RN and consult with the Support Coordinator for any recommendations.

Hospital Discharge

Following any hospital treatment, including treatment in the emergency room, the Health Services Coordinator will ensure that the following steps take place:

- Following any and all hospital treatment (including Emergency Room treatment without admission), written information must be gathered at time of discharge. Employees may not accept the discharge of a person served for return to the home without receiving a plan of home treatment. Suggested information listed under "Hospitalization" in this procedure manual.

- The discharge form will usually include a list of medications. These constitute physician orders. At the time of discharge, employees must check this list compared to the person served's list of medications prior to admission. Ask questions about any differences in the medications and previous orders. Ask for written physician orders to discontinue any medications on the prior list if they need to be discontinued. Include questions about PRNs on the list.

- Before returning home, the new orders from the hospital must be faxed or e-scribed to the pharmacy to implement the new medications. The new medications must be implemented immediately as ordered. Upon return, note any changes on the MAR, including discontinued medications and new medications, and any changes in dosages. Clearly mark the changes to prevent confusion. Old medications, if discontinued, must be noted DC on the MAR, and the medications must be labeled and placed into a bag separate from the medications being administered.

Urgent Care Clinic Visit

If a person served has been seen at an urgent care clinic, the preferred method to receive a first dose over the weekend or after closing hours is:

- Request the physician e-scribes any medication (s) so the medication order is sent electronically to the pharmacy.

- Call and page the pharmacy while still at the urgent care clinic to make sure the ordered has been received electronically.

- Make arrangements with the pharmacy to send the script to a nearby pharmacy (CVS or Walgreens) and the pharmacist can "first dose" one or two pills until the next day when the pharmacy will deliver the remaining doses in a bubble pack with a MAR.

- If a doctor cannot e-scribe, then the next best situation would be to have the doctor page the pharmacy for a call back/verbal order, then follow steps 2 and 3 above.

- If only a written script/prescription can be obtained, call the pharmacy to check thru for allergies or duplicate therapies, then the prescription can be filled at a local pharmacy. Note: in order to do this, you will need person served insurance information and may need to pay a copayment amount when the prescription is filled.

Routine Inventory of Medications

At least once per month for their locations of responsibility, the Direct Support Managers will ensure that the following takes place:

- A designated employee will inventory the medication supply of each person served, and medications on hand in "house stock," comparing the medications in the cabinet with those listed on the MAR and Physician Orders. Any discrepancy must be brought to the attention of the RN immediately.
- If medications are listed on the MAR but are not available in the home, they will immediately be ordered from the pharmacy.
- During the inventory, expiration dates must be checked and any outdated medication (including those that will expire within the next 30 days or before the next planned inventory) must be ordered or purchased. A seven-day supply of all medications should be maintained in the home.

RECEIVING/CHECKING IN MEDICATIONS

PROCEDURE – Community Living Programs (Residential)

When routine "cycle" medications are received from the pharmacy, the Manager or designee will take the following steps:

1. Compare the MAR sheet(s) received with the existing MAR sheet(s) for each person served. For any discrepancies (for example, medications which are noted as discontinued or changed) employees will refer to the physician order sheets for clarification. If necessary, also refer to the hospitalization section of the medical file to determine if orders were changed via a hospitalization.
2. If there is any doubt as to the accuracy of the medications/documents, the supervisor and/or RN shall be consulted.
3. Compare the medication packages with the MAR.
4. If medications are received that are determined to be discontinued, the medications will be returned to the pharmacy.
5. If medications are not received which are prescribed, or an incorrect dosage is received, employees will bring this to the attention of the pharmacy and confirm when the correct medication will be delivered. This should be noted in both the individual's record in Therap and the home communication log so others are aware of the discrepancy and the completed or requested follow-up.

When medications are received from the pharmacy due to a change in physician orders (not part of regular cycle delivery), the employee receiving the medication will take the following steps:

1. Compare the new MAR received from the pharmacy to the physician order or prescription form.
2. Compare the medication label to the MAR and ensure they are the same.
3. If any discrepancy exists, follow the instructions on the physician order/prescription form, and consult with the supervisor and/or RN.

MEDICATION STORAGE AND DISPOSAL

Packaging and Storage of Medications:

a) Heartland Homecare Pharmacy uses a packaging system called "Medicine-On-Time," a multi-dose color coded system where medications are grouped together by time of day. Each medication pack is sealed and labeled with each person's name, calendar day, and time given; each medication name that is in the pack as well, and; each pack is perforated to allow ease for travel, revisions/returns, day service program, or visiting parents over the weekends or holidays. The color coding for these packs are:

    1. Yellow = 8am
    2. White = 12pm noon
    3. Orange = 4pm
    4. Blue = 8pm
    5. Green = PRN (any medications that are not loose which has "as needed" in the directions)
    6. Red = Sequential (short term medication, often antibiotics or steroids. This may include more than one time of day, but each cup is labeled with the day and dose time)

b) Prescribed medications shall be stored in a locked cabinet or closet. Schedule II controlled substances as defined under Missouri Statute (consult pharmacist if unsure) shall be stored under "double lock." "Double lock" is defined as locked by at least two separate locks, excluding the doors of the home. For example, a controlled medication would be kept in a locked box inside of the locked cabinet or closet. Controlled drugs should have a label which reads "Federal law prevents the transfer of the drug to anyone other than for whom it was prescribed". All doses are recorded on the regular MAR after administration. However, a count sheet should be kept for each controlled drug and the medications must be reconciled every shift

c) External and Internal medications shall be separated within the cabinet by shelves or containers.

d) Ointments or liquids shall be kept in the original carton or box. Bottled medications shall always be kept in the original bottle, prescription label affixed.

e) Drugs requiring refrigeration shall be stored in a locked container with the person served's name on the box and the name of the medication, dosage, frequency, time and any individual instructions on the medication label If persons served have access to the refrigerator, the container itself must be locked if there is any concern of misuse.

f) Medication cabinet shelves, bins, and refrigerator containers shall be kept thoroughly clean using soap and warm water. Liquid medication containers (cough syrups, ointments) should be wiped clean with a wet cloth after each use as necessary. To prevent leakage or spills, some medications may be kept in plastic bags. All medications are to be stored in a cool, dry location, free from moisture. Medications that are identified as light sensitive can be altered by exposure to direct light; therefore, the medications should be stored in the packaging provided by the prescribing pharmacy and out of direct light.

g) In program locations which are leased or owned by persons served, individual persons served may designate a location in the home for safe storage of medications. The location chosen should include consideration of medication storage instructions (e.g., refrigeration if applicable), person served preferences and abilities, and roommate safety considerations if applicable.

Disposal of Medications

a) Drugs are disposed of when they are contaminated, discontinued, or outdated/deteriorated.

b) Contamination - Medication shall be considered contaminated if it is spilled/dropped on an unclean surface, handled by an infectious person, affected by liquids, or in any other way altered by a foreign substance or heat. If in doubt, consult the issuing pharmacy.

- If a single dose is contaminated, the medication should be placed in a sealed bag and labeled "to be destroyed." This sealed bag should be kept by the same storage criteria indicated above. Enter a note on the reverse side of the MAR describing the incident and the action. If a second employee is available, have him/her witness and co-sign the disposal of the medication. If a bubble pack is opened, any medications in that bubble pack must either be dispensed (if not contaminated) or sealed in a bag and labeled "to be destroyed." If a medication is determined to be contaminated, the medication should be taken from the last day in the bubble pack (furthest from the current date). Replacement doses should then be requested for any medications that have been contaminated or not administered and labeled for destruction.

- If an entire prescription is contaminated, repackage it, seal the container with adhesive tape and clearly mark it for later disposal. Immediately contact the RN OR issuing pharmacy for instructions on obtaining a refill of the prescription, and how to handle the need for a dose at that time.

c) Discontinued / Outdated / Deteriorated - Medication in this category shall be packaged, sealed with adhesive tape and clearly labeled for disposal. Disposal must be done by an employee in the presence of a pharmacist, registered nurse, or physician. In any case, the employee and professional in attendance shall both document the date, type of medication, amount of medication, and method and reason for disposal.

Any medication labeled for disposal/destruction must be documented on the Certificate of Medication Destruction form used by Heartland Homecare Pharmacy. The employee packaging the medication for disposal/destruction is responsible for indicating the date and medication information (name, strength, RX number, date filled, and quantity to be destroyed). The RN should be contacted any time a medication has been packaged for disposal/destruction. The RN then signs off on

the Certificate of Medication Destruction once he/she has actually disposed/destroyed the medications.

MEDICATION ERROR CLASSIFICATION AND FOLLOW-UP

MEDICATION ERROR CLASSIFICATION AND FOLLOW-UP

Medication will be administered to persons served as ordered from the prescribing physician by qualified employees only. Employees qualified to administer medications will have current Level One Medication Aide training or an approved equivalent and will dispense medications within the training guidelines.

Any Open Options employee cannot begin passing medications until the following have occurred:

a) He/she has successfully completed the Level One Medication Aide training.

b) He/she has attended a medication in-service taught by the RN. These in-service trainings include a component on passing medications using Heartland Homecare's MAR system, as well as a component on task delegation specific to the location(s) where the employee is working.

Medication errors will be identified per the Level One Medication Aide training manual and fall into seven types. Employee medication errors will be monitored and follow-up counseling or disciplinary action may be required. Medication errors will be defined as follows:

1. Wrong Person Served - medication is given to the wrong person.
2. Omission - failure to administer a prescribed medication to an individual. Any "loose" medication (a medication in a form that cannot be specifically counted by discrete unit such as a pill) that is not signed for at the time of administration, is considered an error of omission because there is no clear way to identify that the medication was administered.
3. Wrong Dosage - any dose of medication that is above or below the correct dosage.
4. Wrong Medication - the administration of any medication to a person served for which there is no physician order.
5. Wrong Form - medication is given in a form other than ordered by the physician (such as a tablet instead of concentrate, or a medication is crushed and blended into food without physician authorization).
6. Wrong Route - the administration of a drug by a different route than was specified by the physician, such as giving by mouth a drug ordered by injection.
7. Wrong Time - any medication given more than one hour before or after it was scheduled to be given due to employee oversight. This does not include PRN orders.

<u>Error Procedures and Follow-up</u> - In the event of medication errors as described above, employees shall implement the following procedures:

1. Employees will notify the RN of any medication error as soon as it is identified, to obtain further direction. If the RN cannot be reached, employees should consult with the prescribing physician, the applicable pharmacy, or the poison control center (1-800-366-8888) for any necessary instructions. It is not necessary to contact the poison control center for omission of medications (# 2). Documentation of results of contact will be made in the individual's record in Therap and on the General Event Report and EMT.

2. A General Event Report and EMT must be completed for all medication errors described as #1 - 8 above and submitted to the supervisor.

3. The medication error must be identified and initialed on the person served's medication administration record (MAR). Explanatory notes must be entered on the back of the MAR and in the individual's record in Therap.

Medication Error Counseling/Disciplinary Action Steps

When a medication error is made, the person making the error shall immediately notify the RN, complete a General Event Report to document what the error was, as well as what action was taken when the error was discovered.

Open Options categorizes medication errors based on the outcome/result and the management response is specific to each category. The Medication Error Categories are:

Category A (1 points): A medication error that reached the person served* but did not:

- require action or extra monitoring by employee(s)
- cause harm; require action, treatment, or monitoring by medical professional(s)
- require medical intervention to sustain life
- result in the death of the person served.

Category B (2 points): A medication error that reached the person served*, required action or extra monitoring by employee(s), but did not:

- cause harm
- require action, treatment, or monitoring by medical professional(s)
- require medical intervention to sustain life
- result in the death of the person served.

Category C (3 points): A medication error that reached the person served*, required action or extra monitoring by employees, caused harm, but did not:

- require action, treatment, or monitoring by medical professional(s)
- require medical intervention to sustain life
- result in the death of the person served.

Category D (4 points): A medication error that reached the person served*, required action or extra monitoring by employees, caused harm, required action, treatment, or monitoring by medical professional(s) but did not:

- require medical intervention to sustain life
- result in the death of the person served.

Category E (5 points): A medication error that reached the person served*, required action or extra monitoring by employees, caused harm, required action, treatment, or monitoring by medical professional(s); required medical intervention to sustain life; but did not:

- result in the death of the person served.

Category F (6 points): A medication error that resulted in the death of a person served.

** A medication error that "reached the person served" includes errors of omission, defined as medication that is not given as prescribed by the physician. Omission of medication reaches the person served in that they do not receive their prescribed medication, causing potential damage to their health and well-being.*

The corresponding supervisor response for point accumulation (calculated based on a rolling year measured backward from the current date):

- 1-2 points: Informal training from supervisor or designee to ensure competency and prevent recurrence.
- 3 points: Employee suspended from medication administration until formal, documented, competency-based training occurs.
- 4 points: Employee suspended from medication administration and disciplinary action occurs. Employee does not return to medication administration until formal, documented, competency-based training occurs.
- 5 or more points: Employee receives disciplinary action up to and including termination.

If multiple incidences of a single category have occurred during the med pass, that category response will occur. If multiple categories have occurred during the med pass the more severe error type response will occur.

Any employee who continues to make medication errors may be considered for disciplinary action or termination if he/she cannot safely administer medications and treatments as ordered. Supervisory personnel reserve the right to determine the appropriate course of action based on the specific circumstance.

Documentation Errors involving Medication Administration:

The following, although not considered medication errors per policy, do represent documentation errors and performance concerns and as such are also subject to disciplinary action up to including termination.

a) Documentation Errors – errors including but not limited to the following:
    a. failure to chart or accurately chart the date and time the medication was given
    b. failure to record unusual condition, symptom or reaction
    c. failure to identify initials on administration record

d. an inaccurate spelling of the medication

b) Failure to complete a controlled substance count or discrepancy in a controlled substance record. Missing controlled substances require the supervisor of the home to file police report
c) Failure to document the administration/hold of a medication, treatment, or intervention properly.
d) Failure to ensure medication changes are processed following a physician/health care provider visit. This includes documenting medication changes/additions/etc. on the Medication Administration Record as well as ensuring any new medications are received in a timely manner.
e) Failure to comply with second person review/observation as required.
f) Failure to report a medication error to appropriate person.
g) Improper correction of written documentation (using white out or making original documentation illegible, etc.)

Oversight Responsibilities

In addition, the supervisor and/or Health Services Coordinator of a location may be subject to disciplinary action up to and including termination for the following:

a) An excessive number of medication errors occurring at the location.
b) An excessive number of documentation errors as identified above.
c) Failure to accurately or thoroughly check in medications at the start of a medication cycle or as new medications are received. This includes checking the current Medication Administration Record and Physician Orders for accuracy.
d) Failure to ensure all medications are being stored in a safe, locked location and that all medications are both current and not expired.
e) Failure to ensure all employees who are administering medications have a current Level One Medication Aide certification and have completed their documented observations with the supervisor and RN. This would also include that employees who are administering medications have successfully completed the recertification course prior to their expiration date.
f) Failure to document and/or follow-up regarding a medication error of any type at the location.