MEDICATION MONITORING AND MANAGEMENT – Procedures

ICF/DD Programs

Purpose

To ensure appropriate monitoring and management of medications utilized by persons served in the ICF/DD Programs.

Scope

- This procedure applies to all persons served in the ICF/DD Programs.
- All ERC licensed and non-licensed employees will comply with this procedure.
- Only licensed medical staff (RN's/LPN's) may administer medication in the ICF/DD Programs.

Definitions

- Medication Assistance/Ancillary Aid may include the following activities:
    - Remind the person served when to take the medication and observe to confirm that the person served follows the medication order.;
    - Assist a person served in the self-administration of medication by taking the medication in its container from the area where it is stored and handing the container with the medication to the individual. NOTE: Non-licensed staff do not have access to prescription medications in the ICF/MR Programs.
    - If the person served is physically unable to open the container, the unlicensed person may open the container for the person served; and,
    - Assist, upon request by or with consent of, a physically impaired but cognitively able person served, in removing oral medication from the container and in taking the medication.
    - If a person served is physically unable to place a dose of oral medication in the individual's mouth without spilling or dropping it, an unlicensed person may place the dose in another container and place that container to the mouth of the person served.
    - Ancillary aid will not include calculation of medication dosages or altering the form of the medication by crushing, dissolving or any other method.
- "Medication Monitoring" is defined as the practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. The person served must take the medication without any assistance (other than ancillary aid) from personnel.
- "Medication Management" is defined as the practice of prescribing, administering, and/or dispensing medication by qualified personnel. It is considered management when personnel in any way affect dosage, including taking pills out of a bottle or blister pack; measuring liquids; or giving injections, suppository, or PRN medications.

Staff Credentials, Training and Monitoring

- Only staff licensed to administer medications (i.e., LPN's, RN's) may administer medications in the ICF/DD Programs.
- Non-licensed staff may only provide ancillary aid (as defined in Arkansas Nurse Practice Act) for those individuals who are self medicating.
- All newly hired nurses will be required to successfully complete the On the Job Training Program before administering medications without direct supervision.

- The RN, Administrator (or designee) or Pharmacist will randomly monitor medication passes to ensure appropriate methods are being used.

Individual Program Plan (IPP) and Self Administration of Medication Programs

- The comprehensive functional assessment will address:
  - The ability of a person served to self administer is assessed with the Self Administration of Medication (SAM) Assessment.
  - The Primary Care Physician reviews medications at least annually during the Annual History and Physical and provides a written report to the Interdisciplinary Team (IDT).
  - The RN also completes a Comprehensive Health Assessment and provides a written report to the IDT.
- The findings and recommendations will be addressed by the IDT and added to the IPP. Recommendations will address:
  - Formal Self Administration of Medication Goals/Training, if indicated.
  - For persons served who are self medicating but require ancillary aid, the type of aid required will be listed in the IPP. NOTE: Persons served may be independent with self administration of some medications but not others. This should also be addressed in the IPP.
  - A Medication Monitoring Plan will be developed for persons served taking medication in day programs on an as needed basis. Refer to Medication Monitoring Procedures for ERC's Day Programs.

Medication Orders

- A physician order must be on file for all medications administered.
- When taking medication or treatment orders over the phone:
  - Orders may only be taken by a nurse
  - Orders must be written on the Physician's Order form
  - Order will include name of physician or dentist giving the phone or verbal order, date and time the order was taken, and the five rights of medication administration
  - When transcribing a telephone order, the nurse will read the order back to the physician for confirmation
  - The order will be signed verified telephone order (VTO)/M.D. name/nurse professional signature
  - The telephone order must be signed by the prescribing physician within 7 days of the order.
  - The yellow copy of the order sheet is placed in the medical chart
  - The pink copy is to be used to make the change in the eMAR
  - The nurse is to document in a tlog the order(s) received
- When receiving a written order from a physician or dentist fill out the Physician Order form:
  - Place the original written order on the chart
  - Make changes in the eMAR
- As needed medication or standing orders should include when and why the medication should be given.
- All orders are to be faxed to the pharmacy and a copy of the fax stored in the Pharmacy notebook until the order has been filled.
- Any new medication or treatment order must be added to the eMAR prior to administration of the medication.

Medication Packaging and Labeling

- All prescribed medications will be contained in a properly labeled container from the dispensing pharmacy.
- Labeling must include the person's name, the name of medication, the dosage (including strength or concentration), the frequency, instructions for use (including administration route), the expiration date, the name of prescribing physician, and the dispensing pharmacy (with contact information).
- Licensed nursing staff may prepare up to one dose of medication that is to be taken off site by properly labeling the sealed envelope containing the medication(s). If more than one dose is to be taken while person served is off-site, the entire medication container must be sent.
    - Labeling must consist of persons name, name of medication(s), date, time medication is to be taken and any special instructions.
- Over the counter medications that are used as stock medications must be contained in the original container.
- Any discrepancy between medication orders and medication labels should be reported immediately to the pharmacy.

Medication Storage

- All medications will be stored in the locked cabinets or locked boxes that are designated for medications in each home.
- Controlled medications will be stored in a double locked cabinet.
- Medications requiring cold storage will be locked in the designated refrigerator in the medication room.
    - The refrigerator temperature will be maintained between 36 and 46 degrees Farenheit.
    - Refrigerator temperature will be recorded daily on the Daily Temperature Log.
    - In case of power outage or any other reason that the temperatures of the refrigerator would rise above the acceptable level, notify the physician and pharmacy consultant for further instruction.
    - Only medications are to be stored in this refrigerator.
- Only licensed nursing staff will have access to keys to the locked medication cabinets.
- Persons served who are self medicating may have their own individual locked medication box (per IPP). Both the nurses and the person served will have a key to the box. The box will be stored in the medication room and self administration of medication will be monitored by the nurse and documented by the nurse on the eMAR.

Safe Handling of Medications

- All prescription medications will be delivered by pharmacy personnel and checked in by a licensed nurse at the time of delivery.
    - Monthly cycle medications must be checked in by the nurse receiving the delivery.
    - When monthly medication change out arrives, there will be several boxes of medication cards. The only medication that will need to be verified with the deliverer are the narcotics. Both the licensed nursing staff and the deliverer will check each narcotic and the number match. Licensed nursing staff will then sign that the medication was received.
    - Narcotics will be logged by the nurse on duty receiving the narcotic delivery and double locked.

- Controlled medications must be counted at each change of nurse and the Narcotics Record Log signed by the nurses performing the count. If there will not be a second nurse, a Direct Support Professional or other ERC staff member may witness the count and sign off on the Narcotics Record Log.

Safe Disposal of Medications

- All discontinued prescription medications, with the exception of controlled medications, will be counted by two licensed persons and recorded in the Destroyed Medications Record and destroyed in accordance with state and federal regualtions.
- All controlled medications will be returned to the Arkansas Department of Health per their protocol for destruction. Two (2) LPNs or the RN and the Pharmacy Consultant will prepare controlled medications for return to the Department of Health.
    - In the event there is a discrepancy in the count, the RN Consultant and Administrator (designee) must be notified.
    - Any suspected loss, theft, and/or diversion of any controlled medication will be reported immediately to the Arkansas Department of Health by calling 501-661-2325, the local law enforcement agency and the Office of Long Term Care.
    - Medications dropped on the floor or otherwise contaminated will be disposed of by placing in the sharp's container and documented with a witness.

Automatic Stop Orders

- Automatic Stop Orders are those orders that include a date and time to discontinue the medication. In addition, automatic stop orders may pertain to certain medication categories that require regular review and monitoring by the ordering physician. The Automatic Stop Policy states that the following categories of medications may be discontinued within ten days of the procedure or condition for which the order was written: CII non-narcotics, CII narcotics, CIII, CIV and CV medications. The physician must be notified prior to the last dose to determine if the order should be continued or altered.

Maintenance of Adequate Supply of Medication

- When the new monthly supply of medication arrives at the ICF from pharmacy, nursing will chart, check in, and match each to the eMAR within 24 hours of arrival to the facility. All medications will be verified by comparing each to the eMAR. Any discovered discrepancies will be faxed immediately to pharmacy, in the time period preceding actual change-over of monthly medications, in order to ensure sufficient time for correction and replacement.
- In the event that newly ordered medications are required after hours, pharmacy will be notified per fax and phone call for 24 hour service to be utilized, in accordance with the ordered time frame of that medication being administered.

Medication Administration

- Always read eMAR and Medication Label before administering medications.
    - All information on drug label, eMAR, and physician's orders should always match.
- Any newly ordered antibiotic should be administered to the person served within four (4) hours of receiving the order.
- All other medications should be administered to the person served within twenty-four (24) hours of receipt of order.

- All psychotropic /behavior modifying medications must have Human Rights Committee (HRC) approval and informed consent by the person served and/or guardian. Refer to HRC Procedures.
- Medication rooms and surface areas where medications are taken are kept clean, stocked and clear of trash.
  - If water pitchers are used, they will be cleaned and filled daily and dated.
- Hands are washed before direct person served contact and between each person served; waterless hand cleansers may be used in a 15 second wet rub.
- Person served is identified before any medication is administered via the photo.
- Persons served rights and privacy are maintained.
- Nurse remains with the person served until medications are swallowed.
- Self Administration Training Programs are implemented as written in the IPP.

Documentation of Medication Use

- The electronic Medication Administration Record (eMAR) in Therap will be used for documenting medication and treatment administration.
- The eMAR will include persons served name, drug name, dosage strength, administration route, frequency, medication indication/diagnosis, allergies and prescribing physician.
- The eMAR will be updated with the addition, adjustment or discontinuation of any ordered medication, within four hours of receiving that order. In addition, the eMAR will be updated periodically as needed.
- Documentation in the eMAR will occur immediately after administration of the medication. The legend in the eMAR will be used.
- Any clinical data relevant to the medication being administered will be documented on the eMAR in the comment section at the time of administration. Examples include: BP, HR, CBG, pain level, temp, etc.
- For as needed medication, the eMAR will be completed and include relevant clinical data (see above) as well as follow-up documentation indicating efficacy of the as needed medication.
- If a medication is held, the eMAR will be marked "On Hold" and will note the rationale for holding the medication in the comment section. In the event of a non-over-the-counter medication being held due to a decision based on nursing judgement, the nurse will notify the ordering physician prior to the next scheduled dose.
- If a medication is refused, the eMAR will be marked "Missed/Refused" and will note information related to miss/refusal in the comment section. The RN or Medical Director and IDT will be notified if there appears to be a trend in refusals. If a medication is discontinued or is placed on hold, the eMAR will be marked "deleted" or "on hold" for the appropriate duration of the month.
- New medications will be marked in the eMAR as "Administered (New)". Newly ordered medications will be charted in a tlog for the first 72 hours of administration.
- When persons served are on leave of absence, the eMAR will be marked "Leave of Absence".
- Administration of controlled medications will be documented both in the eMAR and in the Narcotics Record Log book.
- Documentation of Medication Monitoring (in the day programs) will be completed on the Monthly Medication Log in the Program.

Adverse Drug Reactions

- In the event of a significant adverse drug reaction, immediate action will be taken to protect the person served.

- The MD should be notified immediately.
- The consulting pharmacist should be notified and receive a copy of the General Event Record (GER) upon completion.
- Any new orders will be implemented and the person served will be monitored closely for 24-72 hours or as ordered.
- All staff working with the person served will be primed on the incident and given specific guidance how how/what to monitor.
- The following information will be documented on the GER:
  - Factual description of the adverse reaction.
  - Name of prescriber and time notified.
  - Prescriber's subsequent orders.
  - Persons served condition for the next 24 to 72 hours or as ordered.

Medication Errors

- Medication errors occur any time a medication was not given as it was prescribed (or any of the six rights were violated).
- Six (6) Rights:
  - Right person served
  - Right dose
  - Right route
  - Right medication
  - Right time
  - Right documentation
- If a medication error occurs, the nurse discovering the error, will notify the RN and the Primary Care Physician upon discovery of the error.
- A GER must be completed.

Reviewed/Approved by:

COO and Program Directors reviewed and approved Procedure on 3/2014, 4/2014, 11/2016, 11/2017, 6/2018.

Approved by:

Natasha Dennis, COO

06/25/18
Date

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