



Responsibilities in Action

Study Guide

Unit 1 Working at a MAP Registered Program (Pages 14-21)

MAP Consultants

A MAP Consultant is a:

- registered nurse
- registered pharmacist
- Health Care Provider (HCP)

MAP Consultants must be available 24 hours a day, 7 days per week and their contact information must be clearly posted in your work location.

Examples of when you may need to contact a MAP Consultant include if:

- you make or discover a medication occurrence
- the medication was omitted (not given)
- the medication was refused
 - if refused, the prescribing HCP must be notified
- the HCP order, pharmacy label or medication sheet do not agree
- you have a question about a medication or how to administer it

After a MAP Consultant is called, then you contact your supervisor to tell them about the issue.

Learning about the People You Support

Two of your most important responsibilities are watching for and reporting changes in the people you support. Observe for changes physical and/or behavioral. First, get to know the person by

- Communicating with the
 - person
 - family
 - other staff
- Reading the
 - person's health history

- communication log
- Observing the person for what they do both
 - physically and
 - behaviorally

Once you know the person it will be easier to recognize a change. It is your responsibility to report all changes immediately to help decrease the possibility of a problem becoming worse.

Principles of Medication Administration

By following the principles of medication administration you will help to ensure medications are administered safely. The principles of medication administration are

- **Mindfulness**
 - pay attention to what you are doing during medication administration
 - decrease distractions
 - never allow medication administration to become routine
- **Supporting Abilities**
 - support the person to be as independent as possible
 - encourage participation
- **Communication**
 - Reading the HCP order, pharmacy label and medication sheet
 - Ensuring they agree
 - Contacting a MAP Consultant as needed
 - Talking and listening to the person while you administer their medication

Respecting Rights

Like you, the people you support have rights including to be treated with dignity and respect, privacy and to keep personal information confidential. In relation to medication administration, people have the right to:

- know what their medications are and the reasons they are taken
- know the risks associated with taking the medication
- know the benefits associated with taking the medication
- be given medication only as ordered by the HCP
- refuse medication

If a person refuses to take their medication, the first thing you should do is ask them why they do not want to take it and report that information to the prescribing HCP and your supervisor. Until you know why the person is refusing their medications and report the issue, the problem cannot be resolved.

Unit 2 Observing and Reporting (Pages 22-30)

Observations

Observation is the process of watching someone carefully in order to obtain information. Observing, reporting and documenting physical and behavioral changes are your responsibility. Observations are either

- **Objective-** factual information you will see, hear, feel, smell and measure.
Such as:
 - vital signs
 - a purple and red bruise
 - you see a person trip and fall
 - a person's forehead feels warm to the touch
 - a seizure lasting 3 minutes and 36 seconds
 - slapping head for 2 minutes
- **Subjective-** when a person speaks or signs and they tell you something.
Such as:
 - "I feel sick"
 - "I bumped my knee"
 - "I hit my head when I fell"
 - "I feel really cold"
 - "She hit me!"

Reporting

Reporting is to give spoken or written information of something observed or told. You are responsible for reporting any changes, physical or behavioral, you notice. Report the facts. Do not guess at what you think the issue might be.

There are two types of reporting:

- **Everyday reporting-** typically occurs between staff present at shift change regarding day to day matters
- **Immediate reporting-** reporting without delay as soon as possible after a change is observed. Immediate reporting may prevent a small change observed from becoming a major health issue.

A HCP uses the information reported by staff to determine if treatment and medication are needed.

Documentation

Documentation should tell a story from beginning to end whether an issue takes a day, many days or weeks to resolve.

When documenting:

- Use ink
- Write
 - Clearly
 - In complete sentences
- Include
 - Date
 - Time
 - Your full name

When documenting using a medication progress note, use as many lines as needed to explain the situation.

Correcting a Documentation Error

Medication sheets, medication progress notes, narrative notes and HCP orders, etc. are legal documents. If you make a documentation error, never use 'white-out', mark over or erase the error; this can be viewed as an attempt to hide something.

To correct a documentation error:

- Draw a single line through the error
- Write 'error'
- Write your initials
 - Then document what you meant to write the first time

*If the documentation error is made on a medication sheet while transcribing or a transcription error is noted on the medication sheet, the entire transcription must be marked through and rewritten; corrections cannot be made to the transcribed information on a medication sheet. (*Covered in Unit 6)

Unit 3 Medications (Pages 31-45)

Medications are substances that, when put into or onto the body, will change one or more ways the body works.

Medications are known by their brand name and/or generic name. Typically, all medications have a brand and a generic name.

Brand name medications are created and made by a specific pharmaceutical company. When a pharmaceutical company creates a medication they are allowed to name it. Examples of brand name medications are Tylenol, Advil and Prozac.

Generic medications are known by their chemical name and are manufactured by many different pharmaceutical companies. Generic medication is similar to its brand name medication but is less expensive; the name is different and it may have a different color, marking, shape and/or size. Examples of generic name medications are acetaminophen, ibuprofen and fluoxetine.

When the HCP writes a prescription for a brand name medication and the generic medication is supplied by the pharmacy, you will see the generic name of the medication and the letters 'IC' near the brand name of the medication printed on the pharmacy label.

'IC' is an abbreviation for 'interchange'. This means the generic name medication was supplied by the pharmacy in place of the brand name medication.

For example:

Acetaminophen

IC: Tylenol

Medication Categories

There are three categories of medications:

1. **Controlled** - Controlled medications require a prescription written by the HCP in order to obtain the medication from the pharmacy.

Controlled medication requirements include:

- A HCP order for administration
- Labeled and packaged by the pharmacy
 - In a bottle or
 - May be in a tamper resistant package
- Secured in a locked area
- Tracked using
 - Medication Ordering/Receiving log and

- Medication Sheet
- Transfer Document
- DPH Disposal Record

2. **Countable Controlled** - Countable controlled medications require a prescription written by the HCP, in order to obtain the medication from a pharmacy. Countable controlled medication requirements include:

- A HCP order for administration
- Labeled and packaged by the pharmacy in a
 - Tamper resistant package (including liquids)
 - With an Identifier
- Secured in a double locked area
- Tracked using
 - Medication Ordering/Receiving log
 - Countable Controlled Substance Book (Count Book)
 - Medication Sheet
 - Transfer/LOA Document
 - DPH Disposal Record
- Counted every time the medication storage keys change hands

3. **Over-the-Counter (OTC)** - Over-the-Counter (OTC) or nonprescription medication may be purchased from a pharmacy without a prescription from the HCP; however, MAP requires that all OTC medications be labeled by the pharmacy, with some possible exceptions*. This means that you must ask the HCP to write a prescription for all OTC medications so that the pharmacy will prepare and label the medication. Examples of OTC medications include nonprescription pain relievers (Tylenol, Advil) or allergy medication (Benadryl).

OTC medication requirements include:

- A HCP order for administration
- Packaged by the pharmacy
 - In a bottle or may be in a
 - Tamper resistant package
- Labeled by the pharmacy*
- Secured in a locked area
- Tracked using a
 - Medication Ordering/Receiving log and
 - Medication sheet
 - Where the medication is documented after administration
 - Transfer Document

Dietary Supplements

Dietary supplements are products that contain dietary ingredients such as vitamins, minerals, herbs or other substances. Unlike medication, dietary supplements are not pre-approved by the government for safety or effectiveness before marketing. Dietary supplements may be purchased from a pharmacy without a prescription from the HCP however; MAP requires that all dietary supplements be labeled by the pharmacy, with some possible exceptions*. This means that you must ask the HCP to write a prescription for all dietary supplements so that the pharmacy will prepare and label the supplement. Examples include multivitamins, fish oil and shark cartilage.

Dietary supplement requirements include:

- A HCP order for administration
- Packaged by the pharmacy
 - In a bottle or may be in a
 - Tamper resistant package
- Labeled by the pharmacy*
- Secured in a locked area
- Tracked using a
 - Medication Ordering/Receiving log and
 - Medication sheet
 - Where the medication is documented after administration
- Transfer Document

Medication Outcomes

What happens or does not happen after a medication is administered is known as a **medication outcome**. When a medication is given it may cause any of the following outcomes:

- **Desired Effect-** is when a medication does exactly what it was intended to do; the person experiences the beneficial results of the medication.
- **No Effect Noted-** is when a medication is taken for a specific reason and the symptoms continue; no effects are noted from the medication. This could happen for 1 of 2 reasons
 - The medication has not had enough time to work, or
 - The medication has had enough time to work and is not effective
- **Side Effects-** are results from a medication that were not wanted or intended even if the desired effect is achieved.
 - Side effects range from minor to severe. If the side effect is more severe, it is called an **adverse response** to the medication.

Adverse Responses to observe for include:

- **Paradoxical reaction**- when the response the person experiences is the opposite of what the medication was intended to produce.
- **Toxicity**- when a medication builds up in the body to the point where the body cannot tolerate it anymore; this can be life threatening.
- **Allergic reaction**- the body's immune system reacts to the medication as if it were a foreign substance. The person can have a rash or 'itching'.
- **Anaphylactic reaction**- a severe, very dangerous, life threatening allergic reaction. An anaphylactic reaction happens very quickly and requires immediate medical attention, such as calling 911.

Medication Interactions

A medication interaction is a mixing of medications in the body which will either increase or decrease the effects and/or side effects of one or both of the medications; the more medications a person takes the greater the possibility of an interaction occurring. In addition to medications interacting with each other, medications can also interact with dietary supplements, other substances (alcohol/ nicotine/caffeine) and certain foods.

Sensitivity to Medication

Each person may respond differently to the same medication. How a person responds depends on how sensitive they may or may not be to the medication. There are several factors which contribute to a person's sensitivity to medication.

These factors include:

- Age
- Weight
- General health
- Medical history
- Use of other medications or dietary supplements

Medication Information

You are responsible to learn about the medications you administer and know the reason for administration. To monitor the person for the effects of medication you must

- learn about the people you support
- read about each new medication before administering
- know where to find or how to contact medication information resources

Resources for medication information include

- the MAP Consultant
- medication information sheets
 - supplied by the pharmacy for each medication dispensed

- a reputable online source
- a drug reference book

Unit 4 Interacting with a Health Care Provider (Pages 46-60)

Sometimes the changes you observe and report result in a HCP visit.

The procedure to ensure that you are prepared with all the information and forms needed when accompanying a person to a medical appointment is as follows:

Prepare the person for the appointment

- Know the reason for the visit
- Discuss with the person what is going to happen at the visit, as appropriate
- If ordered, give any pre-medication or ensure the person is fasting
- Before you leave for the appointment make sure you have everything you need such as
 - Current medication list
 - HCP order form
 - Insurance information
- When you get to the appointment check in with the receptionist and discuss any accommodations the person may need during the visit.

During the appointment

- Assist the person if needed
- Advocate/Support abilities/Encourage participation
 - Redirect the HCP to the person if the HCP focuses on you
- Provide forms and/or information to the HCP
- Write down any information during the appointment so that it can be communicated to others after the appointment
- Obtain
 - Signed and dated HCP orders which include
 - The 5 rights of medication administration
 - Reason for the medication
 - Special instructions, if needed
 - If a PRN medication is ordered, the order include target signs and symptoms for use and instructions including what you should do if the medication is given and is not effective
 - Prescriptions
 - Ensure the prescriptions have been sent to the pharmacy or
 - If given a paper prescription, ensure it and the HCP order agree

After the HCP Appointment

- Ensure the pharmacy received the prescription
- Pick up new medications at the pharmacy or check to see when the pharmacy will deliver the medication
- Bring back all forms
- Transcribe all medication orders on to the medication administration sheet
 - Post and Verify all orders
- Secure the medication
- Document the visit
- Communicate changes to all staff

People Who Manage Appointments Independently

When a person manages their medical appointments independently your responsibilities will vary depending on the person. Your responsibilities may include:

- Reminding the person of the upcoming appointment date and time
- Ensuring the person has all necessary documents, such as a HCP order form
- Reviewing with the person what needs to be discussed at the appointment
- Arranging transportation
- Reminding the person to obtain prescription refills

Fax and Telephone Orders

It is preferred that fax orders be used in place of telephone orders because the process is less likely to result in a miscommunication and is safer. A fax order is a legal order.

HCP medication orders by telephone are allowed. A telephone order is documentation of a newly ordered medication, a change to an existing medication or a non-medication order given to you by a HCP over the telephone. When you take a telephone order:

- Record the order word-for-word on a HCP Telephone Order Form
- Read back the information given to you by the HCP to confirm you recorded it accurately
- If you're having trouble understanding the HCP, ask another staff to listen in as you take the order, then have that staff read it back and sign the order too
- If you do not know how to spell a spoken word, ask the HCP to spell it
- Draw lines through any blank spaces in the order
- Make sure the HCP signs the original order within 72 hours
- Obtain any prescribed medication from the pharmacy.
- Telephone orders are posted and verified twice:

- First when the order is initially obtained and transcribed
- Again after the HCP has signed the order, ensuring no changes were made.

Unit 5 Obtaining, Storing and Securing Medication (Pages 61-72)

Obtaining Medication

A HCP order is required to administer medications and dietary supplements to people living at MAP registered programs.

The HCP order is a set of instructions, from the HCP to the staff at the program, instructing the staff about what medication the person is to receive and how it is to be administered.

The HCP writes a prescription for each medication ordered. A prescription is a set of instructions from the HCP to the pharmacist. The prescription instructs the pharmacist what medication to prepare and how it is to be administered to the person. The pharmacist uses the information on the prescription to print a pharmacy label.

You will have a HCP order and a labeled container of medication for each medication prescribed. Typically, the HCP will write the brand name of the medication on the order and the prescription. The pharmacy will supply the generic form of the medication. To ensure that the HCP order and pharmacy label agree, the label must include the name of the medication prepared in the container (generic) and the name of the medication as listed on the HCP order (brand).

There are many ways the HCP can send the prescription to the pharmacy, such as:

- E-prescribe
- Fax
- Telephone
- Paper prescription given to you, or the person, to bring to the pharmacy

Once a medication is ordered it must be obtained from the pharmacy in a timely manner. If the medication is not obtained, you must contact the HCP for a recommendation of what to do.

Ensuring the Pharmacy Provides the Correct Medication

As soon as the medication is obtained, compare the HCP order to the pharmacy label; both must agree.

Look at the medication. If the medication is different in color, shape, size or markings from the last time it was filled you must contact the MAP Consultant before administering it. Also, you must check the strength of tablet supplied; it may have changed from the last time the medication was obtained.

Tracking Medication

After medication has been obtained from the pharmacy it must be documented as received into the program and tracked.

Medications are documented and tracked using:

- Medication Ordering and Receiving Log
- Pharmacy receipts
- Countable Controlled Substance Book (Count Book)
- Medication Sheets
- Medication release documents such as
 - Leave of Absence (LOA) form
 - Transfer form
- Disposal record

Medication Storage and Security

The following are medication storage requirements, including liquid and refrigerated medication:

All medication is locked.

- Countable medication must be
 - double locked
 - packaged in tamper resistant packaging
 - Liquid countable medication must be packaged so that once used, the container is empty. You may not use a multi-dose bottle of a liquid countable medication
- Only items required for medication administration may be stored in the locked medication area
- Medication must remain in the original, labeled packaging received from the pharmacy
- Each person should have their own medication storage container with their name
- Medication taken by mouth should be separated from medication taken by other routes.

- The medication storage/preparation area should have minimal distractions; this will help you to remain focused while preparing medication for administration
- Store medication away from
 - food and/or toxic substances such as household cleaners
 - excessive heat, moisture and/or light

The medication storage keys must be carried by you if you are assigned medication administration duties for the shift.

There must also be a back-up set of keys accessed through contact with administrative staff in the event there is an issue with the first set.

Unit 6 Recording Information (Pages 73-102)

When a HCP order is written and medication is obtained from the pharmacy, the information from the HCP order and pharmacy label must be transcribed (copied) onto a medication sheet.

The Medication Book

A medication book typically contains:

- Emergency Fact Sheets (EFS)
- HCP Orders
- Medication Sheets
- Medication Information Sheets

Medication Sheets

The medication sheet includes the:

- current month and year
- allergies
- generic and brand medication names
- strength
- amount
- frequency /time
- dose
- route
- start date
 - the date the person receives the first dose of a medication
- stop date

- Used to identify the date when the last dose of a time limited medication is administered. If the medication will be given on an ongoing basis, the stop date is documented as “cont” (continue).

The right side of the medication sheet is called the ‘grid’; each box in the grid is a ‘medication box’. The medication box is where you will document your initials after administering a medication. Your initials in a medication box means you have administered the medication as ordered.

Acceptable Codes on a Medication Sheet

- DP- day program/day hab
- LOA- leave of absence
- P- packaged(used when a person is learning to self-administer his/her medication)
- W- work
- H- hospital/nursing home/rehab center
- S-school

Only acceptable codes may be used on the medication sheet. The acceptable code identifies where the person is if they are not in the program when the medication is scheduled to be given or if the person is learning to self-administer their medication.

Transcription

Using the HCP order and information printed on the pharmacy label, the following information must be transcribed onto the medication sheet:

1. The month and year
2. The person’s name
3. Allergies or if none, no known allergies
4. Generic medication name
5. Brand medication name
6. Dose (copied from the HCP order)
7. Strength (copied from the pharmacy label)
8. Amount (copied from the pharmacy label)
9. Frequency
10. Route
11. Start date
12. Stop date
13. Any special instructions or parameters for use
14. Reason for the medication

'Frequency' and the word 'time' are used interchangeably. Most HCPs will not order an actual time to administer the medication but instead will order how many times per day a medication is to be given or the amount of time between doses.

Based on the HCP order, a specific time must be written underneath the word "Hour" in the hour column, on the medication sheet. Do not use references to time such as breakfast, lunch, dinner or bedtime.

When writing times in the hour column, it is important to write the time in the appropriate hour box. It is best practice to write 'am' times in the top two boxes and 'pm' times in the bottom two boxes. You must include either 'am' or 'pm' after each time listed.

Discontinuing a Medication

Discontinuing (DC) a medication on the medication sheet is a three step process:

1. Cross out all open boxes on the medication sheet, next to where the medication is scheduled to be given; xxxxx's or a straight line _____ may be used.
2. Draw a diagonal line through the left side, written portion, of the medication sheet and document: DC, the date and your initials.
3. Draw a diagonal line through the right side, grid section, of the medication sheet and document: DC, the date and your initials.

Transcribing a New Medication Order

When transcribing information onto the medication sheet you must copy the dose from the HCP order and strength and amount must be copied from the pharmacy label.

The medication name(s), frequency, route and any special instructions or parameters for use may be found on the HCP order and/or the pharmacy label and copied onto the left side of the medication sheet.

Assign 'times' in the hour column.

Think about the current date and time to determine when the first dose can be administered.

If the medication order is 'time limited' (order for only a certain number of days) count the medication boxes to determine when the last dose will be administered. Make sure boxes leading up to the first dose scheduled and after the last dose scheduled, are crossed out.

Complete the 'start' (first scheduled dose) and 'stop' (last scheduled dose for a time limited medication or 'cont' if a continually administered medication order) dates.

Posting and Verifying

After a HCP order is transcribed onto a medication sheet, the HCP order is Posted and Verified.

The first staff who completes the transcription documents:

- “Posted”
 - on the HCP order form
 - under the HCP’s signature
- Date, time and signature

The second staff must review the transcription completed by the first staff, then documents:

- “Verified”
 - on the HCP order form
 - under the HCP’s signature
- Date, time and signature

Telephone orders are posted and verified twice:

- First when the order is initially obtained
- Again after the HCP has signed the order, ensuring there were no changes

Medication Information Sheets

A medication information sheet is a valuable medication information resource. A medication information sheet must be available for each medication ordered.

Unit 7 Administering Medications (Pages 103-154)

Medication orders are either regularly scheduled (given on an ongoing basis) or PRN (given as needed).

PRN medication orders must include for use:

- Target signs and symptoms
- Measurable objective criteria for use, if applicable
- How many hours apart the doses may be given
 - If the medication is scheduled and PRN, the order must include how close the PRN dose may be given to the scheduled dose
- Parameters
 - Such as, what to do if the medication is given and is not effective

When documenting the administration of a PRN medication on the medication sheet include:

- your initials
- the time administered and
- write a progress note including the reason for administration and what happened after (effectiveness)

The 5 rights of Medication Administration are the:

- Right Person
- Right Medication
- Right Dose
- Right Time
- Right Route

The 3 Checks of the 5 Rights

The **3 checks** of the **5 rights** must be completed before a medication may be administered.

Check 1- Compare the 5 rights on the HCP Order to the Pharmacy Label

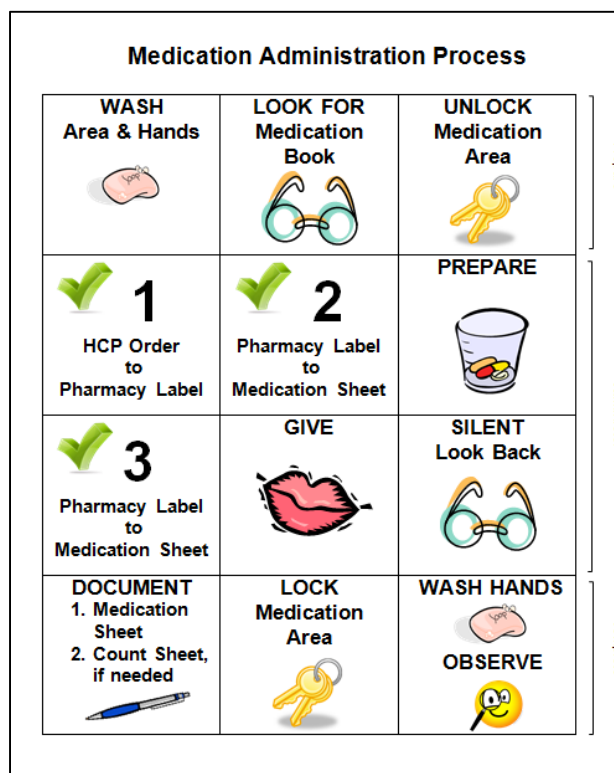
Check 2- Compare the 5 rights on the Pharmacy Label to the Medication Sheet

Prepare

Check 3- Compare the 5 rights on the Pharmacy Label to the Medication Sheet

Medication Administration Process: Prepare, Administer, Complete

- **Prepare:**
 - Wash hands and area
 - Unlock medication storage area
 - Look for the medication book and
 - Locate the medication to be administered
- **Administer:**
 - Check 1
 - Prepare
 - Check 2
 - Administer
 - Look back
 - Check 3
- **Complete:**
 - Document
 - Initial the medication sheet
 - Initial and sign the signature list, once per month
 - If countable, subtract from the count
 - Secure the medication and area
 - Wash your hands



Administer tablets or capsules (as received from the pharmacy) whole with water; do not change the form of a medication unless ordered to do so by the HCP.

Liquid Medication

When the medication is in a liquid form, the identical medication administration process is followed.

The label on a liquid medication includes the strength of the medication based on how many milligrams (mg) per milliliters (mL) is measured. Liquid medications are usually measured in milliliters, teaspoons, or tablespoons.

Always use a proper measuring device. If one is not provided, you must ask the pharmacist for an appropriate measuring device. Never measure liquid medications with household utensils or measuring spoons.

Read the label instructions, often, liquid medication needs to be shaken before pouring.

When preparing a liquid medication, once you determine the amount of liquid to measure into the medication cup based on the dose ordered, make sure you:

- Shake the medication, if needed
- Remove the cap and place it upside down on the table
- Place the medication cup on a flat surface, at eye level
- Locate the correct measurement on the medication cup
- Hold the bottle so that your hand covers the pharmacy label
- Pour slowly
 - If you pour too much, do not pour back into the bottle
 - Extra medication must be disposed per MAP Policy
- Wipe the top of the bottle after pouring, if needed
- After use, wash the medication cup if reusing
 - with dish soap and water

How to Document if a Medication is Not Administered

When a medication is not administered as ordered, this is documented by

- Circling your initials on the medication sheet, and
- Writing a medication progress note explaining why it was not administered and who was notified

MAP Consultants

A MAP Consultant must be notified when a medication is administered in a way not ordered by the HCP or if omitted. When documenting make sure you include

- the MAP Consultant's full name
- what happened and
- the MAP Consultant's recommendation

Medication Refusals

A medication refusal is when the person

- says 'No'
- spits the medication right back out or never takes the medication from you
- spits the medication out later
- intentionally vomits the medication within one half hour of taking it

Medication must be offered at least 3 times before it is considered a final refusal.

The HCP and the supervisor must be notified of the medication refusal.

If a Medication is not Available to Administer

A medication may not be available to administer. Examples include when

- prior authorization is required from the insurance company
 - Immediately contact the prescribing HCP and obtain a recommendation about what you are to do until the medication can be obtained
- the medication is 'too soon to refill'
 - Immediately contact the pharmacist and ask when the medication will be available and what you are to do until the medication is obtained
- no refills remain on the prescription
 - Immediately contact the prescribing HCP and request a new prescription be sent to the pharmacy then,
 - obtain the medication from the pharmacy
 - If you cannot obtain the medication, ask the pharmacist what you are to do until the medication can be obtained

Unit 8 Chain of Custody (Pages 155-195)

All medication must be secure and accounted for.

Access to the medication storage area must be limited to staff assigned to administer medication.

The medication storage keys must remain on the person of the Certified staff assigned medication administration duties, for the shift.

Every time the medication storage keys change hands a two person, 'Shoulder to Shoulder', count of the countable medication must be conducted.

Staff must be certified or licensed to handle, transfer, accept or administer medication at a MAP registered site.

Tracking Documents

There are many documents and methods used to track medications, including:

- A Medication Ordering and Receiving Log
- Pharmacy receipts
- Controlled Countable Substance Book (Count Book)
- Medication sheets
- Medication release document (Transfer form or LOA)
- Disposal Record
- Blister Pack Monitoring
 - Although not a MAP requirement, if used at your program you will
 - Document medication removed from a blister pack by writing your initials, date and time on the back of the blister pack for each tablet removed.

Count Book

A count book has 3 basic sections, including the

- **Index**- lists the person's name, medication, strength and count sheet page number
- **Count Sheets**- used to document the addition and subtraction of countable medication
- **Count Signature Sheets**- documentation of when the medication was last counted and who counted it. The count must be conducted with 2 staff each time

the medication storage keys change hands and when placed into or are removed from the coded lock box.

When Two Signatures are Required in the Count Book

Two Certified and/or licensed staff signatures are required in the count book when

- adding a newly prescribed medication
- adding a medication refill
- disposing medication
- a count sheet page is transferred
 - including 2 signatures at the bottom of the completed page and the same 2 signatures at the top of the newly transferred page
- the medication storage keys change hands
 - including when placed into or removed from the coded lock box

Medication Sheets

Medication sheets are used to track the administration of a person's medication. After you have administered a medication you write your initials in the medication box on the medication sheet documenting you have administered the medication. If the person is at another location, a code is entered in the medication box identifying where the person is, such as

- LOA - leave of absence
- H - hospital, nursing home, rehab center
- DP - day program/day hab
- W - work
- S - school
- P - packaged, if the person is learning to self-administer his/her medication

If the medication is not administered, document this on the medication sheet by

- circling your initials and
 - writing a progress note explaining
 - why the medication was not administered and
 - who was notified

Medication Release Documents

A medication release document is also known as a transfer form.

In the event a medication is required to be transferred from one location to another location a dated medication release document (transfer or LOA form) must be completed.

The medication release document must include:

- Where the medication is being transferred from
- Where the medication is being transferred to
- Medication name and strength
- Total amount of medication (tablets, capsules, mLs etc.) transferred; of each medication
- Signature of person transferring medication
- Signature of person receiving medication

Day Programs

Day programs typically receive their supply of medication(s) from the residential programs. It is the residential staff's responsibility to ensure the day program staff has all required information for medication administration:

- a copy of the HCP order and
- pharmacy labeled medication
 - Complete a medication release document when transferring medication to the day program (the residential and day programs must both have a copy)

Leave of Absence

A leave of absence is when a medication will be administered outside of the person's home, such as a staffed outing or during a visit with family.

The pharmacy must prepare the medication for any leave of absence if the LOA is

- scheduled ahead of time and/or
- greater than 72 hours

If the pharmacy is contacted and is unable to prepare the medication you may prepare it **only** if the LOA is

- unplanned (not scheduled ahead of time) and is
- less than 72 hours

If the person is on a LOA where you are assigned medication administration duties, document a leave of absence on the medication sheet by writing 'LOA' in the medication box.

A LOA form must be completed, including signatures of the

- staff releasing medication and
- person accepting medication

Any unused oral LOA medication may not be returned to the program for use; instead, it must be disposed.

Disposal

All controlled and countable controlled medication to be disposed must be documented on the DPH Disposal Record Form.

When countable medications are disposed, the Disposal Record and Count Book documentation must agree, including the reason why disposal was needed, documented in both places.

Possible reasons for disposal include:

- the medication
 - was refused
 - dropped on the floor
 - was discontinued
 - expired (outdated)
 - medication was prepared incorrectly
- the person died
- the supply of medicine in the program is more than allowed
- unused LOA oral medication was returned to the program

Medication disposals must be completed with two Certified staff, one of which is a MAP Certified Supervisor, however, two Certified staff (no supervisor) may dispose of the medication **only** if the medication was

- refused
- dropped
- prepared incorrectly
 - your supervisor is unavailable and
 - your agency allows it

Medication may not be returned to the pharmacy for disposal.

Medication Supply Discrepancy

Suspicious

A suspicious “count discrepancy” is when the count is off and there is suspicion of tampering, theft or unauthorized use of medication.

All medication losses must be reported immediately to your supervisor.

Prescription (controlled and countable controlled) medication losses must be documented and reported to the Drug Control Program (DCP) within 24 hours after discovery, using the DPH/DCP Drug Incident Form.

Non-suspicious

A non-suspicious count discrepancy is when the count is off however can be easily resolved by checking the addition and/or subtraction documented. If a non-suspicious discrepancy is noted in the count book it must be corrected accurately using as many lines as needed to ‘tell the story’ of what happened. Make sure your documentation also includes that you reported the discrepancy and correction to your supervisor.

Unit 9 Medication Occurrences (Pages 196-208)

A medication occurrence is when one of the 5 rights goes wrong during medication administration, including:

- Wrong
 - Person
 - Medication
 - Dose
 - Time
 - Omission (a subcategory of wrong time)
 - Route

Reporting of medication occurrences provides the opportunity to improve medication administration procedures. When reviewing medication occurrences it is important to focus on what contributed to the occurrence rather than who made the occurrence

Every staff can and should learn from someone else's mistake.

It is important to remember that the safety of the person must always be your primary concern.

Procedure Following a Medication Occurrence

- Check to see if the person is ok
- If not ok, call 911
- Call a MAP Consultant
- Follow all recommendations given to you by the MAP Consultant
- Notify your supervisor
- Document
- Complete a Medication Occurrence Report (MOR)
 - if the medication occurrence is a Hotline Medication Occurrence
 - notify DPH and the MAP Coordinator within 24 hours of discovery
 - if not a hotline, submit the report within 7 days of discovery of the medication occurrence
 - to the MAP Coordinator

Medication occurrences can be greatly decreased by always following the medication administration process you learned in this curriculum. Follow the same process each time you administer medication.

If you make or discover a medication occurrence it must be reported immediately to a MAP Consultant.

When contacting a MAP Consultant make sure to document:

- The date/time
- The MAP Consultant's first and last name
- The issue
- Recommendations given to you by the MAP Consultant
- Your full name