Medication Administration

GET STARTED

THE CLAIBORNE

INTERNAL USE ONLY

TABLE OF CONTENTS

1 Foundations of Medication Administration

> 6 Rights of Medication Administration
> Medication Room Standards
> Medication Cart Standards
> Limitations of Medication Administration

2 Preparing & Handling Medications

> Preparing Medications
> Special Handling – Narcotics Procedures
> Special Handling – Additional Procedures
+ Refrigerated Medication
+ Hazardous Medications
+ Syringes or Injectables
+ Altering Medications
+ Dropped or Spilled Medications

3 Medication Inventory: Orders & Re-Orders

> Routine & Non-Routine Re-Order Process
> Community Managed Medication
> Receiving & Transcribing New Orders
> Pharmacy Process

4 Medication Delivery

> Medication Delivery

5 Administration & Monitoring

> Distribution Methods

6 Medication Assistance Procedures

> Routine Medications
+ Dial-Up Insulin (Insulin Pen)
+ Sliding Scale Insulin
+ Types of Insulin
+ Inhalants: Nebulizer
+ Inhalants: Inhaler
+ Topical Medications or Lotions
+ Transdermal Patches
+ Eye Drops
+ Ear Drops
+ Nose Spray
+ Rectal/Vaginal Suppository

> Observing Medication Effects
> Medication Adverse Events
> Drug Identifier (Guide)

7 Issues & Incident Management

> Medication Refusals (Notification of RP and Documentation)
> Medication Errors
> Emergency Transit Responsibility
> Medication-Related Incident Reporting
> Resident Out of House

8 Documentation

> Documentation & Reporting (OPS 101 & 102)
+ EHR Incident Reporting
+ EHR Alert Charting
+ Incident Reports & Progress Notes: Do's
+ Incident Reports & Progress Notes: Dont's

9 CSL Acronym Library

10 Commonly Used Medical Terminology & Abbreviations

Foundations of Medication Administration

6 Rights of Medication Administration

Right Resident	Ensure the medication is being given to the **right** Resident
Right Route	Administer the medication through the **right** method (e.g., oral, topical, inhaled)
Right Medication	Verify that the medication being given is the **right** one (prescribed).
Right Dose	Ensure the **right** amount of medication is administered
Right Time	Give the medication at the **right** (scheduled) time according to the doctor's orders
Right Documentation	Record the medication administration **right** (accurately) in the Resident's record

Medication Room Standards

Medication Room Standards – Secured Storage	1. All medications (including over-the-counter) should be stored in locked cabinets or medication carts, accessible only to authorized staff. 2. Controlled substances/Narcotics should be stored in separate, double-locked cabinets per regulatory requirements; OR, in a locked cabinet with the medication room door locked at all times. 3. A designated medication refrigerator should be used for cold medication storage (ex: insulin, eye drops).
Medication Room Standards – Organization	1. Resident-specific storage bins, drawers, or sections should be clearly labeled with each resident's name and unit number. 2. Separate medications by type such as oral, topical, inhaled and injectables to avoid cross-contamination. 3. First-In/First-Out (FIFO) system should be used to organize medications by their expiration date to prevent outdated meds from being used.

Medication Room Standards

Medication Room Standards	**The medication room should appear neat and organized at all times. Signage or papers should not be taped or tacked onto the walls. Informative documents should be added to a designated bulletin or magnetic board.** **P-touch or handwritten, sticky labels should not be used for cabinets or drawers.** 1. All medication should be clearly labeled and stored per manufacturers' protocols, including emergency items such as resident-specific EpiPens. 2. Surfaces should be wiped down and de-cluttered daily to maintain cleanliness and organization. 3. Maintain the designated handwashing and PPE station with easy access to gloves and masks. 4. Empty sharps containers should be clearly labeled in an area where they can be easily taken to a resident's unit when replacing a full container. 5. Guidelines on storage, documentation and handling procedures should be posted in an inconspicuous area for staff to view. 6. Extra supplies of essentials such as gloves, disposable distribution cups, masks, etc. should be stocked and inventoried daily.
Medication Room Standards – Privacy	**Protected Health Information (PHI) should never be posted on the walls of the med room or stored in a manner that information could be easily viewed by undesignated CSL representatives.**
No Personal Items	Personal items such as phones, snacks, purses, or clothing should not kept in the med room.

Medication Cart Standards

Medication Cart Standards – Resident-Specific Medications	1. Bins and drawers should be organized using lettered file-guides so the Med-Cards can be found easily. 2. Routine medications should be kept in the front and PRN medications in a separate designated section. 3. Store liquid medications upright in a secured section to prevent spills.
Medication Cart Standards – Supplies	1. Stock single-use, disposable med cups on top or side of the cart. 2. Syringes for injections should be kept in a designated, locked drawer of the med cart. 3. Alteration devices (such as a pill splitter or crusher) can be kept on top of the cart in AL. ***In a Tempus neighborhood, these devices should be kept in a locked drawer.*** 4. A box of gloves should be kept on the cart for infection control.
Medication Cart Standards – Controlled Substances/Narcotics	1. Controlled Substances/Narcotics should be kept in a separate, locked drawer at all times. 2. Unlock the drawer only when retrieving the controlled substance and lock back immediately. **3. Be especially sure to lock the med-cart when stepping away from the cart.**
Medication Cart Standards – Topical & Non-Oral Medications	1. Ointments, creams, eye drops, and patches should be stored separately from oral meds to prevent cross-contaminations. 2. All medications and resident medication supportive devices (i.e., nebulizers, glucometers, inhalers, etc.) should be properly labeled with resident's name.

Medication Cart Standards

Medication Cart Standards	1. All medications and devices should be clearly labeled and stored per manufacturer's protocols. 2. Resident-specific emergency devices (such as EpiPens, glucometers, etc.) should not be shared between residents. 3. Blood pressure cuff, stethoscope, and a touchless thermometer (Vitals Kit) should be kept in the cart for monitoring vitals when necessary (for administration of certain medications). 4. Alcohol-based hand sanitizers and alcohol wipes should be kept in the cart for infection control and cleaning of certain surfaces. ***In a Tempus neighborhood, these items should not be accessible to residents.**** 5. First-In/First-Out (FIFO) system should be used to rotate stock of older and newer medications to prevent waste. 6. Keep the med cart clean by wiping it down after each med-pass route. 7. To promote resident privacy, the med-cart laptop should always be closed when you are away from the cart or performing a resident med-pass.
Medication Cart Standards – Shift Standards	**At the end of or during each shift, the team member responsible for med-admin should review medications on the cart as well as in the Med Room.** 1. If there is less than a 10-day supply on hand, refill/reorder requests should be made. 2. Remove any expired or discontinued meds and check that everything is in its appropriate place.
No Personal Items	**Personal items such as phones, snacks, purses, or clothing should not be on the med cart.**

Medication Cart Standards

CONTROLLED SUBSTANCES

Top of the med cart should be clean. Acceptable items on top include:

- laptop
- pill crusher
- water pitcher
- water & med cups

Top of the med cart should NOT have any personal items such as:

- drinks
- food
- phones

MENU

Limitations of Medication Administration

Scope of Practice	1. Medication Administration should be limited to the scope of practice outlined by your respective state's regulations. If you have questions about your regulations, consult your licensing authority and/or DOW.
Documentation & Recordkeeping	1. Adjusting medication orders or altering the eMAR is not a permitted practice by a MedTech (CMA/CMT). 2. Proper documentation in the eMAR is critical; only document the medication YOU administered personally.
Delegation & Supervision	1. MedTech (CMA/CMT) personnel may not delegate medication-related tasks to other uncertified personnel, even if the medication is "over-the-counter."
eMAR Late Entry	**During Medication Administration it's extremely important to be consistent with documenting med-passes on the eMAR. In the event of an urgent deviation from your work that causes you to miss an entry on the eMAR, notify the DOW.**

Preparing & Handling Medications

Preparing Medications

Administration: The direct application or introduction of a drug/medication (topically or internally) to the body of the Resident by qualified staff.

Prepare Medications	1. **Follow the 6 Rights of Medication Administration (Right Resident, Right Route, Right Medication, Right Dose, Right Time, Right Documentation).** 2. Check the medication orders against the residents' charts. 3. Prepare doses according to prescribed instructions. 4. Make sure resident is sitting up and prepared. 5. Pass the medication(s) to the resident and observe swallowing (offer water). 6. **Do not leave medication(s) sitting on side tables, counters or other surfaces. You must observe the resident consuming the dose.**
NOTE:	Claiborne Senior Living practice prohibits "pre-popping" prior to administration of medications. Medications should be removed from their original packaging at the time of intended administration to ensure accuracy, resident safety, and compliance with regulatory standards. **Do not bulk "pre-pop" medications to prepare for routine med-pass.**

Special Handling – Narcotics Procedures

Controlled Substances/Narcotics Documentation – Narcotic Inventory Sheet ***Important* Narcotic Inventory Sheets are "Resident-Specific"**	1. Use the **Narcotic Inventory Sheet (located in the Narc Book on the cart)** that corresponds to the medication container. 2. Verify the medication belongs to the appropriate resident. 3. On the next blank line of the form, sign with name, date, and time (never leave a blank line on the form). 4. Count the number of pills or measure the liquid before distribution and enter the result in the "Amount on Hand" column. 5. Write the number or measurement to be given at the designated time in the "Amount Given" column. 6. Subtract the number given from the "Amount on Hand" and write that into the "Amount Remaining" column. 7. Count the pills or measure the liquid to confirm it is the same as the "Amount on Hand" you just entered.

Special Handling – Narcotics Procedures

Narcotics Counts	At shift change, narcotics count should be verified by the oncoming and previous shifts 1. Verify with an actual count of the medications. 2. Both outgoing and oncoming shift MedTechs or LPNs should sign the **Narcotic Inventory Sheet.** 3. If the oncoming shift does not have a MedTech or LPN, the outgoing shift can have another staff member witness the count; then lock the medications and secure the keys in the designated location.
Narcotics Counts – Discrepancies	If a narcotic discrepancy happens during shift change or any time during medication administration, follow these steps: 1. Re-check the count; look for simple math errors. 2. Check the previous entry on the log. 3. **Both team members participating in the med count must remain on site.** 4. Notify the DOW per our Incident Reporting Guidelines (OPS-101) and follow their instructions. 5. The DOW will complete an incident report by counting the narcotics together with the two team members. 6. If the discrepancy reason is not determined, the DOW will conduct further investigation.
Narcotics Storage	All narcotics must be stored under 2 locks. Lock #1: Med-Cart key; Lock #2: Med-Cart narcotic drawer key. If a resident is self-administering: Lock #1: Locking Medication Box; Lock #2: Door to resident's apartment (must stay locked).

Special Handling – Additional Procedures

Refrigerated Medication	1. Store only in the designated medication refrigerator in the medication room. 2. Store each medication in a Ziplock bag or plastic container labeled with the resident's name, unit number, and date the medication was opened. 3. Check the refrigerator for appropriate temperatures (usually 37° to 42°) when placing a new medication inside. 4. Record temperature on the **Medication Refrigerator Log Form** once daily.
Hazardous Medications (Chemotherapy, methotrexate, estrogen patches, etc.)	1. Hazardous medications sometimes require the use of PPE (gloves, goggles, gowns, etc.), check the manufacturer's protocols. 2. Handle medications in a well-ventilated, designated area. 3. Administer using a disposable cup and do not alter medications (crush, split, etc.). 4. Dispose of PPE, packaging, and cups into the hazardous waste container, never in the regular trash. 5. Wash hands thoroughly after removing PPE. 6. ALWAYS follow OSHA protocols for **Standard Precautions.** **If you're missing supplies or unsure about hazardous procedures, promptly contact your DOW for guidance.**
Syringes or Injectables	1. Always wear appropriate PPE when assisting with syringes or injectables. 2. Check for a SHARPS container prior to administering any injectable medication. 3. NEVER attempt to re-cap a syringe or needle. 4. Dispose of the syringe directly into the SHARPS container.

Special Handling – Additional Procedures

Altering Medications (for easier ingestion)	Medication alteration must be approved by the primary care physician and come with specific orders. 1. Tablets may be crushed and placed in foods such as applesauce if the resident has difficulty swallowing – only with a physician's order. 2. Scored tablets may be cut in half prior to administration. 3. Obtaining the medication in liquid form if available. **Reminder: Just because there is an alteration order, medications cannot be hidden in food products unless specifically listed on the order(s).**
Dropped or Spilled Medications	If a pill or liquid medication is dropped onto the floor or another contaminated surface, the proper procedure is to waste the substance. To waste routine pills: 1. Place the pill(s) into the nearest sharps container. 2. Follow instructions for documenting a Missed Medication. 3. Notify the DOW and report the wasted amount to the pharmacy for assistance in refilling. To waste liquids: 4. Clean up the liquid using approved cleaning solution from the med cart. 5. Follow instructions for documenting a Missed Medication. 6. Notify the DOW and report the wasted amount to the pharmacy for assistance in refilling. **If the medication is a narcotic or controlled substance, have a co-worker witness the steps you take to waste the medication; then complete the Narcotic Inventory Log.**

Medication Inventory: Orders & Re-Orders

Medication Inventory: Orders & Re-Orders

Routine Re-Order Process	1. The pharmacy will set up “cycle-fill” orders that will auto-generate monthly. 2. Weekly, before delivery, review current Medication/Treatment Records received from the pharmacy to verify or update. 3. If updates are necessary and/or new medications are received it is **VERY IMPORTANT** to carefully compare information on the new records with the old **Medication/Treatment Records** for accuracy including: • Changes in directions and/or medications. • Verifying resident’s name, med name, date, route of administration, frequency, reason, times of administration, strength, and measurements (# of pills/amount of liquids). • Verify that any change orders are carried over to the new Medication/Treatment Record. 4. If updates to “cycle-fill” orders are necessary, send the verified information to the pharmacy using their preferred delivery method (fax, email, phone-in, etc.).
Non-Routine Re-Order Process	Non-routine medications (ex: PRN, ointments, etc.) must be ordered by the Community as they are not on a re-fill cycle. To maintain inventory of non-routine meds, follow these steps: 1.Check non-routine medication supplies weekly, on the same day. 2.If any non-routine medication has less than a ten day’s supply, place a reorder . 3.Pull the tab from the label and place it on a sheet of paper (for each med to be ordered). 4.Once all tabs are collected, fax a copy of the label sheet to the pharmacy. 5.On the cover sheet be sure to include: Community Name, Your name, and “**Reorder Request.”**

Medication Inventory: Orders & Re-Orders

Community-Managed Medication	All community-managed medication (including OTC meds) must have a physician's order on file including new, changed, or discontinued orders. When a physician's order is received, the eMAR will be updated to reflect.

Receiving & Transcribing New Orders

All Community-Managed medication (including OTC medications) must have a physician's order on file including new, changed, or discontinued orders. Follow the procedures below for receiving and transcribing new orders for our residents.

Preferred Pharmacy- Fax Order *if Pharmacy does not input*	*If the Residents are being serviced by the preferred Pharmacy* Fax the order to the pharmacy using your Community's designated **Fax Cover Sheet**. Initial and note on the order, the date and time it was faxed. **(If pharmacy uses eMAR system, designee will need to confirm accuracy of order)**
Non-Preferred Pharmacy Order Received - Transcribe	Transcribe/Enter the order into the eMAR. NOTE: If any part of the order is not legible, incomplete, or seems inappropriate, contact the physician for clarification before transcribing.
Documentation	Document the new order in the resident's **Progress Notes** and **SCL.** Ensure signed physician order is scanned and uploaded to resident chart within August Health, regardless of pharmacy used. If pharmacy entered and a copy of the signed order was not received, call the pharmacy to request.
DOW Follow Up	When the medication is received, the DOW will check the eMAR, verify against the order, and check the delivered medication for accuracy.

MENU

Pharmacy Process

Preferred Pharmacy	If a resident chooses to use the pharmacy that is contracted with our Community, the resident or their responsible party will sign our “Pharmacy Provider Agreement.” This agreement gives the Preferred Pharmacy authorization to review the resident’s medication regimen (initially and as needed) to provide and deliver the medications needed for the resident during routine deliveries. The resident and their responsible party pays the pharmacy directly.
Outside Pharmacy	Residents are permitted to use the pharmacy of their choice. If resident is under our medication management services, we are obligated to ensure their medications are available at the time of administration regardless of who is supplying it. If the medications are not available (for example, the family does not bring the medications in on time), the MedTech/LPN should acquire the medication from the preferred pharmacy to ensure administration per physician order.

Pharmacy Process

Outside Pharmacy	Using Claiborne Senior Living's Community Pharmacy has an array of benefits for our residents! It ensures timely medication deliveries, accurate refills, and quick processing of STAT orders keeping our residents' care seamless and hassle-free. It simplifies coordination with our team, reducing errors and delays. Residents using outside pharmacies (such as VA or family-member deliveries) incur a $300/month fee to cover the additional administrative and logistical needs to facilitate their medication requirements.
Re-Packing	If a resident brings medications in that are not packaged using a bubble-card, Claiborne Senior Living reserves the right to send their medications to the preferred pharmacy to have them re-packaged for a fee to the resident.
Medication Receipt Form	From time to time, residents will have outside medications that come to the Community. These may be new move-ins, or from visits to an urgent care or clinic for non-routine needs (ex: flu) such as antibiotics that may be filled on the way back to the Community. In these instances, our MedTechs and LPNs can receive the medications using our Medication Receipt Form. This form is used to identify, count, and confirm medications from outside entities. The form is then signed by both the Community's team member and the resident.

Medication Delivery

Medication Delivery

Pharmacy Deliveries	When the pharmacy delivers medications to our Community, our MedTechs and LPNs can be available as designated receivers.The following steps should be followed to ensure accurate delivery and inventory. 1. Medications should be presented for delivery in a locked, secure, sealed, tote along with a 2-part delivery manifest. The Claiborne team member will unlock the tote, remove the manifest, and verify that all medications listed on the slip are in the delivery. 2. The designated receiver (MedTech or LPN) and the delivery personnel both sign the pharmacy log indicating the tote has been received and meds are accurate. 3. If there are any discrepancies, they are noted on the manifest and signed by Claiborne and the delivery personnel (ex: missing medication, incorrect medication sent, label or dosing errors, etc.), then faxed back to the pharmacy. 4. Designated receivers should call the pharmacy and request STAT delivery of any missing or incorrect medications. 5. Manifests should be provided to the DOW and maintained for 30 days.
Controlled Substances/ Narcotics Delivered	If the pharmacy delivery includes a controlled substance/narcotic, our team must put them into rotation by generating a new inventory sheet. 1. Fill out the demographics on a new **Narcotic Inventory Log (CLN-603).** 2. Complete a Narc Count with a witness and record the count on the log. 3. Secure the medication in the designated, locked area (use FIFO if med is a refill). 4. Update the shift-change log to reflect the new count.

Administration & Monitoring

Distribution Methods

MEDICATION DISTRIBUTION	
Distribution Times	1. Prescribed medications should be given within **1 hour** of the scheduled time (before or after), except medications that must be taken with meal: • Meds ordered taken **before meals** are given at least **1 hour** before a meal. • Meds ordered taken **after meals** are given within at least **2 hours** after a meal. • Meds ordered to be given **with food** may be administered with a light snack (cookies, crackers, pudding) or with meals – **but should not be given in the main dining room.** 2. Medications in which timing is critical (injectables, inhalers, etc.) will be given priority when scheduled by the DOW and administered per the orders/prescriptions at the designed times. 3. Distribution times that are not interval or timing-specified are determined at the community by the Director of Wellness.

Distribution Methods

MEDICATION DISTRIBUTION	
Distribution Methods Staff-Assisted Administration	1. Resident meds should be packaged using a time pass, bubble pack med card; utilizing a card of meds for each time slot a resident needs to receive a medication. 2. At the appropriate time, staff will pull the med card, release the appropriate scheduled dose, and administer it to the resident in their apartment. **Following CSL standards and regulatory guidelines, medication administration in the dining room should be avoided to ensure compliance with safety protocols.**
Distribution Methods Self-Administration by Resident	If residents are self-administering their medications, they must store their medication in their rooms, in a securely locked storage area to ensure safety and compliance. Claiborne staff members do not assist residents with medication administration who are designated for “Self-Administration” by the Director of Wellness.

Medication Assistance Procedures

Medication Assistance Procedures

Routine Medications	1. **Follow the 6 Rights of Medication Administration (Right Resident, Right Route, Right Medication, Right Dose, Right Time, Right Documentation)** 2. Best Practice: Punch the pill for the corresponding date (ex: Jan-15th, punch bubble #15) / Pour the liquid into a calibrated medication cup (do not use a spoon). 3. Observe the resident taking the meds, then chart the med-assistance.
IMPORTANT	**At no time during a medication assistance procedure should medications be placed on the counter or handed to a resident for them to self-administer later after you have left the area. Claiborne Senior Living med-administration process requires our team members to watch our residents taking/using their appropriate medications.**

Routine Medications- Dial-Up Insulin (Insulin Pen)

1. Pull the cap off the needle end of the pen (there should not be a needle here at this time).
2. Wipe the rubber seal with an alcohol pad.
3. Pull the tab off the new needle cartridge and place the needle into the end of the insulin pen.
4. Turn clockwise until the needle clicks and is tight.
5. Prime the pen by making sure an arrow is present in the indicator window; if the diamond is present, turn the knob at the end of the pen until the arrow appears.
6. Pull the dose knob out until a 0 (zero) is present; then turn the dose knob clockwise until the appropriate number is present in the window.
7. Push the injection button and hold until you hear a click (approx. 5 seconds) – insulin should be observed in the needle now.
8. Assist resident according to specific instructions written by the DOW.
9. To dispense the insulin, the injection button must be held down until a click is felt .
10. Dispose of the syringe directly into the resident's sharps container.

*If resident does not have a Sharp's container, or container is ¾ full – notify the DOW.

Sliding Scale Insulin	Sliding Scale Insulin refers to a method of dosing insulin based on a resident's blood sugar level at the time of the administration. The dose is determined by a pre-set scale provided by the resident's PCP, which outlines specific insulin amounts for different blood sugar ranges. To assist with sliding scale insulin, follow the interpretations listed on the specific resident's eMAR. 1. Check the resident's blood sugar level using their glucometer. 2. Refer to the sliding scale provided on the resident's eMAR. 3. Use the resident's Dial-Up Insulin pen to administer the appropriate amount of insulin. **Note: Dial-Up Insulin Pen instructions are located {here}.**
Insulin	There are various types of insulin that our residents might need to manage their diabetes. Below are the common types of insulin and how they work: **Rapid-Acting:** Humalog (Lispro), NovoLog (Aspart), Apidra (Glulisine) Works within 15 mins, peaks at 1-2 hrs, lasts 3-4 hrs **Short-Acting:** Regular Insulin (Humulin R, Novolin R) 30 mins before meals, works within 30 mins, peaks at 2-3 hrs, lasts 4-6 hrs **Intermediate-Acting:** NPH (Humulin N, Novolin N) 2 times daily, works within 2-4hrs, peaks at 4-12 hrs, lasts up to 18 hrs **Long-Acting:** Langus (Glargine), Levemir (Determir), Tresiba (Degludec) 1 time daily, control over 24 hrs **Premixed Insulin:** Humalog, NovoLog, Humulin Combines short- and intermediate-acting for consistent control

Medication Assistance Procedures

Routine Medications-Inhalants: Nebulizer	1. Assemble the equipment according to the manufacturer's or DOW's directions. 2. Pour the pre-dosed medication into the medication receptacle (usually close to the mouthpiece that will be held by the resident). 3. Turn on the equipment/machine and verify it is delivering steam or vapor to the mouthpiece. 4. Encourage the resident to cover their mouth and continue breathing until the liquid medications are gone. 5. Once the treatment is complete, clean the pieces (mouthpiece, tubing, etc.) according to the manufacturer's or DOW's instructions with an appropriate solution (usually vinegar and water); allow pieces to air dry before storing. *If the treatment was administered for relief of congestion or shortness of breath, be sure to promptly report to the DOW if the symptoms persist after treatment*
Routine Medications-Inhalants: Inhaler	Read the instructions on the eMAR carefully before assisting a resident with an inhaler. 1. Shake the inhaler well and remove the cap. 2. Ensure resident is sitting upright. 3. Assist the resident with positioning the inhaler into their mouth (lips sealed around mouthpiece). 4. Assist the resident to depress the tube or switch on the inhaler and ask them to breathe in deeply. 5. Instruct resident to hold their breath in for at least 10 seconds, then exhale. 6. Repeat steps 3 – 5 for additional puffs (per the eMAR).

Medication Assistance Procedures

Topical Medications or Lotions	1. Remove medication or lotion from the tube onto your gloved, 1st finger. 2. Dot small amounts over the area to be treated from that finger (not from the tube). 3. Move the medication/lotion around the treatment area with a gentle, patting procedure, **DO NOT RUB (you could dislodge a clot).** 4. Secure the medication by placing the cap back onto the tube before storage. 5. Remove and discard your gloves.

Medication Assistance Procedures

Transdermal Patches	1. Prepare the area of the skin for the patch by removing clothing and ensuring the skin is dry and free of lint, powder, or other substances that keep the patch from sticking. 2. Remove backing from the patch. 3. Apply to the area designated by doctor's orders or manufacturer's guidelines. 4. It is important to remove any old patches because they may still contain active medication; adding a 2nd patch could cause a reaction and would be considered a medication error. **Be sure to note any skin irritations or complaints of burning, itching, or stinging and report this to the DOW immediately.**
Eye drops	1. Be careful to not let the tip of the bottle touch anything, including the resident. 2. Assist resident with pulling their lower eyelid down a small amount. 3. Allow the drops to fall into the lower eyelid (count the # of drops and match to the order). 4. Ask the resident to close their eye. 5. Dab away any medication that pools in the corner of the eye after the resident blinks.
Ear drops	1. Assist the resident to lay on their side or place their head on a pillow in their arms. 2. Gently pull the ear up and back from the top of the ear. 3. Be careful to not let the tip of the bottle touch anything. 4. Allow the drops to fall into the ear (count the # of drop to match the order). 5. Have the resident keep their head in place for at least 60 seconds.

Medication Assistance Procedures

Nose spray	1. Position the resident in a chair leaning back for support. 2. Be careful not to let the tip of the bottle touch anything. 3. Gently place the tip of the bottle probe about a half-inch into the resident's nostril. 4. Squeeze the applicator to spray the medicine. 5. Ask the resident to keep their head back for at least 60 seconds. 6. Repeat on the other side if necessary. (Always check the manufacturer's directions for nose sprays before assisting).
Rectal/Vaginal Suppository	1. Be sure to consult the instruction sheet prior to administering suppositories. 2. Position the resident on their left side with their knees bent. 3. Apply a small amount of water-based lubricant to the tip of the suppository. 4. Gently insert the suppository about 1-2 inches into the appropriate orifice. 5. **Do not force the entry.** 6. Have the resident remain lying down for 5-10 minutes after assistance. **Peri-care (such as this) should always be completed in a dignified manner and the resident should be made as comfortable as possible. It's important to remember that these tasks can be embarrassing for the resident and require tact and discretion.**

Observing Medication Effects

Observing Medication Effects	1. Familiarize yourself with common side effects of frequently prescribed medications. 2. Familiarize yourself with the resident's baseline or current status. 3. Educate the resident on potential side effects and encourage them to use their call button if they feel any changes or discomfort. 4. Check on the resident regularly or establish more frequent checks for new medications. 5. Look for: changes in vitals, physical status (rapid breathing, rashes, etc.), and altered mental statuses (confusion, agitation, etc.). 6. Report any side effects or changes in status to the DOW immediately.
Useful Tool: Drug Identifier (Guide)	Located on the Med Cart Chromebook is a drug identifier tool that will take you to a guide that assists in medication identification. Using this tool, you can input the type of imprint on pills as well as their colors and shapes; or you can search by drug name or the National Drug Code (NDC). The icon on the Chromebook should look like this: 

MEDICATION ADVERSE EVENTS

An adverse reaction is an undesirable or unintended harmful effect occurring as the result of a medication or treatment, or an allergic reaction in a resident with no documented history of allergy to the medication.

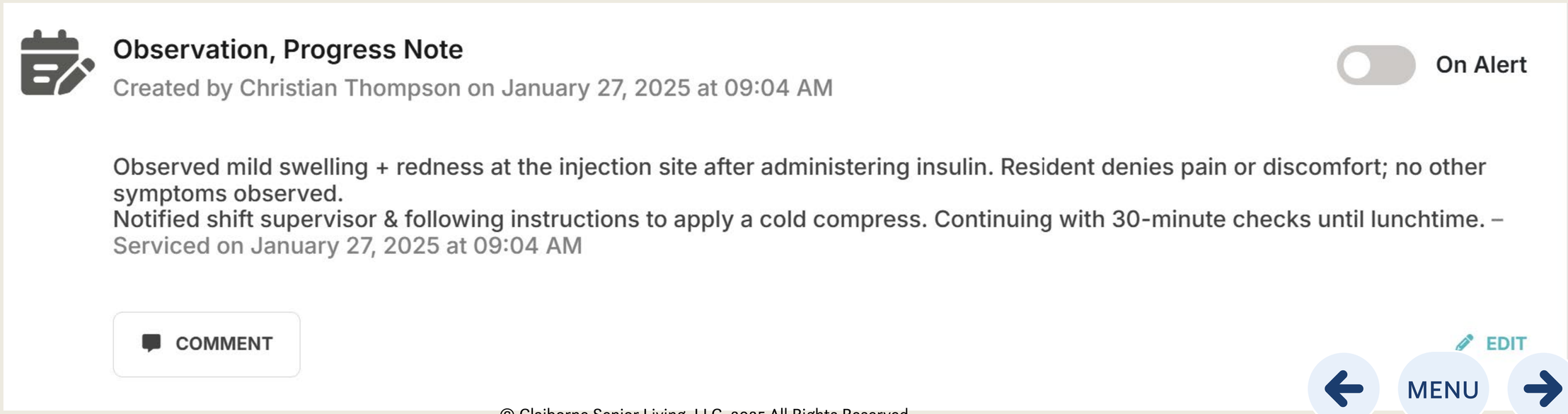
Adverse reactions can include heavy sedation, agitation, psychotic manifestations, severe cramping, nausea, vomiting, diarrhea, rashes or welts, profuse sweating, breathing difficulties, etc.

Adverse Events	**Acute Medical Distress** 1. If the resident is in acute medical distress (like mentioned above), CALL 911!! 2. Contact the DOW immediately and report the status and symptoms of the resident; follow any instructions received from the DOW. **Abnormal Side Effects** 1. If the resident has an abnormal side effect but is not in apparent distress, notify the shift supervisor or contact the Manager-On-Duty and follow any instructions received. 2. Check the resident frequently according to the instructions. 3. Notify the resident's family/responsible party and report on the status of the resident.

MEDICATION ADVERSE EVENTS

Documenting Adverse Events	1.In the Staff Communication Log briefly document the adverse event/reaction so that oncoming shifts can continue to monitor the resident (if still in-house). *Example: Unit 131:mild swelling at the injection site after administering insulin. Notified 2nd shift supervisor; continuing to perform 30-minute checks through 11 pm.*
Progress Notes	1. In the Progress Notes section of the EHR document the adverse event/reaction and any action taken. Use fact-based language only.

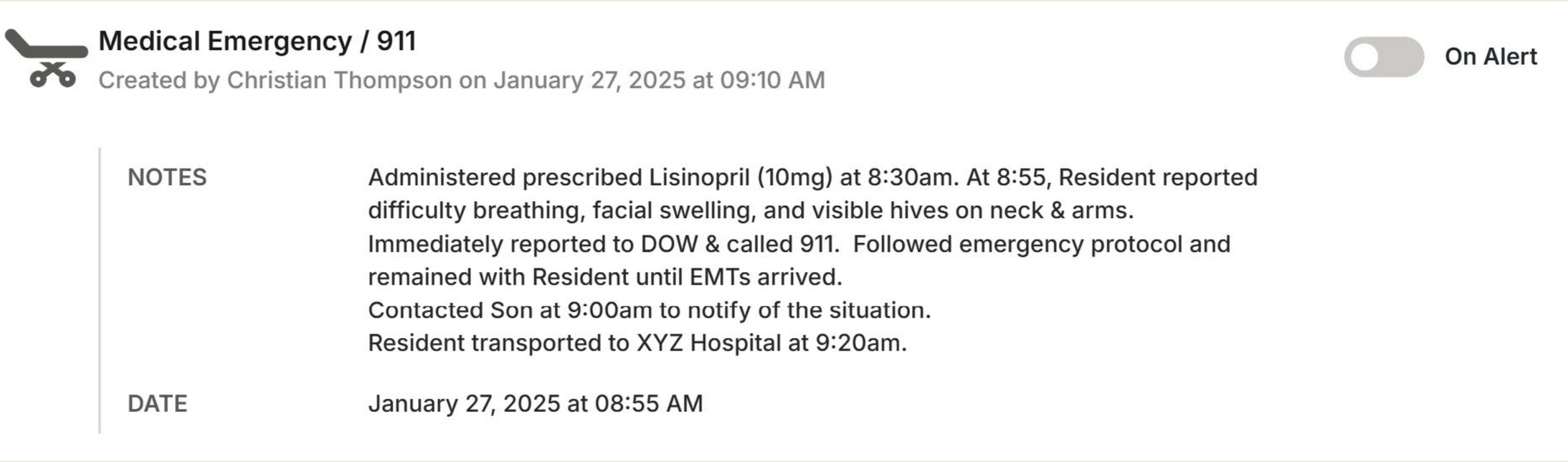
Example 1:



MEDICATION ADVERSE EVENTS

Documenting Adverse Events – Incident Report	If the resident must be transported due to an acute reaction to a medication, document the activity in the resident's **EHR** as an **Incident.**

Example 2:



Issues & Incident Management

Medication Refusals

Notification of Responsible Party	1. If a resident has continued to refuse medication after multiple attempts (3+), the DOW or designee should notify the resident's **Responsible Party (RP).** 2. Details of the attempts to re-approach the resident should be given to the RP as well as the potential implications of the medication refusal. 3. If a resident has refused a critical medication more than once, notify the provider for next steps and document the notification in the resident's record. 4. If the resident is their own RP, details should be listed in the **Progress Notes** of the resident's EHR.
Documenting a Refusal	Once an RP has been notified of a medication refusal, the details should be added to the resident's **Progress Notes.**
Alert Charting for Medication Refusals	Not all medication refusals will require **Alert Charting (1);** however, some medications are critical and would require monitoring.These types of medications include cardiac, diabetes, seizure, pain, Parkinson's, & respiratory medications, antipsychotics, antibiotics, and blood thinners.

Example:

Medication Errors

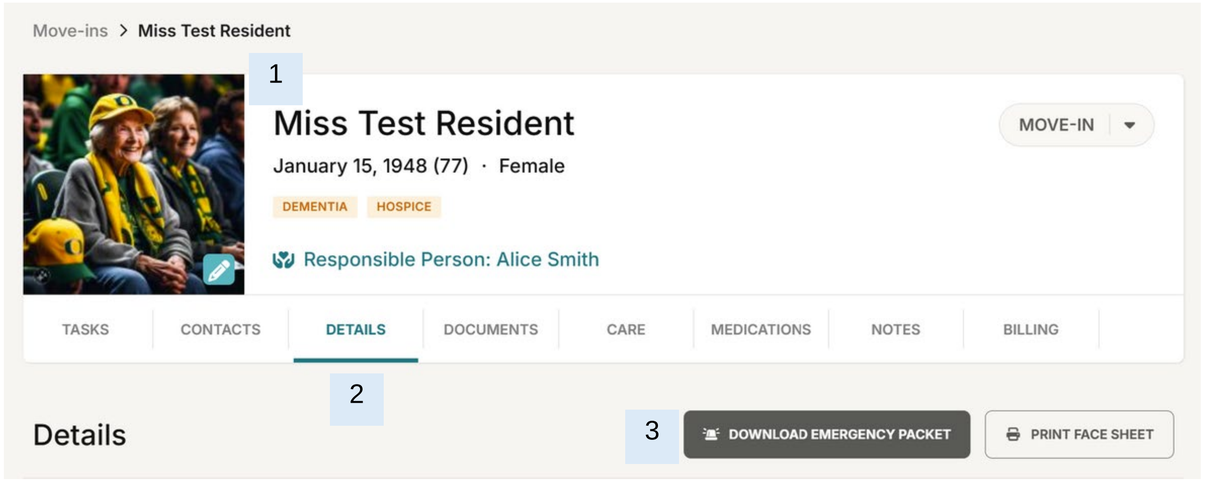
In the event of a medication error, it is critical that you notify the Director of Wellness or designated nurse immediately, per the Incident Reporting Guidelines (OPS101). If the resident is in acute medical distress, call 911!	
Medication Errors	If a medication error has be made while assisting a resident with administration, specific, fact-based information should be noted and reported to the DOW as soon as possible. Medication errors could include: • Meds given to the wrong resident. • Meds missed due to appropriate time window or lack of inventory.

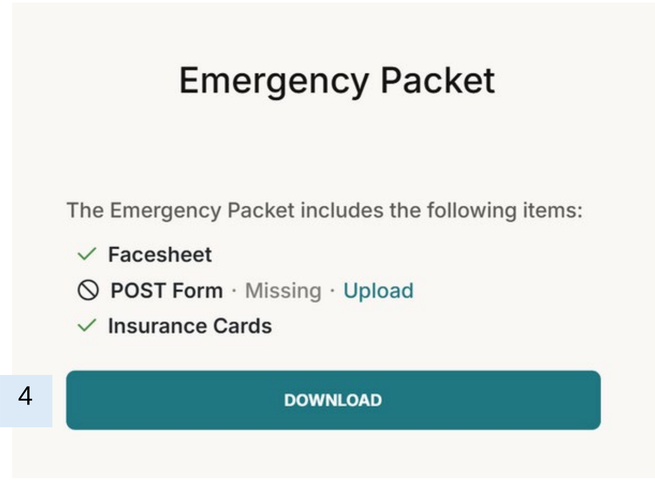
Emergency Transit Responsibility

Preparing a Resident for Emergency Transit	From time to time, a resident may need to be transported due to an emergency, such as a fall with injury. It is important to prepare and participate in residents' transport from our Community so that the residents are kept as comfortable as possible, and the emergency transit service knows the situation and status. 1. Make sure the resident is wearing the most-appropriate apparel. If it is cold outside, be sure to send along a jacket, socks, shoes, and potentially a blanket. 2. Be mindful of the residents' dignity as they are being placed and moved about on the portable ambulance bed. Make sure they are well-covered. 3. Print a copy of the resident's **Emergency Packet** from August Health. 4. Give the **Emergency Packet** and reason for transit to the EMTs upon their arrival. 5. Notify the family or responsible party as quickly as possible without disrupting care to the resident. Sometimes this must happen once the ambulance has left.
Refusal of Emergency Transit	If a resident, legal guardian, durable power of attorney or responsible party refuses to accept emergency transport to acute care setting, the resident and/or decision maker must sign the **Emergency Transport Refusal Form.**

Emergency Transit Responsibility

Emergency Packet in August Health	To print the **Emergency Packet** in August Health: 1. Navigate to the appropriate resident's profile . 2. Click on the "Details" tab. 3. Click the gray "Download Emergency Packet" button. 4. On the pop-up prompt, click the "Download" button. 5. Once the tab opens with the download, click the "print" icon in the top right corner.





Medication-Related Incident Reporting

Incident Reports should be completed **as soon as possible** when any of the following medication-related scenarios happen:

Medication-Related Incident Report(s)	1. The wrong medication or dosage is taken by a resident. 2. The medication is taken at the wrong time (ex: more than 1 hour before or 1 hour after). 3. The medication is ordered but not taken by a resident, including refusals or medications not available. 4. The medication is taken beyond the stop date. 5. A narcotic or routine medication is missing from the wellness area.
Medication-Related Incident Report(s) Follow-up	The DOW will investigate the **Medication-Related Incident Report(s)** and **Progress Notes** for appropriate documentation regarding the scenario and document any follow up preventative actions taken such as changes needed in the resident's ISP. It is important to review all **Progress Notes** regularly for these types of scenarios, alerts, and any changes made to the **ISP**.

Resident Out of House

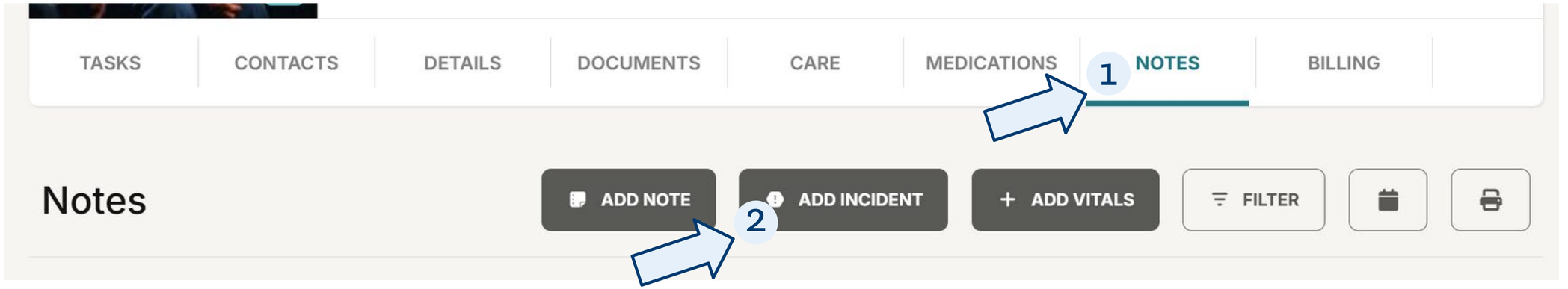
Resident Out of House/Leave of Absence Medication Preparation	From time to time, residents will be absent from the community and will need to take their medications with them. If a resident will be Out of House (OOH) for an extended period, the (entire) bubble-packed medication card should be sent with the resident or their responsible party. Print off the **Medication Receipt & Release Log (CLN-221)** and fill out the required information and sign. Obtain a signature from the resident or responsible party receiving the medications and upload into August Health. *Provide a copy to the family if requested.

Documentation

Documentation & Reporting (OPS 101 & 102)

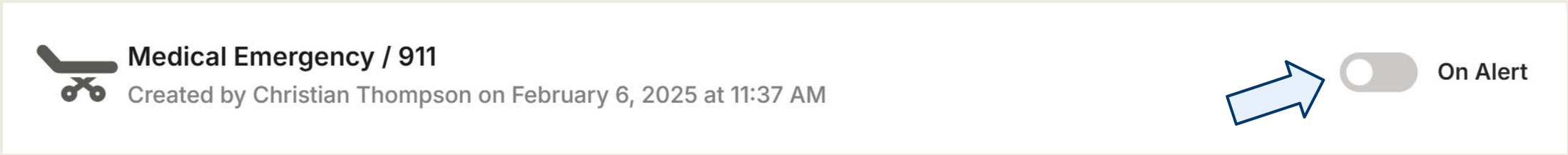
Reporting: Where To Document	An **incident** is defined as any unusual occurrence that results in actual or potential injury to a resident, visitor, staff member, or property. **Resident-related incidents should be documented within the EHR** using **OPS 101: Incident Reporting Guidelines.** Other (non-resident) related incidents should be documented via **OPS-102 Non-Resident Incident Report Form.** An incident report should be initiated and completed as soon as possible after an incident occurs. **OPS 101 and 102** can be found in the staff station, and they provide a detailed accounting of what and how to report incidents, as well as the appropriate follow-through steps.

EHR: Incident Reporting	Using the guidelines from this resource, an **Incident Report** can be made in the EHR. In the (1) **Notes** tab, select the (2)**Add Incident** button to begin your report.

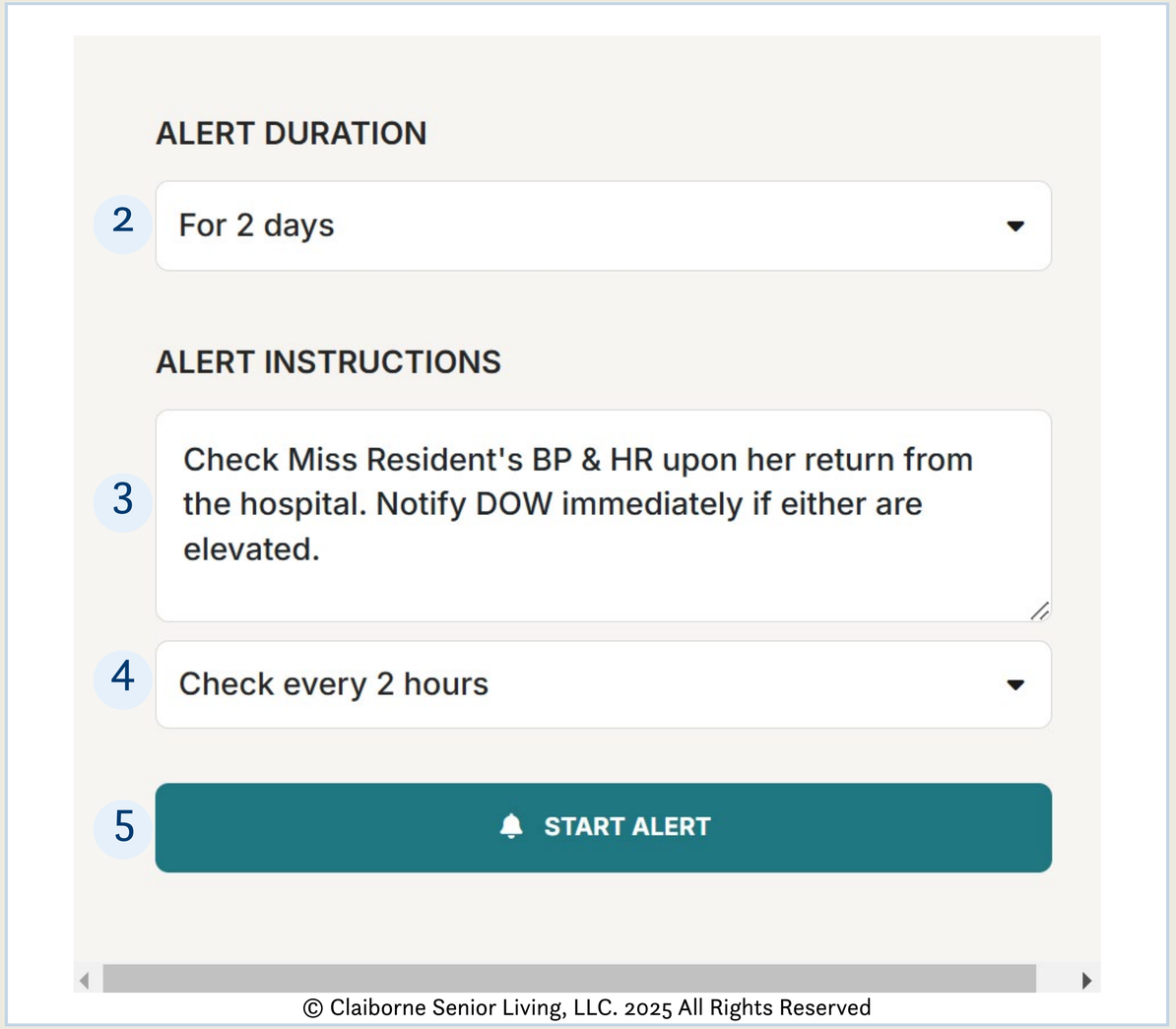


EHR: Incident Reporting	Three (3) comments are required for each incident; one per day for three days.

EHR: Alert Charting	In both an **Incident Report** and resident **Progress Notes**, the resident can be placed **“On Alert”** if follow-up is needed. **Alert Charting** is a proactive way to capture and track changes in a resident’s condition in real time. **Alert Charting** should always be used after an **Incident Report** has been completed. To place a resident **On Alert** navigate to the **Incident Report** or the **Progress Note** in the **Notes** tab. Toggle the (1) radio button in the top right corner of the note to initiate the alert charting.



EHR: Alert Charting (cont'd)	When the **Alert Charting** prompt window appears, select (2) the duration the resident will be on alert, (3) make a brief note with care instructions, and (4) select the frequency for the alert checks. Then press the (5) **Start Alert** button.



EHR: Alert Charting (cont'd) – Effectiveness of Nursing Intervention	**Alert Charting** is also used to track and evaluate the effectiveness of nursing interventions. After initiating an intervention (like follow-up checks after a medication error, or a new pain management regimen), document any steps taken in relation to the intervention **(Alert)** such as: • Resident responses or reactions to interventions. • Any improvements in condition. • Any persistent issues surrounding the intervention. • Necessary adjustments made to maintain the intervention. • Additional support needed from outside HCPs to complete the intervention.

INCIDENT REPORTS & PROGRESS NOTES DO'S & DON'TS

Do's	In both an **Incident Report** and resident **Progress Notes** the following items should be addressed: • Date and time of day. • Where the incident occurred (ex: shower, near toilet, bedroom). • Accurate description of the incident: ▸▸▸What the resident was doing (standing, sitting, walking, etc.). ▸▸▸What may have caused the incident (tripped over a rug, felt dizzy, etc.). ▸▸▸Was there a change in the environment (liquid on floor, moved furniture, etc.). ▸▸▸Take a physical assessment if possible. ▸▸▸Note any complaints of pain, cuts, or bruises, and what intervention was taken (bandaged a cut, called 911, etc.). ▸▸▸ Position resident was found in. ▸▸▸ Vital signs. ▸▸▸ Physician notification. ▸▸▸Safety positioning or devices in use.
Don'ts	• Do not document assumptions. • Do not write "Incident Report Completed" or "See Incident Report" in the **Progress Notes.**

CSL - Acronym Library

This acronym library is intended only for use within this training resource to enhance understanding of key terms related to this material. It is not a reference for medical or clinical documentation and should not be used for official resident documentation.

ADL	Activities of Daily Living
CMA	Certified Medication Assistant
CMT	Certified Medication Technician
CON	Concierge

CPS	Care Plan Summary
CSL	Claiborne Senior Living
DOW	Director of Wellness
EXD	Executive Director

CSL - Acronym Library

FIFO	First In/First Out Rotation
iADL	Instrumental Activities of Daily Living
ISP	Individualized Service Plan
LED	Life Enrichment Director
LPN	Licensed Practical Nurse
MXD	Maintenance Director
N/A	Not Applicable

OOH	Out of House
OPS	Operations
PHI	Protected Health Information
RP	Responsible Party
SCL	Staff Communication Log
VA	Veterans Administration
WKND	Weekend

Commonly Used Medical Terminology & Abbreviations

TERM	ABBREVIATION	DEFINITION
BID/TID/QID	(same)	BID: twice a day / TID: three times a day / QID: four times a day
Blood Pressure	BP	The force of blood pushing against the walls of the arteries as the heart pumps
Buccal		Between the cheek & gum for absorption
Cerebrovascular Accident	CVA	Stroke
Discharge or Discontinue	DC	Discharge from medical facility or discontinue as in a medication or treatment
Diagnosis	DX	Identification of a disease, condition, or injury
EHR	(same)	Electronic Health Record
EMT	(same)	Emergency Medical Technician
ICU	(same)	Intensive Care Unit

Commonly Used Medical Terminology & Abbreviations

Inhalation	INH	Delivered directly to the respiratory system by breathing (mist, etc.)
Intradermal	ID	Injected into the dermis, just below the surface of the skin
Intramuscular	IM	Injected into a muscle for slower absorption
Intravenous	IV	Delivered directly into a vein for immediate absorption
MAR/eMAR	(same)	Medication Administration Record /Electronic Medication Administration Record
Myocardial Infarction	MI	Heart Attack
Nasal (Intranasal)		Administered through the nose (nasal sprays)
Ophthalmic		Applied directly to the eyes (eye drops)
Over-the-Counter	OTC	Medications that are part of a Resident's administration regimen that are not prescribed by a designated healthcare professional
Otic		Administered into the ear canal (ear drops)

Commonly Used Medical Terminology & Abbreviations

Primary Care Physician	PCP	(same)
Per Os	PO	By mouth
Per Rectum	PR	Administered via the rectum
Pro Re Nata	PRN	As needed
Quaque Hora Somni	QHS	Bedtime
Subcutaneous	SC or SQ	Injected into the fatty tissue just under the skin
Sublingual	SL	Under the tongue
Topical	TOP	Applied directly to the skin (for local effect)
Transdermal	TD	Applied to the skin for absorption to the bloodstream
Vaginal	PV	Per vagina