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INTRODUCTION

This manual is designed to prepare a Region V Services (RVS) employee to meet the requirements of the Medication Aide Act and to assume the role and responsibility of the Medication Aide.

The Medication Aide Act provides for the Medication Aide to participate in the administration of medications according to the Five Rights of medication administration, administer by routine routes (oral, topical, inhalation, and instillation into the eye, ear, or nose) and properly document once medication is given. The purpose of the law is to “ensure the health, safety and welfare of the public by providing for an accurate, cost-effective, efficient and safe utilization of Medications Aides to assist in the administration of medications.”

Medication Aide

The Medication Aide is a position that has been created by the Nebraska legislature (Nebraska Law Title 172 NAC 95). The purpose of this position is to provide a safe way for individuals other than licensed health care professionals (M.D., Physician Assistant, Nurse Practitioner, R.N., L.P.N., and pharmacist) to provide medications to individuals who are not able to take medications by themselves.

To become a Medication Aide for RVS you must:

- Be at least 19 years of age and of good moral character.
- Understand and demonstrate the Ten Basic Competency Standards of Medication Provision as established by the Department of Health & Human Services.
- Complete the Region V Services medication administration class and pass the medication administration quiz.
- Be assessed competent to administer medications through direct observation by a licensed healthcare professional (LHCP) to determine whether an individual understands and can actually demonstrate the basic competencies. **No one will be allowed to administer medications without passing the test and having a competency assessment.** A first time Medication Aide applicant has a 30 day grace period in which they may administer medications after their competency assessment is completed. During this time the State registers the individual on the Medication Aide Registry.
• Submit to the Department:

a. a completed application including applicant’s name, address, birth date, Social Security number, alien number (if you are a qualified alien under the Federal Immigration and Nationality Act) and identification of any felony or misdemeanor conviction along with the date of occurrence and county in which the conviction occurred;

b. certified copies of all charges, amended charges, pleas, sentencing and probation orders for convictions related to:
   1) Lewd behavior
   2) Behavior involving minors, except minor in possession (MIP)
   3) Taking something belonging to someone else
   4) Physically, verbally or emotionally threatening, abusing or neglecting another individual
   5) Obstruction of justice/resisting arrest
   6) Failure to appear or comply with a citation
   7) Destruction of property
   8) Trespassing
   9) Manufacture and/or delivery of controlled substances

c. all records, documents or information requested by the Department. If you get a request for additional information from the State, you will not be listed on the Registry as a Medication Aide until that information is provided to the State. It is your responsibility to provide the requested information. It is advised that you also inform your Coordinator regarding the delay.

d. an official record documenting demonstration of competency as specified in regulations (the LHCP will complete this at the time of the competency assessment).

e. the required non-refundable fee as specified in regulation (paid by Region V Services).
• Be registered on the Medication Aide Registry.

• Renew registration every 2 years. Competency must be retested and the renewal form completed and registration fee paid.

• If a person’s Medication Aide registration is expired, they must be assessed competent, reapply to the State and may not administer medications until they are posted as current on the Medication Aide Registry.

• Failure to maintain competencies or demonstrated incompetence will be reported to the State of Nebraska and can result in revocation of registration.

A Medication Aide providing services in a nursing home, intermediate care facility for the mentally retarded (ICF), or an assisted-living facility, is required to complete a forty-hour medication administration course.

Responsibilities of a Medication Aide

As a Medication Aide there are several key duties in providing medication support. You must be able to:
• Use safe practices in monitoring and managing of medications
• Respond to the specific needs of the individual being supported
• Follow laws, rules, regulations, policies and guidelines that apply in your situation
• Assist people in taking medications correctly
• Find additional information regarding medications when necessary
• Communicate effectively with the individual, family, health care provider, pharmacist and your agency representatives.

Direction and Monitoring

Medications may be provided by a Medication Aide only when direction and monitoring is provided and documented. State Regulations define direction and monitoring as the acceptance of responsibility for observing and taking appropriate actions regarding any desired effect, side effects, interactions and contraindications associated with the medication.
There are 3 categories of people who may assume responsibility for direction and monitoring.

1. **Individual**
   A person may direct their own health services if they are competent to do so and state so in writing. This means they fully understand their own health requirements and are capable of communicating when any changes occur. They must have the capacity and capability to make informed decisions about their medications, to refuse medications, and at no time be forced to take medications.

2. **Recipient Specific Caretaker**
   A caretaker may be any competent person who understands the health care needs of the individual and is willing to assume responsibility in writing. This will most typically be a family member or guardian. In this instance, it is the caretaker you contact for authorization of PRN medications or questions regarding an individual’s medical care.

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I, ________________________________, assume responsibility for the direction and monitoring of medications and additional activities for ________________________________ (name of person) while being supported by Region V Services employees. I also authorize Region V Services to administer medications by Certified Medication Aides in their employment. I acknowledge and accept that these Medication Aides have been deemed competent to perform this task by a Licensed Health Care Professional and that the competency assessment has been completed on my behalf.

Signature ________________________________ Date ________________

Printed Name ________________________________
3. **Licensed Health Care Professional (LHCP)**

As part of the job description, the Nurse Consultant assumes responsibility for the direction and monitoring of medications administered by Region V Services staff. This allows for a Medication Aide to administer medications under the Nurse Consultant’s nursing license. This applies to all persons supported by Region V Services, except those individuals who are capable of directing their own health care needs, and those persons where responsibility has been assumed by a caretaker or other LHCP.

**Ten Basic Competency Areas and Standards**

The Nebraska Department of Health and Human Services has developed the following ten competency areas that a Medication Aide needs to show understanding and capability. During your medication competency the area nurse (Health Care Coordinator) will ask questions relating to or directly observe understanding of these competencies.

**Competency 1: Maintain Confidentiality**

*Does not share confidential information except when it affects the recipient’s care and is to the appropriate person(s).*

Federal law protecting health information privacy is known as HIPAA (Health Insurance Portability and Accountability Act). It is against Federal statute to reveal any health related information to persons or organizations without proper authority.

Persons receiving support from RVS have the right to personal privacy. All information about the individual is confidential. This includes any information about identity, diagnosis, medication, health care, payment of services and medical therapies. All information of this nature may be shared only with appropriate persons on a “need to know” basis.

If a person supported has hepatitis B, it is important for the Coordinator and those persons working with him to know this information. RVS personnel that do not work with this person don’t need to know this personal information. On the other hand, if the staff person has hepatitis B, it is important that the person supported, his family/guardian, Coordinator and fellow staff know this information. Again it is on a “need to know” basis. Does someone need to know this information to safely interact with this individual? Contact your supervisor if you have questions or concerns about this.

Never discuss an individual’s behavior, conditions, medications, or other information where others can hear the conversation. Be aware of this particularly when out in the community or in social settings. When discussing information in the presence of the supported individual, advise them of what you are doing and why and ask their permission to discuss it with another “need to know” person.
What can you share about a person without breaking confidentiality? How do you introduce one friend to another? Talk about talents, hobbies, personal interests, job skills, certain likes. Anything that is “public knowledge” is not confidential but not everything that is “public knowledge” is appropriate to share.

**Competency 2: Complying with a recipient’s right to refuse to take medication**

*Does not force recipients to take medication. Uses appropriate measures to encourage taking of medications when directed for recipients who are not competent.*

An individual receiving support has the right to be informed about all aspects of the medication he or she is taking. The individual has the right to refuse to take medication. As the person providing support, your job is to provide the best care possible and this care usually involves administering prescribed medication. Never force a person to take their medication.

If the person is refusing their medication, try to determine why. Is this a bad time for that person? Wait and offer later. Does it taste bad? Offer a choice of yogurt or applesauce. Does it cause unpleasant side effects? The physician may be able to change the time of dosing or offer remedies to help. Other staff can be very helpful in suggesting ideas that may help—she prefers butterscotch to chocolate pudding or he likes his meds in his blue bowl. This information is listed on the medication administration card under special instructions.

The right time for administering a medication is one hour before to one hour after the assigned time listed on the medication administration card. You have a two hour window in which a medication can be correctly administered.

If a person refuses their medication, you must try at least three attempts to get them to take it. Be respectful during medication administration. Medication Aides must respect the personal space of persons they assist. Intimidation by physical presence is not an acceptable method of getting someone to take their medication, nor is physically touching someone, unless that is the method desired by the person supported. Be respectful by not getting in their face, give them a little time, offer preferred tastes, try other staff’s suggestions, suggest an outdoor activity and try to not offer only sugar filled treats. If after all your efforts, the medication is refused; contact a pharmacist or physician for recommendations regarding what to do, potential reactions to anticipate or recommendations for adjusting the next scheduled dose.

Refusal of a medication needs to be documented on the medication administration card and an Individual Report Form. Documenting a refusal on the medication administration card will be discussed later, see page 52. The refusal, efforts you tried and any advice given you by the pharmacist (include pharmacist’s name) need to be documented on an Individual Report Form.

If refusals occur frequently or you start to see a pattern of refusal, notify the Coordinator. The situation needs to be reviewed by the ISP team.
Any medication used for behavioral control is a rights restriction and does require review. Due process includes review by the Individual Support Plan (ISP) and the RVS Program Ethics Committee (PEC).

Competency 3: Maintaining hygiene and current accepted standards for infection control
Utilizes appropriate infection control principles when providing medications.

Universal Precautions
Universal Precautions assume that all human and all human body fluids are infectious and should be handled with appropriate protective measures. These protective measures include:

- wearing protective equipment - gloves, eye protection
- hand washing
- proper disposal of needles and sharps
- decontamination of surfaces that come in contact with blood by cleaning with a mixture of 1:10 bleach to water solution
- wash clothing that is contaminated with blood in hot water and detergent. Bleach may be added as an additional disinfectant measure

Hand Washing
Hand washing is the single most important way to prevent the spread of infection. The importance of good hand washing can’t be underestimated. When providing medications to multiple persons, wash hands between each person’s administrations unless no contact was make with the person or anything the person may have touched.

Hand sanitizers can be a great alternative when soap and water are not available. After using a hand sanitizer, wash your hands as soon as possible. Good old hand washing with soap and water is still the best.

PROPER HAND WASHING:
1. Prepare a paper towel
2. Using warm water, wet your hands before applying soap
3. Rub your soapy hands together for 10 - 20 seconds
4. Rinse your hands thoroughly of soap with fingers pointing downward
5. Turn water off with a paper towel
6. Dry hands with a clean paper towel
7. When leaving a public restroom, use the paper towel to open the door handle
Gloves
For some procedures, disposable gloves may be worn. They should be worn anytime there is a chance of coming in contact with body fluids. This might happen if you need to put medication in someone’s mouth or when applying a cream or ointment. Never touch another person’s medication with your bare hands, only the recipient can touch the medication bare handed. Gloves are not a substitute for good hand washing. Wash hands before and after using gloves.

To remove used gloves properly:
1. Pinch the palm of the first glove and pull toward the fingertips and off the hand.
2. Continue to hold the first glove while removing the second glove. Place fingertips of the first hand between the skin of the wrist and glove. Pull second glove toward the fingertips, turning the glove inside out. The first glove will be inside the second glove.
3. Dispose of gloves. Wash your hands.

Competency 4: Documenting Accurately
Accurately documents all medication provided including the name of the medication, dose, route and time administered and any refusal of medication, and spoilage

When documenting remember:

- A medication card is a legal document. Use black or blue pen, not pencil or erasable pen.
- Do not use “white out”, erase, or try to cover up an error. Draw a single line through the error and initial.
- Don’t leave blank spaces on a medication administration card.
- Document only what is observed, not an interpretation or an opinion of what is observed.
- Sign the back of medication cards (including PRN and Non-Prescription PRN cards) with your initials and signature and your title, CSP (Community Support Professional)
- Document administration of medication immediately after the medication is given. Do not document prior to administration. Documentation means that you’ve already done it.
Forms and their correct documentation that will be discussed in this manual include:

- Medication Administration Card
- Drug Destruction
- Temporary Medication Card
- Individual Report Form
- Prescription PRN Medication Card
- Non-Prescription Medication Card

**Competency 5: Providing medications according to the five rights**

*Provides the right medication, to the right person, at the right time, in the right dose, and by the right route*

To safely provide medications, a Medication Aide must observe the “Five Rights of Medication Administration”. These five rights are the basis for medication administration. You must give the **Right Medication**, to the **Right Person**, the **Right Dose**, at the **Right Time** by the **Right Route**. You must get all five right, if even one “right” is missed, it can result in a medication error and may result in serious harm to the person.

When removing the medication from the locked storage compartment compare the prescription label to the medication listed in the medication book to assure you have the **right medication**. If a generic medication is received from the pharmacy, then the generic name should be listed on the medication administration card.

The photograph in the person’s medication book identifies the **right person**. Call the individual by name. Prepare medication for one person at a time and complete paperwork before going on to the next person.

Always check the proper amount or the **right dose**. Know the abbreviations for tablespoon (Tbsp. or T.) and teaspoon (tsp. or t.) and use calibrated medication cups.

The **right time** for administering a medication is one hour before to one hour after the assigned time listed on the medication card. An exception is a medication that must be given 30 minutes before (ac) or after (pc) a meal. These drugs should be given as close to the specified time as possible.

The **right route** is how the medication is to be taken. Is it taken orally, under the tongue, applied topically?

When removing the medication from the locked storage, read the label to be sure you have the right medication, right person, right dose, right time and right route. When setting up the medication compare the prescription label and the medication card to double check that you are providing the right medication, to the right person, at the right dose, at the right time and by the right route. **Never administer any medication without checking and double checking the Five Rights of Medication Administration.** The persons we support are depending on us to accurately administer medications. This is no time for short cuts.
Violation of these Five Rights of Medication Administration may impact a Medication Aide’s employment.

Right Individual/Person
Right Medication
Right Dose
Right Time
Right Route

I Must Do This Right EVERYTIME

Competency 6: Having the ability to understand and follow instructions.

Comprehends written and oral directions.

Being safe with medications is the Medication Aide’s number one concern when assisting with providing medications to another person. Safety with medications includes the ability to understand and follow directions.

Abbreviations

Many abbreviations are used when administering medications. To be safe when providing medications, a Medication Aide needs an understanding of these abbreviations. Although physicians are discouraged from using many of these abbreviations, you will still see them used and you need an understanding of what they mean. Below is a list of frequently used abbreviations.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ac</td>
<td>before meals</td>
<td>pc</td>
<td>after meals</td>
</tr>
<tr>
<td>bid</td>
<td>twice a day*</td>
<td>po</td>
<td>by mouth</td>
</tr>
<tr>
<td>c</td>
<td>with</td>
<td>prn</td>
<td>as needed*</td>
</tr>
<tr>
<td>d/c</td>
<td>discontinue</td>
<td>q</td>
<td>every*</td>
</tr>
<tr>
<td>h</td>
<td>hour</td>
<td>qd</td>
<td>every day</td>
</tr>
<tr>
<td>hs</td>
<td>at bedtime*</td>
<td>q4h</td>
<td>every 4 hours</td>
</tr>
<tr>
<td>OD</td>
<td>right eye</td>
<td>qid</td>
<td>four times a day*</td>
</tr>
<tr>
<td>OS</td>
<td>left eye</td>
<td>qod</td>
<td>every other day</td>
</tr>
<tr>
<td>OU</td>
<td>both eyes</td>
<td>stat</td>
<td>immediately</td>
</tr>
<tr>
<td>OTC</td>
<td>over-the-counter*</td>
<td>tid</td>
<td>three times a day*</td>
</tr>
</tbody>
</table>

*memorize this information
Measures

In order to provide medications safely, the Medication Aide must also understand measurements and how medications are measured.

- Always use the correct measuring device to give the correct dose.
- All liquid and powdered medications are measured in a calibrated medication cups.
- Always measure liquid medications by putting the med cup on a flat surface and bringing your eye down to the cup to see exactly how much you are pouring.
- Measure thin liquids using the lowest point of the meniscus or the lowest curve of the liquid. A thick liquid is measured using the highest point of the meniscus or the highest curve of the liquid.
- Never pour liquids back if you poured out too much, pour excess into another medication cup to be destroyed according to agency policy.

Listed below are common abbreviations and common equivalences:

cap    capsule
gtt    drop
gtts   drops
mcg    microgram
mg     milligram
ml     milliliter
oz     ounce
tab    tablet
t      teaspoon
tsp    teaspoon
T      tablespoon
Tbsp   tablespoon

Common Equivalences:

1 cc = 1 ml
1 teaspoon = 5 cc or 5 ml
1 tablespoon = 15 cc or 15 ml
3 teaspoon = 1 tablespoon
1 ounce = 30 cc or 30 ml

Note: a milligram (mg) does not equal a milliliter (ml)
An understanding of abbreviations and measurements will help with your ability to understand and follow a medical provider’s orders.

- A medical provider (physician, physician’s assistant, nurse practitioner) will typically write orders on a medical contact form.
- At the medical appointment, the MSA (Medical Service Associate) or the attending staff must check the order for clarity and legibility.
- It is important to repeat the order at the time of the contact to the medical provider to confirm it’s correct.
- On the medical contact form rewrite the order legibly.
- If you receive a faxed order and cannot decipher, contact the person sending the fax for clarification.
- If you do not understand or have a question regarding an order check it out.

**Competency 7: Practicing safety in application of medication procedures.**

*Properly:*

- *a.* Stores and handles all medication in accordance with entity policy;
- *b.* Intervenes when unsafe conditions of the medication indicate a medication should not be provided; and
- *c.* Provides medication to recipients in accordance with their age and condition.

**Medication Storage**

- All medications are stored in the original container (including the original prescription label) in which they are dispensed by the pharmacy. An original container may be a pill bottle, a blister pack, or a cassette. If the prescription label is attached to the box (eg. inhaler, insulin), keep the medication within the original box.
- All prescription and non-prescription medications administered by staff are stored in a locked cabinet (or a locked box within a refrigerator if needed).
- Each individual supported must have their own medication storage container within a locked cabinet to separate their medications from other persons’ medications. This will help prevent giving the wrong medication to the wrong person.
- All controlled substances are stored under double lock. Controlled substances are medications that have a potential for abuse or addiction. A listing of some controlled substances is found on page 90.
- Medications taken orally are stored separately from externally applied medications. Keeping ointments and creams separated in a zip-lock bag will prevent contamination to medications taken orally.
- Keep refill medications labeled, inventoried, sealed and locked until they are needed.
• The key to the locked medication storage cabinet must be in a secure location. Do not leave the key in the lock of a file cabinet. Only individuals who can administer medications can have access to the keys.
• If an individual administers their own medication, a locked drawer or box may be provided. At the very least, the person should keep the meds in a private area, within their bedroom or bathroom. It is always good idea to store medications in a locked area if children are present.

Unsafe Conditions of Medications

These are questions to consider in determining general unsafe conditions of medications:

1. Is the medication past its expiration date?

   Over time, most medications become ineffective, some liquid medications can become more potent as they evaporate, and a few medications become unsafe after the expiration date. Expiration dates may especially be a concern with PRN prescription medications and OTC medications that aren’t given routinely. If there is no expiration date listed, consider a medication expired one year after it is dispensed by the pharmacist.

2. What is the condition of the medication?

   Check for medications that have a cracked coating, an odor or have a color change. Do not give broken or crumbly tablets. If a solution/liquid changes color, becomes cloudy or has a sediment, this may represent a deterioration of the medication. A change in consistency of a liquid could indicate possible tampering. When medications are received from the pharmacy immediately inspect to see that they are all present and in good condition, call the pharmacy for replacements if needed. Are the tablets the same color as last month’s? A different generic equivalent may have been substituted; the pharmacy needs to inform you of these changes. If the individual says it doesn’t look like one they usually take; check it out.

3. Is the prescription label legible?

   If a medication is unlabeled or the label becomes illegible (e.g. cough syrup spilled on the label) do not administer. Take it to the pharmacy to have it relabeled by a pharmacist.
If in doubt about the safe condition of a medication:

1. Review medication information sheets for any information regarding storage and unusual appearance.

2. Contact a pharmacist for guidance in determining if a medication is safe to administer.

3. If medication is deemed unsafe, dispose of it by using the proper drug destruction procedure.

We need to be alert and sensitive to the differing needs of the persons we support. Do they have difficulty swallowing? Do they receive some medications orally and others through a g-tube? How are ear drops instilled in an adult versus a child? We will discuss these issues in the medication administration section of the manual.

Competency 8: Complying with limitations and conditions under which a medication aide or medication staff may provide medications.

Knows that they must:

a. Be competent and have been assessed
b. Always comply with the five rights of provision of medication
c. Record all medication provided or refused; and
d. Have additional competencies to provide additional activities.

Only Medication Aides who have successfully completed RVS approved training in medication administration can administer medications to our persons supported. To accomplish this you must first complete the 2 day medication administration class, pass the medication administration quiz and have a competency assessment by a licensed healthcare professional (LHCP), usually the agency nurse also known as the Healthcare Coordinator.

The competency assessment is a direct observation in which the Healthcare Coordinator observes a medication pass and asks questions related to the Ten Basic Competency Standards. During the competency assessment, the nurse determines if you are competent to administer medications.

If you are currently registered as a Medication Aide through another facility, you are invited to attend both days of the medication administration class but at the minimum; you must take day 2 of medication administration class so you understand RVS’ expectation of Medication Aides and can accurately complete documentation of RVS’ forms. The agency nurse will then assess your competency.

If you are a LHCP, we ask that you take day 2 of class to familiarize yourself with our documentation and meet with the agency nurse for a competency assessment.

You may not administer medications for RVS without a competency assessment.
Always comply with the five rights of medication administration. You must give the Right Medication, to the Right Person, at the Right Dose, at the Right Time by the Right Route. You must get all five right, if even one “right” is missed, it can result in a medication error and may result in serious harm to the person.

Document administration of medication immediately after the medication is given. Do not document prior to administration. Documentation means that you’ve already done it. If a medication is refused after three attempts, document the refusal on the medication administration card, complete an Individual Report Form and notify the pharmacist or the physician of the refusal.

**Additional Activities**

The Medication Administration Act provides for a Medication Aide to give medications according to the “Five Rights of Medication Administration,” administer by routine routes (oral, topical, inhalation, and instillation into the eye, ear, or nose), and appropriately document once medication is given.

It also makes provisions for additional activities. These are:

- Giving medications by routes other than routine routes, e.g. rectal suppository, medication by gastrostomy tube, insulin injection.
- Performing nursing related duties, e.g. glucometer testing, oral suctioning, gastrostomy feeding.
- Participation in monitoring.
- Providing PRN medication.

To administer a medication by a route other than routine or perform a nursing related duty, a Medication Aide must be:

- Trained by a licensed health care professional (LHCP). **Staff can not train other staff.**
- There must be written direction for each additional activity that is recipient specific.
- There must be a written statement by a LHCP that the Medication Aide can competently perform the activity and that it is safe for the recipient to receive the additional activity. This statement of training is kept in the staff’s personnel file.

Training for additional activities should be done only if the Medication Aide is expected to perform the task in the workplace. Once a Medication Aide has been trained on an activity, follow-up monitoring will be done by the LHCP to assure continued competence. The responsibility for the safety of the recipient and the accurate performance of the activity lies with the Medication Aide, the employer, and the LHCP who trains, supervises, and directs the activity.
To participate in monitoring, specific instructions from a LHCP need to be available for what the Medication Aide is to observe and report. Instructions should include timelines for observing and reporting and shall identify the person to be notified. An example may be that you notice a reddened area on a person’s heel. A LHCP may tell you to keep the area clean and keep pressure off the heel for the next 2 days. The LHCP may then advise that if there is no improvement or if you notice an increase in redness or a blister develops, to report this to the physician.

To provide a PRN (as needed) medication, the Medication Aide must be given specific directions that list the reason the medication is to be given, how often it can be given, results to expect after receiving it, and to whom to report observations. This will be discussed more fully under the heading PRN medications. (See page 72)

**Competency 9: Having an awareness of abuse and neglect reporting requirements**

*Identifies occurrences of possible abuse of a vulnerable adult/child and reports this information to the appropriate person/agency as required by the Adult/Child Protective Services Act.*

**Competency 10: Complying with every recipient’s right to be free of physical and verbal abuse, neglect, and misappropriation or misuse of property.**

*Does not misuse recipient property or cause physical harm, pain, or mental anguish to recipients*

Treating people with dignity and respect requires that they are free from abuse and neglect. As employees of RVS you are required to comply with the Nebraska law regarding the reporting of abuse/neglect of vulnerable people.

Any person who observes abuse/neglect, or has reasonable cause to believe that it has occurred must either report, or cause a report to be made to the Nebraska office of either Adult Protective Services (APS) or Child Protective Services (CPS).

Reporting may be done by any RVS employee or their supervisor. If an employee makes any direct report to an outside agency, the employee must also notify a supervisor within RVS. Knowledge of abuse or neglect that is not reported is a criminal offense according to Nebraska statute. **If a person is in immediate danger, law enforcement should be contacted immediately.** To report suspected abuse or neglect, call The Abuse/Neglect Hotline 1-800-652-1999.

**Abuse** is defined as any knowing, intentioned or negligent act or omission which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of needed services to a vulnerable person.
Some examples of abuse:

1. **Physical**: hitting, slapping, pushing, hair pulling, kicking, overuse of restraints, over-medicating, withholding personal care, medical care or food, pulling someone out of bed, keeping an individual awake, driving recklessly, forcing the individual to eat, drink or take medications and unreasonable confinement.

2. **Sexual**: verbal harassment, unwanted sexual touching, unwanted display of sexual parts, exposure to pornography, tricking or manipulation into sexual activity, sexual assault and rape or any sexual relationship between employee and person supported.

3. **Psychological**: denial of right to make a decision, threats to harm the individual or his/her pets or their property, isolating the individual from family and/or friends, humiliation, to cause fears and isolation.

4. **Exploitation**: misuse or theft of financial resources, taking of money, taking of personal property, failure to pay the individual a legal wage for work performed or the unauthorized use of digital social media.

5. **Denial of essential services**: not protecting an individual from abuse, failure to provide sufficient food and clothing, inadequate supervision, failure to intervene to protect someone, failure to utilize available adaptive devices (e.g. hearing aids, communication equipment, wheelchairs, etc) and/or repair such devices.

6. **Verbal**: making demeaning remarks, making fun of, treating in a patronizing way, threats to deny essential services, swearing, talking baby talk to individuals, name calling – telling them they are stupid, worthless, a moron, dumb, bad.

**Neglect** occurs when someone is negligent or omits or fails to provide a needed service to a vulnerable person. This may include denial of food, clothing, shelter, not working assigned hours, withholding medications or necessary treatments, leaving an individual in one position, on the toilet for an extended period of time or in soiled clothing for long periods of time, extended ignoring, inadequate supervision.
Ten Performance Standards to Prevent Abuse

1. Speak to all people politely, as you would like be spoken to.
2. Include people in conversations; speak with them, not about them.
3. Use **positive** verbal and non-verbal communication; avoid being negative.
4. Give explanations so that people can understand. Observe how they receive the information.
5. Encourage people to participate by asking questions rather than giving commands.
6. Teach people to do as much as possible for themselves rather than doing for them.
7. Include people in decision making by providing them information and encouraging the person’s choice. **Don’t be bossy.**
8. Respect differences and personal desires, needs and values.
9. Respect the person’s right to say **no**.
10. If involved in a disagreement, listen to each other’s point of view; if upset, **DO NOT** allow it to affect your behavior.

Medication Packaging

Medications given throughout RVS may be in several types of packaging.

Pill bottle
- The Medication Aide removes the correct amount of medication from the bottle and returns the bottle to the storage area.
- Medications are poured into the lid of the container and then into a med cup or a gloved hand.
- A clean counting tray or a clean saucer and knife are used to count the inventory.
Blister Pack
- The pharmacist packages medications for each individual dose in a blister on a card.
- Medications are removed from the packaging by pressing it through the foil on the back side of the packet.
- The day’s date corresponds to the number printed next to the medication blister. The first day of the month starts a new blister packet and the tablet/capsule in the #1 blister is administered.
- If a medication is ordered three times a day (tid), there will be a separate blister packet for each administration time.
- Inventory is easy in that you count all medications remaining in the blister packets.

Cassette
- A 3X4 inch plastic container with individual sections for holding tablet/capsule. The top of the cassette is clear and slides open to expose one section at a time.
- The cassette may either be marked with days of the week (Mon., Tues., Wed., etc.) or the day’s date (1, 2, 3, etc.).
- After the top is slid open, the medication can be poured into a med cup or a gloved hand.
- Inventory is easy since you can see at a glance how many tablets/capsules are left in the cassette.

MEDICATION ADMINISTRATION ROUTES

A. Administration by the oral route

The oral (by mouth) route is the most frequently used method of medication administration. When giving a medication orally, have the recipient in an upright position. Have a glass of water available and encourage a drink prior to and after giving the medication.

1. Tablet or capsule
   a. Wash your hands. Wear gloves if you will be touching the medication.
   b. Read label as you remove medication from the locked storage container.
   c. Check label on medication against the med card. Review any special instructions.
   d. Place the prescribed amount of medicine in a med cup.
e. Offer recipient a drink of water.

f. Ask recipient to place tablet/capsule on the back of their tongue and swallow with a mouthful of water.

g. Observe the recipient taking the medication. Do not leave the medication with the person to take at a later time. Do not leave the medication unattended. A medication cup left at the dinner table may be missed, contaminated, or taken by the wrong individual.

h. Document administration of the medication immediately after it has been administered.

i. Inventory according to RVS policy which will be covered in the inventory section of this manual.

**OF NOTE:**

1. Capsules should be swallowed whole. Check the medication information sheet or call the pharmacist to determine if a capsule can be opened or dissolved. If a person is unable to swallow a capsule whole, open capsule with a gloved hand and put contents on a spoonful of applesauce, yogurt, etc. Make notation on med card under **Special Instructions** if medication is to be crushed and place in a bite of applesauce, yogurt, etc.

2. Tablets that are scored can typically be broken in half for ease in administration. If a half tablet is ordered, the pharmacy will be responsible for splitting the tablet.

3. Children or persons with difficulty swallowing may need to have medication broken or crushed.
   - Large tablets may be broken in half with gloved hands.
   - Pill cutters are available for splitting pills.
   - Tablets can be crushed between two spoons and mixed with pudding, applesauce, etc.
   - Pill crushers are available at most pharmacies. A preferred crusher has the threads on the outside of the crusher. Wash the crusher daily.
   - If a person is having trouble swallowing, always check their position. By repositioning, such as sitting upright or adjusting head position, the medication may be easier to swallow.
   - If a person has a weak side, give meds on the stronger side of the face.
4. Besides crushing and mixing in food, other ideas for persons having difficulty swallowing medication include dissolving in liquid or placing in food (cookie, pudding, etc.). If these measures are used, make this notation under **Special Instructions** to better assist other staff in administering the medication.

5. Enteric coated means a tablet is coated so it doesn’t dissolve until it reaches the intestine, thus protecting the stomach. An enteric coated tablet must be swallowed whole not broken or chewed.

6. Do not crush time-released tablets (medication name may be followed by initials such as SR-sustained release, CR-controlled release, LA-long acting) as this affects its absorption.

7. **Sublingual (SL)/Buccal medications**
   - Sublingual (SL) and buccal medications are placed next to the mucous membrane in the mouth. The medication is absorbed through the mucous membrane into the bloodstream.
   - Sublingual medication may be dispensed in a darkened bottle (nitroglycerin) or packaged in an individual foil packet. Caution when opening these packets. The medication crumbles easily if pushed through the packet; it’s preferable to peel the packet apart.
   - Sublingual medications are placed under the tongue. The person should not eat or drink until the medication is completely dissolved.
   - Buccal medications are placed between the cheek and gums. The person should not eat or drink until the medication is completely dissolved.
   - Do not swallow a sublingual or buccal medication.

2. **Liquid Form**

   This route is most preferred for children or persons having difficulty swallowing. Again, if person is having difficulty swallowing, reposition. It can also be helpful to put liquid medication in the side of the mouth to aid in swallowing.

   a. Wash your hands.

   b. Read label as you remove medication from the locked storage container.
c. Check label on medication against the med card. Review any special instructions.

d. Place a paper towel down so you have a clean surface to work on. Remove lid and place top side down on the clean surface.

e. Measure the correct dosage. Liquid medication should be measured in a teaspoon or a calibrated medication cup. Put the med cup on a flat surface and bring your eye down to the cup to see exactly how much you are pouring. Protect the label with the palm of your hand and pour away from the label to prevent dripping onto the label and making it messy and difficult to read.

f. Administer medication and observe person swallowing medication.

g. Document administration immediately after medication has been given.

h. Inventory according to RVS policy. Inventory of liquid medications can be difficult and is discussed under inventory.

**OF NOTE:**

1. Some liquids are suspensions and should be shaken first to mix.

2. Frequently liquid medication tastes bad so follow it with fruit juice or a favorite drink.

3. Syrups have a coating effect so avoid giving liquids immediately after giving syrup.

4. Never pour liquids back if you poured out too much, pour excess into another medication cup to be destroyed according to agency policy.

5. A syringe may be helpful for drawing up a specific dose e.g. 12cc.

**B. Topical Application**

Topical application is applying medication to the skin. Topical medication may be used to treat skin lesions, lubricate, or protect the skin. Most topical medications are not absorbed through the skin and their action is
locally or to the skin. Some topical medications (e.g. Nitroglycerin) are absorbed through the skin for a systemic effect (action is throughout the whole body). Topical medications that have a systemic effect may be in the form of a patch.

1. **Lotions, Creams, Ointments, and Gels**
   
a. Wash your hands and apply gloves

b. Read label as you remove medication from the locked storage container.

c. Check label on medication against the med card. Review any special instructions. The physician may write special instructions for the application of a topical medication, for example: apply sparingly and rub in well. These instructions are important because medication action depends on correct administration. **The biggest problem with topical medication is that too much is applied. Small dabs are usually sufficient.**

d. To avoid applying too much medication, put a small amount of topical medication to the back of gloved hand near your thumb. Then use your finger to apply dabs from this supply of topical medication. Topical medication may also be applied with gauze or a tongue blade.

e. Observe the skin. Look for open areas, redness, drainage, swelling, and note the color of the skin.

f. Document administration immediately after the medication has been applied.

g. Inventory of creams and lotions can be difficult and is discussed under inventory.

**OF NOTE:**

1. Lotions may be applied liberally and rub in easily. If the lotion is non-medicated it may be applied without gloves as the person might appreciate the human touch.

2. Creams are white and rub in easily while ointments are clear, oily and absorb more slowly. Both should be applied sparingly.
3. If both a cream and ointment are ordered, apply the cream first.

4. If you need to apply a cream/ointment to several areas, use different fingers.

5. If you are applying a topical medication and the recipient can’t see you, tell them what you are doing.

6. Applying cream/ointment on a dressing then placing on a wound or tender area is more comfortable for the recipient.

2. **Patches (Transdermal Medication)**

a. Wash your hands. Apply gloves. Gloves will prevent the medication from being absorbed into your skin.

b. Read label as you remove medication from the locked storage container.

c. Check label on medication against the medication card. Review any special instructions.

d. Open patch and use the packaging as a clean surface to work on. On the non-sticky side of patch, write the date, time and your initials.

e. Apply patch by removing the adhesive cover and placing the patch on a non-hairy spot of the skin and applying pressure to all the edges. Hold hand over the patch for 60 seconds to seal the patch. You may need to clip hair to insure that the patch will stick. Don’t place the patch in the exact same spot as it may be irritating to the skin. Different patches may require different placement, follow the physician’s recommendation.

   **Suggested sites:**
   - Pain patches - chest, upper back or upper arm
   - Hormone patches - lower abdomen or buttocks
   - Nitroglycerin patch – upper chest
   - Nicotine – upper arm

f. Document administration immediately after application.
g. Disposal: Use gloves to remove a used patch. Used skin patches should be folded sticky sides together with two people watching to verify how it was disposed. The used patch is placed in a bio-hazard box. If two persons are not present, put used patch in an envelope and lock in medication cabinet until disposal can be witnessed by two persons.

h. Inventory according to RVS policy.

**OF NOTE:**
If the individual is receiving hospice service, all directives regarding the pain patch will be addressed with the hospice nurse.

C. Administering Medication by Instillation

Instillation means applying medication directly into the eye, ear, or nose.

1. **Eye Medication Instillation**

Eye medication may be used to lubricate the eye, to treat medical conditions such as glaucoma, or oftentimes used to treat an infection such as pink eye (conjunctivitis).

*Before administering eye medication (drops or ointment):*

a. Read label as you remove medication from the locked storage container. Make sure the medication is marked “ophthalmic use only” (for the eye).

b. Check label on medication against med card. If the prescription label is on the box, keep the drops in the box. Review any special instructions.

c. Check for the expiration date. Observe solution for color changes or sediment, this may mean solution is decomposing. Do not use if it appears abnormal.

d. Double check to see which eye(s) gets the medication. OD = right eye, OS = left eye, OU = both eyes.
e. If person has discharge or crusting of the eye, make sure the eyelid and lashes are clean before administering the eye medication. Using gloves, moisten gauze/cotton ball with warm water. Place gauze/cotton ball on closed eye for a minute and gently wipe once from inner to outer eye. Discard after one wipe. Continue to moisten gauze/cotton ball and wipe eye until clean. If a wash cloth is used to cleanse the eye, make sure different areas of the wash cloth are used and the cloth is immediately put in the laundry. This will prevent cross-contamination.

**Instillation of eye drops:**

a. Wash your hands. Apply gloves.

b. Have recipient sit or lie down and ask them to tilt head back and look upward.

c. Pull down the lower lid with your ring finger of your least dominant hand to form a pocket. This will prevent unnecessary pulling on delicate tissue.

d. Instill the prescribed number of drops in the pocket (usually 1 or 2). This feels better than putting drops directly on the eyeball.

e. Take care not to touch the eye with the dropper tip to prevent contamination of the dropper or injury to the eye.

f. Ask recipient to gently shut, not squeeze eye and then blink.

g. Use a clean tissue to remove excess fluid. Wash your hands.

h. If administering two different kinds of drops, wait at least 5 minutes between drops.

i. Document eye drop administration immediately after instillation.

j. Inventory of eye drops can be difficult and is discussed under inventory.
OF NOTE:
If a person is especially resistant to having drops placed in the eye, wash the closed eye with Baby Shampoo, rinse and let dry. Apply the drop(s) to the inner canthus (close to the nose) of the closed eye, and ask the person to open the eyelid allowing the drop(s) to fall into the eye.

*Instillation of Eye Ointment:*

a. Wash your hands. Apply gloves.

b. Have recipient sit down and ask them to tilt head back and look upward.

c. Pull down the lower lid with your ring finger of your least dominant hand to form a pocket. This will prevent unnecessary pulling on delicate tissue. Within this pocket, squeeze a small ribbon (1/4-1/2") of ointment from the inner canthus (close to the nose) and move outward with a twist and pull movement to lay down the ointment.

d. Take care not to touch eye or eyelid with tip of the tube.

e. With eye closed, gently massage eye with a tissue to distribute over the eyeball.

f. Use a clean tissue to remove excess ointment. Wash your hands.

g. If applying two different kinds of ointments, wait at least 10 minutes between ointments.

h. If drops and ointment are ordered, instill drops first, wait 5 minutes and then administer ointment.

i. Document eye ointment administration immediately after application.

j. Inventory of eye ointment can be difficult and is discussed under inventory.
OF NOTE:
If a person is especially resistant to having ointment placed in the eye, wash the closed eye with Baby Shampoo, rinse and let dry. Apply the ointment to the base of the lashes of the upper lid of the closed eye, and ask the person to open the eyelid allowing the ointment to reach the eye.

2. Ear Medication Instillation

Ear drops may be used to treat infection, to relieve pressure and congestion, or to soften ear wax.

*Instillation of Ear Drops:*

a. Wash your hands.

b. Read label as you remove medication from the locked storage container

c. Check label on medication against the med card. Review any special instructions.

d. Drops are most comfortable when warmed to body temperature. This prevents dizziness and nausea. The best way to warm ear drops is to warm the bottle in the palm of the hand, let the medication sit out to room temperature or place in a glass of warm water. If the medication is a suspension (cloudy), shake the bottle well.

e. The recipient should lie down on their side with the ear to be treated facing up.
f. For an infant or child, gently pull up and out from center of outer ear. For an adult, gently pull top of the ear up and back. This will straighten the ear canal and insure the drops will have their maximum effect.

![Child](Image)

![Adult](Image)

Child  

Adult

g. Draw up medication in the dropper and slowly place prescribed number of drops into the ear canal from one inch away. Do not touch the dropper to any surface.

h. Keep the recipient in the same position at least two minutes to allow drops to enter ear completely. You may *loosely* tuck a small piece of cotton ball in the ear.

i. If drops are ordered for the other ear, wait five to ten minutes before turning to the opposite side and then repeat procedure.

j. Wash your hands. Wipe tip of dropper off with a clean tissue.

k. Document administration of the medication immediately after it has been administered.

l. Inventory of ear drops can be difficult and is discussed under inventory.
3. **Nasal Medication Instillation**

Nasal medications are instilled by means of drops or spray. Drops are more often used for infants and young children. Nasal medications may be used for persons with allergies to relieve nasal congestion by shrinking swollen membranes.

*Instillation of Nose Drops:*

a. Wash your hands. Apply gloves.

b. Read label as you remove medication from the locked storage container.

c. Check label on medication against the med card. If the prescription label is on the box, keep the drops in the box. Review any special instructions.

d. Ask recipient to blow nose and then sit down with the head tipped back.

e. Draw med up into the dropper. Tilt recipient’s head slightly towards you and close the other nostril.

f. Ask recipient to breathe in and out of the mouth. Aim dropper upwards towards the eye as you instill the prescribed number of drops (usually 2-3) into each nostril. Take care not to touch the sides of the nose with the dropper to prevent contamination of the dropper.

g. Ask recipient to keep head tilted back for a few minutes after instillation of the drops. Do not sniff or medication will go down the back of the throat.

h. Document administration of the medication immediately after it has been administered.

i. Inventory of nose drops can be difficult and is discussed under inventory.
**Instillation of Nasal Spray:**

a. Wash your hands.

b. Read label as you remove medication from the locked storage container.

c. Check label on medication against the med card. If the prescription label is on the box, keep the spray in the box. Review any special instructions.

d. Shake bottle gently and remove the cover. It is necessary to prime the pump into the air the first time it is used, or when the spray hasn’t been used in a week or more. To prime the pump, press downward on the shoulders of the spray bottle. Press down and release several times into the air until a fine spray appears.

e. Ask recipient to blow nose and then sit down with the head tilted slightly forward.

f. Close one nostril. Keep bottle upright as you insert nasal applicator into the other nostril.

g. Ask recipient to breathe in through the nose and while breathing in, press down firmly and quickly once on the applicator’s shoulder. Ask recipient to breathe out through the mouth. After spray, lean head backwards for a few seconds. Do not sniff or medication will go down the back of the throat.

h. If ordered, spray the nostril again then repeat procedure with the other nostril. Avoid blowing nose for 15 minutes after using spray.

i. Wipe applicator with a clean tissue and replace cover. Wash your hands.

j. Document administration of the medication immediately after it has been administered.

k. Inventory of nasal spray can be difficult and is discussed under inventory.
D. **Administration of Medication by Inhalation**

Administration of medications by inhalation includes inhalers, nebulizer, and oxygen therapy.

1. **Use of Metered Dose Inhaler**

   Metered dose inhalers (MDIs) are used to treat asthma or other lung diseases. The inhaler delivers medication directly to the lungs, where it can be absorbed quickly and completely at the site where it is needed. MDIs are designed to deliver an exact amount, or metered dose, to the lungs each time they are used. A metered dose inhaler can be used alone or it may be attached to a spacer device before inhaling. Incorrect administration means the medication is wasted and the person may not benefit from the medication.

   a. Wash your hands.

   b. Read label as you remove medication from the locked storage container.

   c. Check label on inhaler against the med card. If the prescription label is on the box, keep the inhaler in the box. Review any special instructions.

   d. Shake the inhaler well. Remove the cap from the mouthpiece. Make sure the metal canister is fully inserted into the actuator (colored plastic inhaler).

   e. Instruct recipient to breathe out fully through the mouth, expelling as much air from the lungs as possible. Place the mouthpiece fully into the mouth, holding the inhaler in an upright position and closing the lips around it.

   f. While the recipient is breathing in deeply and slowly through the mouth, fully depress the top of the metal canister with your index finger.

   g. Instruct recipient to hold his/her breath for 10 seconds and then exhale slowly.

   h. Wait one minute to repeat if more than one puff is ordered.

   i. Document administration of the medication immediately after it has been administered.
j. Inventory of metered dose inhaler can be difficult and is discussed under inventory.

**OF NOTE:**

If the inhaler contains a cortisone medication, the mouth should be rinsed out with water, without swallowing, after inhaling the dose. This will prevent thrush, a yeast infection of the mouth that is common with inhaled cortisone.

2. **Spacing Devices Used with Inhaler**

A spacing device attached to the inhaler can be helpful for children and persons having trouble coordinating the pressing of the inhaler with the breathing-in motion. A spacer is actually a holding chamber that is attached to the inhaler. When the inhaler is pushed, the medication first goes into the spacer, and then inhaled into the mouth. The spacer helps to direct the medication past the tongue and back of the throat directly to the trachea and down into the lungs.

3. **Use of Diskus**

Another way to deliver asthma medication is with a diskus.

a. Wash your hands.

b. Read label as you remove medication from the locked storage container.

c. Check label on diskus against the med card. If the prescription label is on the box, keep the diskus in the box. Review any special instructions.

d. Hold the diskus in one hand and put the thumb of your other hand on the thumb grip. Push your thumb away from you as far as it will go, until the mouthpiece appears and snaps into position.

e. Hold the diskus in a level position. Slide the lever away from you as far as it will go, until it clicks. The diskus is now ready for use. Every time the lever is pushed back, a dose is ready to be inhaled. This is shown by a decrease in numbers on the dose counter.
f. Tell the recipient to breathe out fully through the mouth. Never breathe out into the diskus.

g. Put the mouthpiece to the lips. Instruct the recipient to breathe in quickly and deeply through the diskus, not through the nose.

h. Remove the diskus from the mouth and ask person to hold their breath for 10 seconds. Breathe out slowly.

i. Document the administration of the medication immediately after it has been administered.

j. Inventory the number on the dose counter.

The mouth should be rinsed out with water, without swallowing, after inhaling the dose. This will prevent thrush, a yeast infection of the mouth that is common with inhaled cortisone.

4. **Use of a HandiHaler**

A way to deliver Spiriva, a medication for COPD (chronic obstructive pulmonary disease), is with a HandiHaler.

a. Wash your hands and apply gloves.

b. Read label as you remove medication from the locked storage container.

c. Check label against the medication card. If the prescription label is on the box, keep the Handihaler in the box. Review any special instructions.

d. Open dust cap by pulling upwards. Then open the mouthpiece.

e. Immediately before use, remove a Spiriva capsule from the blister and place it in the chamber. Use a gloved hand if you need to touch the capsule.
f. Close mouthpiece firmly until you hear a click, leaving the dust cap open.

g. Hold the HandiHaler with the mouthpiece upwards and press the green button completely in once, and release. This makes holes in the capsule and allows the medication to be released when breathed in.

h. Ask the person to breathe out completely. Important: Avoid breathing in mouthpiece at any time.

i. Raise the HandiHaler to the person’s mouth and have them close lips tightly around the mouthpiece. Have person keep their head in upright position and have them breathe in slowly and deeply but at a rate sufficient to hear the capsule vibrate. Ask the person to breathe until their lungs are full and then hold breathe as long as comfortable and at the same time take the HandiHaler out of the mouth.

j. Open the mouthpiece again. Tip out the used capsule and dispose in the trash. Close the mouthpiece and dust cap for storage.

k. Document the administration of the medication immediately after it has been administered.

l. Inventory the number of Spiriva capsules remaining.

5. Use of a PulmoMate Nebulizer

A nebulizer may be used to relieve bronchial spasms, reduce swelling in the bronchial tract and help thin mucous and secretions. The nebulizer directs air under pressure through a solution of drug, producing a mist for inhalation. Nebulizers produce a continuous mist, so the person doesn’t have to coordinate breathing with the action of the nebulizer. Proper usage of the nebulizer is necessary so that the drug can reach the airways.

a. Wash your hands.

b. Read label as you remove medication from the locked storage container
c. Check label on medication against the med card. If the prescription label is on the box, keep the medication in the box. Review any special instructions.

d. Place PulmoMate on a level surface. A towel placed under the nebulizer will prevent it from “walking off” the counter. With switch off, plug into outlet.

e. Connect one end of tubing to the air-outlet connector.

f. Unscrew cap on nebulizer chamber and add prescribed medication through a dropper or a premeasured dose container (prefill). Place the cap on the chamber and turn clockwise until snug.

g. Assemble mouthpiece and insert into the top of the nebulizer cap. If using an aerosol mask, insert the bottom part of the mask directly into the top of the nebulizer cap.

h. Attach tubing to air-inlet connector at bottom of the nebulizer chamber. Turn switch on to start the compressor. Check to see if there is adequate misting.

i. Place mouthpiece in the mouth and instruct person to breathe in and out of mouth normally. The person may take a deeper breath every so often. If using an aerosol mask, place mask over nose and mouth. The treatment may last 10-20 minutes until no mist can be seen. At this time, turn the machine off, tap the reservoir and continue the treatment but note that a small amount of medication may remain.

j. Encourage person to cough and spit out mucous and secretions.

k. Document administration of medication immediately after it has been administered.

l. Inventory according to RVS policy.

m. To clean, disassemble mouthpiece from cap, open chamber and remove baffle. Wash all items except tubing, in hot water/mild fragrance-free dish detergent and allow to air dry. The tubing does not have to be washed because only filtered air passes through it. The reusable nebulizer is dishwasher safe and may be reused for up to one year.
n. The filter should be changed every 6 months or sooner if filter turns completely gray. Remove filter cap by grasping it firmly and pulling out the unit. Remove the dirty filter and discard. Replace with a new filter and push filter cap back into position.

E. OXYGEN ADMINISTRATION

All the cells of the body need oxygen. Too little oxygen makes a person feel short of breath or his/her skin may take on a bluish color (cyanosis), especially the tip of the nose, ear, lips, fingers or toes. This lack of oxygen can damage tissues especially those in the brain. A person who requires oxygen may be suffering from a respiratory, blood, or heart disease. Because of this, oxygen is considered a medication. The vendor who supplies the oxygen tank or oxygen concentrator will assist in the set up of the unit and instruct on filling any needed portable tanks. Some tanks will make a “clicking” sound when a person breathes in. This is normal and means the tank is delivering oxygen only when the person is taking a breath therefore oxygen is not being wasted into the air.

1. Oxygen Tank
   a. Wash your hands.
   b. Check oxygen order on medical contact form. Oxygen is a prescribed drug. Never adjust or change the flow without a physician’s order. Recheck flow rate.
   c. Place oxygen cylinder or portable tank in upright position. Check indicator to determine amount of oxygen in tank.
   d. Slowly turn hand knob on cylinder clockwise to crank tank open for a brief second to clear opening of tank, then close.
   e. Humidification may be used to improve comfort for the person. If ordered, fill humidifier with sterile distilled water and attach to flow meter.
1. **Nasal Cannula**
   a. Adjust flow of oxygen as ordered by the physician. The flow is usually set at 6 liters per minute or less.
   
b. Place tips of cannulae in person’s nostrils with the tips pointing toward the face. Hook cannula tubing behind person’s ears and under the chin. Slide the adjuster upwards under the chin to secure the tubing. Check for pressure around the ear as it can cause skin breakdown. If needed, pad the tubing or adjust elastic around the head to take the pressure off and improve the comfort.
   
c. Oxygen administration is not documented on the medication card but person may have specific charting for when and how long oxygen was used.

2. **Mask**
   a. Turn on oxygen flow to liters prescribed. The flow is usually set at 5-10 liters per minute.
   
b. Place person in upright or semi-upright position.
   
c. Place mask over recipient’s nose, mouth, and chin. Mold flexible metal edge to the bridge of the nose.
   
d. Adjust elastic band around the head to hold the mask firmly but comfortably over cheeks, chin, and bridge of nose. Check that there are no areas of pressure that could cause skin breakdown and adjust accordingly.
   
e. Oxygen administration is not documented on the medication card but person may have specific charting for when and how long oxygen was used.
   
f. Turn off when not in use.
2. **Oxygen Concentrator**

An oxygen concentrator is an electrically operated device that draws in room air; strains the air of other gases, then delivers concentrated oxygen.

a. Wash your hands.

b. Check oxygen order on medical contact form. Oxygen is a prescribed drug. Never increase without a physician’s order. A standby oxygen tank may be ordered in case of a power failure.

c. If recommended, fill humidifier bottle with sterile distilled water. Attach humidifier bottle.

d. Press the ON/OFF switch to ON position. An alarm may sound until the proper pressure is reached.

e. Adjust the oxygen flow rate by turning the liter control knob until the flow is at the prescribed number.

1. **Nasal Cannula**

a. Adjust flow of oxygen as ordered by the physician. The flow is usually set at 6 liters per minute or less.

b. Place tips of cannulae in person’s nostrils with the tips pointing toward the face. Hook cannula tubing behind person’s ears and under the chin. Slide the adjuster upwards under the chin to secure the tubing. Check for pressure around the ear and pad tubing for comfort as needed.

2. **Mask**

a. Turn on oxygen flow to liters prescribed. The flow is usually set at 5-10 liters per minute.

b. Place person in upright or semi-upright position.
c. Place mask over recipient’s nose, mouth, and chin. Mold flexible metal edge to the bridge of the nose.

d. Adjust elastic band around the head to hold the mask firmly but comfortably over cheeks, chin, and bridge of nose.

e. Oxygen administration is not documented on the medication card but person may have specific charting for when and how long oxygen was used.

f. Turn off when not in use. May consider leaving the concentrator on if the person prefers white noise.

**Safety with Oxygen Administration**

There is an increased risk of fire with the presence of an oxygen tank. Oxygen tanks should not be near an open fire, lamp, or radiator. Do not smoke in the same room or near the oxygen tank. Keep a fire extinguisher nearby. Keep the tank upright in a secured position so it won’t get accidentally knocked over.
Set up of Medication Book

Each individual supported to whom we administer medications has his/her own medication book. The blue medication book should have a photo of the person within the front cover. This photo helps to identify that you have the right person.

A plastic sleeve in the front of the medication book holds the “Direction and Monitoring” sheet. This sheet gives you guidance in steps to take regarding medication errors and adverse reactions.

A second plastic sheet holds a general information sheet with medical and social history. This form is initially started by the MSA or during an ISP with staff updating as necessary. Review this information annually.

Each medication book contains the following tabbed sections:

- **Med Card** – medication administration cards for the current month. Directly behind the medication administration cards are medical contact forms of each current prescription medication administered. All medication orders (new, discontinued, dose or time change, etc.) are to be highlighted. There needs to be a signed contact form for each current medication or a contact form with medications listed and signed by the physician. **Staff is to review, initial, and date all medical contact forms.** This helps keep all staff informed.

- **Med Info** – medication information sheets of each current prescription medication administered. This form contains important information regarding the medication. Medication information sheets may be obtained from the pharmacy or MSA. Once a medication is no longer being used, the medication information sheet can be removed.

- **Contact Forms** – medical contact forms are filed here. Yearly this section should be cleaned out keeping only the contact forms with current information and treatments. Contact forms that are removed after one year will be stored per agency policy.

- **Annual Exams** – medical, dental, and vision exam forms. Again, medication orders are highlighted, signed, and dated.

- **OTC** – OTC phone authorization form, non-prescription medication authorization form signed by the medical provider, nurse recommendations and the blue non-prescription medication card.
• **PRN** – yellow prescription PRN medication card, nurse recommendations and a medical contact form of each current PRN prescription medication.

• **Medical Consent** – all signed medical consent forms.

• **Misc.** – may contain charts for blood pressure, weight, blood sugars, physical therapy reports, seizure records, bowel charts, etc.

A Medication Administration Manual should be found at each location, but is not necessary in each medication book. By having all medication books set up uniformly, staff can work at different locations and easily find needed information thus reducing the incidence of medication errors. **It is each Medication Aide’s responsibility to keep the Medication Book in this correct order.**

**Physician orders**

**All prescription medications administered must have a physician’s, physician’s assistant’s (PA) or Nurse Practitioner’s (NP) order.**

Prescription medications **cannot be administered** without verbal or written physician’s/PA’s/NP’s orders. Physician’s/PA’s/NP’s orders are usually documented on a **medical contact form** or occasionally on the **physical exam report**. The person who typically takes a person to a medical appointment is the Medical Services Associate (MSA). Besides taking a person to an appointment, the MSA duties include being the liaison person between the physician and RVS staff, making sure that orders are clear and insuring that physician’s/PA’s/NP’s orders are received by the person’s residential and day services staff. There may be times when an MSA is unable to take a person to an appointment and you may be asked to do this. It is then your responsibility to see that the orders are clear and the residential and day services locations are notified of the physician’s/PA’s/NP’s orders.
The process of a medication order:

1. The physician/P.A/N.P. documents an order on a medical contact form. This order may be for a new medication, discontinuing a medication, or a change in dosage or time of day given. Although most physician orders are written on a medical contact form, on occasion a physician may write and sign orders on a prescription slip or a lab result.

2. The MSA or attending staff checks the written order for clarity and legibility. If the order can’t be read, ask immediately for a clarification. The order is then clearly written on the contact form under Region V Comments. It should be labeled, dated, and signed with person’s title.

3. The MSA or attending staff may ask physician’s office to call the prescription into the person’s pharmacy or may take the written prescription slip to the pharmacy.

4. The MSA or attending staff notifies the residence and day service program of the new order. This notification may be by phone, email, text or placing information in appropriate mail slot or log. Please check with your agency to see how this is accomplished.

5. If you receive the order verbally, repeat the information back for accuracy. Log the order into the area’s log book and highlight the order with a marker. The person receiving the order records the order in the area’s log book and highlights the order with a marker. This is to make all staff aware of the verbal order.

6. When the new medication is received, double check the written order (log book entry or medical contact form) against the prescription label. If the order received does not match the prescription label, clarify the order with the MSA, physician’s office or the pharmacy. Do not give medication until the correct information can be determined.

7. If medication is not received within 24 hours after being ordered, check with the pharmacy and/or MSA. Also if you receive a medication that you weren’t expecting, check with the pharmacy and/or MSA.
8. The MSA is responsible for getting the medical contact form to all locations within 48 hours. If you are designated to take someone to an appointment, clarify with your MSA your responsibility regarding the medical contact form and notification of changes/instructions.

9. When the medical contact form is received at the residence or day service, highlight the order in yellow. All routine staff needs to read, initial and date on the line provided on the medical contact form. As a Medication Aide, it is your responsibility to read contact forms and be aware of medication orders and changes.

10. The medical contact forms with current medication orders will be filed in the individual’s medication book under the tab Med Card, directly behind the current month’s medication card. There must be a physician’s order for every prescription medication or a contact form with medications listed and signed by the physician.

**Verbal Order**

If a physician gives you a verbal order, for example on the phone you are advised to discontinue a medication due to a reaction, repeat the order for clarification and contact your MSA or Coordinator so that a Physician contact form can be completed with that order and sent/faxed to the physician for his signature. A copy of this signed order is filed in the person’s medication book under Med Contact Forms or if appropriate, directly behind the medication administration cards.
The “Five Rights of Medication Administration” are:

- Right Medication
- Right Person
- Right Dose
- Right Time
- Right Route

The right documentation has been called the “Sixth Right of Medication Administration.”

When documenting remember:

- A medication card is a legal document. Use black or blue pen, not pencil or erasable pen.
- Do not use “white out”, erase, or try to cover up an error. Draw a single line through the error and initial.
- Don’t leave blank spaces on a medication administration card.
- Document only what is observed, not an interpretation or an opinion of what is observed.
- Sign the back of medication cards with your initials and signature and your title, CSP (Community Support Professional)
- Document administration of medication immediately after the medication is given. Do not document prior to administration. Documentation means that you’ve already done it.
Medication Administration Card

Each medication administration card has an area for basic information at the top of the card and sections to list 4 prescription medications. A section for each medication includes an area for administration, inventory and refill.

On the bottom of the back side of the medication administration card is an area to write in your initials, corresponding signature and title. Sign each card at the start of every month. Signing each card identifies your initials for documentation purposes.

Next to the signature section is a CARD NUMBER _____ of ______. This indicates how many cards are being used for a person for that month. Label cards 1, 2, 3, etc. at the first of the month. The section, of ______, will be filled out at the end of the month since medication could be added or discontinued through the month.

If a person received 11 medications, the card with the first 4 medications listed would be marked 1 of 3. The second card with the next 4 medications would be marked 2 of 3, and the final page with the last 3 medications would be marked 3 of 3.

At the end of the month, or when a medication administration card is no longer in use, mark the box, Check if Card is Completed. Check with your Coordinator for instructions on what to do with completed cards.

A. Basic Information
Basic information includes:
• Month and Year
• Person’s Name
• Allergies – this can be found on the general medical information form
• Pharmacy and its phone number – this information corresponds to the prescription label
• Primary Physician and office phone number– this is usually a general practitioner or a family practice physician

MONTH  October  YEAR 2011
NAME  Stewie Griffin
ALLERGIES  sulfu

PHARMACY  Allgreens
PHONE  477-3191

PRIMARY PHYSICIAN  Dr Bones
PHONE  464-9323

CODE:
R – Refused
A – Absent
C – See Comments
D – Discontinued
B. Administration Section of the Medication Administration Card

All of the information in the administration section is taken from the physician’s orders and the prescription label. Do not copy this information from previous medication cards.

Example of a prescription label:

<table>
<thead>
<tr>
<th>Allgreens 402-477-3191</th>
</tr>
</thead>
<tbody>
<tr>
<td>RX108831 10/3/11</td>
</tr>
<tr>
<td>Dr. Bones</td>
</tr>
<tr>
<td>GRIFFIN, STEWIE</td>
</tr>
<tr>
<td>TAKE 1 TABLET BY MOUTH EVERY DAY</td>
</tr>
<tr>
<td>SERTRALINE 50MG</td>
</tr>
<tr>
<td>DPS ZOLOFT</td>
</tr>
<tr>
<td>QTY: 28 EXP: 10/3/12</td>
</tr>
</tbody>
</table>

Example of a physician’s order:

REGION V SERVICES
MEDICAL CONTACT FORM

Date of exam: October 3, 2011

NAME: Stevie Griffin DATE OF BIRTH: 7/7/99
ALLERGIES: NS
MEDICATIONS: See Back Side
PHARMACY: Allgreens PHONE: 477-3191 FAX:
PROVIDER: Dr. Bones PROVIDER’S ADDRESS: 222 West Lane PHONE: 477-3100
MEDICAID #: 100-200-300-01 MEDICARE #:
OTHER #: N/A
REASON FOR CONTACT: Depression
DIAGNOSIS/TREATMENT/RECOMMENDATIONS/CONTRAINDICATIONS/MEDICATIONS PRESCRIBED:

SERtrALINE

Unless otherwise indicated, I authorize 12 months of refill (or 6 months of refill on controlled medications.)

IF FOLLOW-UP IS NECESSARY, indicate date needed:

(provider’s signature)

Psychotropic med change: Yes X No

Region V Comments:
SERtrALINE 50mg one daily. Recheck at 2nd month. Scheduled 11-1-11.

 Área: EPPRy N/A 10-8-11
Signature/Title Date

copies: Original to RV-MS file Provider-Day Prov. Res. Title-SC
Other RV-RC
Read by Med Aide (Initial and date)
1. **Medication and strength** – Copy the right medication from the right prescription label. Write the medication name as listed on the prescription label. If the generic name is on the prescription, write the generic name so there is no confusion as to what the medication is. Sometimes the pharmacist will list the generic name followed by the brand name, note the example above.

2. **Prescribing MD (if different)** – If the ordering physician is different from the primary physician, list the name and phone number on the line that says Prescribing MD (if different). The name and phone number will correspond to the name on the contact form and the prescription label. An example would be if a specialist ordered the medication.

3. **Schedule** – this information tells you the right dose and the right time

4. Check or write in the right route. Other routes may include inhaler, ear drops or ointment, nose drops, nasal spray, G-tube or subcutaneous injection (SQ).

5. **Prescription Number (RX#)** – This number is taken directly from the prescription label, not from a previous medication administration card.
6. **Special Instructions** include any additional instructions from the physician or pharmacist. Example: “Take on empty stomach” or “May cause sensitivity to the sun.” You may also use this area to convey administration information to other staff. Example: “Put in chocolate pudding.” Or “Watch carefully, tends to spit out.”

7. **Purpose** is the reason a medication is prescribed by the physician. This information may found on the medical contact form as the diagnosis. If you don’t have this information, contact the MSA.

8. Check if the medication is a **controlled substance**. Controlled substances are medications which are subject to abuse and/or addiction. The pharmacist may designate this by using a stamp that states it’s a controlled substance or there may be a “C” (controlled substance) or an “N” (narcotic) at the start of a prescription number (C5632 or N6877). If you are unsure if a medication is a controlled substance or not, consult the medication information sheet or consult the pharmacist. **Remember that controlled substances are stored under double lock.** See page 90 for a partial list of controlled substances.

9. **Time** – If a physician orders a medication at specific times (8 a.m. and 8 p.m.), these times must be listed under the **Time** heading. When a specific time is listed, medications must be administered within one hour, either way of that time. Any longer than this time frame is considered a medication error.
   
   If specific times are not ordered, use designated administration points. Designated administration points correspond to events in daily routines and reflect an individual’s personal schedule. Events in daily routine, such as mealtimes, insure consistent administration of medications. Again, medications must be administered within one hour, either way, to the designated administration points. Any longer than this time frame is considered a medication error. An exception is a medication that must be given 30 minutes before (ac) or after (pc) a meal. These drugs should be given as close to the specified time as possible.

   Typically a “daily”, “once a day” or “one q d” medication is given at breakfast. Occasionally a medication may be ordered as “once a day at bedtime” or “one q H S” (hour of sleep).

   **BID** (twice a day) is approximately 12 hours apart.

   **TID** (three times a day) is approximately 6 hours apart.
QID (four times a day) is approximately 4 hours apart.

If a person eats breakfast at 6:00 a.m., lunch at 11:30 a.m. and dinner at 5:30 p.m. and goes to bed (H.S – hour of sleep) at 8:30 p.m.:

A BID medication would be given at breakfast and dinner.
A TID medication would be given at breakfast, lunch and dinner.
A QID medication would be given at breakfast, lunch, dinner and H.S.

When using designated administration points, if this person wants to sleep in until 8:30 a.m. on Saturday morning and stays up until 10:30 p.m., medications can be administered to fit the person’s schedule by using the time frames of approximate hours apart.

When filling in the boxes under time, do not write in just a.m. or p.m. be more descriptive by writing in breakfast (bkfst) or supper. If a medication is given when a person comes home from a job or day services instead of at dinner, write in the time he usually arrives home.

Occasionally a medication has to be given at an unusual time that doesn’t correspond with a meal or bedtime. Setting the alarm on a cell phone or clock radio can help you remember to administer the medication.

If you realize that you forgot to administer a medication after the allowed one hour time, call the pharmacist for instructions whether to go ahead and administer or hold medication as directed. Complete an Individual Report Form.

10. The numbers across the top of this section, 1-31, correspond to the dates of the month. If a new medication is received on the 5th of the month, draw a line through the boxes below 1-4 to avoid any confusion with documenting.

11. After administering a medication, document this administration by putting your initials in the box that corresponds to the date and time given. Your full signature, initials and title must be written on the back side of each medication administration card.

12. If using a blister pack, the number printed next to the medication blister corresponds to the day’s date. On November 1, the medication marked “1” is given.
13. There may be instances when a medication is not given. For these instances, refer to the **CODE** box on the upper right hand corner of the medication administration card.

14. **R-Refused** – if a person refuses a medication, wait a little while and try again. At least three attempts should be tried before documenting. Place an **R** in the box corresponding with the date and time. In the comment section indicate the reason and complete an Individual Report Form. Contact a pharmacist for recommendations regarding what to do, potential reactions to anticipate or recommendations for adjusting the next dose. A pattern of refusal should be brought to the attention of the Coordinator and may need to be reviewed by the ISP team.

15. **A-Absent** – Place an **A** in the box that corresponds with the date and time if the person is not present for that particular dose. Indicate the reason in the comment section. Always date and initial comments made in the comment section. Possible reasons may include: at day services, visiting parents, or on vacation. In this example, a notation is made that the person receives the noon dose when at day services during the week. A daily notation is not necessary. To help remember to give the noon dose at the residence on the weekend, highlighting the Saturday, Sunday and holiday boxes may be helpful.
16. **C-See Comments** – Place a C in the box that corresponds to the date and time if it is necessary to make a notation in the Comment/Observation space. In the example, the person is ill with nausea and vomiting and the medication is withheld. An Individual Report Form will explain the missed dose. A call to the pharmacist will give you advice on how to proceed with the medication or what to expect if the medication is missed. C may be helpful for a situation that isn’t otherwise addressed in the Code box.

17. **D-Discontinued** – Place a D in the box that corresponds with the date and time if a medication is discontinued. Also cross out and highlight the rest of the month to avoid confusion. A comment that the medication is discontinued should be dated and signed. A medication destruction form is completed if any medication remains. See page 64 for information regarding proper drug destruction.
18. If a medication is discontinued and reordered at a different strength (increase to two tablets daily) or schedule (from once daily to BID), first discontinue the medication as described above, then enter as a new medication on a new section.

<table>
<thead>
<tr>
<th>MEDICATION / STRENGTH:</th>
<th>carbamazepine 200mg (carbatrol)</th>
<th>PRESCRIBING MD (if different):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule:</td>
<td>one capsule</td>
<td></td>
</tr>
<tr>
<td>Oral</td>
<td>□</td>
<td>Topical</td>
</tr>
<tr>
<td>RX #:</td>
<td>39928</td>
<td></td>
</tr>
<tr>
<td>Special Instructions:</td>
<td>do not crush or chew</td>
<td></td>
</tr>
<tr>
<td>Purpose:</td>
<td>seizure</td>
<td></td>
</tr>
<tr>
<td>□ Controlled Substance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
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<td>HB</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments/Observations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/4/11 med change NB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Refill Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RX #:</td>
</tr>
<tr>
<td>Number Received:</td>
</tr>
<tr>
<td>Verified By:</td>
</tr>
<tr>
<td>Count:</td>
</tr>
<tr>
<td># Given</td>
</tr>
<tr>
<td># Left</td>
</tr>
<tr>
<td>Initials</td>
</tr>
<tr>
<td>Med Error</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/4/11 53 capsule set up for destruction NB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATION / STRENGTH:</th>
<th>carbamazepine 300mg (carbatrol)</th>
<th>PRESCRIBING MD (if different):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule:</td>
<td>one capsule</td>
<td></td>
</tr>
<tr>
<td>Oral</td>
<td>□</td>
<td>Topical</td>
</tr>
<tr>
<td>RX #:</td>
<td>39921</td>
<td></td>
</tr>
<tr>
<td>Special Instructions:</td>
<td>do not crush or chew</td>
<td></td>
</tr>
<tr>
<td>Purpose:</td>
<td>seizure</td>
<td></td>
</tr>
<tr>
<td>□ Controlled Substance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments/Observations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/4/11 new med rec @ 4:15 NB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Refill Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RX #:</td>
</tr>
<tr>
<td>Number Received:</td>
</tr>
<tr>
<td>Verified By:</td>
</tr>
<tr>
<td>Count:</td>
</tr>
<tr>
<td># Given</td>
</tr>
<tr>
<td># Left</td>
</tr>
<tr>
<td>Initials</td>
</tr>
<tr>
<td>Med Error</td>
</tr>
</tbody>
</table>

| Comments: |
19. **Comments/Observations** – It is imperative that staff record pertinent observations regarding the effectiveness of a medication and other related information. It is important to observe a person carefully, especially the first few weeks after starting a new medication, for desired effects, adverse effects, and behavioral changes.

a. It is not necessary to record observations daily. Observations should be frequent enough to provide a picture of medication effectiveness. A comment should be made at least once a month.

b. Entries must be dated and initialed.

c. Keep notations brief. If a detailed explanation is required, use an Individual Report Form and/or a daily log format.

d. If a person is on DDAVP for bedwetting, a comment may list the number of wetting accidents that month. A comment for hypertension medication may include blood pressure readings. Comments such as “no apparent problems” or tolerating well” can be used if observed effects can’t be seen as with a vitamin or medication for osteoporosis.

C. **Inventory Section of the Medication Administration Card**

The inventory section of the medication administration card is made up of two parts. This section deals with inventory:

<table>
<thead>
<tr>
<th>Count:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Error</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This section is for refills:

Refill Received:__________________________

RX #:__________________________

Number Received:__________________________

Verified By:__________________________

*If Med Error is marked fill out an Incident Report.*

Refill bottle to be inventoried then it should remain unopened until needed.
A complete count or inventory of all countable prescription medications currently in use is required daily. Refill containers that have been inventoried and sealed shut do not require a daily count until they are opened and in use but continue to check that the packaging remains sealed.

Staff may count medications at any time of the day, but the official count that is recorded is after the last medication administration of the day. Counting at the end of the day is best, since the setting is usually quiet and one can count accurately without distraction.

1. When a medication card is initially filled out, the total number of capsules/tablets is placed in the Count box that corresponds to the date.

2. The official inventory is done after the last medication administration of the day. The staff person looks at the administration boxes directly above and counts the number of tablets/capsules given for that day. This number is written in the box # Given.

3. The staff person then physically counts the remaining tablets/capsules left in the medication bottle, cassette, or blister pack and writes this number under # Left. This number should be the same as subtracting the Count from the # Given to yield the # Left.

4. Initial in the appropriate box after count is completed and post this number in the Count box for the next day.

5. If a half tablet is administered, record as ½ or .5 under # Given. If three half tablets are administered in a day, record 1 ½ or 1.5 as the # Given. Always count the actual tablets, not doses. The inventory for 30 half tablets is 15 (actual tablets) not 30 (actual doses).
6. It is easy to count the medication stored in blister pack or a cassette by visually looking at it. Medications stored in medicine bottles must always be counted under sanitary conditions.

- If medications must be removed from the original container to count, use a clean counting tray or a clean plate and table knife.
- Clean counting tray after every use.
- Medications should never be poured into Medication Aide’s hand or counted with an ungloved hand.

7. Because liquids and cream medications are not countable, they are difficult to inventory.

- When a medication is initially received, the Count may be filled in as “1 tube” or a liquid as “4 oz.”
- # Given may be recorded as “2X” if an ointment was applied BID or “4 teaspoons” if 1 teaspoon was given QID.
- If the remainder is not countable, record the # Left as “N/A” (not applicable).
- Be aware of when the supply of liquid or cream is low, so it can be reordered prior to running out of the medication.

Any discrepancy in inventory must be followed with an Individual Report Form.

8. If a discrepancy is found in the count, it is recorded as a medication error. Place a check mark in the box Med Error on the date of the med error. Correct count by drawing a line through error with your initials, and then complete an Individual Report Form. An error in inventory might simply be a subtraction error or it could be a medication missed or even the wrong dose given. Refer to “Direction and Monitoring” sheet discussed on page 81 for guidance in this situation.
D. Refill Section of the Medication Administration Card

1. The first time a medication is ordered it is the original prescription. If the medication is continued on a regular schedule, later medications received are refills. Refills are defined as the same medication, same dose, and same time and usually but not always the same RX number.

2. If a person is to remain on a prescription, staff should call or fax the pharmacy and order a refill as the supply gets low. Some pharmacies will automatically send a new supply when refills remain on a prescription. Refill information can be found on the pharmacy label.

3. Liquid, ointments and creams are not routinely filled by the pharmacy. The pharmacy needs to be notified when supply is getting low.

4. If the pharmacy contacts you that no refills are left on a prescription that is to be continued, call the MSA immediately who will contact the physician for further refills. Routine medications are often ordered for one year; with a yearly recheck appointment to evaluate the medication’s effectiveness.

5. When a medication refill is delivered or arrives at the location, it must be inventoried immediately. Any discrepancies need to be reported to the pharmacy within 24 hours.

6. To record a refill, refer to the left side of the inventory section. This section is for refills received during the current month. Since some refill medications are delivered towards the end of the month, this area may remain blank until then. When this section is completed, a staff person can tell if the next supply of medications is at the location without looking in the locked medication cabinet.

   • **Refill Received:** Write in the date the new refill was received at the location.
• **RX#:** Fill in the prescription number (RX #) from the prescription label. This should be the same number that is listed above the Administration section. If the RX # has changed, but all the rest of the information (strength, dose, time) remains the same, highlight the RX # on the refill section.

• **Number Received:** Physically count the number of tablets/capsules received and record. On occasion, the pharmacy may send an incorrect number; for example a blister on the blister pack may be missing a tablet. After counting, the lid of a medication bottle can be taped shut with the date, count, and initials of the person who inventoried written on the tape. If using a blister pack or cassette, after counting, place in a bag and staple shut. On the bag, write the date, count, and initials of the person who inventoried. Medication containers that have been inventoried and sealed do not require a daily count but one must continue to check that the packaging remains sealed and has not been tampered with.

• **Verified By:** If you are the one who inventoried the refill, sign here.

7. When medications bottles are used, it is possible that there may be medications still remaining in them at the start of the month. Do not combine the previous and refill medications. When the refill bottle is opened, place an asterisk in the count box next to the number to signify that the refill bottle has been opened.

8. When blister packs or cassettes are used with the day’s date corresponding to the number listed by the tablet/capsule, each month starts with a new blister pack or cassette. Medications are not carried over into the next month. If medications remain in the blister pack or cassette at the end of the month, these medications are returned to the pharmacy for destruction or repackaging by the pharmacist. See page 64 regarding drug destruction.
REMEMBER:

- When filling out a new medication administration card, take the information from the prescription label and the physician’s orders, not from a previous medication administration card.
- Begin a new section for each prescription medication.
- If a medication strength, dosage or time of administration changes, this medication is considered discontinued and a new section begun.
- Document administration of medication immediately after the medication is taken or applied. **Do not document prior to administration.** Documentation means that you’ve already done it.
- Any comments made on a medication card should be dated and signed with the person’s initials.
Pill Planners

Pill planners are plastic containers that one can buy at a pharmacy or drug store. The planner is marked with the days of the week on a tab and the tab opens up to reveal a compartment for that day’s medications. Some planners are larger and have compartments for four medication administration times per day. A pill planner is set up by a Medication Aide, not a pharmacist.

Examples of when a pill planner may be used include a person on a medication self-administering program or when using pharmacy bottle with a large inventory.

As in all medication administration, correct and accurate set-up is critical. If a pill planner is set up incorrectly, the potential for multiple medication errors is great. Fill the planner at a quiet time to avoid distraction and possible errors in set-up. Once a pill planner is set up by a Medication Aide, it needs to be double checked by a second Medication aide to assure it was done correctly. If an individual’s program includes their assistance in medication administration, the supported person can be the second signer.

If using a pill planner for a person on vacation or gone for the weekend, please refer to page 66 regarding the temporary medication card.

Filling a Pill Planner

1. Wash hands. If you will be touching the medication, wear gloves.
2. Read the prescription label as you remove it from the locked storage container to assure that you have the right person, the right medication, the right dose, the right time, and the right route.
3. Check label on the medication against the med card.
4. Open the tabs on the pill planner that coincide with the correct day and time medication is to be given.
5. Place the correct number of tablets/capsules in each section.
6. Count the number of tablets/capsules remaining in the pharmacy bottle. Seal the bottle top with tape. On the tape, write the date, number of tablets/capsules remaining in the pharmacy bottle, and your initials.
sealing the pharmacy bottle, it does not have to be inventoried daily, but inventory will be done on the supply within the pill planner.

7. Count the number of tablets/capsules in the pill planner. Document this number on the inventory section of the medication administration card. Write the number of tablets/capsules remaining in the pharmacy bottle over the number of tablets/capsules in the pill planner. If from a bottle of 31 tablets/capsules you removed 7 to put in the pill planner, 24 would remain in the pharmacy bottle and the inventory under **Count**: it would read 24/7.

8. Continue to fill the pill planner with the next medication, steps 2-7. **Fill planner with only one medication at a time.**

9. Document in the comments section that pill planner is filled through the specific date or the number of medications placed in the planner.

10. A second Medication Aide/competent person is to then double check for accuracy and initial next to your documentation in the comments section.

**Documentation when Using a Pill Planner**

1. Initial the medication administration immediately after medication is given.

2. To inventory, fill in the **# Given** with the number of tablets/capsules administered that day. Count the remaining tablets/capsules in the planner and document as the **# Left**.

3. Continue for each medication administered.
Transfer of Medication

1. A transfer is defined as the movement of medication to a new location of administration.

2. Medications administered regularly at different locations (residence and day services) have separate medications and medications administration cards at each location.

3. It is the responsibility of the staff person obtaining refills to let the pharmacist know that separate containers (bottles, cassettes, blister packs) are needed.

4. If separate containers cannot be procured (such as may occur with a short term medication or eye drops), medications must be transferred from one facility to another in the original container and be in possession of a staff person at all times, do not place the medication in an individual’s lunch box or backpack. In this situation, a single medication administration card should be used and transferred with the medication.

5. Medications should never be transferred from one location to another on a daily basis as this increases the chance of missed administration or loss of medication.

Other Forms

Drug Destruction Form

Any prescription medication that has been contaminated, discontinued or needs to be disposed of for any reason must be destroyed within 30 days. The procedure to set up medications for destruction is as follows:

1. Seal medication to be disposed; label “to be destroyed” with person’s name, medication name and date. Do not use a “sticky note” to label.

   Suggestions for sealing: A blister pack may be placed in a paper sack and stapled shut. A medication bottle lid may be taped shut. An individual tablet may be sealed in an envelope.

2. Inventory medication. Make a comment in the Comment/Observation section of the inventory part of the medication administration card that the medication has been set up for destruction. If contaminated, complete an Individual Report Form and reorder replacement medication from the pharmacy if needed.
3. Complete the Drug Destruction form including:
   • Person’s name
   • The medication’s name
   • RX number
   • Total amount to be destroyed
   • Reason for destruction – contaminated, dose change, missed med
   • Date discontinued/contaminated
   • Location of medication administration
   • Name and signature of person completing the form

4. The Coordinator, MSA, or appropriate staff (as determined by each area agency) takes the sealed medication and completed Drug Destruction form to the pharmacy. In some agencies the pharmacy will pick up the sealed medication and form during their next delivery.

5. The pharmacist signs the Drug Destruction form and returns the form, often by fax. When the Drug Destruction form is returned, staple it to the appropriate medication administration card.

6. If medication to be destroyed has been crushed and put in applesauce, yogurt, etc., put in the trash, observed by two persons and document destruction on an Individual Report Form signed by both people. If two persons are not available, lock it in the medication cabinet until the destruction can be observed by two persons.

7. If your local pharmacy does not offer drug destruction services, medications to be destroyed and attached drug destruction forms should be taken to the agency. The agency’s healthcare coordinator and another
Medication Aide will be responsible for the destruction, typically in coffee grounds, and the documentation of the destruction.

**Temporary Medication Card**

When an individual must take medications with him/her during temporary absences, the following procedures should be followed:

1. **Staff may fill a pill planner, zip lock bag or a medication envelope with the designated amount of medication.** A pill planner must be marked with the individual’s name and the name of the medication. If using a zip lock bag, use a marker to label the bag with the person’s name, medication’s name, and directions for when the medication is to be taken. A medication envelope is marked with the person’s name, medication’s name and directions for when the medication is to be taken. If three different medications are to be taken at breakfast on Saturday, the three tablets could be placed in one envelope as long as all medications and their directions are identified on the envelope.

2. **In the box that corresponds with the date(s) and time(s), mark A for absent.** In the comment section, note the days to be gone. The number removed to be sent with the person is subtracted from the inventory (# Given). This will be done with each medication prepared to be sent.
3. Complete a temporary medication card. The temporary medication card has space for 4 different medications. Use as many cards as necessary.

   a. Complete the top section with requested information. If using a container with several medications within it, under Special Instructions, describe the tablet (blue, triangular shaped, small white). This will help the person who is giving the medication know what is what.

   b. Fill in Medication/Dosage, RX#, Schedule, and Number Sent for each medication. Under the Time box, write in the time or designated administration point.

4. Review the temporary medication card with the person/family member who will be administering the medication. Ask that they write their initials in the corresponding date and time box after medication administration. Highlighting the dates may be helpful. If a person goes home frequently, you may continue to use the same temporary medication card throughout the month. The number of pills sent each week can be noted within parenthesis for each week. Start a new temporary medication card for the next month.

5. When an individual returns, write in number of medications returned, if needed. Any medications returned will be set up for destruction. An Individual Report Form would also detail medications that were not given during the absence. If a person returns home early and medications are still sealed, you may administer those sealed medications. For example a person comes home Saturday night instead of Sunday morning; the sealed bedtime and breakfast medications may be given.
6. If the individual will be gone with a staff person/Medication Aide, the Medication Aide may take the original container (blistер pack, cassette, medication bottle) and the medication administration card with them. The Medication Aide is responsible for keeping the medication safe in a locked container.

**Individual Report Form**

1. All medication errors are documented by an Individual Report Form.

2. A check mark in the Med Error box of the medication administration card indicates a reference to an Individual Report Form.

3. The med error may be a discrepancy in the inventory, not documenting administration or an incorrect administration of medication (wrong time, wrong dose, wrong person, wrong drug, wrong route, or a missed dose).

4. When completing an Individual Report Form use objective language such as “this recorder,” “s/he stated,” “it was observed.”

5. Be brief but descriptive. If a medication is missed, list the name of the medication and scheduled time of the medication.

6. To complete an Individual Report Form:
   
   a. **Individual Involved**: Print the name of the person involved in the incident. If more than one person being supported is involved, complete a separate form for each individual relating the incident to the specific action and outcome as it pertains to each individual.

   b. **Date of Event**: This is the date of the incident, **not** the date of the report.

   c. **Time of Event**: Time of the incident (use a.m. and p.m.).

   d. **Location**: This is the location at which the incident occurred (address of residence, day services).
e. **Description of Event:** Write an objective, accurate, and factual account of the event that took place. Include what was going on that brought about the event, what happened that defined an event (who, what, when and where). This should be as descriptive, yet concise and comprehensive as possible.

Show professionalism by using proper grammar, accurate spelling, and legible handwriting. When the content involves others, use the staff/provider name and title such as John Doe, CSP. Use the first name and the initial of the last name for other people supported (Sally P.).

Describe what you or others did to intervene, how the event was resolved, anything you did to follow up or gain more information and if the action taken was effective.

f. **Persons Notified:** If any medical personnel, supervisors, family, Service Coordinators, etc. were notified, print their names here. Indicate time and date. Should this be a high or medium level report, your supervisor will assist determining who to contact.

g. **Supervisor Comments:** Do not complete this section, your supervisor will complete this and indicate distribution.

h. **Notification to External Agencies:** Do not complete this section. It is to be completed by your supervisor.

i. **Signature of Person Making Report:** Sign (and print) your name and the date you are actually writing the report. Please try to complete the report as soon after the incident as possible.

j. **Signature of Other Reviewers/Witnesses:** If a second staff person is involved, they may sign (and print) name and date of report here.

k. **Signature of Supervisor:** Do not write here. Your supervisor will sign.

l. **Signature of Area Director:** Do not write here. Your Area Director will sign.

m. **Indicate Distribution:** To be completed by the Coordinator and/or Area Director.

n. **Additional Space is Provide on the Back Side:** Continue description, results or comments.
o. **Diagram:** Mark and clarify the location of the injury, if applicable.

Give the report in to your supervisor.

The responsibility of the supervisor once he/she receives the Individual Report Form includes:

1. Reviewing the Individual Report Form with persons involved.
2. Determining how he/she can assist in insuring that this type of error does not happen again.
3. Reporting of medication errors to agency’s LHCP.

**Self-Administration**

The mission of Region V Services is to provide desired training and supports that promote interdependence and relations within community and lessen reliance on agency services. Medication administration is a great area in which to get persons involved in their own care. The goal is not necessarily for a person to become self-administering but for that person to be as involved in their own care as they are capable. Being aware of what a medication is for or what the color of one’s pill is very valuable information. Many a medication error has been thwarted by an individual saying this is not the medication they usually take.

**A. State of Nebraska Definition**

A person must:

1. Be at least 19 years old of age
2. Have cognitive capacity to make informed decision about taking medication
3. Be physically able to take or apply a dose of medication
4. Have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for non-prescribed medication
5. Have capability and capacity to observe and take appropriate action regarding any desired effects, interactions, and contraindications associated with a dose of medication.

B. Determination of Self–Administration

A Self-Administration Assessment guide (see page 91) is a tool the team considers in determining if a person can be considered self-administering. Specific supports for an individual, e.g. person receive a reminder call every day at 5 pm; need to be documented at the person’s ISP (Individual Support Plan) meeting. It is important to realize that persons and situations change which may make it necessary to reassess one’s ability to self-administer.

C. Learning to Self-Administer

1. For persons who are learning to administer their own medications, staff monitoring must continue until it is clear that the person can independently administer his/her own medication.

2. For any person who is learning to self-medicate:
   
a. **A medication administration card** must be maintained.

b. Medications must be kept **locked** as described in “Medication Storage,” unless addressed by the ISP team.

c. **ISP team approved supports** must be in place, which include procedures and safeguards concerning any deviation from the medication administration procedures.

d. Self-administration of medications means that the individual knows **which** medication to take, **when** to take it, **how much** to take, and requires **no staff assistance** in decision making.

e. When an individual completes a medication self-administration training program, **follow-up** monitoring must be done. During the first six months of independent self-administration, follow-up must be regularly scheduled.

f. Once a person is truly self-administering that is no assistance needed, a medication book is not necessary.
PRN Medications

1. PRN medications are those given not routinely, but “as needed.” For example, a cough syrup is given if needed for a bad cough; a pain medication is given as needed for pain.

2. Administration of PRN medications is considered an “Additional Activity” by the Medication Administration Act. To provide a PRN medication there must be specific criteria under which a PRN medication may be given and reporting requirements associated with each PRN medication. Contact Region V Services Health Care Coordinator prior to administration if a nursing recommendation is not written.

3. The procedure for administering a PRN medication, whether prescribed or over-the-counter, is the same as with any other medication.

4. Documentation of over-the-counter (OTC) medication is completed using the non-prescription medication card (blue). See page 76.

5. Documentation of prescription PRN medication will be made on a prescription PRN medication card (yellow).

6. With PRN medications, the administration schedule or dosage may vary “as needed” according to the physician’s directions. Contact Region V Services Health Care Coordinator for clarification.

7. Before giving a PRN medication, check to see when it was last given. Be certain there has been enough time between each dose of medication.

8. The use of PRN medications is discouraged in Region V settings. If at all possible, a regular schedule of administration should be set by the physician.

9. **The use of PRN medication for behavioral control is prohibited.**

10. Prescription PRN medications **must** be inventoried daily. Prescription PRN medications may be controlled substances. Due to the potential of abuse of a controlled substance, once weekly, PRN medications that are controlled substances must be inventoried by two staff to confirm a correct inventory. If two staff are not present, a system needs to be worked out in which one staff inventories and initials the card at the end of
their shift and the second staff inventories and initials the card at the beginning of their shift. It is important that none of this medication is administered between the times of inventorying.

11. Since a PRN medication may be used infrequently, be sure to check the medications expiration date prior to administration. If no expiration date is listed, consider it expired one year after it is dispensed.

12. If an individual is receiving Hospice services, all directives regarding prescription PRN medication will be addressed with the Hospice nurses.

Completion of Prescription PRN Medication Card

1. The Prescription PRN card applies to only one medication. Each additional prescription PRN medication will require a separate card.

2. Fill in the month and year. A PRN prescription card will last for one month.

3. Fill in the name of the recipient, his/her physician, office phone number, pharmacy and pharmacy phone number.

4. From the prescription label, complete the medication name, strength and RX number.

5. From the prescription label, write in the physician’s order as stated by the physician under the **Prescribed for:** write in why it is being used e.g. severe headache, abdominal pain, seizure.
6. Check to see if there is a written nursing recommendation; if so place a check under **See Nursing Recommendations**. The nursing recommendation, found behind the prescription PRN card, will give you a clear indication of when to give it, how much to give, if it can be repeated and what to do if you don’t get the desired effect.

7. If no nursing recommendation is written, call the RVS nurse for directions prior to administering the medication.

8. **Special instructions** include any additional information specific to that particular medication or recipient.

9. Place a check mark if the medication is a controlled substance. The pharmacy may indicate if a medication is a controlled substance by stamping this information or may list a “C” or an “N” at the beginning of the RX number.

10. **Initial #** is the number of tablets/capsules/ounces in inventory. All other tablets/capsules/ounces received during the month will be listed under **Refill Info**.

11. When refill medications are received, complete **RX#**, the **Date received**, **#Received** and initials of the Medication Aide who inventoried the refill medication.

12. **Daily inventory is required on all prescription PRN medications.** Staff may count medications at any time of the day, but the official count that is recorded is after the last administration of the day.

13. The **Count** box is the total number in inventory that corresponds to the date. The **# Given** is the number of tablets/capsules/ounces given that day. The staff then physically counts the remaining tablet/capsules left in inventory and completes **# Left**. If a liquid, check calibrations on the side of the bottle for **# Left**. If the level is not even with the calibration marks on the bottle, mark and date the level with a sharpie marker.

14. **If the medication is a controlled substance, besides a daily inventory once a week two Medication Aides must inventory the medication.** Preferably the double inventory is done at the same time. If this is not possible, two Medication Aides need to inventory within the same day. Two initial boxes are listed for the initials of the persons doing the inventory.
15. After proper medication administration, document the following information:
   a. Date and time (a.m. or p.m.) medication was given.
   b. Number given.
   c. Reason given.
   d. Under Comments and Effectiveness of Medication, note if Health Care Coordinator was notified. Note pertinent observations. Were results achieved? Was pain decreased? Nausea diminished? Diarrheas stopped? If staff noting an observation is not the same staff who administered the medication, they should sign their initials after their comment.

16. If more spaces are needed to document administration of this PRN medication, make an additional copy of the back page of the Prescription PRN medication card.

17. The medical contact form with the prescription PRN medication highlighted is filed directly behind the nursing recommendation or if none present, behind the Prescription PRN card.

18. Check with your Coordinator on what to do with the completed Prescription PRN card.

**Over-the-Counter Medication (OTC)**

**Non-Prescription Medication Authorization/Nursing recommendations**

An individual may not receive a PRN non-prescription /over-the counter (OTC) medication unless it has been approved by a physician/PA/NP. The **Non-Prescription Medication Authorization** is the form that will list all OTC medications that are approved as safe for a person. This form is completed at the time of an annual physical. This form can be found under the OTC tab in the medication administration book. This form is updated by the physician/PA/NP yearly.

If an individual receives a PRN non-prescription/OTC medication on a fairly frequent basis, the Region V Services Health Care Coordinator can write nursing recommendations which give specific indications and directions that will give the Medication Aide approval to administer the medication. These specific indications and directions include clear description of when medication may be given, a specific dosage of medication to be given, and instructions of what to do if medication is ineffective (i.e. repeat administration after a specific time period, contact Region V Services Health Care Coordinator or call physician). When written nursing recommendations are received, highlight the name of the medication on the Non-Prescription Medication Authorization.
If you are concerned that an individual might need an OTC medication, (complaining of a headache, slight cough, itchy rash) check the Non-Prescription Medication Authorization for approved OTC medication. Check to see if a nursing recommendation has been written that would allow you to administer an OTC medication. If no recommendation is written, contact Region V Services Health Care Coordinator/medical provider or if appropriate, the caretaker for approval prior to giving the medication.

**Prescribed Over-the-Counter Medications**

A physician/PA/NP may prescribe an OTC medication at a specified dosage and administration schedule. For example, one baby aspirin daily for heart health. In this situation, the pharmacy will dispense the baby aspirin with a prescription label and you will document and inventory the baby aspirin on a medication administration card as you would any prescribed medication.

**Recommended Daily Over-the-Counter Medication**

A physician/PA/NP may recommend an over-the-counter medication to be given on a regular basis but advises you to pick up an OTC supply. An example may be to take one multi-vitamin daily. To ensure daily administration, document the administration on a medication administration card. In the space for Rx number, write in OTC. An inventory **is not** required because it is not a prescribed but a recommended medication.

**Non-prescription Medication Card**

1. Each person, for whom we administer medications, should have a separate **non-prescription medication card**. This blue colored card is used to record administration of the occasional over-the-counter medications a person may take.

2. If a physician states that a person can’t have any OTC medications, write across the form in large letters **NONE**.

3. To complete the basic information on the **non-prescription card**:
   a. List the year. The **non-prescription card** is replaced yearly with a new card.
   b. List the individual by first and last name, including a nickname in parentheses, if used.
   c. List any of the individual’s allergies.
   d. List the individual’s primary physician.

4. Written on the **non-prescription card** is a reminder that you must have an okay from the agency nurse or the medical provider. If a person’s caretaker has signed that they are responsible for direction and
monitoring of medications, contact them for the okay. This signed caretaker form is found under the medication administration book tab, releases. The Non-Prescription Medication Authorization that the physician completes advises what over-the-counter medications are safe for the individual; it is **not** an okay to administer the medication.

5. **Recording administration of OTC medications:**
   
a. **Date:** month-date-year.
   
b. **Time:** include a.m. or p.m.
   
c. **Reason:** document why the medication was administered.
   
d. **OK’d by:** write the name of the person you received authorization from. This may be the medical provider, the agency nurse (either phone call or followed written nursing recommendations) or if appropriate, the caretaker. If initials are used, on the bottom of the back page write initials and the person’s name, e.g. JP = Jill Peterson.
   
e. **Medication/Strength:** e.g. acetaminophen 325 mg.
   
f. **Dose:** e.g. 2 tablets.
   
g. **Given by:** initials of the Medication Aide that administered the medication. Note on the back side of the card sign your initials, signature and title, CSP (Community Support Professional).
   
h. **Comment on the effectiveness/ineffectiveness of the medication.** If staff making the comment is not the one who administered the medication, they need to sign comment with their initials.
OTC Phone Authorization

The OTC phone authorization is placed in the front of the OTC section of the medication administration book. It is used to record any phone authorizations given by the agency nurse or medical provider. It is a way to communicate to staff that the nurse/medical provider/caretaker has been contacted and their recommendation. In the following example, staff notified the agency nurse that the individual had a scrape on their foot. The nurse advised staff to cleanse the foot well and then apply Neosporin twice a day for the next 3 days but if the scrape becomes warm/red/or person complains of increased pain to call the nurse back. By using this form, staff for the next 3 days know the nurse has been notified and what to do if the situation worsens. Day services and residential staff need to share this information via phone call/log book or copy of the authorization. Use several lines if needed when documenting.

Other Information

- Since an OTC may not be used frequently, be sure to check the medication’s expiration date prior to each administration.

- Every 6 months staff should review all OTC packages for expired medications.

- If OTC medication has expired, it must be discarded. To properly dispose of expired OTC medications, two staff persons must witness the medication being destroyed. Acceptable means of destroying medications include: putting in used coffee grounds, placing in trash and then dousing with water to melt tablets, placing in trash the day of trash pick up. On the non-prescription medication card and an Individual Report Form, the disposal must be documented and signed by both staff.

- When both sides of the non-prescription card are completely filled, check with your Coordinator on what to do with completed cards. Replace with a new non-prescription card yearly even if it is not completely filled.
• Remember there must be a non-prescription card for each person to whom we administer medications, even if the person is restricted from all OTC medications.

Medication Administration Task Analysis

1. Do not set up medications in advance. Do not multitask while administering medications. Your attention needs to be focused on correct and accurate medication administration. **Do not attempt to administer medications to more than one person at a time.**

2. Wash your hands. Gloves may be worn if appropriate for the situation.

3. Read the prescription label as you remove the medication from the properly locked storage container.

4. Make sure you have the right medication. Compare the prescription label with the medication card or the physician’s contact form. Double check that this information agrees. If they do not agree, contact the physician’s office and/or the pharmacy. If they do agree, continue with the next step.

5. Review any special instructions listed on the medication card.

6. Carefully measure or count the correct dosage and compare the amount with the pharmacy label. Double check to see that you have the right dose.

7. Check and double check that you have the right time. If there has been a change of staff near administration time, check medication card to see if the medication has already been given to avoid double dosing.

9. Check and double check that you have the right route.

10. Provide the medication to the individual. Make sure you have the right person. Observe the person taking the medication. Do not leave the medication unattended at the table or with the person for them to take later.

11. Your careful observation of the Five Rights of Medication Administration is of the utmost importance to the safety of the persons you support.
12. After administration of the medication, immediately document (right documentation) that the medication has been given on the medication administration card.

13. Count medication according to policy.


**Medication Errors**

Medication administration errors may include:

1. Giving the wrong medication to a person.
2. Giving a medication to the wrong person.
3. Administering at the wrong time (greater than one hour before or after the scheduled time).
4. Administering the wrong dose.
5. Administering a medication by the wrong route.
6. Forgetting to administer a medication.
7. Administer a medication without a physician’s order.
8. Administer a PRN medication without appropriate approval.
9. Incorrect documentation – discrepancy in count or inventory, not documenting administration of a medication and documenting a medication was given when it was not.
10. Not following appropriate procedure for destroying medications.

All medication books include a “Direction and Monitoring” sheet that contains the following information to give you guidance in what steps to take if you make or discover a medication error.
Direction and Monitoring

As a Medication Aide you are permitted to participate in the observation, monitoring and reporting of desired effects, side effects and interactions of medications with direction and monitoring provided by a licensed health care professional.

As the licensed health care professional taking this responsibility, these are steps I ask you to follow given these circumstances.

If you observe a physical symptom (i.e. rash, headache, nausea, etc.) or a behavior that is out of the usual context for the person (i.e. aggressive behavior, confusion, extreme fatigue, etc.):

1. Contact 911 immediately if reaction causes a dangerous situation – difficulty breathing or loss of consciousness.
2. Check medication information sheet to see if reaction may be related to the medication.
3. Notify MSA and/or Coordinator the day of the observation – if reaction is severe, contact these persons after contacting 911.
4. MSA/Coordinator may contact or ask you to notify the physician.
5. Follow physician’s recommendations.
6. Document observation in the comment/observation section of the medication administration card.

If a medication error is made including wrong person, wrong medication, wrong dosage, or wrong route:

1. Contact physician or pharmacist immediately concerning:
   a. Any medical action to be taken.
   b. Possible effects and significant symptoms that may occur.
   c. Recommendations for adjusting the next scheduled medication dosage.
2. Contact emergency medical assistance immediately if error poses a dangerous situation – e.g. difficulty breathing or unconsciousness.

3. Contact your agency’s Health Care Coordinator immediately, after above has been notified.

4. Contact Coordinator immediately, after above has been notified.

5. Complete an Individual Report Form the day of the error and the Coordinator will send a copy to your agency’s Health Care Coordinator and Nurse Consultant within 2 working days.

If a medication error is made due to a missed dose or wrong administration time, (greater than one hour before or after scheduled administration):

1. Contact pharmacist for recommendations regarding the next administration time and potential side effects to anticipate. If you are unable to contact a pharmacist after hours, your agency will designate who to call. This may be the emergency room at your local hospital or physician on-call.

2. Document error on Comment/Observation section of medication card.

3. Contact Coordinator within 24 hours of error.

4. Copies of the Individual Report Form related to documentation/inventory (missed does, wrong time) errors will be routed to your agency Health Care Coordinator.

5. By the 15th of the next month, the Nurse Coordinator will be sent a summary listing of these errors, the corresponding Individual Report Form and the person responsible, if this is known.

If a medication error is due to incorrect documentation – discrepancy in inventory or not documenting medication administration:

1. Count existing inventory to determine whether the medication has been given but not documented or was inventoried incorrectly.

2. If it appears the medication was given correctly, complete an Individual Report Form and correct inventory count.
3. If it appears the medication was given correctly but administration of medication was not charted, circle the space not documented and complete an Individual Report Form. Person who administered the medication should initial the circled area.

4. Copies of the Individual Report Form related to documentation/inventory errors will be routed to your agency Health Care Coordinator.

5. By the 15th of the next month, the Nurse Coordinator will be sent a summary listing of these errors, the corresponding Individual Report Form and the person responsible, if this is known.

The physician’s orders must be followed exactly. The right medication must be given to the right person, in the right dose, by the right route, and at the right time.

**MEDICATION ERROR CORRECTIVE PROCEDURE**

The following medication error corrective procedure is to be followed when medication errors are made by Medication Aides. These guidelines set a minimum standard. Further action will depend on the specific error, intent, and the impact on the person served. **If a person uses deliberate deception and tries to hide or cover up an error, it will result in immediate termination.**

This procedure is in place for a year from when the first error is made. Errors are removed from the record one year after its occurrence.

Error made is a missed dose, wrong time, documentation or inventory error:

**Step 1.** After one error of this nature, the supervisor will counsel the Medication Aide with a Clarification of Expectations.

**Step 2.** After three errors of this nature, the Medication Aide will receive a written warning from his supervisor.

**Step 3.** Another error made once a person has already received a written warning will result in the Medication Aide having to retake the Medication Administration class. Until this is completed, the staff will not be allowed to administer medications. This may affect their current work schedule.
Step 4. Another error made after written warning and retaking of the Medication Administration class will result in the termination of medication administration responsibilities and the removal of the Medication Aide from the State Medication Aide Registry. Staff who are not able to administer medications must work in a situation where they do not administer medications under any circumstances. This situation may affect their ability to remain working with Region V Services.

Error made is **wrong person, wrong medication, wrong dose, or wrong route:**

Step 1. After one error of this nature, the Medication Aide will receive a written warning from his/her supervisor.

Step 2. Another error of any nature will result in the Medication Aide having to retake the Medication Administration class. Until this is completed, the staff will not be allowed to administer medications. This may affect their current work schedule.

Step 3. Another error of any nature made after a written warning and retaking of the Medication Administration class, will result in the termination of medication administration responsibilities and the removal of the Medication Aide from the State Medication Aide Registry. Staff who are not able to administer medications must work in a situation where they do not administer medication under any circumstances. This situation may affect their ability to remain working with Region V Services.

The intent of this procedure is to insure safe, accurate medication administration to persons served. We expect persons will learn from their errors, not continue to make them again and again. Often times a person who repeatedly makes medication errors is also making errors in other aspects of their job.

It will be at the discretion of the Nurse Consultant, agency’s Health Care Coordinator, agency’s Director and Director of Organizational Supports if the Medication Aide may retake the Medication Administration class more than two times for corrective action.

If Region V Services removes a Medication Aide from the State Medication Aide Registry, we will not participate in reapplication as a Medication Aide.
Side Effects

Generally speaking, medications have two effects: therapeutic effects and side effects. If you take an aspirin for a headache, the therapeutic or intended effect is relief from the pain of the headache. The side effect or unintended effect might be an upset stomach from the aspirin.

Along with its intended results, a drug may cause a number of unwanted side effects. These effects can happen when you start a new medication, decrease or increase the dose of a medication, or when you stop using a medication.

Side effects can be unpleasant or potentially harmful. Since most medications are taken orally, gastrointestinal symptoms—loss of appetite, nausea, bloating, constipation and diarrhea—account for a high percentage of reactions. Gastrointestinal disturbances, headache, fatigue, vague muscle aches, malaise (general feeling of illness or discomfort) and a change in sleep patterns are usually considered mild reactions. However, these symptoms may not seem mild to the person experiencing them.

Moderate reactions include the above symptoms when they become increasingly distressful or intolerable. Added to this list are reactions such as skin rash, visual disturbances, muscle tremors, difficulty in urinating (especially in elderly men) and changes in mood or mental functioning.

Mild and moderate reactions do not necessarily mean a medication will be discontinued. Sometimes the physician may adjust the dosage, frequency of administration, timing of doses, or order the use of other agents to relieve distress. An example would be recommending a stool softener if the medication causes constipation.

Although relatively rare, some medications cause severe reactions that may be life-threatening. Examples include reactions that could cause a bleeding disorder or damage to the liver or kidneys.

Because of your close interactions with persons supported, you may be the first one to recognize changes in a person’s condition. Be especially alert whenever an individual starts a new medication. This is particularly critical when an individual has difficulty communicating. Signs that a person may be having problems with medication include:

- Sleepiness or drowsiness at unusual times
- Change in appetite, thirst or sleep patterns
- Increase or unexpected decrease in usual challenging behaviors. These may include aggression, self-injury, yelling, crying or repetitive behaviors.
- Unusual behaviors for the person. A change in his or her mood.
• Rashes, hives, signs of a “cold”, discomfort or illness

It is important to have a general idea of drug actions and possible side effects. The medication information sheets received from the pharmacy are your best resource for this information. For each prescription medication a person takes there needs to be a medication sheet filed in the medication book. You can contact the pharmacy for medication information sheets. Another source to access medication information sheets is the web site Medline Plus (www.nlm.nih.gov/medlineplus/druginformation.html).

**Allergic Reactions**

Some persons develop allergic reactions to a specific drug. An allergic reaction is actually a response of the immune system to a foreign chemical in the body, in this case the medication. A person can develop an allergy to a medication at anytime. This means even if a person has taken a medicine before, he/she can still develop an allergic reaction to it. Mild to moderate allergic reactions may include skin rashes or eruptions, itching, fever, wheezing and swelling of the eyes, hands, and feet.

A life threatening allergic reaction called **anaphylaxis** or **anaphylactic shock** causes difficulty in breathing, low blood pressure, and cyanosis (blue cast to the skin caused by lack of oxygen). Other symptoms may include: severe hives (raised itchy rash), swelling of the tongue and throat, abdominal pain, and diarrhea. This is a medical emergency and 911 must be called. A person may have an Epi-pen that is ordered to be administered immediately upon experiencing symptoms. This will help the individual keep an open airway until emergency personnel arrive. Administration of an Epi-pen is an additional activity and you will receive training by your agency’s healthcare coordinator if you work with this individual. Persons with known severe allergic reactions should wear a Medic Alert bracelet.

**Tardive Dyskinesia**

Tardive dyskinesia is a drug-induced disorder of the nervous system with involuntary bizarre movements of the eyelids, jaw, lips, tongue, neck, and fingers. This syndrome of side effects is usually associated with long-term use (usually 1-2 years or more) of antipsychotic medication. The drugs most associated with tardive dyskinesia include Mellaril, Thorazine, Navane, Haldol, and Prolixin. These are old generation medications and many have been replaced with medications causing less severe side effects. Reglan (metoclopramide) which is used to treat heartburn related to gastric reflux may also have this serious side effect, usually from long term usage.

Once it starts, the pattern of uncontrollable chewing, lip puckering and repetitive tongue protruding (fly-catching movement) may be irreversible.
Again because of your close interaction with the individual, you may be the first person to note unusual changes in a person’s condition and your quick reaction is of utmost importance.

**Staff Responsibilities Related to Adverse Reactions**

1. All staff who administer medications must be familiar with the potential adverse reactions of the medications they are administering and know where this information can be found.

2. A medication information sheet for each medication administered must be kept in the medication book under tab: med info sheets.

3. If potential adverse reactions are observed:
   a. Contact 911 immediately if reaction causes a dangerous situation – difficulty breathing or loss of consciousness.
   b. Check medication information sheet to see if reaction may be related to the medication.
   c. Notify MSA and/or Coordinator the day of the observation – if reaction is severe, contact these persons after contacting 911.
   d. MSA/Coordinator may contact or ask you to notify the physician.
   e. Follow physician’s recommendations.
   f. Document observation in the comment/observation section of the medication administration card.
   g. Complete an Individual Report Form.

4. Once the physician discontinues the medication, these uncomfortable symptoms usually start to subside. Over-the-counter medications may be offered if approved by the physician. Obtain appropriate authorization to administer.
Comfort measures that may be helpful include:

a. Rash – Applying cool, wet towels to rashy areas helps to reduce itching and warmth. An OTC antihistamine may reduce itching.

b. Nausea – Offer small sips of clear liquids. Allow rest and keep away from food odors. An OTC antacid may help to relieve the nausea.

c. Diarrhea – Offer clear liquids for 12-24 hours to slow movement of the bowel. Once diarrhea starts to subside, offer the BRATT diet (B = bananas, R = rice, A = applesauce, T = toast and T = tea). This diet helps to replace lost nutrients, give the stool form, and relieves cramping. An OTC anti-diarrhea med may slow the bowel and reduce cramping.

d. Constipation – Increase fluids and offer fruit juices. Offer high fiber foods – dried fruits, whole grain cereals and bread, fresh fruits and vegetables. An OTC laxative may relieve constipation.

e. Headache, fatigue, malaise – Allow to rest. Offer OTC analgesic (Tylenol, Advil, aspirin).

Key points to remember
The following is a summary of key you must remember in order to provide medications safely and accurately.

- You must have a physician/physician’s assistant/nurse practitioner’s order to give any medication.

- If you do not understand an order or have questions, check it out.

- Check for written nursing recommendations or call RVS nurse for authorization prior to administering any PRN OTC or PRN prescription medication.

- Wash hands prior to medication administration and between persons as needed.

- Do not give medications if the label is illegible.

- Do not touch medications with bare hands.

- Pour liquids at eye level. Also place the hand over the label while pouring to protect the label.
• Be respectful; don’t get in a person’s face.

• If you do not know the individual check their picture in the med book for correct identification.

• Do not leave medications with a person supported to take at a later time.

• Do not give a medication if the person says it doesn’t look like one that they usually take; check it out.

• Do not give medications past their expiration date.

• Watch for changes in medications such as color or consistency.

• Always lock the medication cabinet when leaving the area.

• Do not crush or chew sustained release, enteric coated, buccal, or sublingual medications.

• Document after administration of medication: documentation means you’ve already done it.

• If you make a documentation error, cross out with a single line and initial.

• Check when a PRN medication was last given before administering.

• Report and record refused and missed medications according to RVS policy.

• Report errors and complete Individual Report Forms according to RVS policy.

• If you administer the wrong medication to the wrong individual, contact physician or pharmacist first for medical guidance.

• Report and record possible reactions to medications.

• Report missing controlled substances to your Coordinator immediately.

• Always practice the “Five Rights of Medication Administration.”
CONTROLLED SUBSTANCES LISTING

Controlled substances are those medications which have a potential for abuse and/or physical or psychologic dependence. Controlled substances are classified as Schedule II (with the highest abuse potential) to Schedule V (with low abuse potential). Schedule I are substances considered illegal for medical use (heroin/LSD). Below is a partial listing by Schedule, generic name is followed by the brand name. Region V’s policy is that all controlled substances should be stored under double lock.

Schedule II
Adderall
Codeine Sulfate
Fentanyl - Duragesic Patch
Hydromorphone - Dilaudid
Methylphenidate - Ritalin/Concerta
Meperidine - Demerol
Morphine - MS Contin/Roxanol
Oxycodone - Oxycontin
Oxycodone with acetaminophen - Percocet/Tylox/Roxicet

Schedule III
Acetaminophen/Codeine - Tylenol #3/Tylenol #4
Butalbital - Fioricet
Guaifenesin/Hydrocodone - Codiclear DH
Syrup/Robitussin AC/Guituss AC Syrup
Guaifenesin/Hydrocodone/Phenylephrine - Donatussin
DC Syrup
Guaifenesin/Hydrocodone/Pseudoephedrine –Nucofed Expectorant/ Novahistine Expectorant
Hydrocodone - Vicodan/Lortab/Lorcet
Hydrocodone/Ibuprofen –Vicoprofen

Schedule IV
Alprazolam – Xanax
Butorphanol - Stadol
Chloral Hydrate
Clonazepam - Klonopin
Clorazepate - Tranxene
Chlordiazepoxide - Librium
Diazepam – Valium
Estazolam - Prosom
Flurazepam - Dalmane
Lorazepam - Ativan
Meprobamate - Equagesic
Oxazepam - Serax
Pentazocine with acetaminophen - Talacen
Phenobarbital - Luminal
Temazepam - Restoril
Triazolam - Halciom
Zaleplon - Sonata
Zolpidem - Ambien

Schedule V
Acetaminophen/Codeine elixir
Lomotil
Promethazine/Codeine Syrup
REGION V SERVICES
SELF-ADMINISTRATION OF MEDICATION ASSESSMENT

NAME: 
DATE: 

RATING SCALE:
1. Completes Independently
2. Completes with Verbal Prompts/Supervision
3. Completes with Physical Prompts
4. Does Not Do

RATE EACH OF THE FOLLOWING STATEMENTS:

1. _____ Takes own medication when placed in his/her hand.
2. _____ Requests own medication at the correct time.
3. _____ Is able to explain why he/she takes each medication.
4. _____ Can visually or verbally identify own medications.
5. _____ Is able to explain side effects of each medication.
6. _____ Is able to take own medications for one day at a time.
7. _____ Is able to take own medications for five days at a time.
8. _____ Is able to identify when to re-order own medications.
9. _____ Can identify pharmacy label, RX number, name and telephone number of the pharmacy.
10. _____ Is able to identify over the counter medications.
11. _____ Is able to explain uses of over the counter medications.

USE ABOVE RATING SCALE TO COMPLETE THE STATEMENTS BELOW:

1. _____ Identifies correct medication and purpose by name.
2. _____ Identifies correct medication and purpose by shape.
3. _____ Identifies correct medication and purpose by size.
4. _____ Identifies correct medication and purpose by color.
5. _____ Specifies medications taken regularly.
6. _____ Specifies medications taken PRN.
7. _____ Specifies the correct route each medication is taken.
8. _____ Administers daily medications correctly.
9. _____ Demonstrates storage and handling procedures.
10. _____ Can identify side effects of medications.
11. _____ Inventories and records medications if necessary.

Evaluator Signature     Date
Evaluator (Print)