Policy Title: Medication Administration	Effective Date	5/6/04
	Revision Date	7-10-15
	Page No.	Page 1 of 13
	Approval	CP (RN) & TH
	File	Policies

I. Purpose

This policy establishes medication administration procedures to ensure medications and treatments are provided as prescribed to persons served by PAI as stipulated in Chapter 245D. Home and Community-Based Services Standards.

II. Revision History

Date	Rev. No.	Change	Reference Section(s)
7-10-15	All	Person Centered wording, 245D update	In Toto
3-11-11	8	Wording addition	VI C 10 b

III. Persons Affected

Individuals whose health service needs have been assigned to PAI in their coordinated service and support plan or the coordinated service and support plan addendum.

IV. Persons Responsible

Approved medication passers are: the assigned LPN and/or unlicensed staff who have successfully completed an approved medication administration training provided by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician assistant, or physician and have successfully passed an observed skill assessment.
Medication administration is the responsibility of the registered nurse. The nurse will determine who may or may not pass medications based on the objective criteria of training.

V. Definitions

Medication Administration Medication assistance means:

- bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person under the direction of the person;
- bringing to the person liquids or food to accompany the medication; or
- providing reminders, in person, remotely, or through programming devices such as telephones, alarms, or medication boxes, to take regularly scheduled medication or perform regularly scheduled treatments and exercises.
- If responsibility for medication assistance is assigned to PAI in the CSSP or CSSPA, PAI will ensure that medication assistance is provided in a manner that enables a person to self-administer medication or treatment when the person is capable of

directing their own care, or when their legal representative is present and able to direct care for the person.

Medication Assistance - means any of the following:

- bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person under the direction of the person;
- bringing to the person liquids or food to accompany the medication; or
- providing reminders, in person, remotely, or through programming devices such as telephones, alarms, or medication boxes, to take regularly scheduled medication or perform regularly scheduled treatments and exercises.
- If responsibility for medication assistance is assigned to PAI in the coordinated service and support plan or the coordinated service and support plan addendum, PAI must ensure that medication assistance is provided in a manner that enables a person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person.

Medication Setup - means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration

Medication Administration Record (MAR):
The form used when documenting the administration of the medication, a treatment or the reason for not administering the medication or treatment and reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed.

LPN: Licensed Practical Nurse
PRN: As Needed
EST: Extended Support Team
CSSP: Coordinated Service Support Plan

Nurses Drug Handbook or WebMD http://www.webmd.com/ drugs & supplements:
PAI approved and available references for looking up medication information, i.e., generic and trade names, pronunciation key, pregnancy risk category, pharmacologic class, controlled substance schedule (if applicable), available forms, indications and dosages, administration (with drug incompatibilities for IV drugs), action (including tables showing route, onset, peak, duration, and half-life), adverse reactions, interactions, effects on lab test results, contraindications and nursing considerations.

VI. Policy

A. Qualifications for Medication Administration

1. Persons who may administer medications in this facility include: physicians, licensed nurses and employees who have successfully completed a 245D compliant medication administration course and passed an in-house training/skill observation by a Registered or Licensed Practical Nurse.
   a. Documentation of the medication passers training and skill observation will be kept in the employee's personnel file.

B. Oral medication Administration

1. Steps to oral medication administration
    a. Wash hands before passing medications and between each medication administration.
    b. Assemble the needed equipment (med. cups, spoons, cups, fluids, applesauce, etc.)
    c. Read the medication administration sheet.
    d. Locate the medication supply.
    e. Compare the medication sheet to the order on the medication label. (If there is a discrepancy, call a nurse BEFORE giving the medication).
    f. When dispensing pills from a bottle, pour the medication into the bottle cap until there is the correct number of pills then pour pills from cap to container(med cup), without touching it.
    g. When dispensing pills from a bubble pack, punch pill out into med cup removing pills in order going down vertical rows. Write date dispensed and initials by emptied bubble.
    h. Should the pill require crushing do the following
        i. Place pill in med cup as indicated in step f.
        ii. Put another med cup inside the first cup.
        iii. Use pill crusher to crush the pill between the 2 cups.
        iv. Wipe pill crusher with alcohol wipe
    i. Check the medication sheet and the medication label again.
    j. Recheck the medication sheet and label once more before returning the medication to the cabinet.
    k. Identify the person that is receiving the medications.
    l. Administer the medication by the prescribed route/directions.
    m. Make sure the medication is fully swallowed.
    n. Offer fluids after the medication is given if there is no restriction of liquids.
    o. Clean and replace the equipment.
    p. Initial the MAR for the medications given.
    q. Wash hands.
        i. **Note:** Screw type pill crushers are not to be shared by individuals and are to be washed out after each use.
2. Prescription medications will be given in accordance with the physician's orders, with the standard window of one hour on either side of the medication administration time, unless otherwise indicated in the physician's order. More than one hour, would be considered a medication error. **The exception to this is seizure and psychotropic medications which have a half hour** window on either side.
3. If there is a conflict with administering the medication(s) at the assigned time, the trained med passer will notify the site nurse or the nurse consultant then the residence to develop an alternate plan.

C. The Medication Administration Record

1. A medication administration record (medication sheet) is kept for each person receiving medications at PAI to record all medication given.
    a. The medication sheet is to have all documentation in black or blue ink only.
2. The medication sheet will include the following information:

a. name
b. month/year
c. medication name, strength, dose to be given, route, frequency
d. time of administration
e. the date the medication was started and if known, the date to discontinue, special considerations. This area could address such things as criteria for giving a medication or how the individual prefers to take a medication, etc.

3. After the medications for each individual are given, the certified medication passer places their initials in the appropriate time/date box on the medication sheet.
4. If the medication is a Schedule II controlled drug, two medication passers need to do a count of the pills left once the med is passed. This is to be done for as long as the medication is on the premises.
5. At the beginning of each month, each med passer must sign their name, initials and title to the bottom of each sheet.
6. The following codes are to be used on the medication sheet. The med passer's initials should accompany the appropriate code and any additional information documented on the back of the medication sheet.

A = absent from the program	R= refused	**S** = self-administered
X = medication error	**/** = P.A.I. closed	**0** = Not given To begin a new medication
H = medication held	**P** = prepacked	

7. New medication orders:
   a. Upon receiving a physician's order fill in all the information on the medication sheet as listed under #1 above, from the physician's order.
   b. In the boxes on the med sheet, draw an arrow to the date the medication is to start. Write the date the medication is to begin on this line.
   c. File a copy of the physician's order in the person's medication book. Remove any copies of old physician order/s that no longer apply.
   d. Record the date, the name/strength of the medication and the amount of medication received (count pills) on the back of the medication sheet.
   e. Place the medication itself in the appropriate locked area.
   f. Notify other medication passers of the new order. Put the original in the nurse's mailbox and a copy in the main chart. Any other communication regarding the start of the medication should also be documented on the back of the med sheet.
8. Controlled Medications
   a. If the medication received is a Schedule II controlled medication, the usual information is transcribed onto the medication sheet and space will be designated for two employees to record a pill count each day.
   b. Schedule II medications need to be double locked
   c. This count should also be done upon receipt of the medication. Each time a new supply of the controlled medication is received; the following information needs to be logged on the back of the medication sheet:
      i. date received
      ii. name and strength of the medication

iii. prescription number
iv. quantity
v. signature of the employee logging-in the controlled medication

9. To indicate the discontinuation of a medication as prescribed by physician
   a. Indicate the date the medication was discontinued on the "Date Discontinued" line.
   b. After the last dose to be given, write the abbreviation "D/C", the date and your initials. Draw a line through the remaining days of the month.
   c. Remove the medication from the stock and send home with the van driver following standard medication transportation requirements.
   d. If a medication is to be destroyed, write a note and put with the container in the medication cabinet for the nurse consultant to destroy. (See **Medication Destruction**)
   e. Indicate on the back of the medication sheet where the stock was moved to and any other communication regarding the stoppage of the medication.
   f. Communicate the medication discontinuation to other medication passers.
   g. Place the physician's order in the medication book.
10. Special Considerations:
   a. Anytime there is a spillage or contamination of a medication, an explanatory note will be entered on the back of the MAR (See **Medication Destruction**).
   b. Medication passers are not allowed to do injections, rectal or vaginal medications.
      i. Exceptions:
      a.) Rectal medications may be administered by trained medication passers at the Linden Program exclusively.
      b.) Emergency use of the epinephrine, e.g., Epipen.
         1) Epipen injections may be administered by trained staff.
      c.) Insulin pen injection may be administered by a medication passer trained and approved in testing blood sugars and using an insulin pen.
   c. Certified medication passers will follow the route specific procedures.

D. Providing the Medication Supply

1. All routine medications will be supplied by the individual's place of residence.
2. All required prescription medications with doctor order must be on site in order for the individual to be in attendance.
3. An individual who requires prn over the counter medications needs to have their own personal stock supplied by their place of residence.
4. Expired medications: Medications with a specific expiration date will not be used after that date.
5. Reordering medications:
   a. The nurse will monitor stocking of medications. It is the primary responsibility of room med passers to regularly re-order medications. A Medication Request Form is sent home with the person. If a medication passer notices that a stock is depleted, or a requested medication has not arrived; it is their responsibility to follow through with the home to ensure the medication is received.

b. When there is less than a 5 day supply of medications, the home should be called versus written communication.
c. All Schedule II controlled medications should be sent in a lock box or delivered directly to the site by the residence.
d. Upon receiving medications, medication passers should record the receipt of the medications on the back of the current MAR. This should include:
    i. the date it was received,
    ii. the name of the medication,
    iii. the strength (mg), the number of tablets/capsules/cc's received,
    iv. the prescription number and the documenter's signature and title.
e. The med passer must verify that the medication has the individual's label on the container.
    i. This may mean opening a secondary package such as a box to check the contents for accuracy.
    ii. Some over the counter meds may not have a pharmacy label. If there is no label, staff will write the individual's name on the bottle.
f. When medications are sent home, due to a change in dose, expired, or controlled medications are discontinued, the information in 6.d., i-iv, pertaining to the return, should also be recorded on the back of the medication sheet.
    i. Medications are sent to the residential provider per medication transportation requirements.

E. Labeling of Medications

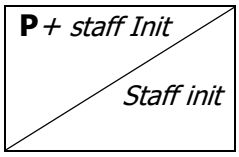
1. All medications must have a pharmacy label, manufacturer's label or an appropriately written label, which includes the individual's name, on the medication container.
2. External medications will be clearly marked "For External Use Only".
3. In the event a medication label is incomplete or the directions for administration are unclear, the certified med passer must clarify the orders prior to administering the medication.
4. If a medication is prepackaged in an envelope, it should be labeled with the following information:

Individual's name & date:	Mary Brown 11/30/14
Med/directions:	Depakote 500 mg i tab (o) at 12 noon
Any special instructions:	Takes best with applesauce
Name of person who set-up the med:	(Staff Name)

5. The person who will actually be administering the medications should double-check the medications with the med passer.
6. The med passer packaging the meds should indicate the medications were sent off site, by putting a "P" in the box on the medication sheet along with their initials. **Example:**

Prepackaged By (Staff Name)

Administered by (Staff Initials)



7. While off-site, the envelope(s) should be secured at all times
   a. staff should keep them or,
   b. if an individual self-administers, they need to be with the person at all times or,
   c. kept in a locked storage area.
8. The person who administered the med will document on the MAR that the meds were given and staple the empty envelope to the MAR.
9. If the med passer is not returning to the site then the med passer will sign the envelope and send it back with the individual.
10. The signed envelope is then stapled to the MAR.
11. If the medications were not given the med passer should document such and follow the appropriate steps (see **Medication Error Procedure**).

F. Physician Orders

1. **All** medications must be accompanied by a signed order by a physician, physician's assistant, or nurse practitioner. This is true for routinely given, short-term and prn medications.
2. Orders may be faxed or sent with the individual.
3. These documents must be current orders. Current defined as dated within the last year and no other orders that supersede this order.
4. The coordinator or designee will:
   a. mark the date received and initial the orders, H&P, SOL once these orders are compared to the current med sheet to verify accuracy.
   b. file the original order in the chart
   c. give a copy to the nurse
   d. A copy of the current medication order(s) for medications assigned to PAI for passing will be kept in the medication book.
5. Expired orders are moved into the individual's file when a more current order is received.
6. Copies of telephone orders signed by a nurse are acceptable temporarily. A final copy signed by the physician needs to be procured and placed in the file.
7. Any questions regarding physicians' orders should be directed to the individual's residential nurse or the nurse consultant.

G. Drug References

1. In order to ensure medications are administered safely, it is important for med passers to be familiar with the individuals receiving the medication.
2. This would include how medications are best swallowed, any allergies or emergency treatment interventions.
3. It is also the responsibility of the med passer to know the medication(s) they are administering, including the intended use, side effects, warnings or special directions for use.

4. The drug references available for employees at each facility are:
    a. Nurses Drug Handbook located in each medication book or
    b. On line at WebMD http://www.webmd.com/ drugs & supplements:
    c. If a medication cannot be located in one of the references provided; information may be obtained from a pharmacy, the nurse consultant, or the residence.

H. Administration of PRN Medications

1. All PRN (as needed) medications must have an accompanying physician's order on file.
2. If there is no order the medication cannot be administered.
3. The order must contain the indication for use (i.e. discomfort, fever, anxiety). The medication then must only be given for that intended use.
4. PRN may not be used:
    a. as a chemical restraint
    b. as a substitute for adequate staffing
    c. for a behavioral or therapeutic program to reduce or eliminate behavior
    d. as punishment
    e. for staff convenience
    f. If it is not a standard treatment for the individual's condition.
5. If it is not known when the last dose of medication was received, a call to the residence will be made to get clarification.
6. If the PRN medication has a frequency of every 4 hours, and the individual has been on-site for 4 or more hours, the medication can be given without calling the home first.
7. When the frequency of the medication is limited to a certain number of doses, the home should be contacted, so the most prudent use of the medication is followed.
8. The medication order may need to be written on the medication sheet. In the "time" column, "PRN" should be transcribed.
9. Follow the order for administration of the PRN medication.
10. After administering the PRN medication,
    a. Initial for the medication on the front of the medication sheet; on the back of the med sheet indicate the date, time, medication, dose route and indication for use of the medication given;
    b. Inform the home regarding the use of the PRN, including dose, time and effectiveness; document the details of the home contact on the back of the medication sheet also.
    c. Approximately one hour after the medication was given, check with the individual regarding the effectiveness of the medication, and document this information on the back of the medication sheet.

I. Administration of Short-Term Medications

1. If a medication is necessary on a temporary basis, a physician's order is required.
2. It is acceptable for the residence to either
    a. Send a supply for PAI to administer in a bottle or card; or
    b. Pre-package enough doses in a properly labeled envelope; or

c. Send a shared supply back and forth between home and work. (Least preferred due to increased risk of med not being received or returned).

3. To transcribe a short-term medication on to the medication sheet:
   a. Write in the order exactly as the physician order reads.
   b. Indicate the time the medication is to be given, in the "time" column on the grid.
   c. Draw an arrow to the date the medication is to start.
   d. Write in the start date and the date to be discontinued on the appropriate lines.
   e. Document on the back of the medication sheet any supporting information, such as, why the individual is receiving the medication.

J. Medication Destruction

1. All medications that are contaminated or discontinued will either be returned to the individual's residence per transportation requirements or destroyed by the PAI Nurse/ nurse consultant.
2. The medication/s to be destroyed will be placed in a sealed envelope and labeled with the individual's name, the name of the medication, the date, and the words "to be destroyed" written on the front of the envelope. The reason may also be written on the envelope.
3. If the medication is sent home for destruction:
   a. A staff person at PAI will call the residence to inform them.
   b. The medication will be transported via Transportation. If this is not possible the medication will be destroyed on site.
   c. Medication should not be given to an individual to carry home.
   d. All communication will be documented on a phone contact sheet/log and the MAR.
4. If the medication destruction is done on site:
   a. It will be done by the nurse and one witness and the following information will be documented on the back of the MAR.
      i. the date
      ii. the name of the drug
      iii. the strength
      iv. the prescription number
      v. the number of tablets/amount of liquid being destroyed
      vi. the mode of destruction
      vii. the signature of the nurse and witness.

   > Example: 11/30/08 Depakote 500mg Rx#34567 1 tab flushed/sewer F. Nightingale, RN/C. Barton TMP.

5. Controlled Medications: A nurse and a pharmacist must destroy all scheduled medications and document this on a Certificate of Destruction form. Therefore, controlled medications will not be destroyed at PAI.
6. All discontinued or contaminated controlled medications will be returned to the home per Transportation Requirements.

K. Medication Error Procedure

1. All employees are responsible for the detection of medication errors. An error includes:
    a. Medication administered to the wrong person;
    b. An incorrect route was used;
    c. An incorrect dose was given;
    d. Medication administered at the wrong time or date;
    e. The incorrect medication given;
    f. The absence of medication documentation
        i. In the event a medication is not documented, every attempt will be made to contact the employee for the administration of the medication, to verify if the medication was given.
    g. Medication was omitted.
2. Notification of an error will be made to:
        i. The site nurse or the nurse consultant
        ii. The individual's home, legal guardian, case manager and others as noted in the individual's CSSP/CSSPA
    b. The nurse consultant will determine if additional follow up will be necessary based on the nature of the error.
        i. The individual's physician
        ii. The Ombudsman and DHS Licensing as stipulated.
3. Documentation
    a. A medication error report will be completed
    b. The report will be routed to the program coordinator and the nurse consultant. A copy will be given to the site director.
    c. The original of the Med Error report will be filed as designated by the site Director
    d. If the med error meets criteria to be reported as an Incident then an Incident report will be filled out and stapled to the Medication error report. These reports will be filed in the program chart under "medical".
    e. An "X" will be placed on the medication sheet, as per the code legend on the medication sheet
        i. Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed will be made on the back of the sheet, when and to whom reports were made per the CSSP/CSSPA.
3. Review of the Medication Documentation and Error Reports
    a. The nurse Consultant or site nurse will review all medication administration records on a monthly basis and address any documentation issues.
    b. The nurse consultant will review all Medication Error Reports on a monthly basis.
5. Correction Plan
    a. It is the responsibility of the nurse consultant and the Designated Coordinator to determine appropriate action to reduce the occurrence of medication errors.
    b. This would include employees who commit medication errors frequently or errors that result in serious outcomes.

c. An educational plan will be developed by the nurse consultant and Designated Coordinator and may include:
    i. A review of medication procedures with the nurse consultant or LPN
    ii. A demonstration of administration and documentation of medications with the nurse
    iii. A back-up system for double checking the med passer until proficiency is obtained.
    iv. Repeating a course in medication administration
    v. Lastly, if a med passer continues to demonstrate repeated inability to correctly administer medications, they may be denied the responsibility of medication administration.

6. Vulnerable Adult Notification
    a. If any error is repeated or of such a nature to have caused harm requiring medical attention, a report will be forwarded to the MN Adult Abuse Reporting Center (MAARC).

L. Self Administration of Medications

1. It is the responsibility of the support team to determine if an individual meets the criteria for self-administration of medications. PAI will comply with the individual's CSSP/CSSPA
2. If the individual requires support to self-administer medication, a certified medication passer will observe the medications when being taken and document the observation on a medication administration record.
3. If there is any indication that an individual is not being responsible in self-administration of their medications, the support team will be notified via a phone call and written documentation.
4. All medications which are self-administered must be packaged and labeled appropriately.
5. Medications which are self-administered will be stored as stipulated in the CSSP/CSSPA, e.g., on the individual or in a locked area.

M. Storage and Transport of Medications

1. All medications to be administered at PAI will be kept in a locked area.
2. Only nurses or certified medication passers will have a key to this area.
3. Medications requiring refrigeration will be kept in a locked box inside a refrigerator or in a designated locking medication refrigerator.
4. Medications, which are Schedule II controlled medications will be double locked.
5. All medications and treatments will be stored in an optimal environment, this includes
    a. Proper sanitation
    b. Light
    c. Temperature
    d. Ventilation
6. All medication containers will be kept closed in storage. Changes in color, odor, consistency, or suspected tampering will be reported to the residence. The medication will not be administered until permission is given.

7. The med passer will administer medications directly to the individual. The medication will not be left unattended.
8. Any individualized security or storage of medications (i.e. job sites) must be approved by the nurse consultant. This alternative procedure will be documented on the medication sheet.
9. Medications to be administered are sent by the residence to PAI per the Medication Transportation Protocol or method designated by the IDT.
10. The med passer on site at PAI is responsible for logging in the medication and storing it properly.
11. PAI staff is informed of the meds being sent via the individual's caregiver/residence. The med passer on site logs in the medication(s) and stores them appropriately.

N. Psychotropic Medication

1. In order to administer psychotropic medications at PAI, the interdisciplinary health team will provide written, measurable, criteria for the use of the medication.
2. Individuals receiving psychotropic medications will provide PAI with all necessary documentation regarding the use of the psychotropic medication.
3. PAI staff will provide all related data and information regarding the psychotropic medication usage.
4. Psychotropic medications used on an on-going, programmatic basis and as treatment for a psychiatric diagnosis, will be administered in accordance with the physician's orders.
5. Psychotropic medications given prior to a medical appointment as a PRN will be recorded on the medication sheet and documented in the same manner as all other PRN medication. Follow up documentation on the MAR will include a review of PRN Psychotropic use. This documentation is to be completed by the Designated Coordinator or Site Director/Manager.
6. Designated Coordinator will forward any recommendations related to the prn use of a psychotropic medication to the individual's residence.

O. Psychotropic Medication Monitoring

1. The documentation required to support the use of the medication will typically be housed with the residential provider.
   a. PAI will assist in the monitoring of medication effects and side effects, through observations while the individual is in the program
   b. Observations will be reported to the home on a regular basis.
2. PAI will provide referral assistance for the psychotropic medication monitoring, in homes where nursing services do not exist.
3. Should PAI be assigned to formally monitor psychotropic medications as delineated in an individual's CSSP or CSSPA:
   a. PAI will adhere to this medication administration policy.
   b. In consultation with the nurse consultant and the individual's support team, PAI will determine how to best meet the needs of the individual given the available resources.

c. All necessary documentation will be included in the person's coordinated service and support plan addendum according to the requirements in sections 245D.07 and 245D.071.
d. a description of the target symptoms that the psychotropic medication is to alleviate; and
e. if required by the prescriber, the documentation methods PAI will use to monitor and measure changes in the target symptoms being alleviated by the psychotropic medication.
    i. PAI will collect and report on medication and symptom-related data as instructed by the prescriber.
    ii. Provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

4. In the event the person or the legal representative refuse to authorize the administration of a psychotropic medication as ordered by the prescriber:
    a. PAI will not administer the medication
    b. PAI will report the refusal to the prescriber as expediently as possible.
    c. PAI will not consider a refusal grounds for service termination any decision to terminate services will be reached in compliance with 245D.10, subdivision 3.

VII. Forms

Medication Administration Record (MAR)
Medication Error Report
Medication Request Form
Medication Reorder Tracking Sheet
Phone Communication Log
Procedures- Route-specific