Responsibilities in Action

Study Guide

Important!

After you have completed your MAP Certification Training, use this Study Guide as you prepare for your Certification Knowledge Test. This Study Guide *does not* replace the Responsibilities in Action (RIA) curriculum; if there is a topic listed in this Study Guide that you do not fully understand, please use the referenced page number(s) to read more about the topic in RIA.

Important!

Your Certification test(s) with D&S Diversified Technologies will be conducted virtually/online; you must be using a computer with an updated browser (such as Google Chrome or Firefox). Outdated browsers (such as Internet Explorer and Safari), tablets and iPhones do not support the technology required for the Transcription test. If you will be completing your Certification test(s) on your home computer, be sure that the browser you will be using is an updated one by practicing the transcription pretest on that computer *before* the day of your test.

Certification Test Plan (This is how many questions come from each section in RIA)

Introduction	**1 question**
Unit 1 Working at a MAP Registered Program	**4 questions**
Unit 2 Observing and Reporting	**6 questions**
Unit 3 Medications	**4 questions**
Unit 4 Interacting with a Health Care Provider	**3 questions**
Unit 5 Obtaining, Storing and Securing Medication	**6 questions**
Unit 6 Recording Information	**5 questions**
Unit 7 Administering Medications	**10 questions**
Unit 8 Chain of Custody	**7 questions**
Unit 9 Medication Occurrences and Appendix	**4 questions**

Introduction (**RIA pages 8-11)**

A MAP Certification is

- transferrable between DPH MAP registered programs only, and
- valid for 2 years until the last day of the month in which you passed your certification test.

You are responsible for ensuring that your MAP Certification remains current.

Recertification must be completed every 2 years. To become recertified, you must pass the recertification skills test.

If your MAP Certification expires, you may no longer administer medication. You have one year to recertify. If you do not recertify within one year, you must complete the full MAP Certification training program again and retake the certification tests.

Unit 1 Working at a MAP Registered Program (RIA pages 15-22)

MAP Consultants (RIA pages 15-16)

A MAP Consultant is a:

- Registered Nurse (RN)
- Registered pharmacist
- Health Care Provider (HCP)

MAP Consultants must be available 24 hours a day, 7 days per week.

DPH requires that the telephone numbers for the MAP Consultants, poison control and other emergency numbers (911, fire, police) be clearly posted near the telephone in all programs.

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 HCP order, pharmacy label or medication sheet do not agree
- you have a question about a medication or how to administer it

Anytime you have health related questions, contact the person's HCP.

Your Supervisor must be informed anytime the MAP Consultant has been contacted.

Learning about the People You Support (RIA page 17)

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.

Recognizing changes and reporting them to the right person will ensure the people you support will receive the best care possible.

Principles of Medication Administration (RIA pages 18-19)

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

- **Mindfulness**
  - paying attention and only focusing on what you are doing during medication administration
  - minimizing distractions
  - never allow medication administration to become routine
- **Supporting Abilities**
  - supporting the person to be as independent as possible
  - encouraging 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 (RIA pages 20-21)

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

- know what their medications are and the reasons they are prescribed
- 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.

A person has the right to be given medication only as ordered by the HCP; you must follow the person's HCP order and/or Support Plan/Protocol when administering medication. A Support Plan/Protocol, when giving directions about medication administration, is considered to be an HCP order.

Unit 2 Observing and Reporting (RIA pages 23-31)

Observations (RIA pages 23-24)

Knowing the people you support will help you recognize when there is a change.

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
  - crying
  - body odor

- **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 (RIA pages 24-28)

All changes must be reported.

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.

Reporting immediately decreases the chances a health issue may become worse.

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

The quality of healthcare a person receives is only as good as the information you report to the HCP.

Documentation (RIA pages 29-30)

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.

Health related issues must be documented from beginning to end.

Correcting a Documentation Error (RIA page 30)

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).

<u>Unit 3 Medications</u> (RIA pages 32-47)

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 and Generic (RIA page 32)

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 *(generic name)*
IC: Tylenol *(brand name)*

Medication Categories (RIA pages 34-38)

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 key-locked area
   - Tracked using
     - Medication Ordering/Receiving log and
     - Medication Sheet
     - Medication Release 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:

   - An HCP order for administration
   - Labeled and packaged by the pharmacy in a
     - Tamper resistant package (including liquids)
     - With an Identifier
   - Secured in a double key-locked area
   - Tracked using
     - Medication Ordering/Receiving log
     - Countable Controlled Substance Book (Count Book)
       - Medication Sheet
       - Medication Release 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:

   - An 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 key-locked area
   - Tracked using a
     - Medication Ordering/Receiving log and
     - Medication sheet
       - Where the medication is documented after administration
     - Medication Release Document

Sunscreen, insect repellant and personal hygiene products may be used and do not require an HCP order.

Dietary Supplements (RIA page 39)

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:

- An 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 key-locked area
- Tracked using a
  - Medication Ordering/Receiving log and

- Medication sheet
  - Where the medication is documented after administration
- Medication Release Document

Nutritional Supplements (RIA page 39)

Nutritional supplements are 'conventional' food items and do not fall under MAP.

Medication Outcomes (RIA page 42)

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 are severe side effects. **(RIA page 43)**

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 (RIA page 43)

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 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. The more medications and dietary supplements a person takes the greater the possibility of an interaction.

Sensitivity to Medication (RIA page 45)

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
- Level of physical activity
- Medical history
- Use of other medications or dietary supplements

Medication Information (RIA page 45)

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

<u>Unit 4 Interacting with a Health Care Provider</u> (RIA pages 48-63)

Sometimes the changes you observe, and report result in an 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 (RIA page 48)

- 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 (RIA page 50)

- 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 (RIA page 52)

- 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 (RIA page 55)

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 an HCP order form
- Reviewing with the person what needs to be discussed at the appointment
- Arranging transportation
- Reminding the person to obtain prescription refills

If a person attends an HCP visit without your help and does not bring back new valid orders and prescriptions, it is your responsibility to obtain them.

If going to the Emergency Room and/or Hospital (RIA page 55)

- Basic information needed for an emergency room visit or hospital admission
    - reason for visit
    - current medication list
    - insurance card
    - HCP Encounter/Consult/Order form

Medication Reconciliation (RIA page 56)

Medication reconciliation is comparing the hospital discharge orders to the orders prior to admission; any discrepancies must be clarified with the HCP. An ER visit is not considered a hospital admission.

Medication reconciliation ensures new medication ordered during a hospital stay is not omitted when the person returns home. It also ensures medication that was discontinued during a hospital stay is not administered when the person returns home.

Fax and Telephone Health Care Provider Orders (RIA page 57)

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 an HCP over the telephone. When you take a telephone order:

- Record the order word-for-word on an 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.

Prescriptions may *not* be used in place of an HCP order.

Exhausting a Current Supply of Medication (RIA pages 60-62)

A current supply of medication may be exhausted if there is a dose and/or a frequency change and the strength of the tablet allows for safe preparation.

If you see a 'directions change' or brightly colored sticker on a medication container, you will know there is a new HCP order, and you cannot rely on the directions printed on the pharmacy label.

A 'directions change' sticker may only be used for a maximum of 30 days.

Unit 5 Obtaining, Storing and Securing Medication (RIA pages 64-78)

Obtaining Medication (RIA page 64)

An 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 an 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:

- Electronic
- 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 medication is delivered to the program while you are busy, you should ask the driver to wait until you can accept the delivery; verify the contents against the ordering and receiving log and sign for the medication. If the medication is not obtained, you must contact the HCP for a recommendation of what to do and this information must be documented.

Pharmacy Label Components (RIA page 69)

1. Prescription Rx number
2. Pharmacy name
3. Pharmacy telephone number
4. Name of the person
5. Date the medication was dispensed
6. Name of the medication
    a. Generic
    b. Brand
7. Strength of medication supplied
8. Total amount of medication dispensed
9. Amount of tablets, capsules or mLs to be administered
10. Route to administer the medication
11. Frequency to administer the medication
12. Special instructions
13. The HCP's name
14. Lot number
15. Expiration date
16. Number of refills

Ensuring the Pharmacy Provides the Correct Medication (RIA page 72)

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.

Medication must remain in the packaging received from the pharmacy.

Know that an alternative pharmacy must be available if the pharmacy typically used is closed.

When to Request a Medication Refill (RIA pages 73-74)

A medication refill should be requested when there is a seven-day supply of medication remaining.

Tracking Medication (RIA page 75)

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 (RIA pages 76-77)

The following are medication storage requirements, <u>including liquid and refrigerated</u> medication:

All medication is key-locked.

- Countable medication must be
    - double key-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 (RIA pages 79-110)

When an 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 Record (RIA page 81)

A medication record typically contains:

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

Medication Sheets (RIA pages 82-86)

A medication sheet is a document used to track the administration of a person's medication.

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.

Accuracy Checks (RIA page 86)

Prior to the first medication administration of the new month, 2 staff check (accuracy check 1 and accuracy check 2) the new month’s medication sheets for accuracy using the HCP orders, pharmacy labels and previous month’s medication sheets ensuring that all current HCP orders are transcribed onto the new month’s medication sheets.

Documentation of completed accuracy checks (accuracy check 1 and accuracy check 2) includes both staff’s full signature, the date and the time completed.

Acceptable Codes on a Medication Sheet (RIA page 87)

- A- absent
- DP - day program/day hab
- H - hospital, nursing home, rehab center
- LOA - leave of absence
- NSS- no second staff
- OSA- off-site administration
- P – packaged (used only if the person is learning to self-administer their medication)
- S – school
- V- vacation

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 (RIA pages 88-95)

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 (such as 'twice daily') or the amount of time between doses (such as 'every 6 hours').

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 (RIA page 96)

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 (RIA pages 97-103)

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’ (ordered 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 date’** (first scheduled dose) and **‘stop date’** (last scheduled dose for a time limited medication or ‘cont.’ if a continually administered medication order) dates.

Posting and Verifying (RIA pages 103-106)

After an 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

All HCP orders must be posted and verified even if no new orders or medication changes have been written. This is documentation that staff are aware that no changes have been made.

If two Certified staff and/or licensed staff are not available when the medication is dues to be administered, the first staff completes the transcription and posts the HCP order. After posting, the medication may be administered by the Certified and/or licensed staff

that posted the order. The next staff on duty must verify the order before administering any further doses.

Transcriptions must be completed accurately to ensure safe medication administration.

Telephone HCP orders are posted and verified twice:

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

Medication Information Sheets (RIA page 110)

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

<u>Unit 7 Administering Medications</u> (RIA pages 111-161)

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

PRN medication orders must include: **(RIA pages 112-115)**

- 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 (RIA pages 116-124)

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

Medication Routes other than oral (RIA page 125)

Routes other than oral require additional training.

Be sure to ask your supervisor to arrange for additional training if you will be responsible for administering medications by routes other than oral.

The 3 Checks of the 5 Rights (RIA pages 126-129)

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

- The reason(s) for check 1 is to make sure
  - there is an HCP order for the medication you are going to administer
  - what the HCP ordered is what the pharmacy supplied, and
  - the order has not changed from the last time you administered it

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

- The reason(s) for check 2 is to make sure
  - the strength of tablets supplied and the amount of tablets to administer printed on the pharmacy label agree with what is transcribed onto the medications sheet, and
  - that you focus on the number of tablets needed

Prepare the medication into the cup

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

- The reason for check 3 is to make sure
  - you placed the correct number of tablets into the medication cup according to the pharmacy label directions and the amount transcribed onto the medication sheet

The standard when administering medication is to administer whole tablets or capsules with water.

Medication Administration Process (RIA pages 134-137)

Prepare, Administer, Complete

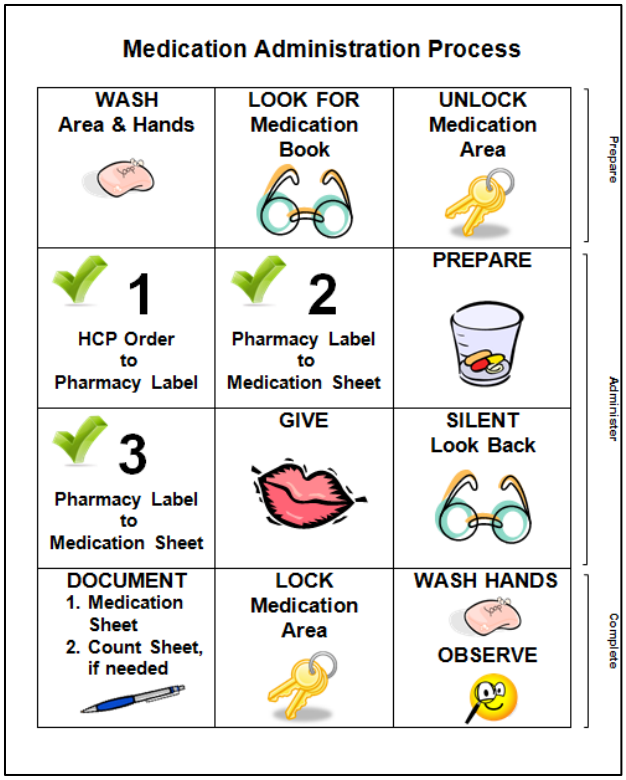
- **Prepare:**
  - Wash hands and area
  - Unlock medication storage area
  - Look for the medication book and
  - Locate the medication to be administered
- **Administer:**
  - Check 1
  - Check 2
    - Prepare
  - Check 3
    - Administer
    - Look back
- **Complete:**
  - Document
    - Initial the 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

Special Instructions (RIA page 132)

An HCP order is required to change the form of a medication (such as crushing, dissolving, or mixing with food or fluid)

If a tablet must be halved or quartered in order to administer the correct dose, it must be done by the pharmacy. You are not allowed to break, split or cut a tablet.

(RIA page 138)



Liquid Medication (RIA pages 141-145)

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

Types of Liquid Measuring Devices (RIA pages 145-148)

- Medication Cup **(RIA page 145)**
- Oral Syringe **(RIA page 146)**
- Dropper **(RIA page 147)**
- Dosing Spoon **(RIA page 148)**

Only use a proper liquid measuring device. If one is not provided with the medication, ask the pharmacist for an appropriate measuring device.

Medication Refusals (RIA page 151)

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.

Documentation of a medication refusal includes
- Your initials circled on the medication sheet
- A progress note indicating
    - why the medication was not administered
    - recommendations given
    - who was notified (HCP and Supervisor)

How to Document if a Medication is Not Administered (RIA pages 151-155)

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

If a Medication is not Available to Administer (RIA pages 159-160)

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

<u>Unit 8 Chain of Custody</u> (RIA pages 162-213)

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 (RIA page 163)

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

- A Medication Ordering and Receiving Log- documentation of medication that is ordered by the program and when it is received from the pharmacy.
- Pharmacy receipts-documentation from the pharmacy of all medication dispensed to a program.
- Controlled Countable Substance Book (Count Book)
- Medication sheets
- Medication Release Document (Transfer form or LOA form)
- 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 (RIA page 166-179)
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 Certified 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 (RIA page 178)

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 (RIA page 180-182)

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 (see unit 6 for list of acceptable codes) is entered in the medication box.

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 (RIA page 183-184 and 197)

A medication release document is used to track medication when it is moved from one location to another location.

Medication may only be transported by MAP Certified or licensed staff for people residing at your work location and only during work hours.

Medication release documents include:

- Transfer forms
- LOA forms

Medication release documentation 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 (RIA page 185-189)

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 Transfer Form when transferring medication to the day program (the residential and day programs must both have a copy)

Day program staff must verify that the amount of medication received from residential staff is adequate.

Only medications scheduled during day program hours and PRN medications that may be needed during day program hours are transcribed onto the medication sheet.

Off-Site medication Administration (OSA) (RIA page 190-194)

Off-site medication administration is when medication will be administered by Certified or licensed staff at an off-site location such as at a community outing, a movie theater, the mall etc.

The pharmacy should prepare all medications for off-site administration. If the pharmacy cannot prepare the off-site medication and the outing is less than 24 hours, then Certified or licensed staff may prepare it. The Certified or licensed staff that prepares the medication for the OSA must be the staff that will administer the medication during the OSA.

'OSA' will be documented on the medication sheet in the date/time box and a progress note must be written before you leave for the OSA and after you return from the OSA.

Leave of Absence (LOA) (RIA pages 195-199)

A leave of absence is when medication is released from a person's home to a family member or a responsible friend to administer who is not required to be MAP Certified or a licensed staff.

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

'LOA' will be documented on the medication sheet in the medication date/time box at the scheduled administration time.

A LOA form must be completed, including signatures of the

- staff releasing medication and
- person accepting medication

When the person is away on a leave of absence, document this by writing 'LOA' in the medication box at the scheduled administration time.

When the person returns to their home, ask the family or responsible friend whether all medications were administered during the LOA.

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

Disposal (RIA pages 200-206)

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 medication 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.

If the medication to be disposed is a countable medication, the countable medication must remain on count until the disposal is completed.

Medication Supply Discrepancy

Suspicious (RIA pages 207-210)

A suspicious 'count discrepancy' is when the count is off and there is suspicion of loss, diversion (theft), tampering, or inconsistencies with documentation. These discrepancies are known as a loss of medication or a drug loss.

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.

Diversion (theft) of prescription medication may result in potential criminal prosecution.

Non-suspicious (RIA pages 211-212)

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.

You play an important role in maintaining the Chain of Custody

<u>Unit 9 Medication Occurrences</u> (RIA pages 214-226) <u>and Appendix</u> (RIA pages 227-244)

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

A Medication Occurrence Report (MOR) is a document used to track and report each time one of the 5 rights goes wrong during medication administration.

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.

Always remain mindful during the medication administration process

- Do not try to do additional tasks, such as answering the phone or talking to a co-worker, while administering medication

It is important to remember that the safety of the person must always be your primary concern, call 911 if needed.

Hotline Medication Occurrence (RIA page 214)

A Hotline Medication Occurrence is when medical intervention, illness, injury or death follows a medication occurrence.

Procedure Following a Medication Occurrence (RIA page 215)

- 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
  - When documenting contact with 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/date/time
- 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

(RIA page 217)

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.

Documentation Quick Guide

The Right Way	What Not To Do	Why
Use blue or black ink. Write clearly, using complete sentences.	Never use a pencil.	Medication sheets, progress notes, HCP orders, etc. are legal documents. Others need to be able to read your handwriting.
Begin each entry with the date and time; end with your signature.	Never wait to document important changes.	Documentation will reflect the correct sequence of events.
Correct errors as soon as possible.	Never try to 'squeeze in' or mark over information	Errors in documentation may lead to errors in care if not corrected promptly.
Use a 'late entry' to clarify information written earlier or to clarify a task that was not documented initially.	Never skip or leave a blank space for another staff to document later. Never post-date an entry.	Late entries will explain (tell the story) of what happened earlier.
Use only objective (factual) and subjective (how a person tells you they are feeling) observations.	Never guess or document your own hunches.	Documentation must be factual and correct to ensure a person receives the best care possible.
Draw a single line through an error. Write 'error' and your initials.	Never erase, mark over or use 'white-out'.	Documentation must be legible. Doing so can be viewed as an attempt to hide something.
Spell out information when documenting. Only use acceptable codes or abbreviations.	Never create your own documentation short cuts.	Doing so prevents others from misunderstanding what you write.
Only document and sign for a task you actually perform, such as when participating in a 'shoulder to shoulder' count or a disposal.	Never sign your signature on a count signature sheet or disposal form, etc. if you were not part of the process.	You are responsible for the information you write; doing so protects you.
Draw a line from the end of your documentation to your signature.	Never leave blank spaces.	Someone else can add incorrect information in front of your signature.
Document only for yourself.	Never document for someone else or cross out someone else's documentation.	You are responsible for the information you write.

Words You Should Know

Abbreviation - A shortened form of a word or phrase.

Accuracy check - A review of the new month's medication sheets completed by two Certified and/or licensed staff, ensuring that all information on the medication sheet is complete and correct.

Adverse Response - A severe side effect.

Allergic Reaction - When the body's immune system reacts to a medication as if it were a foreign substance.

Amount - The number of tablets, capsules or mL needed to equal the dose ordered by the HCP.

Anaphylactic Reaction - A severe, dangerous, life threatening allergic reaction which requires immediate medical attention, such as calling 911.

Authorized Prescriber - Health Care Provider (HCP; see HCP below).

Blister Pack Monitoring - A medication tracking mechanism. Documentation by staff, on the back of the blister pack, each time a tablet or capsule is removed from the package.

Brand name medication - A medication created and named by the specific pharmaceutical company that created it.

Chain of Custody - an unbroken documentation trail of accountability of the physical security of the medications.

Communication - Exchanging of information; this can be accomplished verbally, in writing and/or in the form of listening, body language, tone of voice.

Confidentiality - Keeping information about the people you support private; information to be shared on a 'need to know' basis.

Controlled Medication - Schedule VI medication which requires a prescription to obtain it from the pharmacy; must be single locked and is not required to be tracked in the Count Book.

Countable Controlled Medication - Schedule II-V medication, which requires a prescription to obtain it from the pharmacy; must be double locked and tracked in a Count Book.

Countable Controlled Substance Book - A book used to document and track schedule II-V medications.

Count Book - Another name for the Countable Controlled Substance Book. A book used to track all countable controlled (schedule II-V) medication in a program.

Count Sheet - The middle section of the Count Book used to track the amount of each countable medication when added or subtracted.

Count Signature Sheets - The last section of the Count Book used by staff to document when responsibility for the countable medications is transferred from one staff to another staff.

DCF - Department of Children and Families.

DDS - Department of Developmental Services.

Desired Effect - When a medication does exactly what it was intended to do; the person experiences the beneficial results of the medication.

Dietary Supplements - Products not regulated by the federal government that contain a dietary ingredient such as vitamins, minerals, herbs or other substances.

Discontinue - When the HCP orders a medication or treatment to be stopped; typically abbreviated as D/C or DC.

Disposal - To render a medication unusable and dispose; must be documented on a Disposal Record.

Disposal Record - Document used to track the disposal of all prescription medication.

DMH - Department of Mental Health.

Documentation - To prove something by writing it down; your writing of what happened should tell a story from beginning to end.

Dose - How much medication the HCP orders the person to receive each time the medication is to be administered.

DPH - Department of Public Health.

Emergency Contact List - A single list of contact names and telephone numbers clearly posted for quick and easy staff reference including: MAP Consultants, Poison Control and other emergency numbers (911, fire, police).

Everyday Reporting - Exchanging information on routine, day to day matters.

Expiration Date - Last date a medication may be administered.

Fax Health Care Provider Order - A signed and dated HCP order that is obtained via a fax machine. A fax order is a legal order.

Frequency - Also referred to as 'time'; how often the medication is ordered to be administered.

Generic name medication - A medication known by its chemical name. Many different pharmaceutical companies often manufacture generic named medications.

HCP Encounter/Consult/Order Form - Different names used for the same form; the form used by the HCP to write orders.

Health Care Provider (HCP) - A person who is registered in the state of Massachusetts to prescribe medication.

Health Care Provider Order - A set of detailed orders/instructions many times medication related, however, sometimes not related to medication, written by the HCP for each person.

High Alert Medication - A medication requiring additional training and competencies before certified staff can administer the medication.

Hotline Medication Occurrence - When one of the 5 rights go wrong during the medication administration process; followed by medical intervention, illness, injury or death.

Immediate Reporting - Exchanging information right away.

Index - The first section of the Count Book. The index lists the person's name, medication name and strength and count sheet page number for each countable medication.

Leave of Absence (LOA) - Code used on a medication sheet when medication is released from a person's home to a family member or a responsible friend to administer who is not required to be MAP Certified or a licensed staff.

Leave of Absence Form - Document used to track medication when sent on a LOA.

Lot Number - A number assigned to each 'batch' of medication produced.

MAP - Medication Administration Program.

MAP Consultant - A licensed professional who is available 24/7 to answer your medication questions. A MAP Consultant is a registered nurse (RN), registered pharmacist or HCP.

MAP Policy Manual - Single, topically organized source of MAP information and policies.

MCSR - Massachusetts Controlled Substances Registration.

Medication - A substance that when put into or onto the body will change one or more ways the body works.

Medication Administration Process - When administering medication, what you must do to prepare, administer and complete each time you give a medication.

Medication Grid - The right side of a medication sheet used to document your initials after administering a medication.

Medication Information - A resource that gives information about a medication.

Medication Information Sheet - A resource for medication information typically obtained from the pharmacy.

Medication Interaction - A mixing of medications in the body that will either increase or decrease the effects and/or side effects of one or both of the medications. In addition to medications interacting with each other, medications can also interact with dietary supplements, other substances (alcohol, nicotine and caffeine) and certain foods.

Medication Occurrence - When one of the 5 rights go wrong during medication administration.

Medication Occurrence Report (MOR) - Document used to track and report each time one of the 5 rights goes wrong during medication administration.

Medication Ordering and Receiving Log - Documentation of when a program orders medication and when received from the pharmacy.

Medication Outcome - The result a medication produces after it is administered; Desired Effect, No Effect Noted and/or Side Effects.

Medication Release Document - Document used to track medication when moved from one location to another location.

Medication Reconciliation - Comparing the hospital discharge orders to the orders the person had prior to admission; discrepancies are clarified with the prescribing HCP.

Medication Record - A medication tracking record which typically contains an Emergency Fact Sheet, HCP orders, medication sheets and medication information sheets for each person living at the program.

Medication Refill - A number on the pharmacy label indicating how many times the medication may be obtained from the pharmacy.

Medication Refusal - When a person will not take the medication from you either by: saying 'No", spitting the medication right back out, spitting the medication out later or intentionally vomiting within one half hour of taking it.

Medication Schedule - A number (schedule) assigned by the Drug Enforcement Agency (DEA) to a prescription medication based on the medication's potential to be abused; the lower the number the more likely the medication is to be abused.

Medication Sensitivity - How each person responds to the same medication. Factors that affect medication sensitivity include: age, weight, gender, general health, medical history, level of physical activity and the use of other medication(s) or dietary supplements.

Medication Sheet - Document used to track the administration of each person's medication on a monthly basis.

Microgram (mcg) - one millionth of a gram.

Mindfulness - Always paying attention to what you are doing; focusing on the task at hand.

MRC - Massachusetts Rehabilitation Commission.

No Effect Noted - A medication outcome when a medication is taken for a specific reason and the symptoms continue; no effects are noted from the medication.

Nutritional Supplements - Conventional food items such as Ensure, gastric tube feedings or Carnation Instant Breakfast; nutritional supplements are not medications and do not fall under MAP.

Objective Information - Factual information that you can see, hear, smell, feel and/or measure.

Observation - The process of watching someone carefully in order to obtain information.

Omission - Subcategory of wrong time; occurs when the medication is not administered.

Oral - A route; when a medication is taken by mouth.

ODT - orally dissolving tablet. A tablet designed to be dissolved on the tongue rather than swallowed whole.

Over-the-Counter (OTC) Medication - Medications that may be purchased without a prescription.

Paradoxical Reaction - A response to a medication that is the opposite of what the medication was intended to produce.

Parameters - A set of rules or guidelines that tell you how or when a medication should or should not be administered.

Pharmacy manifest - Documentation provided by the pharmacy listing the names and amounts of medications received by the program. This form often contains more than one person's medications.

Pharmacy Receipt - A document received from the pharmacy listing how many tablets, capsules or mL of each medication was dispensed to the program.

Post - Documentation completed by staff on the HCP order (under the HCP signature) after a medication is transcribed.

Prescription - A set of instructions from the HCP to the pharmacist telling the pharmacist what medication to prepare and how to give it for the person it is prescribed. The pharmacist uses the prescription to print a pharmacy label.

Prescription number - A number on the pharmacy label used to obtain refills; often referred to as the 'Rx' number.

Principles of Medication Administration - Foundation of the Medication Administration Process including Mindfulness, Supporting Abilities and Communication.

Prior Authorization - Approval from an insurance company, required prior to the pharmacy being able to fill a prescription; to ensure the medication will be paid for.

PRN - Latin term meaning a medication to be given only when needed.

PRN medication - Medication that is ordered to be administered only when needed for a specific health issue.

Protocol - A detailed HCP order that includes instructions on when, how and why to give a medication. Typically used when the medication is ordered to help lessen physical symptoms such as seizures or constipation.

Reporting - To give spoken or written information of something observed or told.

Route - The way in which the medication enters the body.

Rx - Abbreviation for a prescription number, used to obtain refills.

Shoulder to Shoulder Count - A specific procedure which transfers responsibility for the safety and security of the medications, from one staff to another staff. Conducted by 2 Certified staff each time the medication storage keys change hands.

Shoulder to Shoulder Disposal - A specific procedure conducted by 2 Certified staff which renders a medication useless.

Side Effect - Result from a medication that is not wanted or intended even if the desired effect is achieved. Side effects can range from mild to severe.

Single Person Count - Procedure conducted when there is only one Certified and/or licensed staff available to count the countable medication; typically completed when only one staff is on duty when putting the medication storage keys into or taking them out of the coded lock box.

Special Instructions - Information listed on the HCP order and/or pharmacy label giving additional information about medication administration.

Start Date - The date a person is scheduled to receive the first dose of a medication.

Stop Date - The date a person is scheduled to receive the last dose of a medication or if given continuously.

Strength - How much medication is contained within each tablet, capsule or mL.

Subjective Information - When a person speaks, or signs and they tell you something.

Support Plan - A detailed HCP order that includes instructions on when, how and why to give a medication. Typically used when the medication is ordered to help lessen a behavior.

Supporting Abilities - Helping a person to be as independent as possible.

Tamper Resistant Packaging - A way the pharmacy packages a medication to physically limit how the medication is accessed.

Telephone Health Care Provider Order - Documentation of an HCP order taken by Certified staff while speaking with the HCP on the telephone. A telephone order must be signed by the HCP within 72 hours.

Toxicity - When a medication builds up in the body to the point where the body cannot handle it anymore; this can be life threating.

Transcribe - To copy information from one document and record it onto another document.

T**ranscription** - The completed document after information has been recorded from one or more documents onto it.

Verify - Documentation completed by a second staff on the HCP order (under the HCP signature) after reviewing the first staff's completed transcription for accuracy.

Wrong Dose - When either too much or too little of a medication is administered at the scheduled time.

Wrong Medication - When medication is administered without an HCP order; includes using an expired or discontinued HCP order, administering past the stop date of a time limited medication order or administering one medication instead of another.

Wrong Person - When medication is administered to a person it is not ordered for either by misidentification, distraction or the medication was left unattended/not secured and someone else ingested it.

Wrong Route - When the medication is administered by a way (route) not ordered by the HCP.

Wrong Time - When the medication is administered too early, too late or parameters or instructions for use of the medication are not followed.