PROCEDURE: CONTROLLED MEDICATION

Security of Controlled Medications

1. Schedule (Class) I medications cannot be administered in the home.
2. Schedule II medications may be administered in the home. Schedule II medications are stored in a locked storage area. Only staff authorized to administer medications have access to the locked area.
3. Schedule III, IV, and V medications may be given at the home.

Reconciliation of Controlled Medications

1. The home maintains the pharmacy receipt(s) as a record of all Schedule II medication. When Schedule II medications arrive from the pharmacy, staff verifies that the quantity listed on the medication label is the amount received and initial and date the receipt. The receipt is filed with the medication administration record. Record receipt of the medication on the Controlled Medication Log.
   a. The home maintains a record of the administration of all Schedule II medications. These medications are documented as administered on the person’s medication administration record per procedure.
2. When Schedule II medication is spilled or dropped, an explanatory notation is entered
   a. In the health progress notes, and signed by the staff responsible and one witness. Contaminated/discontinued medication is returned to the locked area with an attached note stating the name of the Schedule II medication, person’s name, dose, quantity, and the reason for necessary destruction. This medication is labeled MEDICATION TO BE DESTROYED and remains locked up. The pharmacy is consulted to determine if they wish to be responsible for Schedule II medication destruction. Staff will document in the health care progress notes medication turned over to a pharmacy for destruction along with the co-signature of the pharmacy employee collecting the medication.
   b. If the pharmacy will not destroy the medication, a registered nurse destroys the Schedule II medication along with a witness. When a registered nurse is not assigned to the site, the manager/support supervisor contacts the health services manager to make arrangements for the medication to be destroyed.
   c. The procedure for Schedule II medication Destruction is found in front of the health care progress notes in the medical work book.
   a. The Schedule II medication is counted at the end of each shift by the staff leaving shift and the staff coming on shift. The count is recorded on the Controlled Medication log. The Controlled Medication Log is filed behind the medication administration record in the person’s medical work book.
   b. If a dose(s) of Schedule II medication was not administered to the person, a medication/treatment error form is completed and the physician is notified as directed.
   c. If the count indicates dose(s) of controlled medication are missing: the manager is notified at the time staff discovers the count is off, by the person doing the count. If the
manager is unable to reconcile the count, the administrative on call staff and the health service manager are notified. An incident report is completed by the manager. 

d. If problems with reconciliation continue after the above steps are taken, the police may be notified.

References
Controlled Medication Log

(Rev. 06/09/2016)
POLICY: HEALTH SERVICES COORDINATION AND CARE

Mains’l is responsible for meeting and educating on health service needs assigned in the Coordinated Service and Support Plan (CSSP) or the Coordinated Service and Support Plan addendum (CSSP addendum) consistent with the person’s healthcare need.

PROCEDURE: HEALTH SERVICES COORDINATION AND CARE

1. The person’s representative, if any, and the case manager of changes in a person’s physical and mental health needs affecting health service needs assigned in the CSSP or CSSP addendum when discovered, unless there is a reason to know the change has already been purported
   a. Mains’l staff will document when the notice was provided
   b. If responsibility for the person’s health service coordination and care has been assigned to Mains’l in the CSSP or CSSP addendum, Mains’l will maintain documentation on how the person’s health needs will be met, including a description of the procedures Mains’l will follow in order to:
      i. Provide medication setup, assistance or administration in accordance to the Medication Administration & Assistance Policy and Procedure
      ii. Monitor health conditions according to written instructions from a licensed health professional
      iii. Assist with or coordinate health services appointments
      iv. Use medical equipment, devices, adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

Access to Health Services

1. The manager assists with or coordinates health service appointments using a tracking system which is maintained at the site
2. The manager is responsible for the supervision of or assists the person in scheduling, attending, and documenting health related appointments
3. The manager is responsible for ensuring that the appropriate referral form is taken to the appointment with the health care provider and that all orders are implemented.

Monitoring Health

1. The person’s health conditions are monitored according to written instructions from a health care provider and are documented on the Health Needs Record.
   o The Health Needs Record is completed at intake, 45 day meeting, annually, and as needed if there is a change in the person’s health condition
2. When staff believes a medical emergency may be life threatening, they will call 911, or they will call the mental health crisis intervention team when the person is experiencing a mental health crisis
3. Staff will document any changes in the person’s health in a Health Care Progress Notes (HCPN). These changes will be reported to the manager before leaving their shift
4. The manager notifies the health care provider of the changes within 24 hours or sooner depending on the severity of the changes
5. The manager notifies the person, person’s legal representative (if one is assigned), and case manager within 24 hours of noted changes if the person’s physical and mental health affect the service needs assigned in the coordinated service and support plan (CSSP) for the coordinated service and support plan addendum.
The notification is documented on a Health Needs Change Notice form

**Documenting Health**

1. The person’s health status will be documented in the health progress note (HPN)
   a) Date all entries
   b) Sign your name and title at the end of each entry
   c) Use ink (black or blue) – do not use pencil, do not erase and do not use white-out
   d) Writing is to be legible
   e) Do not skip lines between entries
   f) Use only medical abbreviations and symbols that are listed on the approved medical abbreviations form
   g) Errors in HPN documentation will be completed by using a line through the entry, enter error over top of the words, initial and date
   h) Notes may be in electronic or paper form
   i) Other forms as instructed

**Medical Equipment**

1. Orders for the medical equipment are filed in the person’s medical file
2. Staff will be trained by a healthcare provider in the safe and appropriate operation of medical equipment used by the person to sustain life; including but not limited to feeding tubes
   o The training is provided by a licensed health care professional or a manufacturer’s representative, who does an observed skill assessment as part of the training to ensure that the staff person demonstrates the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer’s instructions.
   o Training is documented on the “Training in Use of Medical Equipment” form and filed at the site.

**Mobility and Transfers Equipment**

1. Staff are trained on the safe and appropriate operation of equipment used for mobility and transfers such as mechanical lifts, van lifts, power wheelchairs, chair elevator lifts, standard wheelchairs and transfer equipment for showering/bathing.
   o The training is provided by the manager, who does an observed skill assessment, as part of the training to ensure staff demonstrate the ability of safely and correctly transfer transferring a person using the equipment.
   o Training is documented, by the manager on the “Training in Use of Equipment for Mobility and Transfer” form and filed at the site.
2. A Medical Equipment “User Manual” will be kept for all equipment. If a manual is not available, a copy will be printed from an online source by searching for the equipment:
   o Brand
   o Item
   o Model number
   o serial number
   o Any other identifiable reference
3. A written procedure for each piece of equipment will be available for staff to reference

(Rev. 7/6/17, LB)
HEALTH SERVICES POLICY AND PROCEDURE

Health Needs
Mains’l Services is responsible for meeting health service needs assigned in the coordinated service and support plan (CSSP) or the coordinated service and support plan addendum (CSSP addendum), consistent with the person’s health needs. Mains’l is responsible for notifying the person’s legal representative, if any, and the case manager of changes in a person’s physical and mental health needs affecting health services needs assigned to the license holder in the CSSP or CSSP addendum, when discovered, unless there is reason to know the change has already been reported. Mains’l will document when the notice was provided.

If responsibility for meeting the person’s health service needs has been assigned to the Mains’l in the CSSP or the CSSP addendum, Mains’l will maintain documentation on how the person’s health needs will be met, including a description of the procedures Mains’l will follow in order to:

1. Provide medication setup, assistance or administration;
2. Monitor health conditions according to written instructions from a licensed health professional;
3. Assist with or coordinate medical, dental, and other health services appointments; or
4. Use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

Medication Setup
“Medication setup” means the arranging of medications according to instructions from the pharmacy, the prescriber or a licensed nurse, for later administration when Mains’l is assigned responsibility in the CSSP or CSSP addendum. A prescription label or the prescribers written or electronically recorded order for the medication is sufficient to constitute written instructions from the prescriber.

Mains’l will document in the person’s medication administration record: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.

Medication Assistance
If responsibility for medication assistance is assigned to Mains’l in the CSSP or CSSP addendum, Mains’l will ensure that medication assistance is provided in a manner that enables the person to self-administer medication or treatment when the person is capable of directing their own care, or when the person’s legal representative is present and able to direct care for the person.

“Medication assistance” means any of the following:

1. Bringing to the person and opening a container of previously set up medications, emptying the container into the person’s hand, or opening and giving the medications in the original container to the person under the direction of the person.
2. Bringing to the person liquids or food to accompany the medication; or
3. Providing reminders in person, remotely or through programming devices such as telephones, alarms, medication boxes to take regularly scheduled medication or perform regularly scheduled treatments and exercises.
Medication Administration
If the responsibility for medication administration has been assigned to Mains’l Services, Inc. in the coordinated service and support plan (CSSP) or the coordinated service and support plan addendum (CSSP addendum), Mains’l Services will implement medication administration procedures to ensure a person takes medication and treatments as prescribed.

Medication Administration means:
1. Checking the person’s medication record;
2. Preparing the medication as necessary;
3. Administering the medication or treatment to the person;
4. Documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and
5. Reporting to the prescriber or a nurse any concerns about the medication or treatment including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

Mains’l completes 1-5 listed above prior to administering medication or treatment.

Authorization to administer
Mains’l Services will receive written authorization from the person or the person’s legal representative to administer medication or treatment and will obtain reauthorization annually. If the person or the person’s legal representative refuses to authorize Mains’l Services to administer medication, the medication will not be administered. The refusal to authorize medication administration will be reported to the prescriber as expediently as possible.

Training
The unlicensed staff responsible for medication setup or medication administration must complete medication administration training before having unsupervised direct contact with a person served by the program, or for whom the staff person has not previously provided direct support. The staff person must review and receive instruction on the individual’s CSSP and/or CSSP addendum as it relates to medical needs as well as review and receive instruction on medication administration procedures established for the person as needed.

Intensive Services
For intensive services, Mains’l ensures the following information is documented in the person’s medication administration record:
1. Information on the current prescription label or the prescriber’s current written or electronically recorded order or prescription that includes the person’s name, description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;
2. Information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;
3. The possible consequences if the medication or treatment is not taken or administered as directed;
4. Instruction on when and to whom to report the following:
   a. If a dose of medication is not administered or treatment is not performed as prescribed whether by error by the staff or the person or by refusal by the person; and
   b. The occurrence of possible adverse reactions to the medication or treatment;
5. Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and
6. Notation of when a medication or treatment is started, administered, changed or discontinued.

Medication and Treatment Issues
When assigned responsibility for medication administration, Mains’l will ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors. At a minimum, the review must be conducted every three months or more frequently as directed in the CSSP or CSSP addendum or as requested by the person or the person’s legal representative. Based on the review, Mains’l Services will develop and implement a plan to correct patterns of medication administration errors when identified.

1. If assigned responsibility for medication assistance or medication administration, Mains’l Services will report the following to the person’s legal representative and case manager as they occur or as otherwise directed in the CSSP or CSSP addendum:
2. Any reports made to the person’s physician or prescriber or other health care professional.
3. A person’s refusal or failure to take or receive medication or treatment as prescribed; or concerns about a person’s self-administration of medication or treatment.

Injectable Medications
Injectable medications may be administered according to a prescriber’s order and written instructions when one of the following conditions has been met:

1. A registered nurse or licensed practical nurse will administer the injection;
2. There is an agreement signed by Mains’l Services, the prescriber, and the person or the person’s legal representative specifying what injections may be given, when, how, and that the prescriber must retain responsibility for the unlicensed staff giving the injections. A copy of the agreement must be placed in the person’s service recipient record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.
Access to Health Services
1. The manager assists with or coordinates medical, dental, and other health service appointments using a tracking system which is maintained at the site.
2. The manager is responsible for the supervision of or assists the person in scheduling, attending, and documenting health related appointments.
3. The manager is responsible for ensuring that the appropriate medical referral form is taken to the appointment with the health care provider and that all orders are implemented.

Monitoring Health
1. The person’s health conditions are monitored according to written instructions from a health care provider and are documented on the Health Needs Record. The Health Needs Record is completed at intake, 45 day meeting, annually, and as needed if there is a change in the person’s health condition.
2. When staff believes a medical emergency may be life threatening, they will call 911, or they will call the mental health crisis intervention team when the person is experiencing a mental health crisis.
3. Staff documents any changes in the person’s health in the Health Care Progress Notes (HCPNs) and reports changes to the manager before leaving their shift.
4. The manager notifies the health care provider of the changes within 24 hours or sooner depending on the severity of the changes.
5. The manager notifies the person, person’s legal representative, if any, and case manager within 24 hours of changes in the person’s physical and mental health if they affect the health service needs assigned in the coordinated service and support plan or the coordinated service and support plan addendum. The notification is documented on a Health Needs Change Notice form.

Medical Equipment
1. Orders for the medical equipment are filed in the person’s medical file.
2. Staff is trained on the safe and correct operation of medical equipment used by the person to sustain life, including but not limited to feeding tubes. The training is provided by a licensed health care professional, or a manufacturer’s representative, who does an observed skill assessment as part of the training to ensure that the staff person demonstrates the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer’s instructions.
3. Training is documented on the "Training in Use of Medical Equipment" form and filed at the site.

Mobility and Transfers Equipment
1. Staff is trained on the safe and correct operation of equipment used for mobility and transfers such as Hoyer lifts, van lifts, power wheelchairs, chair elevator lifts, standard wheelchairs, and transfer equipment for showering/bathing. The training is provided by the manager, who does an observed skill assessment, as part of the training to ensure staff demonstrate the ability of safely and correctly transfer a person using the equipment.
2. Training is documented, by the manager, on the “Training in Use of Equipment for Mobility and Transfers" form and filed at the site.
3. A written procedure for each piece of equipment is available for staff to reference.
References:
Health Needs Change Notice
Health Needs Record
Training in Use of Medical Equipment form
Training in Use of Equipment for Mobility and Transfers form

(Rev. 2/9/15)
SAFE MEDICATION ASSISTANCE AND ADMINISTRATION POLICY AND PROCEDURES

It is the policy of Mains’l to provide safe medication setup, assistance and administration:
1. When assigned responsibility to do so in the person’s coordinated service and support plan (CSSP) or the CSSP addendum;
2. Using procedures established in consultation with a registered nurse, nurse practitioner, physician’s assistant or medical doctor; and
3. By staff who have successfully completed medication administration training before actually providing medication setup, assistance and administration.

For the purposes of this policy, medication assistance and administration includes, but is not limited to:
1. Providing medication-related services for a person;
2. Medication setup;
3. Medication administration;
4. Medication storage and security;
5. Medication documentation and charting;
6. Verification of monitoring of effectiveness of systems to ensure safe medication handling and administration;
7. Coordination of medication refills;
8. Handling changes to prescriptions and implementation of those changes;
9. Communicating with the pharmacy; or
10. Coordination and communication with the prescriber.

Medication Setup
“Medication setup” means the arranging of medications according to instructions from the pharmacy, the prescriber or a licensed nurse, for later administration when Mains’l is assigned responsibility in the CSSP or CSSP addendum. A prescription label or the prescriber’s written or electronically recorded order for the medication is sufficient to serve as written instructions from the prescriber.

Mains’l will document in the person’s medication administration record: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.

Medication Assistance
If responsibility for medication assistance is assigned to Mains’l in the CSSP or CSSP addendum, Mains’l will ensure that medication assistance is provided in a manner that supports the person to self-administer medication or treatment when the person is able to direct their own care, or when the person’s legal representative is present and able to direct care for the person.

“Medication assistance” means any of the following:
1. Bringing to the person and opening a container of previously set up medications, emptying the container into the person’s hand, or opening and giving the medications in the original container to the person under the direction of the person.
2. Bringing to the person liquids or food to accompany the medication; or
3. Providing reminders in person, remotely or through programming devices such as telephones, alarms, medication boxes to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

**Medication Administration**
If the responsibility for medication administration has been assigned to Mains’l in the coordinated service and support plan (CSSP) or the coordinated service and support plan addendum (CSSP addendum), Mains’l will implement medication administration procedures to support the person to take medication and treatments as prescribed.

Medication Administration means:

1. Checking the person’s medication record;
2. Preparing the medication as necessary;
3. Administering the medication or treatment to the person;
4. Documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and
5. Reporting to the prescriber or a nurse any concerns about the medication or treatment including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

Mains’l completes 1-5 listed above prior to administering medication or treatment.

**Psychotropic Medication**
Psychotropic medication is any medication prescribed to treat the symptoms of mental illness that affect thought process, mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and non-stimulants for the treatment of attentions deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

**Authorization to administer**
Mains’l will receive written consent from the person or the person’s legal representative to administer medication or treatment and will obtain reauthorization annually. If the person or the person’s legal representative refuses to authorize Mains’l to administer medication, the medication will not be administered. The refusal to authorize medication administration will be reported to the prescriber as soon as possible.

**Training**
The unlicensed staff responsible for medication setup or medication administration must complete medication administration training before setting up or giving the medication without supervision to the person, or for whom the staff has not previously provided direct support. The staff must review and receive training on the person’s health needs as well as receive training on medication administration procedures for that person.
**Intensive Services**
For intensive services, Mains’l ensures the following information is documented in the person’s medication administration record:

1. Information on the current prescription label or the prescriber’s current written or electronically recorded order or prescription that includes the person’s name, description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;
2. Information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;
3. The possible consequences if the medication or treatment is not taken or administered as directed;
4. Instruction on when and to whom to report the following:
   a. If a dose of medication is not administered or treatment is not performed as prescribed whether by error by the staff or the person or by refusal by the person; and
   b. The occurrence of possible adverse reactions to the medication or treatment;
5. Documentation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and
6. Documentation of when a medication or treatment is started, administered, changed or discontinued.

**Medication and Treatment Issues**
- When assigned responsibility for medication administration, Mains’l will ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors. At a minimum, the review must be conducted every three months or more frequently as directed in the CSSP or CSSP addendum or as requested by the person or the person’s legal representative. Based on the review, Mains’l will develop and implement a plan to correct patterns of medication administration errors when identified.
- If assigned responsibility for medication assistance or medication administration, Mains’l will report the following to the person’s legal representative and case manager as they occur or as otherwise directed in the CSSP or CSSP addendum:
  a. Any reports made to the person’s physician or prescriber or other health care professional.
  b. A person’s refusal or failure to take or receive medication or treatment as prescribed; or
  c. Concerns about a person’s self-administration of medication or treatment.

**Injectable Medications**
Injectable medications may be administered according to a prescriber’s order and written instructions when one of the following conditions has been met:

1. A registered nurse or licensed practical nurse will administer the injection;
2. There is an agreement signed by Mains’I, the prescriber, and the person or the person’s legal representative specifying what injections may be given, when, how, and that the prescriber must retain responsibility for the unlicensed staff giving the injections. A copy of the agreement must be placed in the person’s record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

**Training**

Staff competence in medication administration is achieved through the following training:

1. A written test developed by a registered nurse must be passed with 80% comprehension of the material. Staff who receive less than 80% on the test, may retake the test or attend the medication administration class again. If staff receives less than 80% the second time, HR will be notified that the staff will not receive any more training in medication administration and will not be able to administer medications in a home.

2. An observed skill assessment is done as part of the medication administration class by the trainer to ensure that staff demonstrates the ability to safely and correctly follow medication administration procedures.

3. As part of on the job training, a skill assessment and site specific test must also be passed to be medication certified and to allow staff to administer medication without supervision.

4. The skill assessment is done three times at the site and must document:
   a. The skill(s) observed,
   b. A determination of competency,
   c. The date, signature and job title of the person observing the skill(s)

5. The manager/support coordinator ensures that each staff who administers medication is medication certified and there is a copy of their medication certificate filed at the home.

6. Staff who administer medications or provide treatment receive training on general and specific procedures, types of medication, medication related documentation, handling medication, use of a drug reference information, reporting possible side effects or adverse reactions, and other topics.

7. Gastrostomy medication and injectable medication administration is not covered in Mains’I general medication administration training and is provided as needed, for each person. This training is developed in consultation with a health care professional.

**Medication Setup, Assistance and Administration**

*Medication setup* is the arranging of medications according to written instructions from the healthcare provider for later administration, for example in a medi-set or pill envelope. A prescription label or the prescriber’s written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber.

If a medication is to be taken when the person is at school, day placement, or work a copy of the prescriber’s order will be sent to the site. Dates of setup, name of medication, quantity of dose, times to be administered, route of administration at time of setup is documented on the medication administration record.

1. Steps for medication setup by staff in a medi-set.
   a. Staff completes the three way check for each medication.
   b. Staff put the correct dose of medication in the correct time compartment of the medi-set.
c. Staff put the code S/initials in the corresponding box on the medication administration record for each medication they set up.

2. Steps for medication setup for short term (three days or less) off site administration.
   a. Staff completes the three way check for each medication.
   b. Staff places the medication in an envelope that has the following information: name of person, name of medication, dose, route, date and time to be given, any special instructions for administration, signature of the staff who packages the medication.
   c. Staff put the code S/initials in the corresponding box on the medication administration record for each medication.
   d. Staff has the person sign the leave of absence form that the medication was given to.

3. Steps for long term (longer than three days) off site medication administration.
   a. Staff orders the medication from the pharmacy.
   b. Staff arrange for the medication to be taken to the school, day placement, or work site.
   c. Staff put the code L in the corresponding box on the medication administration record.
   d. Staff has the person sign the leave of absence form that the medication was given to.

Medication Assistance

Medication Assistance means staff provides medication assistance to enable a person to self-administer medication or treatment when the person is capable of directing their own care, or when the person’s legal representative is present and able to direct care for the person.

1. Staff brings and opens container of previously set up medications, emptying the container into the person’s hand, or opening and giving the medication in the original container to the person under the direction of that person.
2. Staff brings liquids or food to the person to accompany the medication;
3. Staff provides reminders in person, remotely, or through programming devices such as telephones, alarms, medication boxes to the person to take regularly scheduled medication or to perform regularly scheduled treatments and exercises.

If assigned responsibility for medication assistance, Mains’l will report the following to the person’s legal representative and case manager as they occur or as otherwise directed in the CSSP or the CSSP addendum:
1. If a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person.
2. The occurrence of possible adverse reactions to the medication or treatment.
3. Any concerns about a person’s self-administration of medication or treatment.

Medication Administration

Medication Administration means staff administers medication safely to the person according to the health care provider’s current written or electronically recorded order or prescription.

General Guidelines for Medication Administration

If assigned responsibility for medication administration, Mains’l will report the following to the person’s legal representative and case manager as they occur or as otherwise directed in the CSSP or the CSSP addendum:
1. If a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person.
2. The occurrence of possible adverse reactions to the medication or treatment.
3. Any concerns about a person’s self-administration of medication or treatment.

If intensive support services are assigned to Mains'I, in the coordinated service and support plan or the coordinated service and support plan addendum, documentation of the possible consequences of the person not taking the medication or treatment as prescribed is documented on the medical referral form by the health care professional. If the medication/treatment is refused or administered incorrectly by staff documentation is done on the Medication/Treatment, Error/Refusal and Adverse Reaction Record.

The medication administration record will have the person’s name, the medication/treatment name, frequency of administration and other information needed to safely and correctly administer the medication/treatment to ensure effectiveness. This information is obtained from the prescriber’s written or electronically recorded order, prescription or prescription label on the container of medication.

Medication frequency is determined by the health care provider. If the health care provider orders a medication to be given at a specific hour of the day which differs from the standard medication times, the person must receive the medication at the time the health care provider has ordered. Medications are to be administered within one hour before or after the scheduled time. When medication administration exceeds this time frame the actual time of administration is documented on the medication administration record with staff initials. Whenever possible, medication times are determined to allow the medication to be administered at the home and not sent to day placement.

When 2 staff is working the same shift, they will decide at the beginning of the shift who is administering medications to which person.

Standing order medications are given according to directions on the standing order medication list signed yearly by the person’s health care provider. The reason for giving any medication is documented by the staff in the health progress notes along with the effectiveness of the medication.

The staff administering medications is responsible for knowing the medication’s intended use, reactions or side effects that might occur, and warnings or directions of a specific nature concerning the medication. Medication information sheets, including side effects and contraindications to its use are available for staff in the medical workbook.

It is the responsibility of the staff administering medications to be familiar with the health of the person (i.e., allergies, ability to swallow, etc.) and to set up medications for one person at a time.

The staff administering medications/treatments is responsible for the correct dose, medication, person, time, date, route and documentation. Documentation of administration is done right after the medication/treatment has been given. Medications are administered until discontinued by the health care provider, or until the person has received the prescribed number of doses.

Medications administered to a person are stored in the original container. All containers are kept tightly closed. Changes in color, odor, or consistency, or suspected tampering are reported to the
manager/support supervisor or pharmacy. This medication is not administered until the pharmacy is contacted and confirms that the correct medication was delivered.

The staff responsible for the medications is responsible for the safety of the medications, and the key and locked cabinet.

1. **Steps for Medication Administration:**
   a. At the beginning of the shift, staff checks the medication administration record for medications to be administered on their shift and review the health care progress notes (HPN’s) and the communication book for any changes
   b. Staff washes their hands
   c. Staff assembles any needed equipment (medication cup, glass, water, etc.)
   d. Staff locates the person’s medications
   e. Staff compares the monthly medication administration record with the medication label three times to be sure they correlate. Staff does not give the medication if there is a discrepancy and, if any doubt, contact the manager, nurse, pharmacy, or the physician before giving any medication.
   f. Staff checks the label on the medication three (3) times:

2. **For oral medications:**
   a. When removing the container of medication from the cabinet;
   b. When pouring the medication; and
   c. Before returning the medication container to the cabinet.

3. **For other medications:**
   a. When removing the container of medication from the cabinet;
   b. After gathering supplies (for pre measured medication); and
   c. Prior to administering the medication
      i. Staff prepares the medication or treatment.
      ii. Staff identifies the person by name, photo, or asking another staff and explains what will occur, to the person, and what is expected of them.
      iii. If there are no concerns, staff administers the medication according to the route directions.
      iv. If there are concerns about the medication or treatment, including side effects and effectiveness, notify the nurse or prescriber. Adverse reactions must immediately be reported to the prescriber or nurse. The person’s legal representative and case manager are notified. Notification is documented in the health care progress notes and possibly the Health Needs Change Record.
      v. Staff observes the person to ensure completion of medication administration (swallowed, dissolved, etc.), and washes their hands.
      vi. Staff cleans and replaces equipment used and secures medication in the locked area.
      vii. Staff documents that the medication is given on the medication administration record immediately after the person takes it.
      viii. Staff checks the medication administration record one more time at end of their shift to make sure that all medications/treatments have been administered and documented properly.
ix. All medication ordered from the pharmacy, including the medication on automatic refill, will be documented on a reorder form by the staff who is ordering the medication. When the medication is delivered to the house by the pharmacy delivery person, the staff who receives the medication will document on the same form that the medication was received along with the number of cards/bottles.

4. **Steps for Administration of Oral Medications**
   a. **Tablets or pills:**
      i. Pour the correct number of tablet(s) into the lid of the medication bottle and then from the lid into a medication cup.
      ii. Give the person the medication with a glass of water (unless another liquid is specified).
      iii. Watch the person swallow the medication.
   b. **Lozenges:**
      i. Lozenges are placed on the tongue and kept in the mouth until completely dissolved.
      ii. Water is not given for at least 30 minutes after administering.
   c. **Sublingual medications:**
      i. Sublingual medications are placed under the tongue to dissolve.
      ii. Water is not given for at least 30 minutes after administering.
   d. **Intrabuccal (Intra-buckle):**
      i. Intrabuccal medications are placed between the cheek and gum.
      ii. Water is not given for at least 30 minutes after administering.
   e. **Liquid medications:**
      i. At eye level, carefully pour the liquid medication into a graduated plastic medication cup or medication spoon.
      ii. Water is not given after many liquid medications. Follow directions on the bottle.

5. **Steps for Administration of Other Medications**
   a. **Topical medication**
      i. Staff washes their hands. Explain to the person the treatment that needs to be done.
      ii. Position the person accordingly.
      iii. When indicated the person/or staff washes the area with soap and warm water.
      iv. Never apply topical medications with your bare hands. Use a Q-tip, a tongue blade, gauze square, or disposable gloves, whichever is most appropriate to administer the medication.
      v. Topical medication to groin area: The person needs to apply the topical medication to the area after washing area. If the person is unable to do this, consult with the manager/nurse.
   b. **Eye drops**
      i. Staff washes their hands, puts on gloves
      ii. Explain to the person how the eye drops will be administered.
      iii. Have the person sit or lie down.
iv. Observe affected eye(s) for any unusual condition which should be reported prior to
v. If drainage is present, cleanse each eye with clean tissue, wiping from inner corner outward once
vi. Position the person with head back and looking upward. Separate eye lids by raising the upper lid with forefinger and lower lid with thumb. Approach the eye with the dropper from below the eye, outside of the person’s field of vision. Avoid contact with the eye.
vii. Apply drop(s) gently near the center of the lower lid not allowing drop(s) to fall more than one (1) inch before striking eye
viii. Ask the person to keep eyes gently closed for a few minutes
ix. Gently wipe off excess medication from the eye with a clean tissue, using a separate clean tissue for each eye if the medication is administered to both eyes.

c. **Eye ointment**
i. Staff washes their hands, puts on gloves
ii. Explain to the person what is to be done
iii. Have the consumer sit or lie down
iv. Observe affected eye(s) for any unusual condition which should be reported prior to medication application
v. If drainage is present, cleanse the eye with clean tissue, wiping from inner corner outward once
vi. Position the person with head back and looking upward. Retract lower lid. Approach the eye from below, outside the person’s field of vision
vii. Apply ointment in a thin layer along the inside lower lid. Use care to avoid contact of the medication container with the eye
viii. Position the person comfortably and ask him/her to keep eyes closed gently for a few minutes.
ix. Rub lid lightly in circular motion with cotton ball or tissue for a few seconds.
ix. Gently wipe off excess medication by wiping from inner corner outward

d. **Eardrops**
i. Staff washes their hands
ii. Explain to the person what is to be done
iii. Position the person:
   1. if lying in bed, put bed flat and turn ear to be treated facing up; or
   2. if reclining in a chair, tilt head sideways until ear is as horizontal as possible.
iv. Clean entry to ear canal with a clean tissue or cotton ball, if wax or debris visible
v. Observe the affected ear for any unusual condition prior to eardrop installation
vi. Draw up the ordered amount of medication into the dropper, if applicable
vii. Administer the eardrops by pulling the ear gently backward and upward and instilling the number of drops ordered into the ear canal. Do not contaminate the dropper by touching any part of the ear
viii. Have the person remain in the required position for two to three (2-3) minutes.
ix. If drops are ordered for both ears, wait at least five (5) minutes before putting drops in the second ear, repeating the procedure
x. Leave the person comfortably positioned

e. **Rectal medications: Suppository**
   i. Staff washes their hands
   ii. Carry the medication to the person
   iii. Explain to the person what is to be done. Provide privacy.
   iv. Position the person on left side with right knee bent slightly and lying across left leg.
   v. Put on disposable gloves
   vi. Remove packaging
   vii. Lubricate the tip of the suppository with a water-soluble lubricant. **Do not use Vaseline.**
   viii. Insert suppository into the rectum beyond the sphincter about 2", pushing it in gently with gloved finger. Stop if there is any resistance
   ix. Encourage relaxation by instructing the person to breathe slowly through his/her mouth.
   x. Withdraw finger. Press tissue against anus or press buttocks together until the urge to expel subsides
   xi. Remove, discard gloves, and wash hands.
   xii. Encourage the person to remain flat or on their side for five (5) minutes.

f. **Vaginal medications**
   i. The person needs to wash groin area if indicated and insert/apply the vaginal medication with staff’s prompts. Consult with the manager/support supervisor and the nurse if the person is unable to do this.
   ii. Explain procedure to the person.
   iii. Ask the person to empty her bladder before beginning procedure.
   iv. Wash hands and put on gloves.
   v. Provide privacy.
   vi. Position the person properly on the bed, lying on her back with knees flexed and legs apart.
   vii. If discharge is noted, clean area using disposable wipes. Working from front to back, clean the left side of the perineum, using a downward stroke. Discard wipe.
      1. Using a clean wipe, repeat the procedure for the right side of the perineum and then the center of the perineum. Be sure to use a clean wipe for each stroke. Continue as necessary until the perineum is cleansed.
   viii. If you are administering a vaginal suppository, place the prescribed medication dose in the applicator. Note: You would administer a vaginal jelly, ointment, cream, or tablet in the same manner.
   ix. To make insertion easier, the suppository and applicator tip may be lubricated with water or water soluble lubricating jelly. **Do not use Vaseline.**
   x. Separate labia with one hand. Insert the applicator into the vagina with your other hand. Advance the applicator about two (2) inches, angling slightly toward the sacrum.
   xi. Push the plunger to insert the medication.
xii. Remove the applicator and discard it.

xiii. Encourage the person to remain lying down for about 20 - 30 minutes so the medication can be absorbed.

xiv. Discard gloves and wash hands.

g. **Enemas**
   i. Staff washes their hands.
   ii. Explain procedure to person.
   iii. Provide privacy.
   iv. Position person on left side with right knee at 90 degree angle and lying across left leg.
   v. Place waterproof pad under the person’s hips and buttocks.
   vi. Put on disposable gloves.
   vii. Insert lubricated tip of enema bottle gently into rectum. Advance 3-4 inches for adults.
   viii. Encourage relaxation by telling the person to breathe out slowly through their mouth.
   ix. Squeeze entire contents of enema into rectum slowly over 1-2 minutes.
   x. Withdraw enema tip. You may need tissues to catch fluid.
   xi. Gently hold buttocks together for few minutes.
   xii. Remove gloves and wash hands.
   xiii. Encourage the person to lay flat and hold contents of enema for 5 minutes or as long able.
   xiv. Assist the person to the bathroom. Enemas usually produce bowel movement in 15-60 minutes.

h. **Nasal Spray**
   i. Staff washes their hands and puts on gloves.
   ii. Shake bottle if indicated on the label.
   iii. In an upright position, instruct the person to inhale through the nose while bottle is squeezed.
   iv. Wash off tip of bottle before recapping.

i. **Inhalers:** Refer to the instructions that come with the inhaler.

j. **Other routes:** such as gastrostomy or nebulizers are individualized for the person in consultation with a health professional.

k. **Injectable medications:** Injectable medications may be administered according to a prescriber’s order and written instructions when one of the following conditions has been met:
   i. A registered nurse or licensed practical nurse administers the injection;
   ii. There is an agreement signed by the Mains’l, the prescriber, and the person or the person’s legal representative specifying what injections are to be given, when, how, and the prescriber must retain responsibility for the unlicensed staff.
giving the injections. A copy of the agreement is placed in the person's service recipient record.

iii. Only a licensed health professional is allowed to administer psychotropic medications by injection.

6. **Psychotropic Medication Use and Monitoring**
   a. When Mains’l is responsible for administration of a psychotropic medication, Mains’l will develop, implement, and maintain the following documentation in the person’s CSSP
      i. Addendum:
         1. A description of the target symptoms the prescribed psychotropic medication is to alleviate. The target symptoms are defined by the expanded support team according to the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Test Revision) or successive editions;
         2. The documentation method that will be used to monitor and measure changes in target symptoms;
         3. Medication and symptom-related data will be collected as instructed by the prescriber.
         4. The monitoring date will be provided to the expanded support team for review every 3 months, or as otherwise requested by the person or the person’s legal representative.

7. **Written authorization**
   a. Written authorization is required for medication administration or medication assistance, including medications or injectable medications.
   b. Written authorization will be obtained from the person or the person’s legal representative before providing assistance with or administration of medications or treatments, including psychotropic medications and injectable medications. The authorization is renewed annually.
   c. If the person or the person’s legal representative refuses to authorize the administration of medication, the staff will not give the medication.
   d. The prescriber will be notified of the refusal as soon as possible.

8. **Refusal to authorize psychotropic medication**
   a. If the person or their legal representative refused to authorize the administration of a psychotropic medication, the staff will not give the medication. The refusal will be reported to the prescriber as soon as possible.
   b. After reporting the refusal to authorize to the prescriber, the directions given by the prescriber will be followed and documented.
   c. A court order may be obtained to override a refusal for psychotropic medication administration.
   d. A refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. Mains’l suspension and termination policy will be followed if necessary.
PROCEDURE: MEDICATION AND TREATMENT ISSUES

Medication/treatment error occurs when a medication/treatment is not administered by staff as directed by the health care professional.

1. Medication errors includes:
   a. wrong person
   b. wrong route
   c. wrong dose
   d. wrong date
   e. wrong time
   f. wrong medication
   g. medication not given

2. Treatment errors occur when a:
   a. treatment is not given
   b. treatment is given incorrectly
   c. treatment is not documented

3. A documentation error occurs when the:
   a. medication/treatment was given but not initialed on the medication administration record prior to leaving the shift worked
   b. documented incorrectly

Responding to and reporting medication/treatment errors

1. Staff is responsible for finding and reporting medication/treatment errors. Points are assigned for not reporting the error and completing the medication/treatment error report.

2. Each medication/treatment/documentation error is documented on the medication/treatment error report by the staff who found the error.
   a. Clarify what happened with the staff that made the error when possible. Make every effort to contact them to confirm what happened.
   b. For the following type of errors contact the on call nurse. The on call nurse will give staff instructions on how to respond to the error
      i. person refusing to take the medication or treatment
      ii. wrong person
      iii. wrong time
      iv. missed dose
      v. wrong dose
      vi. wrong route
      vii. wrong person
      viii. failure to provide supervision/education or follow through in regard to medication or treatment that resulted in a negative outcome to the person
      ix. missing or stolen medication
      x. other (with a health or safety concern)
3. For documentation errors:
   a. It is not necessary to contact the on call nurse unless the person has received negative consequences from the documentation error
   b. The staff that discovers the error will circle the appropriate space on the medication administration record and contact the staff to determine if the medication/treatment was given
   c. This staff will also leave a note in the communication book regarding the documentation error, alerting other staff.
   d. The staff who gave the medication will fill in his/her initials in the appropriate space on the medication administration record the next shift worked

4. Notify the manager of the error and fax the medication/treatment error report to the health services manager at the office.

**Documentation of medication/treatment errors:**

1. Circle the appropriate date and time slot on the medication administration record, place an X in the top of the circle (i.e., X)

2. If a medication/treatment error involves more than one person, complete a report for each person involved

3. Document what occurred, who was notified, and the directions given in the health care progress notes

4. Communicate the incident to other staff verbally and in the communication book alerting them to possible adverse reactions (any unexpected or dangerous reaction to a drug) or needed follow up

5. Possible consequences of the person refusing the medication or treatment or receiving the medication/treatment incorrectly by staff is documented on the medication/treatment error report

6. The manager meets with the staff who made the error within one week of the error and together they complete the internal review form. The staff needs to sign the internal review form. The manager sends the internal review form to the health services manager within that week.

**Tracking points for errors:**

1. The manager is responsible for assigning points and keeping track of the total on the medication error point form.
   a. Accumulation of 20 points requires staff to have retraining before he/she can resume passing medications or providing treatments. After medication administration retraining and the staff goes 30 days without an error, their points return to zero. If there is a medication/treatment error within the 30 days, the mediation certificate may be revoked. If this occurs, the staff will not be able to work in a CRS home.
b. If this same staff reaches 20 points again, he/she will receive retraining. After medication administration retraining and the staff goes 30 days without an error their points return to zero.
   i. If there is a medication/treatment error within the 30 days, their medication certificate may be revoked. If this occurs, the staff will not be able to work in a CRS home

c. If this same staff is retrained twice within a 12 month period, they receive a job performance correction which states if they have one more medication/treatment error, their medication certificate may be revoked and, if this occurs, the staff will not be able to work at a CRS home.

d. Retraining is determined by the manager and health services manager and ranges from assigning a co-worker to double check doses before administration, double check the medication administration records before staff leave shift, attending a medication refresher class, and receive training from the nurse

2. If staff’s error requires a person to seek intervention from a physician, the staff is immediately ineligible to administer medications or provide treatments and the staff’s ability to administer medication is reviewed and their medication certificate may be revoked based on the circumstances.

3. Intentional misuse of medication results in suspension and staff’s medication certificate may be revoked based on circumstances.

4. The ability of the staff to administer medications or provide treatments may be restricted at any time by the health services manager if the safety of the person is at risk.

5. Medication administration records will be reviewed a minimum of every 3 months or more often as directed in the CSSP or CSSP addendum or as requested by the person or the person’s legal representative. Based on the review, Mains’l Services will develop and implement a plan to correct patterns of medication administration errors when identified

When the person refuses to take medication
The person’s refusal or failure to take or receive medication or treatment as prescribed will be reported to the person’s legal representative and case manager as they occur or as otherwise directed in the CSSP or CSSP addendum.

References
Medication Administration Review Record
Point System for Medication/Treatment Errors
Medication/Treatment Error/Refusal and Adverse Reaction Record

(Rev. 2/09/15)
PROCEDURE: OFF SITE MEDICATIONS

Physician’s Orders for Off Site Medication
If a medication is ordered for a person who is not self-administering medication during school, day placement, or work hours, a copy of the order for the medication will be obtained and sent to the designated staff at the day placement.

Medication Labeling for Off Site Medication Administration
Medication procedure for short term (three days or less) off site medication administration, including medication to be given short-term

1. The staff will transfer enough medication for the duration of the leave into labeled envelopes.
2. Each medication envelope will display the following information:
   a. name of the person
   b. name of medication and strength
   c. amount
   d. route of administration
   e. date and time to be given
   f. any special directions for administration
   g. signature of staff who packaged medication
   h. name and phone number of the site may be written/stamped on the back of the envelope.
3. All medications to be administered at one time are to be placed in one envelope.
4. Staff will have the person who the medication is given to sign the Leave of Absence Form.

Medication procedure for long term (longer than three days) off site medication administration, including long term medications to be given at day placement.

1. Medications will be sent in a properly labeled container from the pharmacy. Ensure that all new or changed orders are communicated promptly.
2. Staff will have the person who the medication is given to sign the Leave of Absence Form.

Off Site Medication Documentation
All medications sent off site will be documented on the medication sheet, with the appropriate symbol and initials of the staff who packaged the medication.

1. Procedure for when a person returns to the site earlier than expected with contaminated medication:
   a. Any contaminated medication returned in the pass medication envelopes will be placed in the MEDICATIONS TO BE DESTROYED container in the medication cabinet.
   b. The staff will administer the medications from the pharmacy labeled containers.
   c. The staff will document this medication administration by placing an asterisk in the appropriate box(s) on the medication sheet. On the bottom (or back) of the medication sheet, the staff will write the date, time, and their initials with an asterisk to indicate the doses of medication that were administered at the site.
2. If there is any indication that medications were not administered as ordered while the person was off site, the staff will notify the manager or assigned nurse, and document this in the health care progress notes.

(Rev. 2/09/15)
PHARMACY POLICY AND PROCEDURES

Arrangements for Pharmacy Services
Pharmacy services shall be provided under the direction of a qualified licensed pharmacist. After hours pharmacy services are arranged if the pharmacy is not open 24 hours.

Drug Reference Information
1. Homes where staff is responsible for medication administration and set-up have written drug reference information available for all medications used. Information includes side effects, adverse reactions, special administration instructions, and missed dose procedures. Information may come from:
   a. A drug reference book written for use by the general public
   b. A Nursing Drug Reference book
   c. Pharmacy printouts
   d. Print out from an Internet site such as WebMD

The pharmacy, Poison Control and assigned nurse may also be contacted for information.

Security and Storage of Medications
1. Security of Medications
   a. All medications are kept locked, except when being prepared for administration
   b. All Schedule II medications are kept under a locked system. (See the Controlled Medication section for details)
   c. Only staff authorized to administer medications have access to the key of locked medication
   d. Medications requiring refrigeration are kept in a locked box inside the general use refrigerator or in a separate refrigerator

2. Storage of Medications
   a. All medications are stored in an area that has proper control of sanitation, light, temperature and humidity
   b. Medications are stored in a container that separates them from other items if they are kept in a general use area. Medication is not stored with cleaners and poisons
   c. Topical medications are stored separately from oral medications.

Pharmacy Refills for Staff Administered Medication
A designated staff shall check each container of medication on a weekly basis to make certain the supply is adequate. Medications are reordered when there is a minimum of one week’s supply remaining. Expiration dates are checked at least quarterly.

To obtain refills, call the pharmacy and tell them you need to order a prescription refill, or follow the directions on the automated system.

1. Provide the following information from the labels on the medications(s) being refilled:
   a. name of person
   b. name of medication
   c. prescription number
In the event that a medication runs out during evening or weekend hours, call the after-hours pharmacy phone number and reorder the medication. Communicate the level of urgency in receiving the medication and determine when it will be delivered or ready. Communicate this information to other staff verbally and by writing in the communication book.

The pharmacy is notified the next business day when a medication on an automatic reorder system is discontinued.

**Medication Destruction by Staff**

1. Discontinued, expired, or contaminated medications are immediately placed in a container labeled MEDICATIONS TO BE DESTROYED in the medication cabinet.
   a. Place contaminated medications in an envelope with the person’s name, name of medication, strength and reason medication is to be destroyed. Put the envelope in medication to be destroyed container.
   b. Medication is destroyed by the manager/support coordinator or designated staff as determined by the manager/support coordinator and a witness within two months. All Schedule II medications are destroyed by an RN and witnessed by another person unless the pharmacy chooses to destroy Schedule II medication (see Controlled Medications section).
   c. Destruction is documented in the person’s health care progress notes or by completing the medication destruction form and signed by the designated staff and witness. Documentation should include the name of the medication, strength, amount of medication, and reason the medication needs to be destroyed.
   d. Medication is destroyed by mixing the medication (do not crush tablets or capsules) with an unpalatable substance such as kitty litter or used coffee grounds. Then place the mixture in a container such as a zip-top or sealable plastic bag, and throw the container in the household trash. Before throwing out the empty pill bottle and or bubble pack, scratch out or blacken out all the personal information on the prescription label to make it unreadable.

(Rev.12/23/15)