

POLICY:

All medications, both prescription and non-prescription, as well PRN (as needed) medications shall have a written physician's order and shall be administered or self-administered per those orders. Medications shall be kept in a secured locked container, stored as prescribed and shall be properly labeled per physician written order. A stock supply of prescription drugs shall not be maintained in the home.

PROCEDURE:

A. MEDICAL ADMINISTRATION RECORD (MAR) - FACE SIDE

1. On a monthly basis an individual written record shall be developed and maintained for each individual to record any prescription or non-prescription drugs ordered by the individual's physician and administered to the individual or self-administered by the individual. This record is called the Medical Administration Record (MAR) or Treatment Administration Record (TAR). (See sample attached.) The MAR shall include:
 - a. The name of the individual.
 - b. The month and year of the MAR.
 - c. Description of the medication, including the prescribed dosage, e.g., Thorazine 25mg., Tab B.I.D. (twice daily).
 - d. Time noting a.m. or p.m. and date of administered or self-administered medication/treatment e.g., start 1-3-96, at 8 a.m. and 8 p.m each day. NOTE: When discontinued by a physician, write DC'd on the date it was stopped.
 - e. Method of administration, e.g., by mouth (P.O.), on abrasion on arm, rectally (R).
 - f. Treatments should be recorded exactly as ordered, e.g., Mycostatin Ointment to open area on right heel B.I.D. Use sparingly, cover with Band-Aid.
 - g. Space for full signatures of any staff who will administer medications with their initials as an identifying code to be used in the completion of the MAR.

2. Known allergies and any known adverse drug reaction shall be noted as applicable on the individual MAR.

B. MAR BACK SIDE

1. Space shall be provided on the backside of the individuals' monthly MAR to record the following information whenever a PRN is given:
 - a. When the medication was given.
 - b. Why the medication was given.
 - c. The result of the giving of the medication.
2. Space shall also be provided on the back side of the MAR to record any unusual occurrence such as:
 - a. Adverse reactions believed to be due to a medication, e.g., fine red rash on hands (an Incident Report may also be in order).
 - b. Individual home for weekend, medications given to parents for administration.
 - c. Medication sent to work site or school.
 - d. Explanation of any medication error.
 - e. Missing medication.

NOTE: Staff recording on the face of the MAR will indicate referral to the back side for the above.

C. MEDICATION ADMINISTRATION/MAR COMPLETION

NOTE: All medications/treatments including over-the-counter medications, PRN medications, administered or self-administered MUST have current physician order in place and must be entered on the MAR. The entry on the MAR MUST match the physician order and the prescription label on the medication MUST match the order on the MAR. Needed clarification may be added in parentheses on the MAR.

1. At the beginning of the shift, check the Communication Log and the individual's MAR regarding medications and treatments to be given during that shift. Pay particular attention to any changes, new orders, or discontinued orders.
2. If more than one staff member is working the shift, ensure that it is clear who will be responsible for administering the medications and providing treatments for individuals for that shift.

3. Set up medications for only one individual at a time. Compare the medication card/container prescription to the MAR for the individual for whom you will administer the medications or treatments. Ensure that you are giving:
 - a. the right medication
 - b. in the right dose
 - c. in the right manner
 - d. at the right time
 - e. to the right individual

NOTE: Always wash hands thoroughly before administering medications and between the giving of oral versus topical medications/treatments.

4. Compare the prescription label with the MAR three times:
 - a. before the medication is given
 - b. when the medication is given
 - c. when the medication is put away
5. If there is a discrepancy between the MAR and the medication label, do not give without checking with the Site Manager for clarification.
6. Set up medications for only one individual at a time.
7. If medication is in a blister card, punch out the medication into a medication cup from the next blister in decreasing order. As a rule medications should never be punched out before the time of administration. Exceptions would be outings, etc.
8. If the medication is in a non-blister container, dispense their correct dosage into a disposable medication cup.
9. If the medication is a liquid, dispense it into a marked medication cup to the correct dosage level.
10. If the medication is topical (i.e., external) apply to the body or assist the individual to apply to the specific body site(s) per the physician order. Staff should not apply topical medications with a bare hand but rather use a glove, a 4x4 sterile gauze pad, or a Q-tip. Wash hands before and after applying a topical medication. Never reintroduce the glove, gauze pad or Q-tip into the medication again. If additional topical medication is needed use a new glove, pad or Q-tip.

11. Administer the medication to the right individual. If in doubt on the identity of the individual, look for an identifying picture in the medication cupboard or in the individual's file, check with another staff or reliable individual.
12. When giving the medication be careful to insure medication is given via the proper route. When giving an oral medication REMAIN WITH THE RESIDENT UNTIL YOU ARE CERTAIN THEY HAVE COMPLETELY SWALLOWED THE MEDICATION.
13. Immediately chart that the medication has been given by initialing the proper space for day and time on the MAR.
14. Document the giving of a PRN medication by initialing the box on the MAR on the date square the medication was given. Then note on the back side of the MAR the date, time, medication dose, reason for administering the medication, and the subsequent results of the giving of the medication, e.g., individual no longer complaining of headache. NOTE: PRN medications may only be given for the purpose/condition noted on the physician order. Substitutions such as aspirin for Tylenol CANNOT be made.
15. Medications/treatments given more than one hour before or one hour after the scheduled time of administration constitute a medication error. To determine if the medication/treatment should be given when a medication error has occurred, refer to the Addendum to Physician Orders, Medication Administration Irregularities, Physician's Directions Form (attached) for medication administration instructions for each individual. Notify the Site Manager for instructions regarding notification of the physician. An Incident Report must be written. (See Section C for charting of medication errors.)

D. MEDICATION IRREGULARITIES/CHARTING ERRORS

1. Any charting irregularity -- individual gone, medications not available, etc. - or medication error is documented by placing a circle in the applicable block(s) on the front of the MAR. The reason for the circling i.e., medication error or some other irregularity is then documented on the back of the MAR. Incident Reports must be written for all medication errors and irregularities, with the exception of 3a below.
2. Medication errors include:
 - a. Administering the wrong medication to a individual.

- b. Administering an incorrect dosage of the medication.
- c. Administering a medication more than one hour earlier or one hour later than the scheduled time.
- d. Forgetting to give a medication.
- e. Administering a medication using a route other than that prescribed.
- f. Incorrect documentation or charting error for example initialing the wrong box.

3. Medication irregularities include:

- a. Medication sent home, to work, to an outing with another organization or person.
(Incident Report is NOT required) As a reminder circle the block on the MAR or TAR and make an entry on the back of form. Example: Medication given at work. An entry must be made for each medication or treatment irregularity.
- b. Any apparent adverse reaction to a medication such as drowsiness, irritability. Besides noted on the back of the MAR any perceived adverse reaction to a medication should be reported immediately to the Site Manager and physician.
- c. Individual refusing to take medications.
- d. Site Manager will review all MARS/TARS on a daily basis and complete all necessary incident reports and insure any required late entries are followed-up and completed immediately and appropriately.
- e. For all medication irregularities the MD will be notified except in #a.
- f. Late Entries

When an administrative/documentation error is found, staff responsible for the error must make a LATE ENTRY stating why the late documentation, date of late entry and sign their name to entry.

4. To avoid medication errors:

- a. Never leave medication with individual or on the counter.
- b. Never give medication prescribed for one individual to another individual.
- c. Never dispense medication that was set out by another person.
- d. Never use medication that is outdated or from an illegible or unlabeled container.

- e. Never give a medication that you have questions about until you have checked with the Site Manager, the individuals' physician or the pharmacist.

E. HEALTH CARE AND MEDICATION TREATMENTS AT THE WORK SITE

- a. All staff will be inserviced regarding the health care needs and drug information of each individual at a work site. A current copy of the health care portion of the ISP will be available at the work site, in addition to the clients vocational/ATE ISP.
- b.
 - 1. Medications given at the work site requires that a medication administration record be initiated for ONLY the drugs being dispensed at the work site. At the end of the month the work site MAR will be attached to the residential MAR and filed in the Clients permanent record. A copy will be kept for the vocational record. The MAR that is used at the work site will be prepared by the residential staff at the beginning of each month.
 - 2. For those individuals requiring a licensed nurse at the work site the home's chart and MAR/TAR will be transported to the work site (needs variance). All medical records will be kept in the client's records at the residence.
- c. Blister packed medication and treatments for the work site will be obtained from the home and will be locked in either a tackle box or a locking bag.
- d. Vocational progress notes will be kept at the home to keep a accurate record of important events that may occur during work hours. For example seizures, falls, illness.
- e. Upon return to the home medication will be checked in with staff to verify accuracy of administration at the work site. A report will be given to the house staff at the end of the workday discussing any health care concerns that happened during work hours. The staff is responsible for filling out graphic records at the house; e.g., seizure records, menus, intake and output records, progress entries and incident reports.

F. CONTROLLED MEDICATION

- a. For all controlled medications the residential staff will contact the Pharmacy to obtain individually labeled narcotics to be given at the work site.
- b. The staff will sign out the narcotic on the Controlled Drug Sheet prior to leaving for the job site. Controlled medication administered by the staff will be verified upon return with the residential staff.
- c. Controlled Medication Count Sheet will be kept at the residential site.

Approved by: _____ Date: _____
Jon Cooper, Director