

# Medication Administration Curriculum



**2010**



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## Introduction

***DESIRED OUTCOME: All employees working in the homes demonstrate competency in the area of medication administration.***

All new employees will be provided this training and must demonstrate competency within the first 120 days of employment:

1. Attend the Medication Administration Training course offered through the Central Training Unit.
2. Administration observation and review of the Transcription Knowledge portion is to be completed by the Site Manager/HSS or House Trainer identifying any further supports needed in either the knowledge or actual administration of medication.

After completion of the initial competency based training, each employee must attend a one-day Medication Administration Refresher course every two years. This will be done through the Central Training Unit.

Successful completion of a Medication Refresher Challenge Test (once available – July 1<sup>st</sup>, 2010), the test may substitute for the one-day medication refresher course.

Beginning April 1, 2010, all staff who do not receive a score of 85% or better on the med documentation tests will not be considered "current." Staff with less than 85%, will be required to attend the "Initial Medication Administration Course" until they receive a score of 85% or better. Staff will not be able to pass medications until they are "current" in Medication Administration.

1. Administration observation and review of the Transcription Knowledge portion is to be completed by the Site Manager/HSS or House Trainer identifying any further supports needed in either the knowledge or actual administration of medication.
2. If the employee, at the time of completing the Medication Administration Refresher course, has not exceeded the 2-year period between trainings, at the discretion of the Site Manager, may continue to administer medications. The Observation and Transcription knowledge review must be completed within 15 days or before the 2- year period has elapsed, which ever is less.
3. In the event an employee is unavailable to complete the Observation and Transcription knowledge review within 15 days of course completion or prior to their expiration of approval, whichever comes first, the employee may not pass medications until such time as the Observation and Transcription knowledge review is completed.

This training does not include training on delegated duties that are often done in medical homes. A delegated duty falls under the license of a registered nurse. Any employee performing a delegated duty must be trained and signed off by the RN.

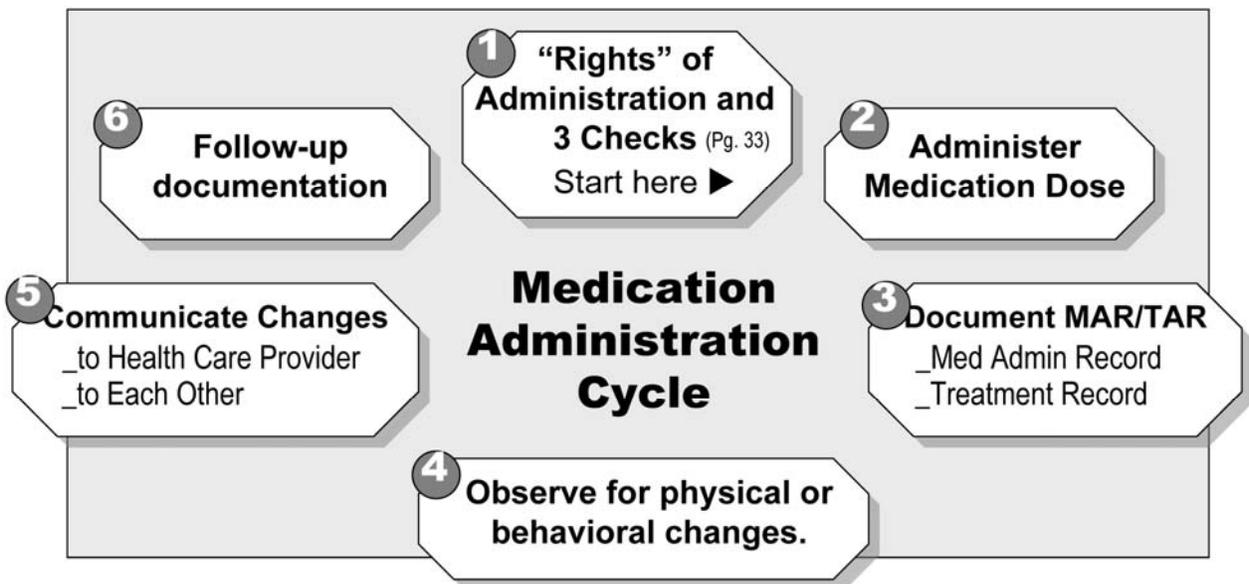
# LESSON 1: Why medication training?

**DESIRED OUTCOME:** *Maximizing safety for individuals who might benefit from medication as part of their treatment plan.*

## **Why we have medication administration training?**

- Many individuals need prescribed medications to benefit fully for a high quality of life in their homes and communities.
- Caregivers may not be familiar with some of the medications that the psychiatrist and primary care physicians (PCP) prescribe.
- All medications/treatments, including treatments available over the counter without prescription, can have undesired effects or cause rare responses in some people.
- All medications are potentially dangerous and no medication is absolutely safe.
- In addition to protecting the health and well being of the individuals that are supported, your knowledge of appropriate medication procedures for administering medications will serve to protect you and SOCP from faulty medication practices, which may have serious consequences (i.e. hospitalization, wrong medication to people, etc.).
- Knowing how to document medication administration correctly requires training. The procedure of thorough documentation is called "looping." This means that you should be able to follow from beginning to end (that's the "loop") the outcomes of medication administration.

We want you to be successful at your job. The more you know about medications that are used by the people you support and the proper use of them the better you will be equipped to perform your job.



## **Administration – Be Aware**

Failure to correctly perform each step in the medication administration cycle can result in negative consequences:

- Persons go to a doctor because of a change in physical or behavioral signs. Our individuals may not receive needed medical attention unless you conscientiously observe him/her and report any significant changes.
- A medication may be prescribed that an individual is allergic to unless you communicate important information to the physician or other health care providers.
- An individual may not receive a prescribed medication unless you receive a prescription at a visit to their physician and follow the proper procedure.
- An individual may receive the wrong amount of medication unless you follow procedures and the medication administration record correctly. Always be honest with the individual and answer any questions to the best of your ability or refer them to their physician or health care provider.
- An individual may continue to suffer undesirable effects unless you observe, document and report all physical/behavioral changes to the Site Manager ASAP.

## **Values, Attitudes and Concerns**

Everyone holds differing beliefs and ideas about using medication. However, those "beliefs and ideas" should not impact your delivery of medications/treatments as ordered by the physicians.

SOCP policies cannot always allow for medication practices that might be used in typical homes or vocational settings. However, staff should make every effort to use procedures that are as normal as possible within the rules and regulations.

### *Medication Concerns and Appropriate Responses*

You can anticipate some types of concerns, as they are common for many people who must take medication, especially for behavior stabilization. It can be helpful to have an idea of what to say when these issues arise.

There are a number of common concerns you might hear from individuals who take medications, especially psychotropic medication. When performing medication administration, your response to statements like the ones below can be either helpful or harmful. Many times, this is an opportunity to relieve fears with a bit of education. It helps to know some positive responses in advance.

**Refusal to take medication:**

- Remember this is a right that our individuals have.
- Our individuals might want to show some control by refusing.
- It is always helpful to point out how the medications have helped them so far or have helped other people, even if no one likes taking medication.
- It is our responsibility to handle this doing our best to assure the medication is taken.
- Try to determine why your individual is refusing:
  - You had to wake them up (check the addendum and come back later if possible)
  - They are mad at you (have a co-worker ask what's up?)
  - They are simply in a "bad mood" (re-approach later/check addendum)

**Those pills are the wrong color:**

- Double check (call the pharmacy or look for a new physician's order)...the person often has memorized the colors of their medication and they are right
- Explain the doctor changed the order and the pill is now a new color

**I won't be able to learn at work/play sports/go on dates/etc. because of this medication:**

- People who are anxious, depressed, or having trouble thinking clearly at times also have those kinds of difficulties.
- The medication will make it easier for you to do what you want to do without having those problems interfering with your goals.

Remember to never give any information that you do not know or are unable to provide. Try to use these moments as an opportunity to encourage the individual to discuss these concerns and any other she/he might have with the health care provider

## LESSON 2: Categories and Effects of Medications

**DESIRED OUTCOME:** *Knowing the categories a medication falls under provides helpful clues about its appropriate use and intended effects.*

### **Categories of medications**

A medication is any non-food substance placed into or on the body (oral and/or topical) for therapeutic purposes (*American Society of Health-System Pharmacists, ASHP*). To understand medications better, they can be divided into several important categories based on their differences and similarities, such as:

#### **Availability and source**

##### **Prescription (Rx) medication/treatment:**

- Available only upon the order of a licensed health care professional such as physician, dentist, certified nurse practitioner or physician's assistant.
- Cannot be purchased over-the-counter (*e.g. Tylenol vs. Tylenol with codeine*)

##### **Over-the-counter medication (oral – taken internally):**

##### **Any ingested liquid(s)/tablet(s), nasal spray, eyedrops and/or suppositories.**

- Requires a physician's order, but can be purchased more cheaply over-the-counter.
- It must be left in the original container and you must put the individual's name on it.
- Be careful to purchase the dose that will be compatible with the physician's order (*e.g. order states 500 mg. - you cannot purchase 325 mg. Tablets*).

##### **Over-the-counter treatment (topical – on the body):**

- Does not require a physician's order (*preventative use only eg. Prevent dry/chapped skin, prevent sunburn, prevent infection of minor scratches/abrasions, etc.*)
- It must be left in the original container and you must put the individual's name on it.
- The order on the Treatment Administration Record (TAR) would be transcribed as written on the container (*e.g. Neosporin Ointment, Eucerin Cream, KY Jelly, etc.*).

***The abuse potential of any medicine is the chance it might be used for non-therapeutic purposes.***

**Controlled medications** - Prescription medications that have been legally designated because they contain "controlled substances" (high risk of use for non-therapeutic reasons).

- Packages for these medications often display symbols that show the abuse potential. Controlled medications always carry some risk of abuse.



Controlled substances / Controlled medication examples:							
Schedule	Category	Description	Prescribing Rules	Examples by Class of Compound			
				Narcotics	Stimulants	Depressants / Antianxiety	Other
I	Highest abuse potential	Most potent narcotic & all hallucinogens	Use in U.S. limited to research only	Heroin			LSD, "ecstasy," PCP
II	High abuse potential with high probability of dependence	Narcotics, potent stimulants & sedatives with highest withdrawal dangers	No telephone prescriptions or refills	Morphine, oxycodone (Percodan©, OxyContin©, Tylox™), meperidine (Demerol™)	Cocaine, amphetamines, methamphetamine (Desoxyn®), methphenidate (Ritalin®, Concerta©)	Most barbiturates	Marijuana, Dronabinol (Marinol®, marijunan derivative)
III	Less abuse potential than Sked. II & moderate dependence probability	Lower doses per unit or less potent narcotics, stimulants and sedatives	Up to 5 monthly refills, prescription must be rewritten after 6 months	codeine (<90 mg/tab), hydrocodeine (Vicodin©, Lortab©, Hycodan©)	Phendimetrazine	Mixtures of barbiturates	
IV	Less abuse potential than Schedule III and limited dependence probability	Low potency sedatives and anti-anxiety agents and non-narcotic analgesics (pain relievers)	Up to 5 monthly refills, prescription must be rewritten after six months	pentazocine (Talwin©), propoxyphene (Darvon©), butorphenol (Stadol®)		choral hydrate, phenobarbital, benzodiazepines, alprazolam (Xanax©), chlordiazepoxide (Librium©), clonazepam (Klonopin©), clorazepate (Tranxene©), diazepam (Valium™), lorazepam (Ativan©), oxazepam (Serax©), tiazolam (Halcion©), zolpicem (Ambien®), carisoprodol (Soma)	

Medications not listed on a Controlled Substance/Scheduled Medication Examples list would be called non-controlled or non-scheduled medications. All medications, however, require a licensed professionals order.

## Name and number of manufacturers

### Name brand:

- One manufacturer has patent protection.
- Usually the first letter is capitalized.

**Examples:** *Emycin, Tylenol, Motrin, Depakote, Ritalin, Remeron or Zyprexa.* Also called a trade name or a proprietary name.

## Generic:

- Usually produced by a number of companies.
- Can be chemically identical to brand name drugs and are generally less expensive
- Usually the first letter is in lower case.
- **Examples:** erythromycin, acetaminophen, ibuprofen, valproate, methylphenidate, mirtazapine, or olanzapine.
- The pharmacy can substitute a less expensive generic drug unless the physician orders no substitutions.

## Time and use:

- PRN - comes from the Latin phrase pro re nata and means "as needed".
- Routine (*regularly scheduled*) - Medication given consistently at specific times.
- Single Order - medication that is administered only once (*e.g. one dose sedative prior to a dental appointment*).
- STAT - medication that is administered immediately and one time only.
- Time Limited - medication given for a specific time period only (*e.g. Penicillin 250 mg. QID X 5 days*)
- Part of the Body Affected (*route medication given*)
- Ophthalmic - For the eyes
- Otic - For the ear
- Oral - For the mouth or by mouth
- Nasal - For the nose
- Suppository - Inserted in a body cavity, usually the rectum or vagina
- Epi pens and insulin injections are administered by staff as a "Delegated Task."

**Note:** There are times when an ophthalmic (eye) medication is prescribed for use in the ear (otic). Always, double check if you have a question.

## **RN (as needed) medication**

PRN medications are often used to provide short-term relief of mild to moderate symptoms. Many times these are medications that are available over-the-counter (non-prescription) for people outside a facility to use without a specific diagnosis. Other PRN medications by prescription are used to relieve the symptoms of a known condition.

- PRN medications may be given for specific physical complaints they might relieve such as pain or nausea. Note: they relieve the symptoms (fever) rather than treat the illness (flu) causing the symptom.

***Example** - someone who has had recent surgery or an injury will take pain medication as needed while they recover.*

- Oregon regulations do not allow psychotropic medications to be prescribed as a PRN.
  - Psychotropic medication cannot be administered on a PRN basis without ISP team approval, guidelines written into the individuals ISP and an approved variance from Licensing.

Using PRN medications to relieve symptoms is also an example where it is not always possible to administer medication to individual's in the group home setting exactly like one would in their private home.

- You must have a doctor/licensed health care professional's order to be able to administer any medication (*PRN or regular order*).
- In any administration situation of a PRN, it is always required that each use, the specific reason for the use, and the results be documented on the back of the MAR/TAR.
- When using PRN medications staff who administer them must report prolonged episodes that persist, recur frequently, are not explained by known conditions or are otherwise concerning to them to the Site Manager and health care professional.

When administering PRN medications, specific information is needed that is different than scheduled medications:

- The order must specifically state under what conditions the medication can be given
  - Complaint of headache/fever over 101 degrees
  - Small cuts/scrapes
  - Dry skin including soles of feet
- In most cases the order must indicate the lapse of time between administrations
  - Every 4 hours
  - Twice a day

- If a topical treatment is purchased over-the-counter (*OTC*), the directions must be copied as written on the container onto the TAR with the same information included.
- Over-the-counter topical directions that indicate a range in time (*e.g. 2-4 times per day*), pick the greatest allowed times [4] or number (*apply every 2-4 hours*), pick the amount that gives the maximum number of applications [2]. Indicate-not to exceed...
- Whenever there is concern about interactions between medications, consult the pharmacy to make sure that the topical over-the-counter medication doesn't interact adversely with any current medications.

### ***Effects of medication***

Medication, when properly prescribed and administered, can have several outcomes:

- Desired effects - The beneficial and desired effect of the medication.
  - Those administering medications and making observations need to know why the individual is getting that medication.
  - Some medications are given for different diagnosis.
    - ***Examples:***
      - *Depakote, Tegretol can be given for seizures or as a psychotropic or,*
      - *Benadryl allergy relief or sleep aid*
- Unwanted effects - Undesired effects, any results other than the desired effect. (*Examples of unwanted medication effects are on the page 16*).
  - Unwanted effects are sometimes called side effects, but what might be an unwanted effect in one case may be a desired effect in another.
  - Some over-the-counter allergy medicines (*Benadryl*) make people sleepy, so the same chemical (*diphenhydramine*) is sold under a different brand name as a sleep aid.
- No apparent effect - The absence of the desired effect, after allowing sufficient time for the medication to work.

***Staff is best able to observe and report any and all suspected effects of medications.***

## ***Drug interactions***

Drugs can interact with other drugs or food. Taking multiple medications at the same time may result in a drug interaction.

- May affect the desired effect of one or more of the drugs.
- The effects of the drug may be increased or decreased.
- May produce a new and unique unwanted effect.
- Example: Maalox (antacid) decreases effectiveness of tetracycline (*antibiotic*).
  - Tetracycline needs stomach acid to be absorbed
  - Maalox inhibits stomach acids
- You cannot see these interactions...they are physiological (*happening inside the body*)...watch and observe for possible changes over time.

### **Food may also interact with drugs.**

- Grapefruit juice should not be given with ANY medications as it may adversely affect absorption of the medication.
- Some medications must be given on an empty stomach for maximum absorptions.
- Certain antibiotics must not be given with dairy or calcium containing products.

**NOTE:** For individuals prescribed medications causing photosensitivity (increase probability of sunburn), sunscreen with at least 30 SPF should be applied before going outside.

**Daily Log note:** All new/changes in medications and treatments must be listed for seven (7) days on the Daily Log so all staff are aware and can follow-up on side-effects, etc. This includes changes in dosage, new medications or discontinued meds.

## Medication side effects

Some undesired effects grouped by affected part with common medications that might be the cause:

### Skin

- Hives (Raised blebs/welts/urticaria) -
- Rashes - many, especially anti-seizure meds
- Increased sweating - Ritalin®
- Decreased sweating - Haldol®, Zyprexa®, lithium
- Acne – prednisone

### Digestive system

- Diarrhea - Antibiotics
- Nausea/vomiting - codeine, other narcotics, lithium
- Heartburn - anti-inflammatories (ibuprofen, naprosyn)
- Gum/teeth problems - Dilantin® (phenytoin)
- Dry mouth - antihistamines (Benadryl®, etc.)
- GER (Reglan)

### Nervous system

- Dizzy/lightheaded
- Seizures - Wellbutrin™, other antidepressants
- Muscle tightness/ abnormal movements - antipsychotics (thorazine, Haldol®)
- Tics - methylphenidate (Ritalin®)
- Hallucinations/delusions - many
- Agitation - Prozac®, Zoloft®, Ritalin®, amphetamines
- Sleepiness - antidepressants, antipsychotic, antihistamines, narcotics
- Malaise (feeling ill or "out of it"), unpleasant sensations-antibiotics

### Respiratory system

- Irregular breathing - Prozac®
- Wheezing - inhalers

### Cardiovascular system

- Fainting - blood pressure medications
- Irregular pulse (faster/slower)- Ritalin®

### Blood

- Easy bruising - aspirin or blood thinners
- Low red cell counts (anemia) - anti-inflammatories
- Low white cell counts-valproate (Depakote®), carbamazepine (Tegretol®)

### Endocrine (hormones)

- Menses changes - birth control pills
- Hair growth - prednisone
- Hair loss - prednisone
- Thyroid problems - Lithium

### Urinary system

- Trouble voiding - antihistamines, older antidepressants

### General / constitutional

- Increased appetite/Weight gain - Prozac®
- Decreased appetite / Weight loss amphetamine (Adderal®)
- Fever- antibiotics
- Muscle cramps - blood pressure medications, lithium
- Itch - narcotics, especially Demerol®

### Special senses

- Vision changes
- Ringing in the ears (Tinnitus) - aspirin

## **Medications review**

The job of the caregiver is to watch for and report changes. You are responsible for noting changes, **not** to determine if the change you see is actually the result of a given medication.

If you see something that is different, report it. More detailed information about recognizing those important changes, how to report them, and to whom you should report will be covered in depth in Lesson 3.

## **Pill Book (or side effect sheets)**

Know where your **Pill Book** or **side effects sheets** are for your home. Sheets can be printed from PDR.net.

- For every medication currently being used in your home you **must** have access to this information and are responsible to know the side effects of prescribed medications.
- Remember that no one can expect to know everything about any given medication (*even doctors and nurses look things up daily to be sure*). You should always look up the details if you do not know or you are not sure. The key points of the discussion while doing this review are to:
  - Get a background picture of what to expect when you are a staff member administering medications in your home.
  - Learn new terms and practice using them to describe the conditions and medications you will commonly encounter. This means be descriptive and objective (factual) not subjective (opinions) in your documentation and reporting of side effects.
    - **Objective** = hands shaking slightly (*liquid does not spill out of full cup*), 6 oz just at meals vs. requesting fluids a minimum of every hour, sleeping additional 3 hours on/off during dayshift during the past 3 weeks, verbally aggressive with little provocation which is not usual
    - **Subjective** = I think Joe is depressed, Joe seems angry...
  - Know why medications are used.
  - Become familiar with the most important unwanted effects of those medications.

## LESSON 3: Observing and reporting

**DESIRED OUTCOME:** *Watching for important changes that may be related to medication and communicating that information effectively and appropriately.*

Observing and reporting physical and behavioral changes is an important responsibility for all staff. It is an important phase of the medication cycle that makes understanding medication administration more than just "passing out meds."

Reviewing your Pill Book/side effects sheets in the last lesson suggested some observations that might make you suspect medication as a cause, but there may be other causes for the changes that you will need to note.

***You are responsible to watch and report.***

### Reporting procedures and forms

There are three levels of things to report from most severe and urgent to the least:

- **Level 1:** Health emergencies (*IR must be completed*)
- **Level 2:** Non-emergency, possibly health threatening conditions (*IR may be completed*)
- **Level 3:** Other notable conditions (*IR would not necessarily be completed*)

### Notification system

Use the Notification System (*call and leave a message*) for all medical/behavioral situations of emergency/concern nature.

- **Level 1 emergency:** you will get an immediate response from the Site Manager or Program Manager. These pertain to clients or staff.
  - Deaths
    - Attempted suicides
    - AWOL
  - Abuse and neglect allegations
    - Emergency room/hospitalizations
    - Accidents resulting in injury
  - Involvement or calls made to law enforcement/fire departments
  - Any suspected illegal activities (*e.g., drugs, etc.*)
- **Level 2 non-emergency,** possibly health threatening conditions (*return call within 1 hour*)
- **Level 3 other notable conditions** (*return call by the end of the shift*)

**DHS**  
Oregon Department of Human Services  
Seniors and People with Disabilities  
State Operated Community Program

Incident Report (IR)  
Part 1

Date Stamp

Residential or  Vocational  Home or  Community

Name: (Last/First/MI) \_\_\_\_\_ Incident occurred Date: \_\_\_\_\_ Time: \_\_\_\_\_  A.M.  P.M.  
House name: \_\_\_\_\_ Date initiated report: \_\_\_\_\_ IR #: \_\_\_\_\_

A) What happened before the incident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B) What happened during the incident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C) What intervention did you do? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D) What resulted from intervention? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other staff involved: \_\_\_\_\_  
Name and title of person completing IR: \_\_\_\_\_

Notification	Date	Time	Fax	Phone	Delivery	In person
Guardian/Parent/NIA:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Service Coordinator:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Site Manager:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Program Manager:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Director:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Program Administrator:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Services Manager:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Manager:	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Distribution: Original - SOCP Central Office; Caregiver Copy - House; Pink Copy - Client Files  
OAR 411-325-0195; 411-345-0230 Mandatory Page 1 of 4 DHS 4595 (05/09)

DHS 4595

## Health emergencies

### **e·mer·gen·cy** (*definition*)

- A serious situation or occurrence that happens unexpectedly and demands immediate action.
- A condition of urgent need for action or assistance.

### **Examples to watch for:**

*(these are standard CPR/1st Aid issues)*

- Sudden wide-spread hives, especially if there is facial swelling.
- Seizures, especially new or unexpected if life threatening.
- Breathing difficulty.
- Disorientation
- Severe pain.
- Inability to stand or walk
- Medication overdose if life threatening.
- Rapid pulse or fainting or decreased level of consciousness
- Marked weakness especially on one side of the body.
- Marked behavior change.
- Uncontrolled bleeding.
- Change in mental status.
- Compound fractures

Mental status refers to a person's mood and the way they appear to be thinking and feeling. Medications other than psychotropic may cause mental status changes or other behavioral effects, especially when medication interactions occur.

### When and to whom to report it:

- Immediately. Call Local Emergency Number: 911
  - Provide first aid if necessary until help arrives.
  - Follow directions from emergency personnel during contact phone calls. Do not hang up...
- Poison Control (for accidental ingestions): 800-222-1222 (now a single national number, easily remembered, reaches your closest center) Usually 911 will give you direction to call when appropriate.

### After all emergencies:

- Call the Site Manager/Program Manager and inform them of what happened as soon as possible after the crisis/emergency. Leave them a message and give them your call back number.

- Follow-up with the completion of an Incident Report (4595, 4595A, 4595B, 4595C and/or 4595D). When emergency calls are made or trips to the emergency room, these are considered a "Change in Condition" and should be so noted on the Incident Report. Documentation also needs to occur in the homes Daily Log (4629) and Progress Note (4595) of the individual.
- The person writing the Incident Report should document what they saw and observed not impressions or suspicions!
- If individual has a Nurse-Client Relationship established, report to the nurse and inform the site manager.

### **Non-emergency, possibly health threatening conditions**

Non-Emergency **BUT** possibly a threatening condition might be those that you have been observing over a period of time (*hours or a shift, etc.*) that are not resolving themselves with usual medical interventions. This is change that is unusual to the individual.

#### **Examples to watch for:**

- A fever which is not reduced by PRN medication.
- Change in bowel habits (*ie. constipation or diarrhea*)
- A rash that lasts for several days or a rash that appears to be getting worse.
- A change in the type of seizure an individual typically experiences.
- Ingesting something (*dish soap, laundry detergent, etc.*) where you need to call poison control.
- An increase in seizure activity.
- Repeated episodes of anger or behavior, which may be manageable, but are not typical for the person.
- A persistent sore throat.
- Other behavior changes that are out of character as you have come to know them.
- Unusual refusal to take prescribed medications.
- Unusually withdrawn behavior on the part of a person who ordinarily has frequent interactions with others.

#### *When and to whom to report it:*

- Report to the Site Manager if deemed necessary using a Level 2 response/ notification procedure that means you will get a response within one hour.
- Report to doctor making appointment as needed as soon as possible after the ongoing condition or change is observed/ noted.
- Document on an Incident Report (4595), in the Daily Log (4629), and on the individuals Progress Note (4596). *When in doubt, document.*

## Other notable changes

### Examples to watch for:

- Report anything that could be significant such as changes in sleep patterns, unexplained bruises, slight rash, or upset stomach.
- Remember to report anything that is out of the ordinary especially if medications were recently changed.

### When and to whom to report:

- As soon as possible after the condition is observed.
- Document changes noted in individuals Progress Notes (4596). If a significant change in condition is noted, an Incident Report (4595) should be completed. All unexplained injuries (including bruising) must have an Incident Report.
- Document in the Daily Log (4629) for other shifts to review and continue reporting as needed.
- Follow the “Reporting procedures for the 3 emergency levels” on page 18. Notify the Site Manager if deemed necessary and visit a physician when it is recommended.

## ***WHEN IN DOUBT, BE ON THE SAFE SIDE and MAKE THE CALL!***

**SPECIAL NOTE:** Any reported injury must have (even those that don't fit into the above listed categories) regular follow-up and documentation.

1. Document status on DHS 4596 Progress Notes and DHS 4623 Injury Tracking Form
2. All injuries must have a DHS 4595 Incident Report with a copy of the Injury Tracking Form inserted.

Continue documenting the status in the progress notes until the injury is healed. You don't need a physician to indicate "healed." Staff attending to the individual can identify that an injury is healed or resolved based on their observations.

The image shows a form titled "Injury Tracking Form" from DHS (Division of Human Services, Geriatric Peace and Wellness, New Orleans Community Program). It includes a header with the DHS logo and title. Below the header, there is a section for "Client" information and a note: "Follow up documentation is required by each shift each day, until the injury is resolved. An injury is resolved when it no longer is at risk of infection. Documentation of the injury and its progress in healing is documented in the client's Progress Notes." (DHS 4596). The main body of the form is a table with the following columns: "Date injury observed", "Incident report completed", "Location and description of injury", "Date injury resolved", and "Staff signature". Each row contains a "Yes" and "No" checkbox for the first two columns. At the bottom, there is a note: "An injury can be resolved when there is no longer a scab, oozing, bleeding and no longer at risk of infection. Bruises can be resolved when it is yellowing, not raised and no signs of tenderness." The footer contains the text "3.000 Incident report attachment 4 Mandatory Page 1 of 2 DHS 4623 (08/05)".

## **DHS 4623 Injury Tracking Record: Definitions**

- **Bruise:** A discoloration of the skin without a break or tear in the top layer
- **Abrasion:** Wearing away or scraping of the skin layers by friction.
- **Rash:** Change in color/texture of the skin that may be warm, dry, cracked, bumpy or itchy.
- **Healed/resolved:** Skin condition that has cleared and skin is intact without a scab present.



State Operated Community Program
Incident Report (IR) Part 1

CORE IR#

Residential or Vocational

Home or Community

Name: Smith, Joe (Last) (First)

Date Incident Occurred: 11/14/08

Time Incident Occurred: 0915

House Name: Adell

Date Report Initiated: 11/14/08

A) What happened before the incident? "Before" doesn't necessarily mean immediately. Think about about interactions with others over hours, shifts, or days. Consider outings and locations where a person might have come in contact with branches or hard edges. Look at how they have been sleeping (or not), have they appeared more lethargic or active than usual. Read "Progress Notes" to see if others have noticed changes, etc. Was your individual in a "Protective Physical Intervention" (restraint)?

B) What happened during the incident? Think about what actually happened at the moment of the incident. If this is an injury that you didn't see happen, your research in the previous section is even more important to possibly understanding why the person has a bruise or scratch, etc. If the individual reported what happened, make sure your writing clearly indicates this is what the person said. Use "quote marks" if appropriate.

C) What intervention did you do? Following Dr.'s orders, calling doctor, going to the emergency room, moving a sharp object ...etc. Be sure you are checking the environment for safety hazards if that is a probable cause and whenever possible fix or secure it in some way so others aren't injured. Called 911, went to emergency room ... be thorough.

D) What resulted from intervention? If you are documenting a behavior event, and you don't see an injury right now, did something happen that might result in an injury tomorrow? Be thorough in your thinking. If there were no ongoing issues after you did your first aide, make a statement to that effect. Everything went well at ER with new orders, etc.

Other staff involved: none

Name and title of person completing IR: M. Howard, HTT2

Notification table with columns for Guardian/Parent/n/a, Service Coordinator, Site Manager, Program Manager and rows for Date, Time, Fax, Phone, Delivery, In Person.

Distribution: Original - SOCP Central Office; Canary Copy - House, Pink Copy - Client Files

## Incident Report (IR) Part 2

Name: Smith, Joe Date: 11/14/08 Time: 0915  
(Last) (First)

Protective physical intervention (PPI)       Emergency protective physical intervention       Emergency psychotropic medication

Program administration authorization: Yes  No  Time notified: \_\_\_\_\_

Program Administrator name: \_\_\_\_\_ Time approved: \_\_\_\_\_

### List Protective Physical Intervention (PPI) used:

Type of PPI? \_\_\_\_\_

How long was person in PPI? Min: \_\_\_\_\_ Secs: \_\_\_\_\_

Staff administering PPI? \_\_\_\_\_

Type of PPI? \_\_\_\_\_

How long was person in PPI? Min: \_\_\_\_\_ Secs: \_\_\_\_\_

Staff administering PPI? \_\_\_\_\_

Type of PPI? \_\_\_\_\_

How long was person in PPI? Min: \_\_\_\_\_ Secs: \_\_\_\_\_

Staff administering PPI? \_\_\_\_\_

Type of PPI? \_\_\_\_\_

How long was person in PPI? Min: \_\_\_\_\_ Secs: \_\_\_\_\_

Staff administering PPI? \_\_\_\_\_

Type of PPI? \_\_\_\_\_

How long was person in PPI? Min: \_\_\_\_\_ Secs: \_\_\_\_\_

Staff administering PPI? \_\_\_\_\_

Type of PPI? \_\_\_\_\_

How long was person in PPI? Min: \_\_\_\_\_ Secs: \_\_\_\_\_

Staff administering PPI? \_\_\_\_\_

Did an injury occur? Yes  No

Type of injury: Swollen knee Location of injury: Rt. knee cap Size: (inches) 2"

Treatment Cold moist pack X2 20 min each.

### How should the incident be classified: (check all that apply)

- |                                       |  |  |  |   |
|---------------------------------------|--|--|--|---|
| <input type="checkbox"/> Death        | <input type="checkbox"/> Suicide           | <input type="checkbox"/> Hospitalization                   | <input type="checkbox"/> Self-Injurious behav. | <input type="checkbox"/> Aggression                       |
| <input type="checkbox"/> Illness      | <input type="checkbox"/> Attempt           | <input type="checkbox"/> Prop.destruction                  | <input type="checkbox"/> Pica                  | <input type="checkbox"/> Referred for (OIT) investigation |
| <input type="checkbox"/> Medical      | <input type="checkbox"/> Threat            | <input type="checkbox"/> Emergency PPI                     | <input type="checkbox"/> Incident w/public     | <input type="checkbox"/> Missing                          |
| <input type="checkbox"/> Police       | <input type="checkbox"/> Choking           | <input type="checkbox"/> Program PPI (approved in BSP)     |  |   |
| <input type="checkbox"/> Fire         | <input checked="" type="checkbox"/> Injury | <input type="checkbox"/> Emergency psychotropic medication |  |   |
| <input type="checkbox"/> Other: _____ |  |  |  |   |

Distribution: Original (White) – SOCP Central Office

Canary Copy – House

Pink Copy – Client files

## LESSON 4: Obtaining and using medication

**DESIRED OUTCOME:** *Providing accurate information to health care providers and understanding medication orders. Getting the facts about medication for safe and beneficial administration.*

### **Importance of information**

Information plays an important role in the medication cycle as you have seen in the previous lessons.

- Health care providers need accurate and complete information as they try to ensure that medication is being used to the best benefit of the individual and as safely as possible.
- Specific types of information related to medication are an essential part of the basic health record for an individual. This information is important for a doctor to safely prescribe medication.
- Basic directions are always given for administration on the labels for medication and these directions must be followed **exactly**.
- Medical information can be found in the Individual Program Book, on the MAR/TAR and on the Physician's Visit Order Form. When you go to the doctor's office your house procedure may have you to take the Individual Program Book, PVO (*and Addendum*) with you. You will not take the MAR/TAR's.

### **Medication questions**

In order to understand completely a new medication's benefits and risks and to use it wisely, you must either be sure you know it already or find it out when needed, usually by asking (*pharmacist or physician*) or looking it up (*Pill Book or side effects sheet*).

- What is the purpose and desired effect of the medication?
- What is the response time? When should we see this take effect?
- Are there any unwanted effects to watch for specifically?
- Are there any possible interactions with other medications or foods, including PRN medications?
- Are there any special administration and/or storage instructions?
- Is this medication a controlled substance?
- What should staff do if the following occurs?
  - A dose is missed?
  - A dose is refused?
  - A dose is regurgitated?
  - A dose is spit out?
  - An extra dose is given.
- Is the medication intended to be a psychotropic? Can it have effects on behavior?

**Information for the doctor**

**Fill in before appointment.**  
It is the responsibility of the person going to the doctor to verify accuracy from an exact copy of original physician's order.



State Operated Community Program  
**Physician's Visit/Orders (PVO)**

Client Name: First and last name Date: Appointment date

Name of Physician: Attending doctor Other Specialist: \_\_\_\_\_

Reason for Visit: Clear description of why you are at the doctor's office, complaints directly from the client, or observed changes in physical or behavioral signs.

**Current Medication/Treatments – Dosage and Time**

**Oral Medication**

**LIST all current oral meds taken on a regular basis** – taken directly from MAR, exact copy of original physician's order. Injectable medication included here.

**Treatment Medication**

**LIST all current topical/treatments used on reg. basis**– take directly from MAR, exact copy of original physician's order.

**PRN Medication/Treatment**

**List all PRN medications and treatments.**

**Prosthetics**

**List or note as NONE**

**Special Diets**

**List or note as NONE**

**Known Allergies/Adverse Drug Reactions**

**List or note as NONE**

**Psychiatric Diagnosis**

**Found on BSP from last psychiatric consult or client's Health List. If there is no diagnosis – write NONE**

**Significant Findings of Examination**

**Physician's Orders**

**ONLY the Licensed Profession writes in this section: Doctor, Nurse, Physician's Assistant, Dentist, etc. Staff DO NOT WRITE in this section for any reason.**

Attention Physician: Please state time per

Physician's Visit Order – taken from Medication Administration Training materials

<p><b>DHS</b> Oregon Department of Health Services Seniors and People with Disabilities</p> <p style="text-align: center;">State Operated Community Program Physician's Visit/Orders (PVO)</p> <p style="text-align: right;">9</p> <p>Client Name: <u>Waty Jusas</u> Date: <u>11/19/08</u>          Name of Physician: <u>Dt. Fix-it</u> Other Specialist: _____          Reason for Visit: <u>Annual Exam</u></p> <p style="text-align: center;"><b>Current Medication/Treatments – Dosage and Time</b></p> <p><b>Oral Medication</b></p> <ul style="list-style-type: none"> <li>• Artane 2 mg. 2 tabs po q am</li> <li>• Artane 2 mg. 1 tab po bid</li> <li>• Resperdal 2 mg. 1 tab po bid</li> </ul> <p><b>Treatment Medication</b></p> <p>None</p> <p><b>PRN Medication/Treatment</b></p> <ul style="list-style-type: none"> <li>• Tinactin Powder apply PRN to feet for complaints of itching, no more than every 6 hours until itching subsides.</li> <li>• Acetaminophen 325 mg 2 tabs po every 4 hours as needed for pain or temp over 100°.</li> </ul> <p><b>Prosthetics</b></p> <p>None</p> <p><b>Special Diets</b></p> <p>None</p> <p><b>Known Allergies/Adverse Drug Reactions</b></p> <p>None</p> <p><b>Psychiatric Diagnosis</b></p> <p>Mental Retardation / Schizoaffective disorder</p> <p style="text-align: center;"><b>Significant Findings of Exam</b></p> <p><u>Eyes are normally dry. Noticed increased shaking of</u></p> <p>Client: <u>Waty Jusas</u>          Policy #4.004 Attachment A Page 1 of 2</p>	<p><b>DHS</b> Oregon Department of Health Services Seniors and People with Disabilities</p> <p style="text-align: center;">State Operated Community Program Physician's Visit/Orders (PVO)</p> <p style="text-align: center;"><b>Physician's Orders (Medication, Treatment, Revisions, etc.)</b></p> <ul style="list-style-type: none"> <li>• <u>Use 1-3 drops in each eye BID x 5 days.</u></li> <li>• <u>Increase Artane to 5 mg 1 tab po BID.</u></li> <li>• <u>Return in two weeks to recheck eyes.</u></li> </ul> <p>Attention Physician: Please state time period for all orders (ie. take until gone, use until rash disappears, etc.)</p> <p>Pharmacy: <u>Oak</u> Phone: <u>503-555-1234</u> Fax #: <u>503-555-5678</u>          Physician's Signature: <u>Dt. Fix-it</u> ← Date: <u>11/19/08</u></p> <p style="text-align: center;"><b>Staff Information</b></p> <p>Staff Signature: ← Date: ←</p>
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**Staff should document any additional information:**

- BP – from the nurse
- Weight – from the nurse
- Verbal clarifications from the Doctor. If it constitutes an order, the Physician must put it in writing.
- How the client did at the appointment
- Note the follow-up appointment date/time etc.

**NOTE:** You do not have to repeat all of this info. In the DHS 4596 Progress Notes, you can refer to the DHS 4576 Physician Visit Orders (PVO).

**Signature, title and Date are required** – even if no notes are recorded in this section.

- Usually the physician will write the orders in the "Physician Order" section. If, however, they write up in the section listing medications...the physician must sign where the order was changed as well as at the bottom of the form.
  - Assure you have clear orders written. **Example:** if the order says 2-4 drops you must have the health care provider clarify specifically how many drops (cannot do 2-4), or specific area of a rash, etc.
  - If the order is not ongoing, the health care provider must specify an ending date or note "until healed," etc.
- If any clarifying information is directly related to the actual order (ie. Forgot to indicate how often the medication was to be given, etc.), the health care provider must write the clarification on the order. You cannot alter or clarify in the health care provider section of the PVO (4576).
- If you don't think the medication will be delivered from the pharmacy in time for the next dose, you can ask the physician to clarify right on the order "upon delivery from pharmacy." This allows continuation of a previous dose until new one arrives and makes it easier to pick up the orders on the MAR from the physician's perspective.

- Upon returning home, staff **must:**
  - Fax or drop off new order to pharmacy.
  - Make a note that the individual made a visit to the doctor's office on the Progress Notes (4596) in the Individual Program Book. You do not need to restate everything that is on the PVO (4576) form.
  - Transcribe any new medication/treatment orders onto the MAR/TAR (4573). When done transcribing the orders, staff must bracket: Signature/title, date and time on the PVO and on the MAR/TAR.
  - Put new medication/treatments or changes in medications/treatments on the Daily Log (4629) for seven (7) days to assure staff knows of any medication/treatment additions or changes.
  - At this time, you should also update the PVO (4576) as necessary for the next physician visit.
  - Notify the Site Manager or on coming shift if the medication has not arrived at the home by the end of the shift.
  - Add follow-up appointment to house calendar/appointment book and Daily Log (4629).

DHS 4629 Daily Log

DHS 4576 Physician Visit Orders (PVO)

DHS 4596 Progress Notes

DHS 4573 Medication Administration Record

# Medication administration irregularities



## Addendum to Physician Orders Medication Administration Irregularities Physician's Directions

Client: Joe Smith Physician: Dr. Dolittle

Current medications are listed on physician's orders. In the event that a medication or treatment is missed, I, Dr. Dolittle wish the following to occur:

Medication:	Procedure to use when medication is missed (check one):
Risperdol 2 mg. TID by mouth	<input type="checkbox"/> a. Give medication as soon as he/she comes home. <input checked="" type="checkbox"/> b. Give up to <u>3</u> hours late, after that time lapses call for directions. <input type="checkbox"/> c. Give up to _____ hours late, after that time lapses wait for the next scheduled dose. <input type="checkbox"/> d. Call for directions immediately. <input type="checkbox"/> e. Other: _____
Lithium 250 mg. ii tabs by mouth TID	<input type="checkbox"/> a. Give medication as soon as he/she comes home. <input checked="" type="checkbox"/> b. Give up to <u>4</u> hours late, after that time lapses call for directions. <input type="checkbox"/> c. Give up to _____ hours late, after that time lapses wait for the next scheduled dose. <input type="checkbox"/> d. Call for directions immediately. <input checked="" type="checkbox"/> e. Other: <u>Don't give if within 2 hours of next dose. Give next dose only. Notify via FAX if this situation occurs.</u>
Write order EXACTLY as on the PVO	<input type="checkbox"/> a. Give medication as soon as he/she comes home. <input type="checkbox"/> b. Give up to _____ hours late, after that time lapses call for directions. <input type="checkbox"/> c. Give up to _____ hours late, after that time lapses wait for the next scheduled dose. <input type="checkbox"/> d. Call for directions immediately. <input type="checkbox"/> e. Other: _____
	<input type="checkbox"/> a. Give medication as soon as he/she comes home. <input type="checkbox"/> b. Give up to _____ hours late, after that time lapses call for directions. <input type="checkbox"/> c. Give up to _____ hours late, after that time lapses wait for the next scheduled dose. <input type="checkbox"/> d. Call for directions immediately. <input type="checkbox"/> e. Other: _____
	<input type="checkbox"/> a. Give medication as soon as he/she comes home. <input type="checkbox"/> b. Give up to _____ hours late, after that time lapses call for directions. <input type="checkbox"/> c. Give up to _____ hours late, after that time lapses wait for the next scheduled dose. <input type="checkbox"/> d. Call for directions immediately. <input type="checkbox"/> e. Other: _____

**NOTE:** A Medical Incident Report (MIR) needs to be completed. On the MAR/TAR form (circle on front/explanation on back). Physician/Nurse (per policy) must be notified (phone/fax) only if you are outside the parameters listed above.

If there are any other medication administration errors/overdose/wrong dose/wrong person/wrong route, etc., it **MUST** be reported on a Medical Incident Report (MIR) and the doctor (or their designated back up) must be called immediately for instructions.

Physician Signature: Dr. Dolittle Date: 1-21-08

**The additional time given by the physician on this addendum is calculated from the time the dosage is scheduled to be given on the MAR/TAR.**

The **DHS 4621 Addendum to Physician Orders**, is used to provide physician's directions for each medication in the event that the original order cannot be followed. Medication/treatment cannot be administered outside the parameters of the addendum without obtaining a telephone or faxed order from the health care provider.

- The medications/treatments included on the addendum form are at the discretion of the health care provider. This helps avoid unnecessary contact with the health care provider.
- Staff should transcribe the exact physician's order into the medication column.
- The doctor must fill in the procedure section and sign the form.
- Unless the physician specifically indicates on the addendum form how he/she wants notification, notification is not necessary.
- This is a physician's order. Staff cannot write over written orders, modify or change them in any way. You can put one diagonal line through the "medication" section only to discontinue an order (*signature/title, date and time should be included as with any discontinued order*).

### **REMEMBER:**

- When you discontinue a physician's order on a MAR/TAR (4573), if you also have an addendum order for that same medication/treatment, you must discontinue it as well.
- Whenever an order or any part of an order changes, you must have a new addendum form as well. These must match exactly with the orders on the original physician's order form. You can update these in three ways:
  - Take the Addendum form (4621) with you each time you go that is already filled out with the original orders so that the doctor can update and sign on the spot;
  - Have the doctor write directly on his original PVO (4621) the addendum orders, copy and highlight those orders and staple them to the addendum orders you have, or
  - After you are home, update the new addendum form and deliver/fax to the physician to sign and return.

***The key is that your Addendum (4621) is current with Physician's Order (4576)!***

## DHS 4664 Telephone Orders

<b>Telephone Orders</b>		
<b>Facility name:</b> _____	Your "home" name	<b>Address:</b> _____
Name: _____		Address of your home
<small>Individuals last name</small>	<small>First name</small>	<small>Name of the doctor called</small>
<b>Date ordered:</b> _____	<b>Date discontinued:</b> _____	<b>Orders:</b> _____
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;">           Date of conversation         </div>	<div style="border: 1px solid black; padding: 5px; margin: 10px auto;">             _A complete order including medication, dose, route, number of times a day, etc.              _Write the order as given by the doctor or nurse.           </div>	
<b>Signature :</b> _____	<small>Person receiving the order: initial, last name and title</small>	<b>Time:</b> _____
<b>Physician's Signature :</b> _____	<small>FAX, mail, hand carry for signature</small>	<b>Date:</b> _____
<b>ORIGINAL COPY: Physician please sign and return within 48 hours.</b>		

- This form is used every time a staff receives instructions from a physician or physician's nurse on the telephone regarding an individual. You can get the forms from your pharmacy.
- Be sure the phone order form contains the following information: individual's name, physician's name, name of the medication or the treatment, dose or strength of the medication, manner in which it is to be administered (*by mouth, etc.*), time(s) of day it is to be administered (*B.I.D., one time a day, etc.*), length of time it is to be administered (*if applicable, e.g.. ten days, etc.*), date the order is given, and time and signature/title of the person taking the order over the phone.
- **Transcribe the order onto the MAR/TAR (4573):**
  - Follow transcription procedures outlined for standard physician's orders.
  - File a copy of the order in the individual's record.
  - Bracket the order then put your signature/title, date & time on the order when you have finished transcribing it.
- **Mail, hand carry, or fax the order** to the physician's office for his/her signature.
  - If you do not make arrangements to pick up the signed order, ensure that you provide the physician with a self-addressed stamped envelope or your fax number to return the signed telephone order.
  - When the signed telephone order is returned place the signed original in the individual's record on top of the copy that was used for transcribing the order onto the MAR/TAR (4573).

<b>Telephone Orders</b>		
<b>Facility name:</b> <u>SOCP House</u>	<b>Address:</b> <u>101Somewhere Lane, Salem, OR</u>	
<b>Name:</b> <u>Smith</u> <u>Sally</u>	<b>Attending Physician:</b> <u>Dr. Fix-it</u>	
<i>Individuals last name</i> <i>First name</i>	<i>Name of the doctor called</i>	
Telephone Orders	<b>Date ordered:</b> <u>01/06/06</u>	<b>Date discontinued:</b> _____
	<b>Orders:</b>	
	<u>Correction of PVO dated 01/06/06 change to read:</u>	
	<u>Apply a thin film of Hydrocortisone 1% cream to rash</u> <u>on upper left arm 4 times per day for 3 days.</u>	
<b>Signature:</b> <u><i>dt, Dorothy M. Toto, FTT2</i></u>		<b>Time:</b> <u>1530</u>
<i>Person receiving the order: initial, last name and title</i>		
<b>Physician's Signature:</b> _____		<b>Date:</b> _____
<i>FAX, mail, hand carry for signature</i>		
<b>ORIGINAL COPY: Physician please sign and return within 48 hours.</b>		

*Above is an example of what a telephone order should look like if you have not yet transcribed the incorrect order to the MAR/TAR (4573).*

<b>Telephone Orders</b>		
<b>Facility name:</b> <u>SOCP House</u>	<b>Address:</b> <u>101Somewhere Lane, Salem, OR</u>	
<b>Name:</b> <u>Smith</u> <u>Sally</u>	<b>Attending Physician:</b> <u>Dr. Fix-it</u>	
<i>Individuals last name</i> <i>First name</i>	<i>Name of the doctor called</i>	
Telephone Orders	<b>Date ordered:</b> _____	<b>Date discontinued:</b> <u>01/06/06</u>
	<b>Orders:</b>	
	<u>Apply a thin film of Hydrocortisone 1% cream to rash</u> <u>on upper left arm 1-4 times per day for 3 days. <i>OR</i></u>	
	<u>D/C current hydrocortisone order</u>	
<b>Date ordered:</b> <u>01/06/06</u>	<b>Date discontinued:</b> _____	
<b>Orders:</b>		
<u>Apply a thin film of Hydrocortisone 1% cream to rash</u> <u>on upper left arm 4 times per day for 3 days.</u>		
<b>Signature:</b> <u><i>dt, Dorothy M. Toto, FTT2</i></u>		<b>Time:</b> <u>1530</u>
<i>Person receiving the order: initial, last name and title</i>		
<b>Physician's Signature:</b> _____		<b>Date:</b> _____
<i>FAX, mail, hand carry for signature</i>		
<b>ORIGINAL COPY: Physician please sign and return within 48 hours.</b>		

*The order above is another way a telephone order can look, especially if you have already transcribed the incorrect order on the MAR/TAR.*

If you notice this problem while at the office of the health care provider, you can ask the doctor to clarify it right on the original PVO (4576) and initial the correction (*much easier all around*).

**Fax orders**



# FAX COVER SHEET

<b>Date:</b> [ ]	<b>Sender:</b> [ ]
<b>To:</b> [ ]	<b>Office Name:</b> [ ]
<b>Office Name:</b> [ ]	<b>Address:</b> [ ]
<b>Address:</b> [ ]	<b>City:</b> [ ]
<b>State:</b> [ ] <b>Zip:</b> [ ]	<b>State:</b> [ ]
<b>Phone No.:</b> [ ]	<b>Phone No.:</b> [ ]
<b>Fax No.:</b> [ ]	<b>Fax No.:</b> [ ]
<b>Total Pages:</b> [ ]	
<b>Re:</b> [ ]	

Include the "Cover Sheet" in your page count.

- Urgent**   
  **For review**   
  **Please comment**   
  **Please reply**   
  **Please recycle**

Receiving physician's orders:

A faxed copy of an order is legal and should be treated as an original doctor's order (*transcribed onto MAR, signed off and filed in the Individual Client Book*).

Sending for advice from your physician:

Using your DHS approved "confidential statement" fax coversheet you can, if agreeable with your physician, use the fax process in order to get assistance from them. You could write your concern on the fax requesting advice. The doctor could respond with a written order. You must have a doctor's signature as with all physician orders. If there is an order, it should be treated as an original doctor's order (*transcribed onto MAR, signed off and filed in the Individual Client Book*).

***You fax your copy to the pharmacy insuring they receive it. Remember double check with your pharmacy to make sure they also received the order.***

**Confidential and legal**

the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

DHS 2009 (REV 9/2003)

## **Information from the doctor**

When a doctor or other health care professional licensed to prescribe decides that a medication is needed, they "order" its use. The information in that order is called a prescription.

Each time you give a medication, you must systematically and conscientiously check your procedure against these five rights. This is essential **everytime** you administer **any** medication - including medications that an individual has been taking for a long time.

Each time you give a medication, you need to remember to do the "**three checks.**"

# **3**

## **checks**

### **Three (3) Checks:**

- **Check 1:** Remove the medication from the secure locked area and check the prescription label against the MAR/TAR to make sure they match.
- **Check 2:** As you remove the medication from the bubble pack/pour the liquid, etc., you again check the prescription label against the MAR/TAR.
- **Check 3:** When you are documenting after the administration you again compare the prescription label to the MAR/TAR.

*The majority of medication errors that occur within SOCP are a result of not performing these three checks. When not done the individual is put at risk and as an administrator of medications you are not doing your job. These are the most important steps to successful and safe medication administration.*

## **Rights of medication administration**

Everyone who administers medications should know the five "rights."

### **Right person**

In order to make sure that you are about to administer medications to the right individual, you have to know the individual.

Even when you know the individual well, mistakes can happen. To reduce the risk of errors:

- Prepare medications for only one individual at a time.
- Compare individual's name on MAR to the name on the bubble pack. If they don't match...**STOP**...and clarify.
- Give the medication to the individual as soon as you prepare it.
- Do not allow yourself to be distracted.
- Do not administer medication prepared by another individual.
- Do your documentation immediately after you administer to each individual.

## Right medication

Some of the new brand names can be very confusing and many drugs appear in different formats, such as long-acting or slow release that can have quite different effects. In order to be sure that you are giving the right medication, you must:

- Read the medication label carefully (remember that some medications have more than one name: a brand name and at least one generic name).
- Read the MAR/TAR carefully. Make sure that the medication name on the label, MAR/TAR and medication order match **before** giving the medication. If they do not match, or if there is any doubt that you are giving the right medication, **STOP!**
- Look at the medication. If there is anything different about the size, shape or color of the medication, call the pharmacist **before** you give it. It could be that you have been given a different generic brand of the medication. But sometimes when a medication looks different it means that you have been given the wrong medication.

## Right dose

The right dose is **how much** of the medication you are supposed to give the individual at one time.

- Make sure the numbers have the decimal point at the right place (*some pills are 0.1 mg. and others 100 mg*) and the units (*milligrams or tablets for example*) are correct.
- To determine the dose, you need to know the **strength** of each medication.
- In the case of liquid medications, you need to know the strength of the medication in each liquid measure. The dose equals the strength of the medication multiplied by the amount.

<b>RX#:</b> 828291	<b>Town Pharmacy</b>
	100 Main Street Pineville, OR 00000 503-000-0000
<b>Jeff Smith</b> 01/04/06	
Valporic Acid 250 mg (Depakote)	
Take 2 tabs by mouth twice a day	
	Dr. B.J. Honeycutt
<b>Lot#:</b> PS56721	<b>Exp. Date:</b> 01/01/07 <b>Refills:</b> 4

The **strength** of each Valporic Acid pill is 250 mg.

The **dose** is 500 mg twice a day.

Strength (*250 mg per pill*) X Amount (*2 tabs*) = 500 mg.

## Right time

- Some medications must be administered only at very specific times of the day. For other medications, the time of day that you give the medication is less critical.
- It is very important for medication to be given at the time of day that is written on the medication order. If no specific time is written on the physician's order, use the times consistent with administration in your house as appropriate.
- Compare the time on the prescription label and the MAR/TAR. If they do not match, or if there is any doubt that you are giving the medication at the right time, **STOP!**
- **SPECIAL NOTES:** Medications must be given within one hour of the time listed on the MAR/TAR. This means you have one hour before and one hour after the medication is ordered to administer it. This **does not** apply to PRN medications. They must be administered as ordered. Follow addendum orders if applicable in the event of a medication omission.

## Right route

- The route means how and where the medication goes into/or on the body. Most medication is taken into the mouth and swallowed, but others enter the body through the skin, rectum, vagina, eyes, ears, or nose.
- Sometimes mistakes happen when you are giving several medications by different routes at the same scheduled time. Avoid mistakes by completing the administration of one route first (*e.g. eye drops*), put them away and wash your hands. Then administer the next medication (*e.g. ear drops*).
- If a route is not listed on the actual physicians order, it can be added to the MAR/TAR (4573) in parenthesis () if you know for sure the route intended by the health care provider. If you don't know for sure, you should contact the physician/pharmacist for clarification.

***You must investigate and correct all problems before you can proceed.***

## Common medical abbreviations

Abbreviation	Explanation
<b>gtts.</b>	drops
<b>@</b>	at
<b>am</b>	morning
<b>BP</b>	Blood pressure
<b>b.i.d./bid</b>	Twice a day
<b>gm. or GM</b>	gram
<b>c̄</b>	with
<b>cc</b>	cubic centimeter
<b>hs</b>	Bedtime (hour of sleep)
<b>Tx</b>	treatment
<b>tsp</b>	teaspoon
<b>Hr or hr</b>	hour
<b>NKA</b>	no known allergies
<b>Rx</b>	Prescription
<b>D/C or d/c</b>	discontinued
<b>mg.</b>	milligrams
<b>p.o. or po</b>	by mouth
<b>PRN or prn</b>	as needed
<b>Q. or q</b>	every
<b>Q.4h or q4°</b>	every 4 hours
<b>c/o</b>	complaint of
<b>Wt.</b>	weight

Abbreviation	Explanation
<b>X</b>	times
<b>↑</b>	increase
<b>↓</b>	decrease
<b>TPR</b>	temperature, pulse, respiration
<b>WNL</b>	within normal limits
<b>p̄</b>	after
<b>QD or qd</b>	daily or every day
<b>Q.6h or q6°</b>	every 6 hours
<b>Q.8h or q8°</b>	every 8 hours
<b>Q.12h or q12°</b>	every 12 hours
<b>QID</b>	4 times daily
<b>q.o.d. or qod</b>	every other day
<b>s̄</b>	without
<b>tab.</b>	tablet
<b>t.i.d. or tid</b>	three times a day
<b>NPO</b>	nothing by mouth
<b>oint</b>	ointment
<b>Tbsp</b>	tablespoon
<b>i</b>	one
<b>ii</b>	two
<b>iii</b>	three

Oregon Administrative Rules (OAR) 411-325-0120 (4)(a-c) require that medications be kept in their original containers and have original labels that should be easily read and understood to avoid misunderstanding which could lead to mistakes.

Abbreviations are discouraged in modern pharmacy practice yet there are times when they occur in a physician's order or pharmacy label.

## LESSON 5: Documentation and storage

***DESIRED OUTCOME:*** *Keeping medication administration records. Knowing how medication is safely and legally stored. Recognizing and handling medication errors.*

### **Documentation**

A MAR (4573). is required.

- To maintain the quality of each step throughout the whole medication cycle.
- Reviewed regularly for accuracy.
- Record the details when errors occur.
- Errors must be reviewed and changes may need to be made to procedures to prevent the same thing from happening again.
- Medication errors are described later in this lesson.

Each time a medication is administered, it must be documented. Your documentation of medication administration must be completed as soon as you give the medication. You must complete all of the documentation that is required on the MAR/TAR(4573):

- Documentation must be done in blue/black ink.
  - Red ink can be used only when discontinuing orders (*optional*)
  - Do not use felt tip/gel and other pens that leak/bleed.
  - Always make sure your writing is legible to anyone needing to read what is written.
  - Keep your initials within the square you are initialing for the administration.
- No pencil or white out can be used.
- If you make a documentation error during the medication administration process, do not scribble out or write over the error.
  - Error in narrative form, one line through it with initials.
  - Error in initials in wrong box, circle the square and explain on back what happened.
- As you have finished giving medications, double-check your documentation and again at the end of your shift.
  - If there is another medication trained staff available to double-check your documentation, ask them to go over the MAR/TAR to assure it is complete and correct.
  - You cannot sign for/ask others to sign for missed documentation. Always check the bubble pack to see if the medication is out of the pack when you find an empty square that should have initials. If the medication is gone, document on the back of the MAR (4573) as a documentation error. If the meds were still in the bubble pack, this would be a medication error and require a MIR (4630) be completed (*omission*).

**All documentation must be done immediately after the medication is administered for each individual.**

## **Medication errors**

A medication error occurs any time an individual is placed at risk because medication administration procedures were ignored, usually because one of the five rights was not correct. Medication errors occur when:

1. Administering the wrong medication to an individual.
2. Administering an incorrect dosage of the medication.
3. Administering a medication more than one-hour before/after a scheduled time.
4. A medication omission. This includes refusal by the individual to take medication.
5. Administering a medication using a route other than the one prescribed.
6. An apparent adverse reaction to a medication that results in a change in condition status for the individual.
7. The **DHS 4570 Individual Narcotic Count Sheet** (*Policy 4.012*) has a discrepancy in the number of pills.
8. Any medication is missing.

These situations require the completion of a Medication Incident Report (MIR) (4630) and documentation on the MAR/TAR (4573). with notification of the physician (*except 7, 8 no call to physician needed*). A note should also be made in the Progress note (4596) that a medication error was made.

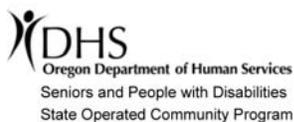
Other irregularity such as the individual is gone (*e.g. on outing and medication went along*), documentation error, etc. must be:

- Documented on the MAR/TAR (4573) by placing a circle in the appropriate square on the front of the document with accompanying explanation on the back.
- Do not require a MIR (4630) as they do not affect the health of an individual.

It is extremely important and wise to regard all deviations from the five medication rights as situations that require prompt action following policy and procedure to the letter to minimize the chance of harm.

- Prompt recognition and reporting, rather than trying to hide an error. You must handle medication errors as directed by Policy #4.004.
- The Site Manager and Program Manager of each home carefully review all medication errors. The purpose of the review is to find and correct the root causes, rather than to find someone to blame. Correcting the causes of medication errors will help prevent future errors. Therefore, reviewing errors carefully and thoughtfully is an important component of the process to make sure that mistakes are not repeated.

# Medication Incident Report DHS 4630



## Medication Incident Report

Date stamp:

House Name: \_\_\_\_\_ MIR #: \_\_\_\_\_

Client Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Medication/Treatment: \_\_\_\_\_

Dosage: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Wrong Medication         | <input type="checkbox"/> Medication Omission           | <input type="checkbox"/> Adverse Reaction   |
| <input type="checkbox"/> Incorrect Dosage         | <input type="checkbox"/> Wrong Route                   | <input type="checkbox"/> Narcotic Count     |
| <input type="checkbox"/> Wrong Time               | <input type="checkbox"/> Medication Refusal (Omission) | <input type="checkbox"/> Medication Missing |
| <input type="checkbox"/> Medication Not Available | <input type="checkbox"/> Other: (explain) _____        |   |
| <input type="checkbox"/> Details: (explain) _____ |  |   |

### Action taken

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> MIR completed         | <input type="checkbox"/> Phone order completed  | <input type="checkbox"/> Physician instruction  |
| <input type="checkbox"/> PVO Addendum followed | <input type="checkbox"/> Documented in Progress | <input type="checkbox"/> Other: (explain) _____ |

Physician notified:  Yes  No      Date: \_\_\_\_\_ Time: \_\_\_\_\_  Phone  FAX

Physician response: \_\_\_\_\_

Other: \_\_\_\_\_

Name and title of person completing MIR: \_\_\_\_\_ Date: \_\_\_\_\_

### Preventative action/Management review:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Review signatures      Site Manager: \_\_\_\_\_      Program Manager: \_\_\_\_\_

Notification	Signatures	Date/Time	Fax	Phone	Delivery	In person
	County services coordinator ( <i>Notification only</i> )	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SM: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NM: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PM: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review signatures      Director: \_\_\_\_\_      Prog. Admin. (PA) \_\_\_\_\_      Nurse Mngr: \_\_\_\_\_

**DISTRIBUTION:** White and Yellow copies – SOCP Central Office; Pink copy - House

Policy #4.004, #5.005 Mandatory

DHS 4630 (05/10)

## ***Preventing medication errors***

The best preventative measures for eliminating medication errors are to:

- Assure all five medication administration rights are followed
- Do the triple check:
  - When you take down from cupboard
  - When you are removing from bubble pack/container
  - When documenting passing of meds
- Minimize interruptions while you are administering medications
- Know what medication you are giving (*research unfamiliar medications*)
  - If the medication doesn't look familiar, check it out
  - If the individual says it's not their medication, check it out

What if... (*Additional “What ifs” can be found in the Appendix*)

- Wrong medication is accidentally punched out of the bubble pack?
  - Dispose of the medication documenting on the drug disposal record
  - Contact pharmacy for replacement
  - Make a note in the Daily Log, etc. so other staff know medication is ordered
- Break the seal on a pill not being used right now.
  - **DO NOT** tape it back together
  - Follow disposal procedures
  - Contact pharmacy for replacement
  - Make a note in the Daily Log (4629), etc. so other staff know medication is ordered
  - If the meds come from the pharmacy taped (*very infrequent, but has happened*) it should be initialed by them and a note may accompany the bubble pack.
- Right when getting ready to administer med/treatment, discover outdated.
- **DO NOT** administer. Follow procedures for documentation and completion of MIR (4630) if actual error results
  - Dispose of medication/treatment per procedures
  - Contact pharmacy immediately for replacement
  - Note on Daily Log (4629), etc.
- If an individual's medication is missing, staff will immediately:
  - Notify the Site Manager or designated Site Manager on call.
  - Complete a Medication Incident Report (MIR) (3630).
  - Seek instructions from the Site Manager as to what should be done regarding medication administration for the missing dose(s).

## **Storage of medications**

**Policy #4.012 (Medication Handling)** and good pharmacy practice requires that:

- All medications will be kept in their original containers in a secured locked cupboard/cabinet or container.
- Liquid items will be stored below dry items or in a separate cupboard/cabinet or container.
- Each individual's medications will be stored separately from others living in the home in plastic bins or other containers that can be kept clean and orderly.
- Medications stored in a refrigerator are to be kept in a secured locked container.
- Oral medication will be stored separately from other medication (this is to prevent someone from accidentally swallowing an external medication) and under proper conditions of sanitation, temperature, moisture and light.
- At times, the doctor will provide samples of medication for use. You must have a written order to use these medications/treatments. When this happens the following options are available for use:
  - Put individuals name clearly on each dose/tube, etc.
  - Put in a zip lock baggie or other sealed container and put individuals name on the container.
  - Do not write the order on the dose/container, only the individual's name.
- When medication order changes, the pharmacy will not always take “Returns”, sometimes requesting house use “Change of order stickers.”

## **Controlled substances**

Controlled medications must be accounted for as changes occur and between all shifts.

- Assure accurate/current count of **ALL** controlled medications by the personnel accepting responsibility for passing medications. This includes those that come and "wait" for the beginning of the month/med cycle. Controlled medication is counted in four situations:
  - Upon receipt
  - When dispensing
  - When disposing
  - Between shifts
- **DHS 4570 Individual Narcotic Count Sheet** (use either the one sent by the pharmacy or the SOCP form) will be utilized for each controlled medication. Any discrepancies will be documented on the next available line and a Medication Incident Report (MIR) (4630) will be completed. Staff is responsible to assure there is a count sheet in place.
- **DHS 4663 Medication Administration Accountability Sign-Off Sheet** or the **DHS 4570 Individual Narcotic Count Sheet** will be used to document availability of controlled medication between shifts.
- If using the **DHS 4663 Medication Administration Accountability Sign-Off Sheet**, you do not list individual clients and their medications. You count all narcotics in the house and verify if they are correct or incorrect.



If you use this form to count between shifts to verify medications are accurate, you would need to count all controlled medications in the home and document the number of pills.

The medications are not identified individually by person, when using this form.

Print

**DHS**  
Oregon Department of Human Services  
Division: Senior People with Disabilities  
State Operated Community Program

**Medication Administration Accountability Sign-Off Sheet**

House: \_\_\_\_\_ Month: \_\_\_\_\_

Two (2) staff from each shift must sign off below, signifying that all scheduled meds, PRN, treatments and narcotic(s) have been checked, dispensed and documented per medication administration procedures: OAR 309-046-023 (3/0/03/08).

Day	Day shift signatures (2)	Check time	Error Y/N	Swing shift signatures (2)	Check time	Error Y/N	Night shift signatures (2)	Check time	Error Y/N
1st									
2nd									
3rd									
4th									
5th									
6th									
7th									
8th									
9th									
10th									
11th									
12th									
13th									
14th									

Policy #4.012 Attachment B (Mandatory) Page 1 of 2 DHS 4663 (9/09)

**Instructions:** Do not individually list client/name or medication counts. Count all controlled/narcotic medications in the house and sign on one line to verify that the counts were correct or incorrect. If there is a discrepancy in count, a MIR must be completed. This form can be used in conjunction with the Individual Narcotic Count Sheet (4570) either provided by your pharmacy or SOCP form.

### Disposing of medication

Discontinued, contaminated or expired medications will be kept in a locked cupboard or locked box at a specified, secured, locked location until it can be disposed.:

**Two medication disposal options exist:**

**Preferred method:** Contact the Pharmacy and check for acceptance – requires one staff or manager’s signature.

**Alternate method:** Contact SOCP Outreach nurse – requires multiple signatures.

The original DHS 4590 form is kept in the home for 2 years in both disposal options.

- If there is a controlled medication to be disposed of and for some reason it cannot be disposed of immediately, the Individual Narcotic Count (4570) Sheet must continue to reflect this until the disposal is completed and documented.
- The Drug Disposal Sheet (4590) will be used to document the disposal of the medication.

Print

**DHS**  
Oregon Department of Human Services  
Division: Senior People with Disabilities  
State Operated Community Program

**Drug Disposal Sheet**

Date MM/DD/YY	Client's name	Drug description: Why taken:	Dose	Amount	Reason for disposal				Method of disposal: Return to Pharmacy or Central Office Disposal	Disposal signatures	
					Recalled	Outdated	Unused	Other		House required signatures: 1 <sup>st</sup> = SM, BV/S1, BV/S2 or PM Nurse	Central Office required signatures: 1 <sup>st</sup> = Nurse Mngr 2 <sup>nd</sup> = Witness
					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						
					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						
					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						
					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						
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					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						
					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						
					<input type="checkbox"/> Pharmacy <input type="checkbox"/> Office						

\* NOTE: Pharmacy disposal requires signature of a staff or manager at the house. SEE BACK for process details.  
Original Drug Disposal sheet remains at the house for 2 years and a copy goes with the outreach nurse.  
OSEHA Requirements / OAR 411-325-120 Medication Administration, Medications Storage and Disposal of Medications DHS 4590 (03/10)

**NOTE:** 2010 procedure change – **NO disposing of medications in “Sharps” container.**

- a. If disposing of an oral medication in the home,
  - Check with Pharmacy to see if they will take return medications, or
  - Call Outreach nurse for pickup.
- b. If disposing of topical/aerosol in the home, put in paper sack or other bag you cannot see through and dispose of in the outside garbage can (not in any receptacle inside the home).
- c. If the pharmacy will accept a return, attach the pharmacy receipt for the medications to the Drug Disposal Sheet (4590).

**Alternate method: Preparing medications for return/disposal through Central Office/Outreach Nurse(s)**

**HOUSE:** Requires two signatures - 1<sup>st</sup> signature: Site Manager, BVS1, BVS2 or Program Manager and the 2<sup>nd</sup> signature is the Outreach nurse

- Medications remain in the bubble wrap.
- Original DHS 4590 form is kept in the home for 2 years
- Duplicate the DHS 4590 form and send the copy with the outreach nurse.

**Upon arrival at Central Office and/or Milton Nurse Station:**

Outreach nurse is required to recount the medications upon arrival at Central Office / or the Milton Nurse Station. Two signatures are required: 1<sup>st</sup> signature: Nurse Manager and 2<sup>nd</sup> signature is a witness / outreach nurse.

**Medication disposal / accountability signatures process**

Two medication disposal options exist:

Preferred method: Contact the Pharmacy and check for acceptance – requires one staff or manager’s signature.

Alternate method: Contact SOCP Outreach nurse – requires multiple signatures.

- Original DHS 4590 form is kept in the home for 2 years in both disposal options.

**Alternate method:** Preparing medications for return/disposal through Central Office/Outreach Nurse(s)

HOUSE: Requires two signatures

1<sup>st</sup> signature: Site Manager, BVS1, BVS2 or Program Manager.

2<sup>nd</sup> signature: Outreach nurse

- Medications remain in the bubble wrap.
- Original DHS 4590 form is kept in the home for 2 years
- Duplicate the DHS 4590 form and send the copy with the outreach nurse.

**Central Office/Milton Nurse Station:**

Outreach nurse is required to recount the medications upon arrival at Central Office / or the Milton Nurse Station:

Two signatures are required:

1<sup>st</sup> signature: Nurse Manager

2<sup>nd</sup> signature: Witness / outreach nurse

OSHA Requirements / OAR 411-325-120 Medication Administration, Medications Storage and Disposal of Medications DHS 4590 (03/10)

*The back page of Drug Disposal Sheet (4590) – outlines the 2 methods, process and signatures needed.*

## LESSON 6: Administering medications

***DESIRED OUTCOME:*** *That all staff administering medications do so understanding the importance of and potential dangers associated with giving medications to others. To assure that all medication/treatments are given exactly as ordered by the physician or health care provider or as stated on the manufacturer's instructions.*

### ***When not to give medications***

#### **Do not give a medication:**

- If any one or more of the following required items are missing:
  - MAR (4573) or TAR
  - Original and legible pharmacy label or manufacturers label
  - Over-the-counter purchases has an illegible label on the container
- If the individual exhibits a dramatic change in status which you suspect is a result of taking the particular medication.
- If you have any doubt regarding the five rights.
  - Right person
  - Right medication
  - Right dose
  - Right time
  - Right route
- If the individual refuses to take medication.
- If the individual says that it is not their medication.
- If the individual has difficulty in taking the medication.
- If the physician's order specifies not to administer (e.g. do not give if BP < >120/60)
- If the medication has expired.
- If you question the medication or packaging of it.
- If the medication is an injection, unless it is an Epi Pen or Insulin.

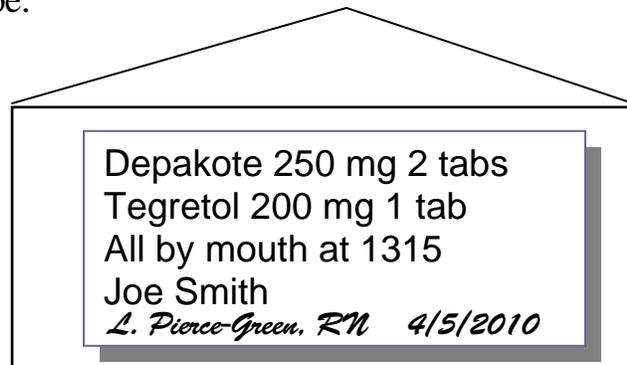
You must seek assistance, follow Physician Addendum orders (4621) or contact the physician or pharmacist for clarification as needed in these situations.

## Medication administration while away from home

### Outings with staff

- Only the staff that will be administering the medication can package them for the outing.
- One envelope for all meds for one administration time (*size of envelope may vary based on number of medications needing to be in it and orders legibly written on the outside*). If you will be gone through two administration times you would need two envelopes of medication. On the envelope you must write the following for each of the medications that are in the envelope:

- Name of medication/dose
- Name of individual
- Time to be administered
- Route of administration
- Signature, title and date



- If you have a medication that is a different route of administration, you must have a separate envelope.
- Some medications cannot be put in these small envelopes (*e.g. ear drops, eye drops, treatments*). In this case you could put the medication container into a baggie and again put on the baggie using a self adhesive label the name/dose, etc. as listed above. Be sure that if refrigeration is needed to take these in a cooled/secured container, etc.
- If going out for less than 72 hours (*ie. Camp with staff in attendance*)
  - Take the bubble packs and a copy of the MAR/TAR (4573).with you.
- **In all cases** the medication must be in a secure locked container (*bag, tackle box, etc.*) or in your possession at all times.
- Upon returning home, the staff must go to the MAR/TAR's and double check for completion:
  - On the original MAR/TAR circle the appropriate square for the medications that had been given. Document on the back of the MAR/TAR that the medications were given on the outing and see attached copy of the MAR/TAR.
  - Attach the copy to the original MAR/TAR.

## Working with staff

- Take a separate/original MAR with you to the worksite (*per Vocational OARs*) that have only the specific medications/diets or treatments that will be administered in the work area.
- Make sure by the end of your shift that documentation on the "original" house MAR/TAR is complete:
  - Circle any square where medication was taken to the work site.
  - Documentation on the back of the MAR/TAR filling in blanks as appropriate and indicating "meds sent to work." Be sure to list specifically what medications you have taken.
  - A co-worker may have completed this documentation in your absence at medication dispensing time. They would have checked the bubble pack and made notation that the medication was not in it. They would only be able to document it going to work if they had first hand knowledge that this was the case.
- Preparing the medication to take with you-three options:
  - Take the regular bubble pack for the dose being administered.
  - Have the pharmacy set up a special bubble pack (*or other pharmacy packaging*) just for work. (*extra cost involved*)
  - If you are the staff that will be administering the medication, pop the pill into an envelope and clearly mark it with the individual's name, medication, dose, time, route, etc. (*same as for outings*)
  - If the medication is a controlled drug, you must sign the medication out on the **DHS 4663 Medication Administration Accountability Sign-Off Sheet**. The sheet stays at the house.
  - **In all cases** the medication must be in a secure locked container (*bag, tackle box, etc.*) or in your possession at all times.

## Visit (of 72 hours or less) where staff will not be staying

- The person that will be dispensing the medication(s) (including parents and/or guardians) must package into envelopes following directions for "preparing medications" above.
- Staff cannot prepare medication for administration for someone else.
- That means that if you were transporting the individual you would take the medication bubble pack and a copy MAR/TAR (4573) with you to compare labels, etc. When done with this process, the copy of the MAR/TAR is shredded. You can set up the envelopes ahead of time to make it easier for the family, but careful comparing must happen by the family.

- If the person is at the house, you can use the MAR/TAR & pills right there. DO NOT leave the original MAR/TAR or bubble pack with the family.

### **Extended time away from home**

- If the individual is going to be gone for more than 72 hours, you **must** have the pharmacy set up the medications for them. You cannot put them in envelopes. For extended outings, hospitalizations, etc. the following documentation must occur at home on the MAR/TAR's:
- With the first circle on the front of the MAR/TAR (*1st dosage time of absence*) an entry is made on the back of the document explaining the circumstances
- Each square is then circled at medication time (*no notation on the back of the MAR/TAR needed each time*).
- When the individual returns home a final entry on the back of the MAR/TAR is made noting their return.
- If you are taking drops/topicals out of the house, put them in a zip lock baggie for clean keeping.

### **Medication administration overview**

Here are the instructions, step-by-step, to administer each of the different types of medication as allowed by the regulations for those who successfully complete this training. You will find that they appear on these pages so that they can easily be copied for future reference as needed. These are also the steps that you will need to follow to successfully complete your skill test at the end of the training and as part of the observations required.

All of the procedures regarding medication administration are intended to assure the "Five rights" of medication administration:

#### **Five rights:**

- Right person   • Right medication   • Right dose   • Right time   • Right route

#### **Five always:**

- Always have a signed physician's order for every medication or treatment (*except over-the-counter topical*).
- Always wash your hands before/between giving medication and doing treatments.
- Always pop the medication from the bubble pack into a medication cup (*or directly into the individuals hand if they prefer or into a med cup then into the envelope for an outing*) never into your hand. Pour any liquid medication directly into a calibrated medicine cup.

- Always identify your individual and stay with them until the medication is swallowed.
- Always keep the medication storage area locked, clean and orderly.

**Five nevers:**

- Never leave medication with the individual or on the table, counter or bedside.
- Never give medication prescribed for one individual to another.
- Never dispense medication that was prepared by another person.
- Never use medication that is outdated or from an illegible or unlabeled container.
- Never give a medication that you have questions about until you have checked with the pharmacist, the individual's physician or the individual's nurse.

**Five musts:**

- You must have the Medication Administration Record (MAR/TAR) (4573) prior to compare to the labels when giving medications/treatments.
- You must read the label and compare it with the MAR/TAR three times when administering the medication:
  - When comparing container or label to MAR/TAR
  - When removing medication from bubble pack or container, and
  - When you document after the administration
- You must ensure that the individual is in a good position for swallowing the medication. This would primarily apply if you were actually putting the medication into the mouth of the individual. It is difficult to swallow when their neck is hyper-extended or the person is lying down.
- You must record the administration of the medication immediately on the individual's MAR/TAR.
- You must know why you are giving the medication (*what did the doctor order the medication for*), it's desired action, and the possible side effects you should watch for.

If individuals are taking medication that is purchased over-the-counter because it is more cost effective:

- Do not remove from the original container.
- Be sure the medication dose on the container is exactly the same as what the physician is ordering.
- Follow the instructions of the physician.
- Individuals name should be put on the container

The order must be on the MAR/TAR.

## LESSON 7: Miscellaneous information

Be aware if an individual has **protocols** for any of the "fatal four" health issues:

- **Aspiration**
- **Constipation**
- **Dehydration**
- **Seizures**

A **protocol** is written when a person(s) have a specific, chronic, or frequent problem or condition. *Protocols are specific to the individual and to the setting.* These protocols identify the individual is at risk.

Protocols are sometimes confused with procedures:

- Protocols are problem oriented.
- Procedures are task oriented and provide step-by-step instruction on how to do a task.

Sections of the "Protocols" identify:

1. Description of preventions
2. Signs and symptoms
3. What to do if any signs or symptoms are observed
4. When to call 911

If an individual has a Nurse-Client Relationship, it means their health care needs require the oversight of a professional nurse for eight or more continuous days or has been certified by a physician or registered nurse as requiring ongoing nursing services.

Unless otherwise indicated by the doctor or nurse, weights should be done monthly generally at the same time each month and same time of day using **DHS 4649 Weight Record**. *Example: 4<sup>th</sup> weekend before breakfast.*

If there is a 5 pound difference, from the previous weight, you must reweigh the client.

### ***Self-administration of medication***

There is no specific training related to self-administration of medication in this curriculum.

Individuals who "independently" take medications are considered self-administering. Client and staff ***both*** sign the MAR/TAR and accompanying data sheet(s) from the time they begin "training" and continues after the client is fully capable of self-administration.

This information will need to be individually trained by the specific house.

## **Administration tips**

### **General tips**

- Always communicate with the individual and explain what it is you are going to do.
- Allow ample time to administer carefully and accurately.
- Hands should be thoroughly cleansed before handling medication, as it is considered the single most effective way to reduce the spread of infection.
  - Use liquid soap whenever possible since it doesn't become contaminated under normal circumstances.
  - When soap/water is not available commercially packaged antiseptic hand cleansers or towelettes may be used.
  - Use hand lotion as needed for dry/cracked hands. This will reduce the risk of dryness and one's susceptibility to infection.
- Generally concerned with two types of drug administration:
  - Local (*effect is limited to the site of application*) e.g. ointments, creams, eye drops, and
  - Systemic (general effect in which the drug is absorbed into the blood stream and carried to one or more of the tissues of the body) e.g. tablets, capsules, liquids, injections, transdermal (*patches*)

### **Oral administration**

#### **• Oral administration highlights:**

- Disadvantage of being slower in onset of action.
- Some may irritate the stomach and are "Enteric Coated" to prevent them from being broken down in the stomach. These should never be crushed or cut into smaller pieces. Always check Pill Book if uncertain in this area.
- Unless identified as chewable, tablets should not be chewed since this will cause the medication to be released in the mouth and cause improper absorption and unpleasant taste.
- If needed, most tablets can be given with applesauce. But liquid should always be offered to prevent choking or gagging.

#### **• Oral administration of liquids:**

- Only pour when you are ready to pass.
- Hold label in the palm of your hand (prevents spilling onto the label).
- When measuring:
  - Use felt marker (to mark the dose line) on the medicine cup, as it is held at eye level.
  - Read the dose level at the lowest point of the curve.





- Eye medications must:
  - Be sterile
  - Have the word "ophthalmic" or "eye" on the label.
- Medication should be stored at room temperature.

## Ears

- Remove any secretions on external ear with damp gauze pad (*separate for each ear*)
- Tilt head to opposite side where medication is to be applied
- Pull ear up and back
- Put drops down into the outer ear and allow it to gently trickle into the ear
- Do not allow the tip of the dropper to touch the ear, as this will contaminate the contents
- Have individual wait 5 minutes with ear up whenever possible
- May use a cotton ball to ensure medication stays if appropriate
- Apply to other ear 5 minutes later if ordered
- Positions
  - Sitting upright with head tilted back and supported
  - Lying with shoulders elevated above the level of the head
  - Laying on back with head lowered over the side of the bed



## Nose

- If possible have the individual blow their nose or clear of all discharge possible
- Draw enough medication into dropper for both nostrils
- Tip head back, hold dropper at entrance of nostril and slowly instill prescribed number of drops
- Repeat in other nostril
- Encourage individual to keep head back for a while

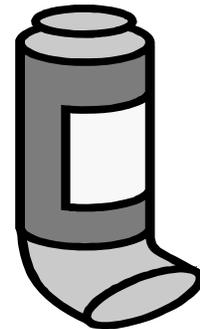


## Nasal sprays

- Positions same as for drops
- If possible have the individual blow their nose or clear of all discharge possible
- Insert tip of the spray bottle, pump or inhaler into the nostril. Have the individual inhale as you squeeze the bottle or activate the pump/inhaler. Repeat for second nostril.
- Clean the spray, pump or inhaler after each use with gauze pad moistened in warm water.

## Inhalers

- Have individual stand up - this lowers the diaphragm and allows for better lung expansion
- Shake the inhaler well - shake for 15-30 seconds
- Put spacer (*if appropriate*) on the inhaler
- Have individual breathe out to the end of a normal breath
- Tilt chin up - do not hyperextend
- Place spacer or inhaler in mouth - seal lips around the tube
- Activate the inhaler having the individual inhale slowly and deeply over 5 seconds (*don't use nose*) and hold breath for 10 seconds before exhaling
- Wait 2-5 minutes between puffs if additional puffs are ordered
- Give water to rinse mouth after all doses are taken
- Clean and dry inhaler thoroughly after each use.



## LESSON 8: Transcription examples

### *Time conversions*

The military clock measures time beginning at midnight and going for a full 24 hours until the next midnight. The military clock uses hours that are the same length as the standard clock. For example if it is 6:00 P.M. a military clock says that it is 1800. You read this time "eighteen hundred". This simple means that it is 18 hours and 0 minutes after midnight. If it is 8:15 P. M. you say it is 2015. You read this time "twenty fifteen". This means it is 18 hours and 15 minutes after midnight. *The chart below will help you with converting standard time to military time.*

<b>Military(24-hour time)</b>	<b>Standard (12-hour time)</b>
-------------------------------	--------------------------------

0100	1:00 A. M.
0200	2:00 A. M.
0300	3:00 A. M.
0400	4:00 A. M.
0500	5:00 A. M.
0600	6:00 A. M.
0700	7:00 A. M.
0800	8:00 A. M.
0900	9:00 A. M.
1000	10:00 A. M.
1100	11:00 A. M.
1200	12:00 Noon
1300	1:00 P. M.
1400	2:00 P. M.
1500	3:00 P. M.
1600	4:00 P. M.
1700	5:00 P. M.
1800	6:00 P. M.
1900	7:00 P. M.
2000	8:00 P. M.
2100	9:00 P. M.
2200	10:00 P. M.
2300	11:00 P. M.
0000	12:00 midnight







# Daily Log



## State Operated Community Program Daily Log

House: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Notes to staff:**

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APPOINTMENTS	Client	Time	Appointment
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OUTINGS	Client	Time	Outing / Activity
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

IR's / MIR's	Client	Brief Description
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

**New Medication Follow-Up x7 days:** *Staff who picks up order sets up 7-day follow-up on log sheets.*

Client	Order date	Medication	Side Effect Noted (y / n)			Progress note done		
			D	S	N	D	S	N

**Individual Client Daily Report**  
*(Medical, behavioral and general information)*

<b>DAY SHIFT</b>	Client	DAY SHIFT: Medical, behavioral and general information

<b>SWING SHIFT</b>	Client	SWING SHIFT: Medical, behavioral and general information

<b>NIGHT SHIFT</b>	Client	NIGHT SHIFT: Medical, behavioral and general information

DHS 4629 Daily Log Page 3 allows for Additional Notes.

DHS 4629E Shift Report - Eliot Home use - allows for client details on all shifts.

### General set-up

Each month/medication cycle, if your pharmacy doesn't automatically generate a MAR/TAR for your home, you must transcribe orders from the previous month/medication cycle onto the new MAR/TAR.

- This is usually done up to a few days before the actual first of the new month or they are received from the pharmacy a day or two before the end of the month.
- Only transcribe those orders that are currently being administered.
- If a new order is received in those in between days, staff must transcribe the order onto the old and new MAR/TAR. You would only sign off on the "old" MAR/TAR and can then add your initials/date on the new MAR/TAR in the lower right hand corner.
- Staff doing the first administration on the first of the month (*or nightshift if so designated*), **MUST** carefully double check the old MAR/TAR's against the new to assure that any new orders in the few days separating the setting up and the use are also transcribed onto the new documents.

## Components of doctor's orders and setting up a MAR/TAR

Oregon Department of Human Services		Seniors and People with Disabilities										State Operated Community Program																								
Date of Last Order	<b>Medication Administration Record</b>															Month/Year: January 2006																				
	<b>Medication</b>	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
9/15/04	Tegretol 200 mg. 2 tabs by mouth TID	8 am																																		
		2 pm																																		
		8 pm																																		
	<p><b>Name of medication</b></p> <p>a. Match PVO and bubble pack</p> <p>b. Use (parenthesis) if adding any information to the original PVO</p> <p><b>Dose</b> (if applicable) – include number of tablets/amount of liquid at that dose.</p> <p><b>Administration times</b> (eg. Twice a day, once a week, every other week, etc.)</p> <p><b>Specific times</b> to be administered (hour column)</p> <p><b>Route</b> to be given (eg. By mouth, etc.)</p> <p><b>Any specific instructions</b> (eg. Take BP before, etc.)</p>																																			
<b>Initial medications and identify below with signature (Signature: First/last name, position title.)</b>																																				
<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Initials</b>	<b>Signature</b>	<b>Record Checked By:</b>		
MH	Marie Howard HTT2																																		Date/Initial: mh 12/30/05	
																																				At Risk: Cholang
																																				Seizures, dehydration
																																				Page 1 of 1
Name: <u>First Name &amp; Last name</u> Allergies: <u>Food, Medication, or NKA (no known allergies)</u> Wt: <u>165 lbs</u> DOB: <u>2-5-70</u>																																				

DHS 4573

**Name of medication**

- a. Match PVO and bubble pack
- b. Use (parenthesis) if adding any information to the original PVO

**Dose** (if applicable) – include number of tablets/amount of liquid at that dose.

**Administration times** (eg. Twice a day, once a week, every other week, etc.)

**Specific times** to be administered (hour column)

**Route** to be given (eg. By mouth, etc.)

**Any specific instructions** (eg. Take BP before, etc.)

# Setting up a new MAR/TAR

Oregon Department of Human Services      Seniors and People with Disabilities      State Operated Community Program

Date of Last Order: \_\_\_\_\_      **Medication Administration Record**      Month/Year: January 2006

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

**Setting up a new MAR/TAR:**  
 When doing your initial set-up of a new MAR/TAR:

1. Fill in the client's first and last name.
2. Fill in the current month and year.
3. List all allergies or history of adverse side effects of medication.
4. Fill in the client's weight.
5. Fill in the date of birth (DOB).
6. Fill in page numbers.
7. Record you signature and initials.
8. Initial and date in the lower right hand corner as the person setting up and checking the document.

**FILL IN ALL THE BLANKS FIRST THING!**

Your signature should be – First and last name to include your work title.  
 Your initials must appear exactly as your initials in the boxes.

Marie Howard HTT?

Initial medications and identify below with signature (Signature: First/last name, position title.)								
Initials	Signature	Initials	Signature	Initials	Signature	Initials	Signature	Record Checked By:
MH	Marie Howard CT							Date/Initial: mh 12/30/05
								At Risk: Choking
								Seizures, dehydration
								<b>DHS 4573</b>
								Page 1 of 1

Name: \_\_\_\_\_ Allergies: Food, Medication, or NKA (no known allergies)      Wt: 165 lbs      DOB: 2-5-70

**Fill in ALL the blanks first thing!**

1. Client's first and last name
2. Current month and year
3. List all allergies
4. Client's weight
5. Date of Birth
6. Page numbers
7. Record you signature and initials
8. Initial and date lower right hand corner as person setting up and checking the document.

*Your signature should be the first and last name to include your work title.  
 Your initials must appear exactly as your initials in the boxes.*



# Discontinuing Orders

Oregon Department of Human Services		Seniors and People with Disabilities		State Operated Community Program																																
Medication Administration Record		Month/Year: January 2006																																		
Date of Last Order	Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
9/15/04	Tegretol 200 mg. 2 tabs by mouth TID	8 am	nef	nef	nef	nef	nef	nef	nef	nef	nef																									
		4 pm	nef	nef	nef	nef	nef	nef	nef	nef	nef																									
		8 pm	nef	nef	nef	nef	nef	nef	nef	nef	nef																									
1/5/06	Risperdal 2 mg. 1 tab by mouth BID (Twice a day)	8 am							nef	nef	nef																									
		8 pm							nef	nef	nef																									
	<del>M. Howard HTT2 1 pm 1/9/06 M. Howard HTT2 1 pm 1/5/06</del>																																			
1/9/06	Tetracycline 250 mg. 1 cap by mouth QID before meals and before bed for 10 days	7 am																																		
		11 am																																		
		4 pm																																		
		8 pm																																		
	<del>M. Howard HTT2 1 pm 1/9/06</del>																																			

**Discontinuing Doctor's Orders**

1. Draw one diagonal line through order and write "D/C." **Red ink is required.**
2. Draw a line through the remaining blank squares. **Use a ruler!**
3. Put your signature/title/time/date in the order area.
4. Take the bubble pack or treatment out of the storage container and prepare for disposal, or return to the pharmacy.

Initial medications and identify below with signature (Signature: First/last name, position title.)							
Initials	Signature	Initials	Signature	Initials	Signature	Initials	Signature
mh	Marie Howard HTT2						
hh	Heather Hoover HTT2						

Record Checked By: \_\_\_\_\_  
Date/Initial: mh 12/30/05  
At Risk: Choking  
Seizures, dehydration  
Page 1 of 1

Name: \_\_\_\_\_ Allergies: Food, Medication, or NKA (no known allergies) wt: 165 lbs DOB: 2-5-70

*D/C preferable to not be confused with "David Campbell."*

1. **RED INK** is required when "Discontinuing Doctor's Orders."
2. Draw one diagonal line through order and write "DC."
3. Draw a line through the remaining blank squares.
4. Use a ruler!
5. Put your signature/title/time/date in the order area.
6. Take the bubble pack or treatment out of the storage container and determine if it can be returned to the pharmacy **or** use the DHS 4590 Drug Disposal Sheet and call the Outreach Nurse for pickup.

*(See page 43 for more information about medication disposal.)*

# PRN Orders

Oregon Department of Human Services		Seniors and People with Disabilities										State Operated Community Program																							
Date of Last Order		Medication Administration Record																		Month/Year: January 2006															
		Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
9/15/05		Tylenol 325 mg. 2 tabs by mouth PRN Every 4 hours for pain or fever over 101°	PRN																																

**PRN Doctor's Orders**

1. Be sure you have a current order
2. Initial square and document on the back of the MAR/TAR the date/time and reason for giving the medication. Document the illness on the Progress Note. You don't need to document the giving of the medication in the Progress Note.
3. **ALWAYS do follow-up documentation.** Ask the person or do an observation of the condition and document under results/responses. If you can't do it, make sure the oncoming shift knows they need to do the follow-up.

Marie Howard HTT2  
Heather Hoover HTT2

Initial medications and identify below with signature (Signature: First/last name, position title.)

Initials	Signature	Initials	Signature	Initials	Signature	Initials	Signature	Record Checked By:
MS	Marie Howard CT							Date: DHS 4573
HH	Heather Hoover CT							At Risk: Choking Seizures, dehydration
								Page 1 of 1

Name: First Name & Last name      Allergies: Food, Medication, or NKA (no known allergies)      Wt: 165 lbs      DOB: 2-5-70

Intramuscular Injection Site Code:					Subcutaneous Injection Site Code:		
1) left gluteus (dorsogluteus)	6) right gluteus (dorsogluteus)	A) left abdomen	E) right abdomen				
2) left vastus lateralis (quadriceps)	7) right vastus lateralis (quadriceps)	B) back	F) right arm				
3) left rectus femoris (quadriceps)	8) right rectus femoris (quadriceps)	C) left arm	G) right leg				
4) left deltoid	9) right deltoid	D) left leg					
5) left ventrogluteal	10) right ventrogluteal						

Date	Time Given	Medication & Dosage	Reason	Initials	Results or Response	Time Noted	Initials
1/9/06	2 pm	Tylenol 325 mg. X 2tabs	Complaint of headache	Mh	Said "better."	5:30 p	hh

**ALWAYS do follow-up documentation.** If you are unable to do the follow-up, be sure the oncoming shift knows they need to do the follow-up.





# What If...

## OTC treatments by staff

Oregon Department of Human Services		Seniors and People with Disabilities		State Operated Community Program																													
Date of Last Order	Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1/7/06	Neosporin Cream (not to exceed) 4 applications typically daily for scratches and abrasions (no doctors order needed) <i>M. Howard HFT2 1 pm 1/7/06 10</i>	PRN																															

**OTC treatments by staff**

1. Put on MAR/TAR with directions from the box.
2. Clearly mark PRN.
3. Follow documentation as any with other PRN.
4. DC just like any other order when done with the treatment.
5. Include route.

In this situation, "Best Practice" would have a doctor's order even though it is not required.

If you have an ongoing issue like a rash, you should be consulting your PCP.

Initial medications and identify below with signature (Signature: First/last name, position title.)								
Initials	Signature	Initials	Signature	Initials	Signature	Initials	Signature	Record Checked By:
<i>mh</i>	<i>Marie Howard HFT2</i>							Date/Initial: <i>mh 12/30/05</i>
<i>hh</i>	<i>Heather Hoover HFT2</i>							At Risk: Choking
								Seizures, dehydration
								Page 1 of 1

Name: First Name & Last name Allergies: Food, Medication, or NKA (no known allergies) Wt: 165 lbs DOB: 2-5-70

DHS 4573

1. Put on MAR/TAR with directions from the box.
2. Clearly mark PRN.
3. Follow documentation as any with other PRN.
4. DC just like any other order when done with the treatment.

In this situation, "Best Practice" would have a doctor's order even though it is not required.

If you have an ongoing issue like a rash, you should be consulting your PCP.

# Client purchases OTC

Oregon Department of Human Services		Seniors and People with Disabilities		State Operated Community Program																													
Date of Last Order		Medication Administration Record		Month/Year: January 2006																													
Medication		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1/5/06	Carmex Lip Balm-apply freely to lips	INFO																															
OTC	Topically	ONLY																															
TX	(Joe is carrying in his pocket) <i>M. Howard HFTT2 1 tm 1/7/06 10 am</i>																																

**Client purchases OTC**

- Put on MAR/TAR with directions from the box.
- Clearly mark "information only."
- No initialing needed.
- Make note indicating individual is carrying the item (team reviews).
- DC just like any other order when done with the treatment.
- Include route.

Do not put these on your PVO if you clearly understand that these are OTC purchased treatments.

If the doctor orders the treatments, you must transcribe them as with any order.

Initial medications and identify below with signature (Signature: First/last name, position title.)								
Initials	Signature	Initials	Signature	Initials	Signature	Initials	Signature	Record Checked By:
<i>mh</i>	<i>Marie Howard HFTT2</i>							Date/Initial: <i>mh 12/30/05</i>
<i>hh</i>	<i>Heather Hoover HFTT2</i>							At Risk: Choking
								Seizures, dehydration
								Page 1 of 1

Name: First Name & Last name Allergies: Food, Medication, or NKA (no known allergies) Wt: 165 lbs DOB: 2-5-70

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- Put on MAR/TAR with directions from the box.
- Clearly mark "information only."
- No initialing needed.
- Make note indicating individual is carrying the item (team reviews).
- DC just like any other order when done with the treatment.

Do not put these on your PVO if you clearly understand that these are OTC purchased treatments.

If the doctor orders the treatments, you must transcribe them as with any order.

# Pharmacy doesn't deliver . . .

Oregon Department of Human Services		Seniors and People with Disabilities										State Operated Community Program																						
Date of Last Order		Medication Administration Record										Month/Year: January 2006																						
Date of Last Order	Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
9/15/04	Tegretol 200 mg. 2 tabs by mouth TID <i>M. Howard HTT2 1 pm 1/6/06</i>	8 am	mh																															
		4 pm	mh																															
		8 pm	hh																															
1/5/06	Risperdol 2 mg. 1 tab by mouth BID (DC this order when Risperdol 2mg 2 tab arrives) <i>M. Howard HTT2 10am 1/5/06</i>	8 am						mh	mh	mh	mh																							
		8 pm						hh	hh	hh	hh																							
1/9/06	Risperdol 2 mg. 2 tab by mouth BID (Start this order and DC Risperdol 2 mg 1 tab when medication arrives from pharmacy) <i>M. Howard HTT2 1 pm 1/9/06</i>	8 am																																
		8 pm																																

**Pharmacy doesn't deliver . . .**

1. Transcribe the new order.
2. Draw lines to date/time you anticipate med being available.
3. In (parenthesis) write instructions for starting/DCing orders.
4. If med doesn't arrive, extend line and continue original dose (make Progress Note.)
5. Don't forget to update your addendum to reflect change in orders.

Initial medications and identify below with signature (Signature: First/last name, position title.)							
Initials	Signature	Initials	Signature	Initials	Signature	Initials	Signature
mh	Marie Howard HTT2						
hh	Heather Hoover HTT2						

Record Checked By: \_\_\_\_\_  
Date/Initial: mh 12/30/05  
At Risk: Choking  
Seizures, dehydration  
Page 1 of 1

Name: \_\_\_\_\_ Allergies: Food, Medication, or NKA (no known allergies) Wt: 165 lbs DOB: 2-5-70

DHS 4573

1. Transcribe the new order.
2. Draw lines to date/time you anticipate med being available.
3. In (parenthesis) write instructions for starting/DCing orders.
4. If med doesn't arrive, extend line and continue original dose (*make Progress Note.*)
5. Don't forget to update your addendum to reflect change in orders.



**Additional “What ifs...”**

**The correct medication is punched from the wrong date?**

- *Circle the date punched out of the bubble pack.*
- *Circle the date it should have been punched out of on the bubble pack.*
- *In the Daily Log – note the situation. Punched out the 9<sup>th</sup> and should have punched out the 8<sup>th</sup>. Please use the 8<sup>th</sup> pill on the 9<sup>th</sup>.*
- *On the 9<sup>th</sup> there is not a pill in the bubble pack, check the “Daily Log’s” note to please use the 8<sup>th</sup> pill. -*
- *Be a good steward of the individual’s and program’s money.*

**There’s no pill in the bubble pack for a certain date, what do I do?**

- *Use the last pill of the “cycle fill.”*
- *Order a replacement pill from the pharmacy.*

**Additional scenarios:**

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**Reference materials / links:**

**Electronic Documentation for Providers Supporting People with Developmental Disabilities**

<http://www.therapservices.net/>

**SPD/DHS Developmental Disabilities Nursing Manual**

[http://courts.oregon.gov/DHS/spd/provtools/nursing/ddmanual/all\\_sections.pdf](http://courts.oregon.gov/DHS/spd/provtools/nursing/ddmanual/all_sections.pdf)

**SPD/DHS Developmental disabilities Nursing Manual Companion Guide: Protocols and Guidelines**

<http://www.oregon.gov/DHS/spd/provtools/nursing/ddmanual/companion.pdf>

**Community-Based Registered Nurses: Tools and Resources**

These materials have been developed for nurses working in community-based settings but can also be useful for community-based providers, case managers and other industry-related or interested parties.

<http://www.oregon.gov/DHS/spd/provtools/nursing/>

**Nurse to Nurse: Oregon's Community Based Care Nursing Newsletter –**

<http://www.oregon.gov/DHS/spd/provtools/newsletters.shtml#ntn>

A publication dedicated to the promotion of quality, community-based nursing practice.

If you have questions about information contained  
in this Medication Administration Manual  
and / or are requesting updated materials:

**Contact the State Operated Community Program.**

SOCP Central Training Unit	503 378-5952 ext. 256
SOCP Clinical Service Manager	503 378-5952 ext. 244
SOCP Nurse Manager	503 378-5952 ext. 224

The seal of the State of Oregon is a circular emblem. It features an eagle with wings spread, perched on a shield. The shield contains a plow and a sheaf of wheat. Above the eagle is a banner with the motto "THE UNION". The words "STATE OF OREGON" are written around the top inner edge of the seal, and "1859" is at the bottom. The seal is rendered in a light gray, semi-transparent style.

[www.dhs.state.or.us](http://www.dhs.state.or.us)

Department of Human Services  
Seniors and People with Disabilities  
State Operated Community Program (SOCP)  
(503) 378-5952

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