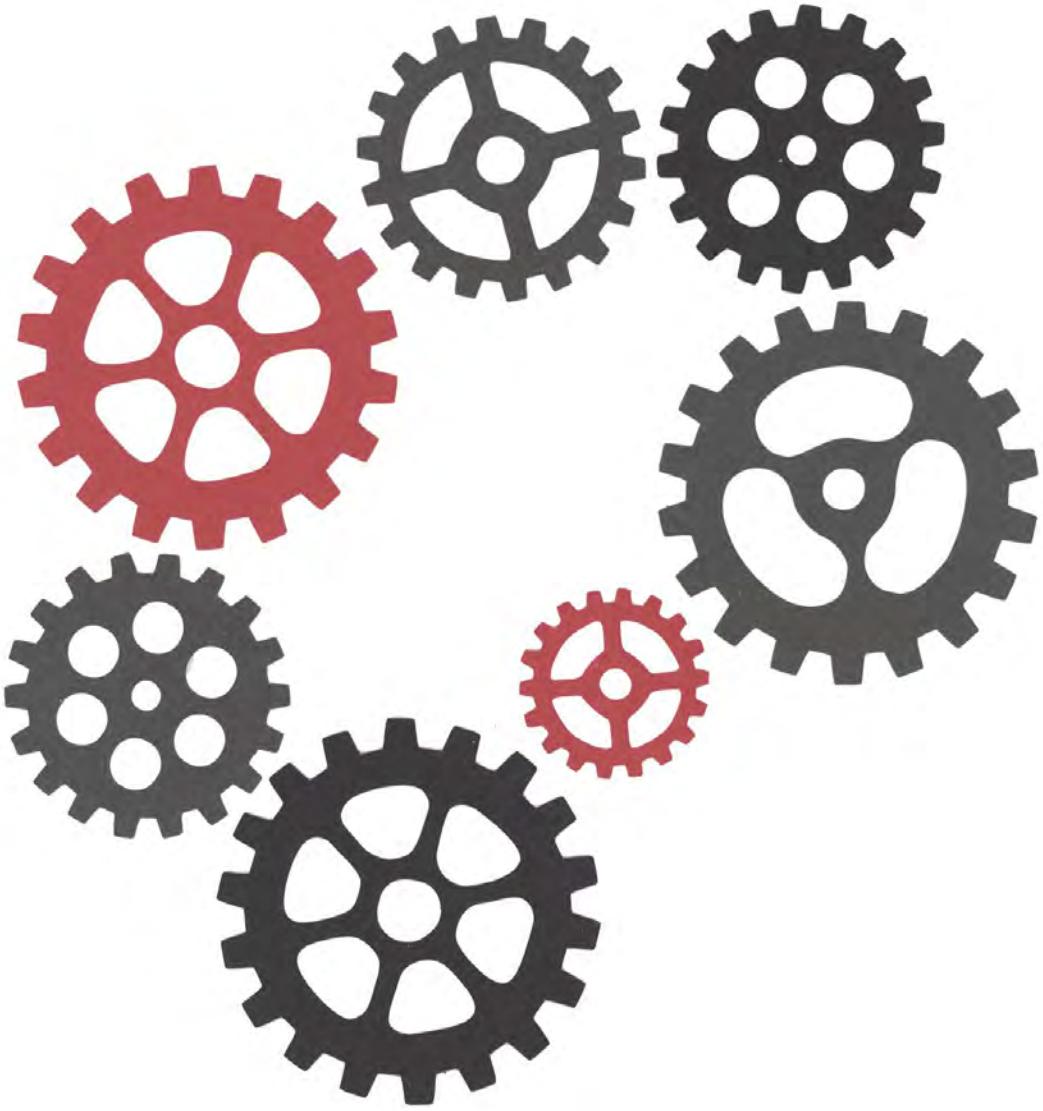
Responsibilities in Action: Understanding the Connections

The Massachusetts Medication Administration Program Certification Curriculum

December 2025

Responsibilities in Action

Understanding the Connections



The Massachusetts

Medication Administration Program

Certification Curriculum

Re·spon·si·bil·i·ty - The state of being accountable for something.

'Responsibilities in Action' is based on a concept. This concept is that a set of responsibilities[1] must be done accurately to have 'Safe Medication Administration.'

Consider each 'gear' on the cover as a 'Responsibility.' Each gear depends on the gear before and after it for the system to function. If one gear fails, the entire system fails. When all gears are working together, the result is a system that runs smoothly. Think of yourself as one of the gears. You will play an important part in the outcome of the medication system in your work location!

Part of your job is to learn about each responsibility. Then you apply what you have learned at your work location. This helps to improve the quality of life for the people you support. It also creates a safe work environment for you.

The following are your responsibilities as a MAP Certified staff:

- Observe and Report
- Help with visits to the Health Care Provider (HCP)
- Obtain medication from the pharmacy
- Transcription[2]
- Medication security
- Medication administration
- Documentation[3]

This curriculum shows you the details of each responsibility. You should use it as a resource when you become MAP Certified. Look back at this curriculum often. Practice what you are taught every day!

[1] Tasks required as part of job for which staff are accountable.
[2] The process of copying information from the HCP order and the pharmacy label onto the medication sheet.
[3] To record information by writing it down.

‘Responsibilities in Action’

Content Writers:
Gina Hunt, RN and Carolyn Whittemore, RN

Content Developers:
Susan Canuel, RN; Mary Despres, RN; and Sharon Oxx, RN

Case Studies:
Mary Dewar, RN (Scott Green) and Carminda Andrade, RN (Jonathan Brock)

Editors:
Marie Brunelle, RN; Bob Boyer, RN; Mary Dewar, RN; Lisa Kaliton, RN; Jo-Anne Shea, RN, Joanna Thomas, RN; Daniel Silva, RN; Heather Lake, RN; Matthew Meredith, RN; Smita Chirayath, RN; and Holly Easton, RN

Contributors:
Claude Augustin, RN
Evelyn Brezniak, RN
David Bruno, RN
Pat Coupal, RN
Lori Gross, RN
Jackie Heard, RN
Tanya Jenkins, RN
Denise McGrath, RN
Denice Vignali, RN
Theresa Wolk, RN

Michele L. Deck, RN-use of a blank 12 box ‘grid’ as a teaching strategy

Reviewed and Approved by the Massachusetts Department of Public Health

Initial release July 2017
Revised September 2020; March 2024; September 2024; December 2025

Contents

Introduction

The Department of Public Health (DPH) is the lead agency for the Medication Administration Program (MAP). This program is carried out by the Department of Developmental Services (DDS), the Department of Mental Health (DMH), the Department of Children and Families (DCF), and MassAbility (formerly known as the Massachusetts Rehabilitation Commission).

The goal of MAP is to make sure there are appropriate policies and procedures for safe medication administration[4] by direct support staff at MAP Registered sites. Direct support staff know the needs and concerns of each person. MAP makes it possible for direct support staff to give medication as part of the person's daily routine.

The Departments and MassAbility allow direct support staff who have a current MAP Certificate to administer medication in:

- DDS adult residential and respite sites, and day programs
- DMH adult residential and respite sites, and DMH youth residential and day programs
- DCF youth congregate care
- MassAbility adult residential sites and day programs.

These sites are registered with DPH. MAP Certification can be transferred only between DPH MAP Registered sites.

Certification Process

The MAP Certification Online Training Program:

- Is taught by approved MAP Trainers
- Is a minimum of 16 hours in length
- Is a blended format with both
  - standardized online content and
  - face-to-face (virtual or in-person) skill session(s).

After you complete the training program, you are eligible to take the MAP Certification Test. You must pass the test within a limited time.

MAP Certification is:

- Effective on the date that the test results are posted on the testing vendor's website
- Valid for 2 years until the last day of the month in which you passed the test. For example, if you passed the test on March 24, 2024, your expiration date would be March 31, 2026.

[4] The process of giving medications to the people you support.

All DDS/DMH/DCF/MassAbility MAP Registered sites must have acceptable proof of staff's MAP Certification. Acceptable proof is a printout of your Massachusetts MAP Certification letter.

You are responsible for making sure that your MAP Certification remains current. If your MAP Certification expires, you cannot give medication or do any medication-related tasks.

Recertification Process

The Recertification Process must be completed every 2 years. To become Recertified, you must complete Recertification Training and pass the Recertification Skill Test. The Recertification Training is conducted by a MAP Trainer prior to Recertification Testing. The Recertification Skill Test is a medication administration demonstration.

Before Your MAP Certification Expires

You should recertify before your MAP Certification expires.

If you do not pass the Recertification Skill Test, you cannot give medication or do any medication-related tasks.

- If you fail the Recertification Skill Test 3 times, you must take the MAP Certification Online Training Program again.
    - Then you must successfully complete the Certification Test process.

After Your MAP Certification Expires

If your MAP Certification expires, you cannot give medication or do any medication-related tasks.

- You have one year from the date of expiration to complete the Recertification Training and to pass the Recertification Skill Test.
- If you do not pass the Recertification Skill Test within that year, you must take the MAP Certification Online Training Program again.
    - Then you must successfully complete the Certification Test process.

You are encouraged to recertify before your MAP Certification expires.

Limitations of MAP Certification

MAP Certification is not valid for administration of medication to people who are under the age of 18 in DDS and MassAbility sites. It is also not valid at any of the following locations:

- Assisted Living Facilities
- Community-Based Acute Treatment (CBAT)
- Community Crisis Stabilization (CCS)
- Correctional Facilities
- Crisis Intervention Centers
- Day Habilitation
- Department of Youth Services
- Detoxification (Detox) Centers
- Home Care
- Hospitals
- Hospital Diversion Centers
- Intensive Community-Based Acute Treatment (ICBAT)
- Intensive Residential Treatment Programs (IRTP)
- Nursing Homes
- Rest Homes
- Schools (Public and Private)
- Stabilization Programs
- DDS, DMH, DCF and MassAbility sites that do not have a Massachusetts Controlled Substance Registration (MAP MCSR) from the Department of Public Health

MAP Massachusetts Controlled Substances Registration (MCSR)

All eligible sites must be registered with the Department of Public Health. The site receives a MAP MCSR as proof of registration with DPH.

The MCSR allows medication to be stored at the site. It also allows MAP Certified staff to administer or help to administer medications. The MAP MCSR number begins with the letters MAP or COM, followed by 5 numbers.

Throughout the training curriculum, you will see this symbol. This means there is information specific to your work location that you must ask your supervisor about.

Ask your supervisor where the MAP MCSR is found in the medication area at your work location.

The MAP Policy Manual

Throughout the training curriculum you will see this symbol. It means there is more information about a topic in the MAP Policy Manual. The MAP Policy Manual is a resource to be used as a guide for service providers, trainers, and staff.

Each site registered with DPH must have access to the online version of the policy manual. If a paper copy is maintained, it should be the most updated version. It is a part of the required reference materials for MAP Certified staff. The MAP Policy Manual is available at:

www.mass.gov/dph/map

Symbols and Abbreviations[5]

Throughout the training curriculum you will see the word ‘year’ abbreviated as ‘yr’ at the end of a date. You will see this on Health Care Provider orders, pharmacy labels, medication administration sheets, etc. For training and testing purposes only, 'yr’ represents the current year.

You will also see several symbols. When you see the following symbols, you will know:

	There is information specific to your work location that you must ask your supervisor about.
	There is more information about the topic in the MAP Policy Manual.
	The information is important.
	There is an exercise to complete.
	The information that follows is important to remember.

[5] A shortened form of a word or phrase.

Case Studies

Meet the characters in this curriculum. Read about each one. You will complete exercises with these characters throughout the curriculum.

Juanita Gomez is a 36-year-old woman. She uses facial expressions and nods her head yes or no to communicate her likes and dislikes. She has a seizure disorder. She also has contractures that cause chronic muscle pain. These are managed with physical therapy and pain medication that she gets twice daily. Juanita also has chronic constipation. This is managed by keeping track of her bowel movements (BMs) and giving her bowel medication PRN (as needed). She has difficulty swallowing and requires supervision when eating or drinking. Juanita needs total assistance with activities of daily living (ADLs), including medication administration.

Ellen Tracey is a 42-year-old woman. She communicates using simple words and short sentences. Her health conditions include high blood pressure and high cholesterol. Both are well controlled with diet and medication. Ellen also has an anxiety disorder. When she is anxious, she bites her hands and slaps her head. Ellen's anxiety is managed with Ativan taken twice daily and once daily PRN. When staff prepares her medications, Ellen will fill her glass with water.

Tanisha Johnson is a 22-year-old woman. She has a history of seizures due to an acquired brain injury. Her seizures are well controlled with medication. She is interested in learning about her medications and their possible side effects. However, she often refuses her medication. She enjoys going to her health club and working with a trainer. She works at the local florist shop and goes to her family's home on weekends.

David Cook is a 52-year-old man with Down Syndrome. David is independent with ADLs and receives community-based day supports. During day program hours, he participates in outings and volunteers in the community. In the evening, David enjoys spending time with friends and family. David has sleep apnea. Sleep apnea is a serious sleep disorder in which breathing repeatedly stops and starts. At night, David wears a C-PAP (continuous positive airway pressure device). This helps keep his airway open. He is on several medications to treat high blood pressure, GERD (gastroesophageal reflux disease), swollen, painful joints (osteoarthritis), and a seizure disorder.

Scott Green is a 48-year-old man who has had multiple psychiatric hospitalizations. He is on several medications to treat schizophrenia and a mood disorder. He also takes medication for high blood pressure, high cholesterol, and diabetes (non-insulin dependent). He takes PRN medication for headaches, heartburn and difficulty sleeping. Scott wanted to become more independent with his medications. In the past, he packed his medication with staff supervision. Recently he has stopped taking some of his medications. Staff have increased their support, and now they administer his medication. Staff reported that Scott preferred to take his medication in the evening. His doctor changed the timing of his medication from the morning to the evening.

Jonathan Brock is a 6-year-old boy with poor concentration and irritable behavior. He has angry outbursts. He is in kindergarten and receives significant support at school. His school uses a first/then schedule system with built-in incentives. Teachers report that his interest in activities such as playgroups and structured school activities has decreased. He has PTSD (post-traumatic stress disorder) and ADHD (attention-deficit/hyperactivity disorder). These are managed with medications. Jonathan used to struggle during medication administration time. He would either spit out or refuse to take the medication. Staff encouraged him to take the medication in applesauce, at the doctor's request. Jonathan told staff that he was refusing the medication because he could not swallow the tablets without choking. The psychiatrist changed the medication to a chewable form. Later, when Jonathan started on a medication to help with sleep, it was ordered in liquid form. He completes ADLs with staff support and prompts.

Unit 1

Working at a MAP Registered Site

Responsibilities you will learn

- Who will answer your medication and health-related questions
- How you will get to know the people you support
- Medication administration principles
- Rights in relation to medication

Getting Your Medication and Health-Related Questions Answered

A MAP Consultant is a valuable medication information resource. A MAP Consultant is:

- a Registered Nurse (RN)
- a Registered Pharmacist (RPh)
- a Health Care Provider (HCP)
    - an Authorized Prescriber

An authorized prescriber is someone who is registered with the state of Massachusetts to prescribe medication.

Examples of an authorized prescriber are a Health Care Provider (HCP), doctor, dentist, nurse practitioner, etc. In this training, an authorized prescriber is the same as a person's HCP.

Anytime you have health-related questions, contact the person's Health Care Provider.

MAP Consultants will help answer your questions about medication procedures and other specific medication issues. They can also give advice about what you should do next, following an issue**.** You should have a few things ready when you call a MAP Consultant with your question. These are the HCP order, the medication, and the medication sheet available for reference. You may need to read them to the MAP Consultant.

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

- Too much or too little of a medication was administered (given).
- The medication was omitted (not given).
- The HCP order, pharmacy label or medication sheet do not agree.

MAP Consultants are available 24 hours a day, 7 days a week. DPH requires that a single page emergency contact list be posted near the telephone at all sites. The emergency telephone numbers include 911 (rescue, fire, police), poison control, MAP Consultants and others.

This is an example of the Emergency Contact List in David Cook's home. It is found near the phone for quick and easy staff reference.

Emergency Contact List

Rescue + Fire + Police
911

Poison Control
800-222-1222

MAP Consultants

Greenleaf Pharmacy
111-222-3434
Monday-Friday

Registered Nurse
Rebecca Long
781-000-4500
Saturday-Sunday

Health Care Provider(s)
Dr. Richard Black 617-332-0000
Dr. David Jones 617-332-0001
Dr. Shirley Glass 508-123-1234
Dr. Chen Lee 617-332-0002

Administrator on Duty
617-000-0000
Site Supervisor
Linda White
780-000-2222

Ask your supervisor where the Emergency Contact List can be found at the site where you work.

Who can act as a MAP Consultant? Answer True (T) or False (F) if the person listed can act as a MAP Consultant.

1. ____ Licensed Practical Nurse (LPN)
2. ____ Pharmacy Technician
3. ____ Registered Nurse (RN)
4. ____ Receptionist at the HCP office
5. ____ Health Care Provider (HCP)
6. ____ MAP Certified Supervisor or Program Director
7. ____ Registered Pharmacist

Learning about the People You Support

Two of your most important responsibilities are watching for and reporting changes in the people you support. A change may be physical or behavioral. You will first get to know the person by learning about their personality and abilities. You must also learn about their physical conditions and medications. This will help you notice a change in the person. You can learn about a person who is new to you by:

- Observing (watching) the person
- Talking with the person
- Listening to the person
- Communicating with
    - the person's family
    - your co-workers
- Reading about the person's life and health history.

You want to make sure the people you support receive the best care. You can help make this happen by noticing changes and reporting them to the right person.

Principles of Medication Administration

You will help make sure medications are given safely. You will do this by following the principles of medication administration. These are mindfulness, supporting abilities, and communication.

- **Mindfulness**
  - Remain alert and focused during medication administration. Pay attention.
  - Think about what you are doing and not something else. Be observant and report your observations.
    - You will become familiar with a number of things as you begin administering medication. This includes which person receives what medication at what time. It can also include the size, shape, color, and markings on the medication itself. Because of this:
      - Do not allow medication administration to become routine
        - Consider changing the order of who you give medications to first. This helps you remain mindful.
        - Remember: No cell phones, ear buds, smart watches, or other Bluetooth devices during medication administration.
- **Supporting abilities**
  - Help the person to function as independently (on their own) as possible.
    - Encourage a person to participate fully in the medication administration process based on their abilities.
- **Communication**
  - Read the HCP order, pharmacy label and medication sheet.
    - Make sure they agree.
    - Contact a MAP Consultant as needed.
      - Tell your supervisor after contacting a MAP Consultant.
  - Talk and listen to the person while you are administering their medication.

Communicating is a big part of your job. To communicate is to share or exchange information. In your role as a MAP Certified staff, you will communicate with many people. This will include the people you support and their family members. It will also include your co-workers and supervisors. You will also communicate with the HCP, pharmacist, nurse, and others.

In addition to talking, communication also includes:

- Documenting
- Listening
- Tone of voice
- Facial expression
- Body language

For communication to be effective, remember:

- Speak clearly and slowly.
- Look directly at the person you are talking with.
- Listen carefully.
- Take notes during your shift if needed. This will help you with accurate documentation.
- If information is given to you, repeat it back to the person. This helps make sure you understood it correctly.
- Ask questions if you do not understand something.

Answer each question based on the case studies found in the Introduction. Write the principle of medication administration that applies. The principles are mindfulness, supporting abilities and communication.

1. Juanita takes her medication whole in pudding or applesauce. How would you know if she did not like a certain pudding flavor? _____
   What is the principle? _____

2. How do you support Ellen's abilities during medication administration?
   _____
   What is the principle? _____

3. Usually, you administer medications to the people in your work location in the same order each day. How can you make sure the medication administration process does not become routine? _____
   What is the principle? _____

Respecting Rights

Like you, the people you support have the right to be treated with dignity and respect. Everyone also has the right to privacy. Confidentiality means keeping information private. Only share information about the people you support with others who are involved in their care.

In relation to medication administration, people have the right to:

- Know what their medications are and the reasons they are taken
- Know the risks of taking the medication
- Know the benefits of taking the medication
- Be given medication only as ordered by the HCP
- Refuse medication.

A person may refuse to take their medication. If this happens, the first thing you should do is ask them why they do not want to take it. Then report that information to the prescribing HCP and your supervisor. In the end, you want the people you support to get their medications as ordered by the HCP. The problem cannot be addressed until you know why the person is refusing their medications and report the reason.

A person has the right to be given medication only as ordered by the HCP. Here is an example:

Ellen Tracey has an order for a PRN medication. The medication is to decrease her anxiety. You will only give the medication when she displays symptoms of anxiety. The symptoms are described in her HCP order and/or Support Plan. A Support Plan, if needed, is an extension of an HCP order. Ellen communicates using simple words and short sentences, but she cannot tell you when she is anxious. Her plan describes what you will observe when she experiences anxiety. This is how you will know when to give the medication. You cannot administer PRN anti-anxiety medication for symptoms other than those described in her HCP order and/or Support Plan.

Protocols and Support Plans that reference medication are considered HCP orders. The instructions in an HCP order will include how and/or when to give a medication. Sometimes these instructions are long. If that happens, the order will be written as a Protocol or Support Plan. A Protocol is used when the reason for ordering the medication is to lessen a physical symptom. An example of this is a seizure protocol. This type of protocol gives instructions for the use of an anti-seizure medication. A Support Plan is used when the reason the medication is ordered is to help lessen a behavior. An example of this is a support plan for anxiety.

Ellen Tracey Support Plan
Anxiety Management
No Known Allergies

Specific symptoms that show us Ellen is anxious:

1. Biting hands for more than 4 minutes
2. Head slapping for longer than 30 seconds or more than 5 times in 4 minutes

    A. Staff will attempt to talk to Ellen in one-on-one conversation about current feelings and difficulties.
    B. Staff will attempt to direct and involve Ellen in a familiar activity such as laundry, meal preparation, etc.

If unsuccessful with A and B, the Ativan may be administered.

Ativan 0.5mg once daily as needed by mouth; must give at least 4 hours apart from regularly scheduled Ativan doses. (Refer to HCP order)

If anxiety continues after the additional dose, notify HCP.

HCP signature: *Shirley Glass MD 2/1/yr*

Posted: **Sam Dowd 2-1-yr 4pm**
Verified: ***Linda White 2-1-yr 4pm***

Review the support plan and answer the following questions.

1. What is the reason the PRN Ativan is ordered? _____
2. If Ellen was crying and attempted to hit you, could you give the PRN Ativan? _____
3. After the PRN medication was given, Ellen kept slapping her head and biting her hands. What would you do? _____

Let's Review

- Contact a person's HCP for health-related issues, concerns, or questions.
- MAP Consultants are available 24 hours a day, 7 days a week. They can answer medication questions and/or give advice about medication issues.
- MAP Consultants are a:
    - Health Care Provider
    - Registered Pharmacist
    - Registered Nurse
- Your supervisor must be notified anytime the MAP Consultant has been contacted.
- To recognize changes, staff must learn about the people they support.
- Medication Administration Principles include:
    - Mindfulness
    - Supporting abilities
    - Communication
- Everyone has the right to be treated with dignity and respect.

Unit 2

Observing and Reporting

Responsibilities you will learn

- The difference between objective and subjective observations
- When to report changes you observe in a person
- How to accurately report the changes you observe
- How to correct a documentation error

Observation is watching someone carefully. You have close contact every day with the people you support. You will quickly learn a person's daily routine, their habits, likes, and dislikes. You may be the first staff to observe a change.

Observing, reporting, and documenting changes are your responsibilities. These responsibilities are key to a person receiving quality healthcare. Observations are either objective or subjective.

Objective observation is factual information you can see, hear, feel, smell or measure.

- See
  - Examples:
    - Redness
    - Bruising
    - Scratch
    - Swelling
    - A person falls and bumps their head

- Hear
  - Examples:
    - Crying
    - Coughing
    - Sneezing
    - Moaning

- Feel
  - Examples:
    - Warm
    - Cool
    - Dry
    - Moist

- Smell
    - Examples:
        - Body odor
        - Halitosis (bad breath)
- Measure
    - Examples:
        - Number of hours a person sleeps
        - How long a seizure lasts
        - How much liquid a person drinks
        - How many pounds a person weighs
        - Vital Signs (blood pressure, temperature, pulse, respirations)

Subjective observation is when you work with a person who speaks or signs and they tell you how they are feeling.

- Examples:
    - "I have a headache."
    - "My throat hurts."
    - "I'm sad."
    - "I'm tired."

Label each observation as objective (O) or subjective (S):

1. ___ Frowns getting off the van
2. ___ Limping
3. ___ David says he has "sharp pain."
4. ___ Right knee is swollen, red and warm to touch.
5. ___ David says, "My knee still hurts."

Reporting

Reporting is giving someone information about something observed or told. The report can be spoken or written. You are responsible for reporting any changes you notice. These changes can be physical or behavioral. The changes can be objective observations about what you see, hear, feel, smell or measure. The changes can also be subjective observations when the person says how they are feeling. Report the facts. Do not guess at what you think the issue might be. The more details you report, the better. Your detailed reporting will help the HCP figure out the most appropriate treatment.

The quality of healthcare a person receives is only as good as the information you report to the HCP. When you report changes, follow up the next time you are working to see what action was taken.

The responsibility of reporting changes to the HCP can be different from service provider to service provider. You might:

- Call your supervisor first.
- Contact the HCP directly. Report the change and make an appointment if needed. Then call your supervisor after.
- Contact someone else before your supervisor.


Ask your supervisor who is responsible for contacting the HCP to report changes in the people you support.

There are two types of reporting:

- **Everyday reporting**
- **Immediate reporting**

Everyday reporting normally happens between staff at shift change. Outgoing staff are expected to provide incoming staff with information. Everyday reporting may be about basic household details. For example:

- A grocery list has been started.
- The dishwasher is broken.

Everyday reporting may also be about medication-related administration details that require staff follow up. For example:

- PRN Ativan was given to Ellen Tracey 30 minutes ago. Later in the shift, a medication progress note is needed documenting her response to the medication.
- Tanisha Johnson went to the dentist today. Look at her HCP orders. An antibiotic was ordered. Her first dose will be at 4pm. The medication is a liquid and is locked in the refrigerator.


Ask your supervisor how information is shared between shifts. For example, how new HCP orders are communicated if there are no staff present when you arrive for your shift.

Immediate reporting is reporting as soon as possible after a change is observed. It may prevent a small change from becoming a major health issue. Immediate reporting allows treatment to be ordered as quickly as possible.

Examples:

- A runny nose could be a symptom of allergies or a symptom of a sinus infection.
- A slight cough could be a symptom of a cold or a symptom of pneumonia (severe lung infection).

There are many people you will speak with to report information immediately, such as:

- 911 when:
    - You are not sure if a person is okay
    - A person falls and cannot get up
    - A person complains of chest pain, has a hard time breathing or is choking
    - A person is unresponsive
    - A MAP Consultant recommends you hang up and call 911
    - You are directed by a current HCP order or Protocol.
        - For example:
            - An HCP order or Protocol says, 'Call 911 for seizure activity greater than 5 minutes.'

- Poison control when a:
    - Person ingests a foreign substance, such as laundry detergent
    - MAP Consultant recommends you hang up and call poison control.

- A MAP Consultant when:
    - An occurrence (error) is made while giving medication
        - For example:
            - Tegretol 400mg is ordered and Tegretol 600mg is given.
    - The medication received from the pharmacy seems different from the HCP order
        - Even if other staff have given it
    - You notice the medication is different in color, size, shape and/or markings from the last time it was obtained
    - You are not able to give the medication due to the strength of medication received from the pharmacy.
        - For example:
            - The dose ordered is 50mg and you receive a 100mg strength tablet from the pharmacy.

- The HCP who prescribed medication when:
    - Medication is refused
    - Medication is not available from the pharmacy
    - There are no refills left
    - A medication parameter (guideline) for HCP notification has been met
        - For example:
            - An HCP order states, 'If pulse is below 56, do not give the medication and contact the HCP.'
    - A MAP Consultant recommends you hang up and call the HCP
    - An order is missing the person's name, medication, dose, frequency, route or the HCP signature and the date.

- Your Supervisor when
    - There is a math error in the Countable Controlled Substance Book
    - The count signature pages in a Count Book are almost full
    - The Count Book binding is loose
    - A medication seems to be tampered with
    - The medication supply is low, and you are unsure if a refill has been ordered
    - You cannot find a medication to administer.

A Countable Controlled Substance Book is a method used to track certain medications and is also called a Count Book. For training purposes, the term Count Book will be used.

Make sure the person you contacted answers all of your questions. Document the conversation including:

- Your question or concern
- The response given to you
- The name of the person you contacted
- Date, time, and your signature.

In MAP, a signature is defined as your full first name followed by your full last name. It must be legibly written.

Review the narrative note regarding David's knee pain.

NARRATIVE NOTES			
Name of Individual		*David Cook*	
DATE	**TIME**	**NARRATIVE** Include observations, communications, information sharing, HCP visits, medication changes, changes from the familiar, etc.	**STAFF SIGNATURE**
3/3/yr	3PM	David frowns getting off the van today, is limping and says he has 'sharp pain' when bending his knee. His right knee is now swollen, red and warm to touch. _____	John Craig
3/3/yr	3:15PM	Ibuprofen 400mg was given for complaint of 'sharp knee pain'. Call made to Dr. Black and message left. _____	John Craig
3/3/yr	*4:15pm*	*David received Ibuprofen 400mg at 3:15 PM and still complains of right knee pain. Even though Ibuprofen has been given as ordered, his symptoms continue.*	*Sam Dowd*
3/3/yr	*4:45pm*	*Dr. Black returned call, no medication changes but would like to see David tomorrow, appointment made for 2 PM.* _____	*Sam Dowd*

Place a checkmark next to the most complete information to report to the HCP.

1. ___ David's osteoarthritis has been bothering him. His knee is red, swollen, and painful. He has received Ibuprofen for the pain.

2. ___ David has injured his knee. He is limping because his knee hurts; it is red, swollen, and warm to touch.

3. ___ David has received Ibuprofen and says his right knee still hurts. It is warm to touch, red and swollen. He is limping.

4. ___ David says he has 'sharp pain' when he bends his right knee. He frowns getting off the van and is limping. His right knee is now red, warm to touch and swollen. He has received Ibuprofen 400mg for right knee pain and his symptoms continue.

Documentation

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

When documenting:

- Use blue or black ink
- Write
  - Clearly
  - Using complete sentences
- Include
  - Date
  - Time
  - Your signature

You will be documenting medication administration on the front side of a medication administration sheet. However, there are times when more documentation is needed.

More medication-related documentation is normally written on a medication progress note. This is usually on the backside of a medication administration sheet. Medication progress notes are kept in a medication book. When documenting using a medication progress note, use as many lines as needed.

Name Juanita Gomez **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
3/3/yr	8:27pm	Magnesium Hydroxide	1200mg	X				Third day with no BM	_____	Serena Wilson
3/3/yr	11pm	No BM as of 11pm. Night staff will continue to monitor. _____								Serena Wilson
3/4/yr	8:42am	No BM overnight. Dr. Jones notified. Telephone order taken to give Magnesium Hydroxide 1200mg tonight if there is still no BM by 8pm. If the medication is administered and there is still no BM, call Dr. Jones tomorrow morning. See HCP order. _____ *Timothy Miller*								
3/4/yr	3:31pm	Had a large ~~bowl~~ (error SW) bowel movement. _____								Serena Wilson

A person may have an ongoing (chronic) health issue for which a PRN medication is ordered. This can be a health issue like constipation. In this case, documentation in the medication progress notes is important. It helps keep track of how often the PRN medication is needed and if it has any effect. This is key information for an HCP. For example, the HCP learns that Juanita is receiving PRN Magnesium Hydroxide every week. The HCP may order a daily bowel medication in an effort to reduce PRN Magnesium Hydroxide use.

You may work in a location that uses a separate form to document additional medication information. You may use this form instead of a medication progress note. In this case, additional medication or health-related documentation may be written on progress notes. These are sometimes called narrative notes, which are filed in the person's confidential health record.

NARRATIVE NOTES

Name of Individual		Juanita Gomez	
DATE	**TIME**	**NARRATIVE** Include observations, communications, HCP visits, medication changes, changes from the familiar, reportable events, etc.	**STAFF SIGNATURE**
3-3-yr	8:27pm	Magnesium Hydroxide 1200mg administered at 8pm since third day with no BM.	
		———————————————————	Serena Wilson
3-3-yr	11pm	No results as of 11pm. Night staff will continue to monitor.	Serena Wilson
3-4-yr	8:42am	No bowel movement overnight. Dr. Jones notified. Telephone order taken to	
		give Magnesium Hydroxide 1200mg again just tonight if there is still no BM by	
		8pm. If the medication is administered and there is still no BM, call Dr. Jones	
		tomorrow morning. See HCP order. ———————	*Timothy Miller*
3-4-yr	3:31pm	Large ~~bowl~~ (error SW) bowel movement. ———————	Serena Wilson

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. These can be seen 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.
        - For example, see the medication progress note and/or the narrative note entries dated 3-4-yr at 3:31pm

Let's Review

- Knowing the people you support will help you notice when there is a change.
- Objective information can be seen, heard, felt, smelled, or measured.
- Subjective information is what a person tells you.
- All changes must be reported.
- Reporting immediately lowers the chances a health issue may become worse.
- An HCP uses the information reported by staff to figure out if treatment and medication are needed.
- Health-related issues are documented from beginning to end.
- A signature is defined as your full first name followed by your full last name.
    - It must be legibly written.

Unit 3

Medications

Responsibilities you will learn

- The purpose of medications
- Medication categories
- Medication outcomes
- Medication information resources

Medications are substances that, when put into or onto the body, will change one or more ways the body works. Medications are used to treat illness, disease, pain, or behavior. The goal of prescribed medication is to:

- Decrease the person's symptoms
- Improve their quality of life.

You will learn how to administer medications safely to the people you support. You will follow the same steps each time you administer a medication.

Brand and Generic Names

Medications are known by their brand name and/or generic name. Most medications have both a brand and a generic name.

Brand name medications are created and made by a specific pharmaceutical company. When the 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. They are manufactured by many pharmaceutical companies. Generic medication is similar to its brand name medication but is less expensive. The color, marking, shape, and/or size of the medication may be different. Examples of generic name medications are Acetaminophen, Ibuprofen, and Fluoxetine.

The pharmacy may supply the generic medication when the HCP submits a prescription for a brand name medication. In that case, the generic name of the medication and the letters 'IC' will appear near the brand name of the medication 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.

Review the pharmacy labels. Fill in the generic medication supplied.

Zestril _____ Prilosec _____ Motrin _____

Rx#138	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **1/31/yr**
David Cook		
Lisinopril 20 mg **IC Zestril**		**Qty. 60**
Take 2 tablets by mouth one time a day in the morning. **Hold if systolic blood pressure is below 100 and notify HCP.**		
Lot# 269	**ED: 1/31/yr**	**Dr. Black** **Refills: 2**

Rx#174	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **6/30/yr**
David Cook		
Omeprazole 20 mg **IC Prilosec**		**Qty. 30**
Take 1 tablet by mouth once a day before supper		
Lot# 1436	**ED: 6/30/yr**	**Dr. Black** **Refills: 2**

Rx#140	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **8/31/yr**
David Cook		
Ibuprofen 400 mg **IC Motrin**		**Qty. 90**
Take 1 tablet by mouth every eight hours as needed for complaints of right knee pain. If symptoms continue for more than 48 hours notify HCP.		
Lot# 745	**ED: 8/31/yr**	**Dr. Black** **Refills: 2**

Medication Schedules

All prescription medications are controlled substances. This means a prescription from an HCP is required to obtain the medication from a pharmacy.

Controlled substances are placed into schedules. The schedules are numbered II, III, IV, V and VI. A substance is placed in a schedule based on its potential for abuse.

Medication Categories

There are three categories of medications:

- **Controlled (Schedule VI)**
- **Countable Controlled (Schedule II-V)**
- **Over-the-Counter (OTC)**

Controlled (Schedule VI) Medication

Controlled medications require an HCP prescription to obtain the medication from the pharmacy. The pharmacist uses the information on the prescription to prepare and label the medication. Examples of controlled medications include:

- Antibiotics[6] (such as Amoxicillin)
- Antidepressants[7] (such as Prozac)
- Antipsychotics[8] (such as Haldol)

Controlled medication requirements include:

- An 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 a
    - Medication Ordering/Receiving log
    - Medication sheet
        - Where the administration of medication is documented
    - Medication Release Document
    - DPH Disposal Record

[6] Medications that treat bacterial infections.
[7] Medications that treat depression.
[8] Medications that treat mental illness.


DPH identifies certain controlled medications as ‘high alert’. Additional training and documentation are required for these medications. High alert medications include Coumadin and Clozaril (Schedule VI).


Ask your supervisor if anyone has HCP orders for ‘high alert’ medication at your work location. If so, ask how they are tracked.


DPH sometimes identifies certain Schedule VI medications as having a ‘high risk’ for potential abuse. These Schedule VI medications must be tracked as if they were countable controlled medications.


Ask your supervisor if anyone has HCP orders for ‘high risk’ Schedule VI medication at your work location.

Countable Controlled Medication (Schedule II-V)

Schedule II-V medications are sometimes called narcotics. Examples of countable controlled medications include:

- Prescription pain relievers (such as Percocet and Vicodin)
- Antianxiety medication (such as Ativan)

Countable controlled medications are at high risk of being stolen and abused. For these reasons, they must have additional security measures in place.

Countable controlled medications require an HCP prescription to obtain the medication from the pharmacy. The pharmacist uses the information on the prescription to prepare and label the medication.

The pharmacy must also add an ‘identifier[9]’ on the package of the countable controlled medication. This alerts you to the fact that it is a countable controlled medication.

[9] An identifier is a special marking on the package.

The identifier may be:

- A ‘C’ stamped on the package
- An Rx (prescription) number that may start with a ‘C’ or an ‘N’
- A color-coded package.

Pharmacy ‘identifier’ examples:

Ask your supervisor how the pharmacy identifies countable controlled medication at your work location.

If the pharmacy label has no identifier, the pharmacist must be contacted. The pharmacist will help you figure out which medications are countable controlled medications.

Countable controlled medication requirements include:

- An HCP order for administration
- Labeled and packaged by the pharmacy in a
  - Tamper-resistant package
    - To decrease the chance that the medication inside is replaced with a different medication
    - With an identifier
- Secured in a double key-locked area
  - A key lock within a key lock
    - To maintain medication security
- Tracked using a
  - Medication Ordering/Receiving log
  - Count Book
    - Added into a Count Book as medications come into the site
    - Subtracted from a Count Book as medications are removed from the package or transferred
  - Medication sheet
    - Where the administration of medication is documented
  - Medication Release Document
  - DPH Disposal Record
- Counted every time the medication storage keys change hands
  - Ensures medications are secure and
    - Protects you from being accused of mishandling or misusing medication
    - Helps you in adhering to laws, regulations, and policies

If controlled substances or countable controlled substances are stolen, it will be investigated[10]. This will most likely involve the police.

[10] A formal examination of facts to find out what happened and who did it.

Over-the-Counter (OTC) Medication

Over-the-Counter (OTC) or nonprescription[11] medication may be purchased from a pharmacy without a prescription from the HCP. Examples of OTC medications include:

- Nonprescription pain relievers (such as Tylenol and Advil).
- Allergy medication (such as Benadryl).

MAP requires that OTC medications be managed in one of the two ways described below.

OTC medication requirements include:

- An HCP order for administration
- Packaged
  - By the pharmacy in a tamper-resistant package or bottle or
  - In the manufacturer's container
- Managed in one of two ways:
  - Labeled by the pharmacy
    - You must ask the HCP to submit a prescription for the OTC medication.
      - The pharmacy will then prepare and label the medication.
  - Verified by the Service Provider designee
    - The designee buys the OTC medication.
      - They will make sure that the manufacturer's label agrees with what the HCP ordered.
    - After the OTC medication is verified, you will receive 'OTC Medications and Dietary Supplements without a Pharmacy Label Training' before administering the OTC medication.
      - You must be trained before administering the OTC Medication.
      - You will know the verification[12] procedure was completed when you see:
        - the person's name, the verification date and the designee's initials printed on the OTC medication container
        - the designee's initials and verification date will also be in the margin of the HCP order.
    - 'OTC Medications and Dietary Supplements without a Pharmacy Label Training' is person and product specific.
- Secured in a key-locked area
- Tracked using a
  - Medication Ordering/Receiving log
  - Medication sheet
    - Where the administration of medication is documented
  - Medication Release Document

[11] Medication that does not require a prescription from the HCP.
[12] Confirmation that the product purchased is what the HCP ordered.

The Service Provider designee may be a Licensed Nurse, Registered Pharmacist, or an HCP. If need be, the designee can also be a MAP Certified Supervisor. A Site Supervisor must check with a MAP Consultant to make sure the product purchased agrees with what the HCP ordered.

Below is an example of the OTC medication verification process. Linda White, Site Supervisor, is the Service Provider designee. Linda checked with a MAP Consultant to make sure that the manufacturer's label of the Acetaminophen that she purchased agreed with what the HCP ordered. She then documented the date and her initials in the margin of the HCP order. Finally, she documented the name of the person, her initials, and the date on the Acetaminophen container.

HEALTH CARE PROVIDER ORDER

Name: Scott Green	**Date:** October 30, yr
Health Care Provider: Dr. S. Pratt	**Allergies:** No Known Allergies
Reason for Visit: Scott has been complaining of a headache.	
Current Medications: See attached current medication list	
Staff Signature: Linda White	**Date:** October 30, yr
Health Care Provider Findings: After discussing with Scott his complaint of headaches, he has agreed to try acetaminophen.	
LW 10/30/yr **Medication/Treatment Orders:** Acetaminophen 325mg PRN every 6 hours by mouth, if self-reports headache	
Instructions:	
Follow-up visit: Yearly physical	**Lab work or Tests:**
Signature: Dr S. Pratt	**Date:** October 30, yr

Posted Linda White **Date:** 10/30/yr **Time:** 5pm **Verified** Charles Martin **Date:** 10/30/yr **Time:** 6:16pm

 Sunscreen, insect repellant, and non-prescription personal hygiene cleansing products do not require an HCP order. However, the Service Provider, with the person's HCP, may decide if one of these products requires an HCP order for tracking and follow-up.

In addition to the three categories of medications, there are Dietary Supplements.

Dietary Supplements

Dietary supplements are products that contain dietary ingredients. For example, vitamins, minerals, herbs, or other substances. Unlike medication, dietary supplements are not pre-approved by the government for safety or effectiveness[13]. Dietary supplements may be purchased from a pharmacy without a prescription from the HCP. Examples include Multivitamins[14], Fish Oil and Shark Cartilage.

MAP requires that all dietary supplements be managed in one of the two ways described below.

Dietary supplement requirements include:

- An HCP order for administration
- Packaged
    - By the pharmacy in a tamper-resistant package or bottle or
    - In the manufacturer's container
- Managed in one of two ways:
    - Labeled by the pharmacy
        - You must ask the HCP to submit a prescription for the dietary supplement.
            - The pharmacy will then prepare and label the dietary supplement.
    - Verified by the Service Provider designee
        - The designee buys the dietary supplement.
            - They will make sure that the manufacturer's label agrees with what the HCP ordered.
        - After the dietary supplement is verified, you will receive 'OTC Medications and Dietary Supplements without a Pharmacy Label Training' before administering the dietary supplement.
            - You must be trained before administering the Dietary Supplement.

[13] The process of determining how well the product works.
[14] Multivitamins are supplements that contain different vitamins and minerals.

- You will know the verification procedure was completed when you see
    - the person's name, the verification date and the designee's initials printed on the dietary supplement container
    - the designee's initials and verification date will also be in the margin of the HCP order.
- 'OTC Medications and Dietary Supplements without a Pharmacy Label Training' is person and product specific.

- Secured in a key-locked area
- Tracked using a
    - Medication Ordering/Receiving log
    - Medication sheet
        - Where the administration of the dietary supplement is documented
    - Medication Release Document

Ask your supervisor if there are OTC medications and/or dietary supplements without a pharmacy label at your work location. If so, ask when you will be scheduled for 'OTC Medications and Dietary Supplements without a Pharmacy Label Training'. You cannot administer OTC medications and dietary supplements without a pharmacy label until you receive this training.

Nutritional Supplements

Nutritional supplements are food items such as Ensure, gastric tube feedings or Carnation Instant Breakfast. They are not medications and do not fall under MAP. Although they do not fall under MAP, the use of such products is usually tracked on various types of forms.

Look at the manufacturer's label to know if a product is an OTC medication, a dietary supplement, or a nutritional supplement.

Over-the-counter medications have a Drug Facts label.

Dietary supplements have a Supplement Facts label.

Food items have a Nutrition Facts label.

True (T) or False (F)

1. _____ Additional training is required to administer OTC medications and dietary supplements without pharmacy labels.
2. _____ Sunscreen, insect repellant, and non-prescription personal hygiene products do not require an HCP order.
3. _____ Nutritional supplements fall under MAP.
4. _____ The 'OTC Medications and Dietary Supplements without a Pharmacy Label Training' is person and product specific.

Multiple different medications may be packaged by the pharmacy in a single tamper-resistant package. This is known as multi-dose medication packaging.

Ask your supervisor if multi-dose medication packaging is used at your work location. If so, ask when you will receive the 'Pharmacy Packaged Multi-Dose Medication Packaging Training.'

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**
- **No Effect Noted**
- **Side Effects**

Desired effect is when a medication does exactly what it was intended to do. The person experiences the expected results of the medication. For example:

- Tylenol is administered for a headache and the headache goes away.
- Dilantin is administered to control seizures and the person is seizure-free.

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 occur for one of two reasons.

- The body will not respond to the medication and a different medication will need to be ordered. For example, Erythromycin is ordered for an ear infection. The person has ear pain and a temperature of 100.2. After taking the medication for 2 days, the person still has the same symptoms, ear pain and a temperature of 100.2. No effect was noted from the medication. The person continues to experience symptoms and the HCP must be notified.

- The medication has not had enough time to work. For example, a person was started on a new antidepressant medication a week ago and is still experiencing symptoms of depression. Some medications take longer to work than other medications. In this case, several weeks may be necessary for the person's symptoms to improve.

When a new medication is started, you should document what you observe, even if there are no effects noted. This will help the HCP figure out if the medication is working as intended.

Side effects are results from a medication that are not wanted or intended. They:

- Can happen even if the desired effect is achieved
- Are usually mild
- May be uncomfortable
- Are usually not severe enough for the HCP to discontinue the medication.
    - Examples:
        - An antibiotic may cure an ear infection, but it may also cause mild nausea.
        - A cold medicine may reduce a cough and runny nose but may also cause sleepiness.

Side effects range from mild to severe. If the side effect is more severe, it is called an adverse response to the medication.

Adverse responses (severe side effects) to observe for include:

- **Allergic reaction:** The body's immune system reacts to the medication as if it were a foreign substance. An allergic reaction begins with a rash. The rash may start on one area of the body and then spread. An allergic reaction may happen even if the person has taken the medication before without an issue.

- **Anaphylactic reaction:** A severe, very dangerous, life-threatening allergic reaction. An anaphylactic reaction happens very quickly. This reaction requires immediate medical attention, such as calling 911. An anaphylactic reaction usually consists of difficulty breathing, rash, and changes in vital signs.

- **Paradoxical reaction:** The person experiences the opposite effect of what the medication was intended to produce. For example, a medication is ordered to help a person relax and instead the person becomes restless.

- **Toxicity:** A medication builds up in the body and the body cannot handle it anymore. This can be life-threatening. Toxicity is more common with certain medications than others. For example, even a very common medication, such as Tylenol, can be toxic. Many anti-seizure medications also can build up in the body and cause toxicity. Usually, a person's blood will be monitored to make sure the medication level is not toxic.

Medication Interactions

A medication interaction is a mixing of medications in the body. This can either increase or decrease the effects and/or side effects of one or both medications. The more medications a person takes, the greater the chance of an interaction occurring. Medications can also interact with dietary supplements, other substances, and certain foods.

Examples of medication interactions:

- If an antibiotic is taken with calcium, the calcium interacts with the antibiotic, decreasing the effects of the antibiotic. This means the person will not get the desired effect from the antibiotic.
- Vitamin K, often found in green leafy vegetables, interacts with Warfarin Sodium (a blood thinner). This decreases the effects of the Warfarin Sodium. This means the person will not get the desired effect (for the blood to be thinned) from the Warfarin Sodium.
- If more than one pain medication is taken at a time, they can interact. This can increase the effects and/or side effects of either pain medication.

Alcohol, Nicotine, and Caffeine

Alcohol, nicotine, and caffeine can interact or interfere with the absorption of medication in the body. You must inform the HCP if any of the people you support use these substances.

Read the interactions section of the Tramadol medication information sheet. Circle what could happen if Tramadol is taken with an alcoholic drink.

Sample Medication Information Sheet

Tramadol: is an analgesic used to treat moderate to severe pain, chronic pain. Brand names for Tramadol are Conzip, Rybix, Ryzolt, Ultram, and Zytram.

How to take: Oral tablets, take with or without food.

What to do if you miss a dose: Take as soon as possible unless it is one hour before the next dose. If so, skip the missed dose. Never double up on dose.

Side Effects: Vertigo, depression, seizures, headache, fatigue, hypotension, blurred vision, nasal congestion, nausea, anorexia, constipation, GI irritation, diarrhea, pruritus, and urinary retention.

Interactions: Tell your HCP of all the medications you are taking. Do not use with St. John's Wort. Using Tramadol together with alcohol may increase side effects such as dizziness, drowsiness, confusion, and difficulty concentrating.

Contraindications: Hypersensitivity, acute intoxication with any CNS depressant, alcohol, asthma, respiratory depression.

Special Precautions: Monitor vital signs, if respirations are less than 12 withhold, track bowels, and check urinary output.

Overdose reaction: Serotonin syndrome, neuroleptic malignant syndrome: increased heart rate, sweating, dilated pupils, tremors, high B/P, hyperthermia, headache, and confusion.

Sensitivity[15] 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 that contribute to a person's sensitivity to medication.

These factors include:

- Age
- Weight
- Gender
- General health
- Medical history
- Level of physical activity
- Use of other medications or dietary supplements

For example, an HCP would not necessarily order the same medication or dose of medication for a

- 100-pound woman as they would for a 275-pound man
- Healthy 25-year-old and an 85-year-old with many health issues.

Medication Information

You are responsible for learning about the medications you administer. You must also know the reason for administration. To monitor the person for effects of medication, you must

- Learn about the people you support, including their medical conditions and any medications prescribed
- 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
- The medication information sheet
    - supplied by the pharmacy for each medication prescribed
- A reputable online source
- A drug reference book

Ask your supervisor where these are found at your work location:

- The current (less than 2 years old) drug reference book or
- The current (less than 2 years old) medication information sheets for all prescribed medications

[15] Being unable to tolerate medication when the medication is ordered at a usual dose or less.

Match the terms to the related examples or actions required.

1.	___	Controlled Medication	A	Mild itching and rash occur after taking a new medication
2.	___	Medication Sensitivity	B	A prescription is required to obtain it but does not require counting. Or is also a schedule VI medication
3.	___	Anaphylactic Reaction	C	A 100-pound person becomes very sleepy after receiving a normal dose of Ibuprofen
4.	___	No Effect Noted	D	Coumadin and Aspirin taken together cause a person's gums to bleed
5.	___	Dietary Supplement	E	Medication is ordered to help calm a person, instead, the person becomes restless
6.	___	Paradoxical Effect	F	Must be counted every time the keys change hands
7.	___	Countable Medication	G	Immediate 911 call required
8.	___	Toxicity	H	Mild upset stomach after receiving an antibiotic
9.	___	Side Effect	I	Tylenol is taken for back pain and the back pain goes away
10.	___	Desired Effect	J	The body stores up more medication than it can handle
11.	___	Allergic Reaction	K	Multivitamin
12.	___	Medication Interaction	L	An antibiotic is ordered for bronchitis; after 2 days the person is still coughing and has a fever

Let's Review

- A medication can change one or more ways the body works.
- Medications are known by their brand name and/or generic name.
- Categories of medications are:
    - Controlled (Schedule VI)
    - Countable Controlled (Schedule II-V)
    - Over-the-Counter (OTC)
- Medication outcomes include:
    - Desired effect
    - No effect noted
    - Side effects
- Adverse responses are severe side effects.
- Medications and dietary supplements can interact with
    - each other, alcohol, nicotine, caffeine, and certain foods.
        - The interaction may increase or decrease the effect of the medication, dietary supplement, or both.
        - The more medications and dietary supplements a person takes, the greater the chance of an interaction.
- An HCP order is required to administer all medications and dietary supplements.
    - There are some OTC product exceptions.
- Additional training is required to administer OTC medications and dietary supplements without a pharmacy label.
- You are responsible for learning about the medications you administer.
- You are responsible to know the reason a medication is ordered.

Unit 4

Interacting with a Health Care Provider

Responsibilities you will learn

- A procedure to make sure an HCP visit is successful
- When medication reconciliation[16] is required
- The process of taking a telehealth/telephone order
- Requirements to use an existing supply of medication when there is a dose or a frequency change

Sometimes the changes you observe and report result in an HCP visit. You may go with the person for:

- A particular problem, issue, or concern that you, other staff or the person wants to discuss with the HCP
- Their routine yearly physical exam.

There is a procedure to make sure that you are prepared for the HCP visit. The procedure is as follows:

Prepare the Person for the Appointment:

- Tell the person the date and time, when appropriate.
- Discuss what will happen at the visit.
- Follow any instructions ordered to prepare for the visit.
    - For example:
        - Pre-medications ordered prior to the appointment
        - Fasting, such as no food or fluid prior to the appointment
- Think About:
    - Items to help the person feel relaxed
        - This could include music, stress balls or other comfort items
    - Encouraging the person to wear loose and comfortable clothing in the event the HCP needs to physically examine the person.

Before leaving the site, make sure you have the following:

- Person's insurance card
- Copy of current medication sheets or a list of medications

[16] The process of generating the most complete and accurate list of the person's currently prescribed medications.

- HCP Encounter/Consult/Order Form
    - The top portion is completed by site staff
        - Name of person
        - Date
        - Allergies
        - Reason(s) for visit
        - List of current medication, including dietary supplements and PRNs
        - Name of HCP
        - Signature of staff person completing the form

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** June 1, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states that he has burning in his throat after eating.	
Current Medications: Zestril 40 mg by mouth once a day in the morning. Check blood pressure before administering medication. If systolic reading is less than 100, hold medication and notify HCP. Motrin 400 mg by mouth as needed every 8 hours for right knee pain. Notify HCP if right knee pain continues for more than 48 hours.	
Staff Signature: *Sam Dowd*	**Date:** June 1, yr
Health Care Provider Findings:	
Medication/Treatment Orders:	
Instructions:	
Follow-up visit:	**Lab work or Tests:**
Signature:	**Date:**

Staff Complete Top of Form

HCP Completes Bottom of Form

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

Each department, DDS, DMH, DCF and MassAbility, uses standardized forms and/or tools, and the forms used have required information that must be included relating to an HCP visit.

Ask your supervisor what HCP visit forms are required specific to the people you support.

Another staff may complete the paperwork. Make sure you read it before leaving. You will then be able to tell the HCP why the visit is needed when you are asked.

Make sure you also have:

- Driving directions
- Money for parking, gas, food, or drink
- Service Provider on-call information (in case you need to contact someone)
- Family/Guardian information
- Name of the pharmacy, telephone number and directions
- A charged cell phone

When You Get to the Appointment

- First, check in with the receptionist:
    - Introduce yourself and the person you are accompanying.
    - State the reason that you are there, e.g., "David Cook has a 2pm appointment to see Dr. Black."
    - Discuss any accommodations[17] the person may need.

During the Appointment

- Assist the person, if needed.
- Advocate, encourage participation[18] and support abilities.
    - Provide HCP Encounter/Consult/Order and other forms.
    - Provide information to the HCP when asked.
    - Communicate the reason for the visit.
        - This is especially important if the person does not speak.
    - If the person can speak about their health, encourage them to do so.
    - The HCP may ask you questions. Redirect the HCP to the person you are assisting. This is so they may answer whenever possible.
        - Help the person to answer questions, if needed.
    - Ask the HCP for answers to any questions the person or you have.

[17] Changes made to the environment so the person can access treatment.
[18] Being involved in the appointment.

- Write down information given to you that is not on the forms. You must communicate it to others after the appointment.

- Obtain any Written Results and Recommendations of the Appointment including:
  - HCP Encounter/Consult/Order Form
    - Make sure the HCP's portion of the form is completed.
      - HCP orders must include:
        - The 5 Rights of medication administration
          - Person's name
          - Medication name
          - Dose
          - Frequency
          - Route
        - Allergies
        - HCP findings
        - Special Instructions, if any
        - Target signs and symptoms, instructions and/or parameters, what to do if the medication is given and is not effective for PRN medication
        - Acceptable HCP signatures:
          - A 'wet' signature
            - The order is signed with pen and ink by the HCP
          - An 'image' of the HCP's signature
          - An 'electronic' signature
            - The orders are received, unaltered through an electronic system (e.g., email, patient portal system, etc.)
        - Date of the order, including the year

When more than one page of HCP Orders are present, each page must be numbered (e.g., page 1 of 4, 2 of 4, etc.) and dated, the pages must be fastened together as one packet, and only the last page of the HCP order needs to be signed and dated by the HCP.

HCP orders, including Protocols/Support Plans, are valid for 1 year. Renewal of the orders usually corresponds to the person's yearly physical exam. There are times when the exam cannot be scheduled before the orders expire. When this happens, the orders are valid until the day after the HCP visit occurs, as long as:

- The person's health insurance plan requires more than a year between exams; and
- Staff tried to make an HCP appointment on the earliest date allowed.

In DMH and DCF only, psychotropic medication orders must be updated at clinically appropriate intervals. The intervals are determined by the prescribing HCP.

- Prescription:
  - The HCP may:
    - Submit the prescription electronically to the pharmacy
    - Call the prescription into the pharmacy
    - Give the prescription to
      - you to bring to the pharmacy
      - the person to bring to the pharmacy, if self-administering.
  - If given a written prescription, ensure it and the HCP order agree before leaving.
    - Both must include the 5 Rights of medication administration.
- Sample medication may be received from an HCP. It can be administered if:
  - The HCP labels the sample medication
    - With the same information as on a pharmacy label
    - The label includes the HCP's name.
  - The HCP writes an order for the sample medication.
- Set up another appointment with the receptionist, if needed.

A copy of the prescription for the HCP ordered medication may be used as an HCP order.

After the Medical Appointment

- Ensure the pharmacy received the prescription.
- Pick up new medications at the pharmacy or check when the pharmacy will deliver the medication.
- Bring back all forms, HCP orders, and information regarding the next appointment.
- Share the information with the appropriate people.
- Transcribe all medication orders on to the medication administration sheet.
    - Post[19] and Verify[20] all orders.
- Secure the medication.
- Document the visit.
- Communicate changes to all staff.

Only Certified staff, including relief staff, who have successfully completed the Service Provider's Transcription of Medication Management (TMM) System Training may transcribe HCP orders, post and/or verify HCP orders, and complete monthly accuracy checks of HCP orders.

[19] Documentation completed by staff on the HCP order (under the HCP signature) after a medication is transcribed.
[20] Documentation completed by a second staff on the HCP order (under the HCP signature) after reviewing the first staff's completed transcription for accuracy.

Review the HCP order below and fill in the blanks.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** June 1, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states that he has burning in his throat after eating.	
Current Medications: Zestril 40 mg by mouth once a day in the morning. Check blood pressure before administering medication. If systolic reading is less than 100, hold medication and notify HCP. Motrin 400 mg by mouth as needed every 8 hours for complaints of right knee pain. Notify HCP if right knee pain continues for more than 48 hours.	
Staff Signature: *Sam Dowd*	**Date:** June 1, yr
Health Care Provider Findings: Gastroesophageal reflux disease (GERD)	
Medication/Treatment Orders: Prilosec 20 mg by mouth once a day before supper	
Instructions: Remain upright 30 minutes after eating.	
Follow-up visit: 1 month	**Lab work or Tests:** None today
Signature: *Richard Black, MD*	**Date:** June 1, yr

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

1. HCP name _____
2. Reason for visit _____
3. Staff completing form _____
4. Allergies _____
5. HCP findings _____
6. New medication ordered _____
7. HCP instructions _____

Tanisha went to the dentist today. She received a new order for an antibiotic. You return to Tanisha's home with a signed HCP order. Review the HCP order and complete the following exercise.

HEALTH CARE PROVIDER ORDER

Name: Tanisha Johnson	**Date:** Feb. 2, yr
Health Care Provider: Dr. Chen Lee	**Allergies:** No known medication allergies
Reason for Visit: Complaining of soreness in back of mouth.	
Current Medications: Phenobarbital 64.8mg once daily in the evening by mouth Clonazepam 1mg twice daily at 8am and 4pm by mouth	
Staff Signature: *Sam Dowd*	**Date:** Feb. 2, yr
Health Care Provider Findings: Inflammation of gum-line on left side of mouth	
Medication/Treatment Orders: Amoxil Suspension 500mg every 12 hours for seven days by mouth	
Instructions: Notify HCP if Tanisha continues to complain of mouth soreness after 72 hours.	
Follow-up visit: Feb. 16, yr	**Lab work or Tests:** None
Signature: *Dr. Chen Lee*	**Date:** Feb. 2, yr

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

1. Circle the new medication order.
2. What is the dose ordered? _____
3. What is the frequency ordered? _____
4. Place a checkmark next to Tanisha's current medications.
5. Does Tanisha have any medication allergies? _____

People Who Manage Appointments Independently[21]

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 the person does not bring back new valid orders and prescriptions, it is your responsibility to obtain them.

If going to the Emergency Room, Urgent Care, and/or Hospital

- Take the person's
  - current medication list
  - insurance card
  - HCP Encounter/Consult/Order form.
- Be prepared to tell Emergency Room (ER), Urgent Care, and/or hospital staff why you are bringing the person.
  - The person might be scheduled to receive medications during the time they are at the ER or Urgent Care. If so, you should discuss this with the HCP. Obtain an HCP recommendation[22] to address any medications that might be missed.
    - Once at your work location, document your discussion with the HCP on the medication progress note.
      - If medication was missed and an HCP recommendation was not obtained:
        - Contact the MAP Consultant immediately after the person returns to the site.
          - Document the discussion and recommendations.
- When a person has been seen in the ER and/or Urgent Care, HCP orders must be obtained for any medication changes.

[21] By themselves; without support staff.
[22] An instruction or order or referral.

- You may have concerns about taking the person home or to work/day program after the visit. If so, tell the ER, Urgent Care, and/or hospital staff. Make sure to contact your supervisor before leaving.

Sometimes a person is admitted to the hospital following an ER or Urgent Care visit. Medication reconciliation is required before the hospital discharge. Medication reconciliation is done by comparing the hospital discharge orders to all HCP orders that were in place before the admission. The same medication may appear on both sets of orders. If so, the discharge HCP order will take the place of the prior HCP order.

Medication reconciliation ensures:

- HCP orders that were in place prior to the admission are continued
- New medication ordered during a hospital stay is not omitted when the person returns home
- Medication that was discontinued during a hospital stay is not administered when the person returns home.

Medication Reconciliation/Discharge HCP Orders (Sample Guide)

Medication Reconciliation is the process of generating the most complete and accurate list of the individual's currently prescribed medications. This must be done during every transition of care (i.e., transferred to/from a Health Care Facility [for example, hospital, nursing home, crisis stabilization[23] unit or rehabilitation[24] center, etc.]).

HCP Orders that were in place (at the MAP Registered site) prior to the Health Care Facility admission must be reconciled with the new Health Care Facility discharge orders to create a complete and accurate *Medication List; if the same medication appears on both sets of orders, the discharge (new) HCP medication order supersedes (take the place of) the prior existing HCP medication order.*

Checklist

1. Before the individual is discharged from the Health Care Facility:

   ☐Obtain all HCP Orders that were in place prior to the admission (from the individual's home).
   ☐Obtain the new HCP medication orders being prescribed (using the Health Care Facility discharge orders).
   ☐Compare the medications on the two sets of HCP Orders (prior and new); bear in mind the five (5) rights. Pay particular attention to dose and/or frequency changes for medications that appear on both sets of orders.
   ☐If there are discrepancies between the two sets of HCP Orders, review the discrepancies with the Health Care Facility HCP prior to the individual's discharge/transfer (from the Health Care Facility).
   ☐Prior to discharge/transfer, be sure to obtain dated and signed HCP Orders for any new or changed medications.
   ☐Obtain any new prescriptions or ensure that the pharmacy has been notified by the Health Care Facility HCP of any new medication prescriptions.

2. Once the individual has returned home:

   ☐Notify the Primary Care Physician (PCP), and any other prescribing HCP(s), that the individual had a transfer of care.
   ☐All new or changed medication/treatment HCP Orders are reported to the PCP and any other prescribing HCP(s).
   ☐Obtain any newly prescribed medication from the pharmacy.
   ☐Compare Health Care Facility HCP Discharge Orders to all HCP Orders that were in place prior to the discharge; if the same medication appears on both lists, the Health Care Facility HCP Discharge Order will supersede (take the place of) the prior HCP Order.
   ☐Update the Medication Administration Record:
   - HCP medication orders that have been superseded by new HCP Orders must be noted as discontinued, and the new HCP Order transcribed.
   - Any newly prescribed HCP medication orders must be transcribed; and
   - All HCP Orders must be Posted and Verified.

   ☐Communicate the changes to others involved in supporting the individual (for example, coworkers, Supervisor, Day Program staff, School staff, family members, etc.) according to the Service Provider Policy.

[23] Short-term treatment for a mental health disorder.
[24] Short-term care to improve abilities or recover from physical injuries.

Health Care Provider Orders Received by Fax and Email

Fax and email orders are legal orders. It is preferred that fax and email orders be used instead of telehealth and telephone orders to help prevent errors.

Health Care Provider Orders Received by Telehealth and Telephone

HCP orders by telehealth and telephone are allowed. Telehealth orders are documentation of instructions given by an HCP during a telehealth appointment. Telephone orders are documentation of instructions given by an HCP over the telephone. The instructions may include:

- A newly ordered medication
- A change to an existing medication order
- A non-medication order, such as to begin monitoring a person's weight.

Telephone orders are sometimes necessary. For example, blood work results become available 3 hours after the HCP appointment. Based on those results, the HCP may determine a new medication, or a medication change is needed. The HCP will call to give you a telephone order for the new medication, or the medication change.

When you take a telehealth or telephone order:

- Document the order word-for-word on an HCP Telehealth/Telephone Order form.
- Read back the information given to you by the HCP to confirm you recorded it accurately.
- If you are 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 on the order form.
- If you are the staff that obtains the telehealth/telephone order, you should be the staff to transcribe the order. This helps make sure the order is accurate.
- Make sure the HCP signs the original order within 72 hours.
    - Staff may administer a medication while waiting for the signature for the first 72 hours.

Provide the pharmacy contact information to the HCP. This helps to make sure the HCP submits the prescription to the right pharmacy. Call the pharmacy to see if the prescription was received. Ask when the medication will be ready for pick up or when it will be delivered.

Telehealth/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.

Although MAP allows Certified staff to take a telehealth/telephone order, some service providers do not. Ask your supervisor if the service provider you work for allows you to take a telehealth/telephone order. If so, ask where the telehealth/telephone order forms are kept at your work location.

Sample HCP Telehealth/Telephone Order Form

Site address:	**Site Telephone/Fax number:**
Date of telehealth/telephone order:	**Time of telehealth/telephone order:**
Name of person:	**Allergies**:
Date of Birth:	
Discontinue/Reason for Medication/Change:	
New order:	
Generic Name:	
Brand Name:	
Dose:	
Frequency:	
Route:	
Special Instructions/Precautions (include instructions for common side effects):	
If in a self-administering training program, include number of days person may package and hold:	
If vital signs are required, list guidelines:	
Date of next lab work (if any):	
HCP Name (print):	
HCP telephone number:	
HCP fax number:	
Staff Signature/Title:	**Date:**
Posted by:	**Date:** **Time:**
Verified by:	**Date:** **Time:**
HCP Signature:	**Date:**
Posted by:	**Date:** **Time:**
Verified by:	**Date:** **Time:**

Answer the following HCP Telehealth/Telephone Medication Order questions.

1. Are MAP Certified staff allowed to take a telehealth/telephone order? _____

2. What must you do to ensure you have taken the telehealth/telephone order correctly?

   _____

   _____

3. A telehealth/telephone order must be signed by the HCP within how many hours? _____

4. May this medication be administered before the HCP signs the order? _____

Exhausting a Current Supply of Medication

Sometimes there is an HCP order to change the dose or frequency of a person's current medication. Under certain conditions, it is acceptable to exhaust (use) the current supply of medication.

You must confirm with the MAP Consultant that the current supply of medication can be used with the new prescription. After confirming with the MAP Consultant, document the discussion on a progress note.

In addition, the following must be in place:

- A new HCP order reflecting the change.
  - The medication block for the old order is marked as discontinued on the medication sheet.
  - The new order is transcribed on to a medication sheet.
- The medication strength on hand allows for safe preparation.
  - Examples:
    - A 10mg dose is increased to a 20mg dose.
    - A frequency is changed from morning to night.
- The medication container has a 'directions change' sticker.
  - A brightly colored sticker may be used in place of a 'directions change' sticker.
    - The sticker is placed close to, but does not cover, the pharmacy label directions.
  - A 'directions change' sticker may only be used for a maximum of 30 days
- The 'current supply' of medication must be disposed when:
  - The 'current supply' of medication cannot be exhausted (used) and/or
  - The 'new supply' of medication ordered by the HCP is received from the pharmacy.

Note the ‘directions change’ sticker is placed close to, but does not cover, the original pharmacy label directions.

If you see a ’directions change’ or brightly colored sticker on a medication container, you will know there is a new HCP order. This means the information on the new HCP order and the information on the old pharmacy label will not agree until a new label is applied by the pharmacy.

Within 30 days of receiving the new HCP order, the pharmacy label must reflect the new HCP order.

HEALTH CARE PROVIDER ORDER

Name: Tanisha Johnson	**Date:** March 18, yr
Health Care Provider: Dr. Lee	**Allergies:** No Known Allergies
Reason for Visit: Tanisha has had a recent increase in seizure activity. See seizure data.	
Current Medications: Clonazepam 1mg twice daily, at 8am and 4pm by mouth Phenobarbital 64.8mg once daily in the evening by mouth	
Staff Signature: *Sam Dowd*	**Date:** March 18, yr
Health Care Provider Findings: Seizure data reviewed reflects an increase in seizure activity.	
Medication/Treatment Orders: DC Phenobarbital 64.8mg once daily in the evening by mouth Phenobarbital 97.2mg once daily in the evening by mouth	
Instructions:	
Follow-up visit: 3 months	**Lab work or Tests:** Phenobarbital level
Signature: *Dr. Chen Lee*	**Date:** March 18, yr

Posted: Sam Dowd Date: 3/18/yr Time: 2pm Verified: Linda White Date: 3/18/yr Time: 4pm

Note the medication supply being exhausted (used) on the previous page. Review the new HCP order above to answer the question below.

You will no longer administer 2 tablets once daily in the evening according to the directions on the pharmacy label. How many tablets will you now administer once daily in the evening? _____

Let's Review

- Preparation before an HCP visit helps to ensure a successful appointment.
- During an HCP appointment make sure:
    - The person participates in the appointment and/or you advocate for them, as needed.
    - You obtain new HCP orders that
        - include the 5 Rights of medication administration
        - are signed and dated by the HCP
            - electronic HCP signatures are acceptable
        - agree with prescriptions.
- If a prescription is obtained, make sure
    - The HCP sent new prescriptions or prescription refill requests to the correct pharmacy.
        - After the appointment, make sure medications are obtained from the pharmacy.
- 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.
- Prescriptions may be used in place of an HCP order.
- Changes are communicated to all staff involved in the person's care.
- Basic information needed for an Emergency Room visit, Urgent Care, and/or hospital admission:
    - Reason for visit
    - Current medication list
    - Insurance card
    - HCP Encounter/Consult/Order form
- Medication reconciliation before a hospital discharge is required.
    - Must be completed before the person leaves the hospital
- Fax and email orders are preferred instead of telehealth and telephone orders.
    - Telehealth and telephone orders:
        - Must be posted and verified twice
        - May be administered without the HCP signature for 72 hours
        - Must be signed by the HCP within 72 hours.
- A current supply of medication may be exhausted (used) if the strength of the tablet allows for safe preparation.

Unit 5

Obtaining, Storing and Securing Medication

Responsibilities you will learn

- The difference between an HCP order and a prescription
- How to make sure the pharmacy has supplied the correct medication
- What you do if the medication looks different from the last time it was obtained
- Where the medication storage keys are kept when in use and when not in use
- How to access the backup set of medication keys

Obtaining Medication

A current HCP order is required to administer medications and dietary supplements to people living at MAP registered sites. If there is no HCP order, you may not administer the medication.

HCP orders are instructions from the HCP for staff at the site. The instructions include the 5 Rights of medication administration. Staff use the HCP orders when giving medication.

Prescriptions are instructions submitted from the HCP to the pharmacist for all controlled and countable controlled medication ordered. The instructions include the medication to prepare and the directions for use. The pharmacist uses the information on the prescription to print the pharmacy label.

OTC medication has a 'Drug Facts' label. A dietary supplement has a 'Supplement Facts' label. To be labeled by the pharmacy, you must ask the HCP to submit a prescription.

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

- Electronic prescribing
- Telephone
- Although rare, an original paper prescription may be handed to you
    - or the person it is written for if self-administering[25]
        - to bring to the pharmacy.

[25] When the medication is under the complete control of the person.

At times, 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. The HCP order and the pharmacy label must agree. If the pharmacy supplies the generic form of the medication, the label must also include the brand name.

If the HCP orders the generic form of the medication, only the generic name needs to be on the pharmacy label.

Review the HCP order and note the brand name medication that is circled. The generic medication is substituted by the pharmacy. The corresponding pharmacy label on the next page has both the generic and brand names circled.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** June 1, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states that he has burning in his throat after eating.	
Current Medications: Zestril 40 mg by mouth once a day in the morning. Check blood pressure before administering medication. If systolic reading is less than 100, hold medication and notify HCP. Motrin 400 mg by mouth as needed every 8 hours for complaints of right knee pain. Notify HCP if right knee pain continues for more than 48 hours.	
Staff Signature: Sam Dowd	**Date:** June 1, yr
Health Care Provider Findings: Gastroesophageal reflux disease (GERD)	
Medication/Treatment Orders: Prilosec 20 mg by mouth once a day before supper	
Instructions: Remain upright 30 minutes after eating.	
Follow-up visit: 1 month	**Lab work or Tests:** None today
Signature: Richard Black, MD	**Date:** June 1, yr

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

Rx#174	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **6/1/yr**
David Cook **Omeprazole 20 mg** **IC Prilosec** **Take one tablet by mouth once a day before supper**		**Qty. 30**
Lot# 1436	**ED: 6/1/yr**	**Dr. Black** **Refills: 2**

Once the HCP orders a medication, the expectation is the person will receive the medication as ordered. There must be a system in place to ensure the medication is obtained from the pharmacy in a timely manner.

For example:

- You must contact the pharmacy to ensure the prescription was received. Once the medication has been prepared by the pharmacy, you must:
  - Pick up the medication at the pharmacy or
  - Confirm a date and time that the pharmacy will deliver the medication to the site.

Every site must have a method for obtaining medication from the pharmacy.
For example:

- You pick up new or refilled medication from the pharmacy.
- The pharmacy delivers new or refilled medication to the home.
- The pharmacy supplies automatic refills.

Medication may be delivered to the site while you are busy. If so, ask the driver to wait until you can accept the delivery. Verify the contents against the ordering and receiving log, and then sign for the medication.

Ask your supervisor what method your work location uses to obtain medication refills from the pharmacy.

Sometimes a medication is ordered by the HCP and there is a delay in obtaining it from the pharmacy. Reasons for the delay can include:

- Prior authorization[26] is needed from an insurance company.
- Guardian consent is required.
- An antipsychotic medication prescribed requires court approval under a Rogers Decision.

If there is a delay, you must contact the HCP immediately. You will obtain HCP orders saying what should be done until the medication is obtained.

There are times when a new medication is ordered, and the pharmacy used by your work location is closed. Ask your supervisor which pharmacy is to be used instead.

Antipsychotic medications are used to decrease symptoms of mental illness. These medications cause side effects.

Rogers Decision

In November 1983, the Massachusetts Supreme Judicial Court issued a decision that is called the 'Rogers Decision'. This gave people who take antipsychotic medications new rights. The rights help protect them from the overuse of these medications. In addition, the maximum daily dose that an HCP can order is limited.

Ask your supervisor if there are HCP orders for antipsychotic medications requiring a Rogers Decision at your work location.

[26] Approval

Pharmacy Label Components

Medication received from the pharmacy may be packaged in a

- Prescription bottle
- Container
- Tamper resistant package, such as a blister pack.

Whatever the packaging, it must be labeled by the pharmacy.

The pharmacy label usually contains the following information:

1. Prescription Rx number (Rx is an abbreviation for medical prescriptions, used to obtain refills)
2. Pharmacy name and address
3. Pharmacy telephone number (used to contact the pharmacy or a pharmacist)
4. Name of the person
5. Date the medication was dispensed
6. Name of the medication
    a. Generic and/or
    b. Brand
7. Strength of medication supplied (how much medication is in each tablet, capsule or mL supplied)
8. Total amount of medication dispensed (number of tablets, capsules, or mL in the container)
9. Amount of tablets, capsules, or mL 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 (A number that is assigned to each batch of medication produced. All medication from the same batch shares the same lot number)
15. Expiration date (the last date the medication may be administered). Usually, the words expiration date are abbreviated on a label as ED or Exp. Examples of other words that may be printed on a pharmacy label instead of 'expiration date' include:
    a. 'Discard After' or 'Use By,' followed by the date
16. Number of refills (how many remaining times the medication may be obtained from the pharmacy)

Number the pharmacy label items below with the corresponding pharmacy label components (numbered 1-16) listed on the previous page.

☐ Rx # C201 ☐ Greenleaf Pharmacy 20 Main Street Treetop, MA 00000 ☐ 111-222-3434

☐ 3/4/yr

☐ David Cook

☐ Tramadol ☐ 50mg

☐ IC Ultram

☐ Qty. 21

Take ☐ 1 tablet ☐ by mouth ☐ every 8 hours for 7 days

☐ Take with water ☐ Dr. Black

☐ Lot # 776-5433 ☐ ED: 3/4/yr ☐ Refills: 0

Often you learn about medication recalls on the news. If you do, contact the pharmacy with the medication name and follow the pharmacist's advice.

Answer the following questions by choosing the best response.

1. The expiration date on a pharmacy label is the

   A. ___ Date the pharmacy last filled the prescription
   B. ___ Date the prescription was purchased at the pharmacy
   C. ___ Last date the medication may be administered
   D. ___ Last date to call in a refill

2. The Rx number is used to obtain a

   A. ___ New HCP order
   B. ___ Renewal of the prescription
   C. ___ Medication refill
   D. ___ Newly prescribed medication

3. There is a 7-day supply of medication available. What do you need to refill the medication before it runs out?

   A. ___ Lot number
   B. ___ Generic name
   C. ___ Expiration date
   D. ___ Rx number

4. The pharmacy telephone number can be used for many reasons. Check all that apply:

   A. ___ Determine when a medication will be delivered to the site
   B. ___ Call in medication refills
   C. ___ Determine when a medication will be available for pick up
   D. ___ Ask about possible medication interactions and/or side effects
   E. ___ Ask if the strength of tablet on hand may be used with a change in a medication order

Remember, it is your responsibility to learn about a medication before you administer it. The pharmacist and the medication information sheet are both excellent resources for medication information.

Ensuring the Pharmacy Provides the Correct Medication

One of your most important responsibilities is to make sure the pharmacy supplied the medication as ordered by the HCP. This is one of the critical medication-related tasks that helps to make sure you administer medications safely.

As soon as the medication is obtained:

- Compare the 5 Rights on the HCP order to the 5 Rights on the pharmacy label
    - then to the 5 Rights on the medication sheet.

The 5 Rights must agree between the HCP order, the pharmacy label, and the medication sheet.

When comparing the 5 Rights to make sure the pharmacy supplied the correct medication, you will:

Locate the person's name:

- Written on the HCP order
- Printed on the pharmacy label and
- Transcribed on the medication sheet.

If the names are different, you will contact a MAP Consultant.

Locate the medication name(s):

- Written on the HCP order
- Printed on the pharmacy label and
- Transcribed on the medication sheet.

If the medication names are different, you will contact a MAP Consultant.

Locate:

- the dose written on the HCP order,
- the strength of the tablet and the amount to administer printed on the pharmacy label and
- the dose, strength and amount transcribed on the medication sheet.

If the dose does not agree, you will contact a MAP Consultant.

Locate the frequency:

- Written in the HCP order
- Printed on the pharmacy label
- Transcribed on the medication sheet.

If the frequencies are different, you will contact a MAP Consultant.

Locate the route:

- Written in the HCP order
- Printed on the pharmacy label
- Transcribed on the medication sheet.

If the routes are different, you will contact a MAP Consultant.

Many medications come in different formulations that have similar names.

For example:

- Depakote DR (Delayed Release)
- Depakote EC (Enteric Coated)
- Depakote ER (Extended Release)

These are different forms of Depakote that can be easily confused. Make sure that the HCP order, pharmacy label and medication sheet match for the specific medication formulation.

Compare the 5 Rights between the HCP order and the pharmacy label of the medication supplied by the pharmacy. Do the 5 Rights agree? ___ If no, why not?

_____

HEALTH CARE PROVIDER ORDER

Name: Scott Green	**Date:** March 3, yr
Health Care Provider: Dr. Glass	**Allergies:** No Known Allergies
Reason for Visit: Annual physical exam	
Current Medications: See attached medication list.	
Staff Signature: Tom Salowsky	**Date:** March 3, yr
Health Care Provider Findings: Start Aspirin EC as preventive measure secondary to diabetes.	
Medication/Treatment Orders: Aspirin EC 81mg by mouth once daily in the morning	
Instructions:	
Follow-up visit:	**Lab work or Tests:** CMP and CBC
Signature: Shirley Glass MD	**Date:** March 3, yr

Rx #555	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **3/3/yr**
Scott Green		
Aspirin 81mg		**Qty. 30**
Take 1 tablet by mouth once daily in the morning		**Dr. Glass**
Lot# 777	**ED: 3/3/yr**	**Refills: 5**

Compare the 5 Rights between the HCP order and the pharmacy label of the medication supplied by the pharmacy. Do the 5 Rights agree? ___ If not, why not?

_____

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** March 3, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states he has 'trouble going' when having a bowel movement.	
Current Medications: See attached medication list.	
Staff Signature: Sam Dowd	**Date:** March 3, yr
Health Care Provider Findings: constipation	
Medication/Treatment Orders: Colace 200mg by mouth once daily in evening	
Instructions:	
Follow-up visit:	**Lab work or Tests:** None
Signature: Richard Black, MD	**Date:** March 3, yr

Rx #201	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **3/3/yr**
David Cook		
Docusate sodium 100mg **IC Colace**		**Qty. 60**
Take 2 tablets by mouth every evening at 8pm		
		Dr. Black
Lot# 463	**ED: 3/3/yr**	**Refills: 5**

Look at the medication. The pharmacy may purchase the same medication from different pharmaceutical companies. Depending on the pharmaceutical company used, the same medication may look different. The medication may be different in color, shape, size, or markings from the last time it was filled. If so, you must contact the MAP Consultant before administering it.

The strength of a tablet must allow the correct dose to be administered. Otherwise, you must return the medication to the pharmacy and obtain the correct strength. For example, if the dose ordered is 75mg and the pharmacy provides 50mg tablets, the medication cannot be given. You must return the 50mg tablets to the pharmacy and obtain the correct strength.

Pharmacy labels usually include a description of the medication on the container. If included, read the description of the medication, and compare it to the medication in the container.

Also, you must check the strength of tablet supplied. It may have changed from the last time the medication was obtained.

A person has an HCP order for Topiramate 100mg twice daily. The pharmacy had been supplying Topiramate 25mg tablet (round and white) with instructions to give 4 tablets twice daily. The following month's refill was obtained. The pharmacy supplied Topiramate 100mg tablet (round and pink), with instructions to give 1 tablet twice daily.

1. What could happen if you did not read the label closely to see the strength and amount had changed? _____
2. In addition to the label directions changing, what is different about the appearance of the tablet? _____

The pharmacy label directions may change. For example, when a different strength tablet is supplied by the pharmacy. The current transcription on the medication sheet must be marked through. This indicates that the transcription was rewritten to reflect the pharmacy label changes. See example below:

Start	Generic **Lisinopril**	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand **Zestril**	8am	WS	AS	JC	WS																											
	Strength **10mg** Dose **30mg**																																
Stop	Amount **3 tabs** Route **Mouth**																																
Cont.	Frequency **Daily in the morning**																																

Rewritten See Below 5-4-Yr SD

Rewritten See Below 5-4-Yr SD

Special instructions: *Reason:* **high BP**

Start	Generic **Lisinopril**	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand **Zestril**	8am	X	X	X	X																											
	Strength **30mg** Dose **30mg**																																
Stop	Amount **1 tab** Route **Mouth**																																
Cont.	Frequency **Daily in the morning**																																

Special instructions: *Reason:* **high BP**

When to Request a Medication Refill

A medication refill is getting more of the same medication from the pharmacy. The number of refills left appears on the pharmacy label. This number indicates how many times the medication can be refilled from the pharmacy. If you see numbers 1,2,3, etc. on the label, that means you can get that number of refills from the pharmacy. A medication refill should be requested when there is no less than a 7-day supply of medication remaining. To determine a 7-day supply, you must review:

- The dose and frequency in the HCP order
- The pharmacy label to know the strength of the tablet supplied
- The total amount of tablets needed to administer daily.

This will make sure medication is available to administer as ordered.

A refill may not arrive with the pharmacy delivery as expected. If so, immediately contact the pharmacy to determine when the medication will be received.

When the last medication refill is obtained, the number of refills on the pharmacy label will read '0'. You must immediately contact the person's HCP, and request a new prescription be submitted to the pharmacy. Contacting the HCP immediately will allow 30 days for the HCP to send a prescription to the pharmacy.

Class Discussion

Juanita Gomez has an HCP order for Phenytoin 200mg twice daily by mouth. The pharmacy supplies the medication in 100mg strength capsules. Look at the medication package and answer the following questions.

1. How many capsules are needed for a 30-day supply? _____
2. How many capsules are currently in the package? _____
3. How many capsules would you expect to see if there was a 7-day supply left in the package? _____
4. Is it time to request a refill? _____
5. Why or why not? _____
6. How many capsules should there be in the package when you request a refill? __
7. Why is it important to order a refill when a 7-day supply remains instead of a 3-day supply? _____

Tracking Medication

All medication obtained from the pharmacy must be tracked. All sites must maintain a record of:

- When a prescription is ordered
- When a prescription is filled, and
- The quantity of medication dispensed by the pharmacy.

This is documented using a Medication Ordering and Receiving Log.

Medications are also documented and tracked using:

- Pharmacy receipts
- Count Book
- Medication sheets
- Medication release documents such as
    - Leave of Absence (LOA) form
        - when medication is administered away from a site
    - Transfer Form
        - when medication is moved from one location to another
- Disposal records

Medication Storage and Security

The following are medication storage requirements, including liquid and refrigerated[27] medication:

- All medication is key locked.
- Countable medication must be:
    - Double key locked
        - This means a key lock within a key lock.
    - 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.
        - Some liquid countable medication is packaged by the manufacturer in the specific dose ordered.
        - If not, the pharmacy must prepare a single dose of liquid countable medication into an oral dosing syringe. Each syringe must have a tamper resistant seal.

- 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.
- A medication supply will run low. Do not mix the supply of medication in the current bottle with the new supply of medication. Each medication should remain in its own container.
- Each person must have their own medication storage container with their full name.
- Medication taken by mouth must be separated from medication taken by other routes. For example, use different shelves or different storage containers. This will help decrease the chance of a medication being administered by the wrong route.
- The medication storage/preparation area should have minimal distractions. This will help you to remain mindful while preparing medication for administration.
    - Avoid distractions from other people.

[27] Medication that must be kept in the refrigerator.

    - Turn off your cell phone.
- Store medication away from:
    - food and/or toxic substances such as household cleaners
    - excessive heat, moisture and/or light; these factors can result in the medication becoming less effective.


Ask your supervisor where medications requiring refrigeration are stored at your work location.


You must carry the medication storage keys when you are assigned medication administration duties.


There must also be a backup set of keys in the event there is an issue with the first set. Only administrative staff can access the backup keys. An administrative staff person is someone who usually does not work at the site.

For example:

- There are two combination locked boxes located at the site.
    - Each ‘box’ contains a set of medication keys.
- The combination to the 1st box is known only to MAP Certified staff at the site.
- The combination to the 2nd box is known only to administrative staff.
- In the event there is an issue with the 1st set of keys.
    - MAP Certified staff calls the administrative staff for the combination.
    - The combination must be changed afterwards by administrative staff.


Ask your supervisor how to access the backup set of keys at your work location, if needed.

Let's Review

- An HCP order is required to administer all medication and dietary supplements.
- The HCP must provide a prescription for each controlled and countable controlled medication.
- The HCP must also provide a prescription for each OTC and dietary supplement ordered if it is to be labeled by the pharmacy.
- The pharmacist uses the prescription to prepare and label medication.
- Medication must remain in the packaging received from the pharmacy.
- You must compare what is received from the pharmacy to make sure it agrees with what the HCP ordered.
    - This is one of the critical medication-related tasks to help make sure medications are administered safely.
- When medication is received from the pharmacy:
    - you must check the color, shape, size and/or markings of the medication
        - if different from the last time it was obtained
            - a MAP Consultant must be contacted.
- Check to see if the strength of the tablet received has changed from the last refill.
- Request medication refills when there is no less than a 7-day supply left.
- All medications must be key locked.
- All countable medications must be:
    - Double key locked
    - In tamper resistant packaging
    - Tracked
    - Counted.
- Medication storage keys must remain on the person assigned medication administration duties for the shift.
- Backup keys are accessed only through contact with administrative staff.

Unit 6

Recording Information

Responsibilities you will learn

- The purpose of a medication sheet
- How to transcribe information from an HCP order and pharmacy label onto a medication sheet
- Acceptable abbreviations for use on a medication sheet
- How to 'Post and Verify' an HCP order
- The importance of monthly accuracy checks

Recording information is the process of documenting or writing down information.

To **transcribe** is to copy information from one document and record it onto another document. The completed document is a **transcription**. You will transcribe 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.

You must receive specialized training to be authorized to:

- Transcribe
- Post and verify HCP orders
- Complete monthly accuracy checks of HCP orders.

This specialized training is specific to a Service Provider's Transcription of Medication Management System (TMM System). Ask your supervisor if you will receive training in the TMM System for your work location.

The Medication Record

A medication record typically contains:

- Emergency Fact Sheets (EFS)
- HCP Orders
- Medication Sheets
    - Medication Progress Notes (usually found on the back of medication sheets)
- Medication Information Sheets

The terms Medication Record and Medication Book are used interchangeably.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** March 3, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states his 'head hurts' and he has had a runny nose for 2 days, temperature is 100.3.	
Current Medications: Amoxil 500mg three times daily for 10 days by mouth Also, see attached medication list.	
Staff Signature: *Kay Mathers*	**Date:** March 3, yr
Health Care Provider Findings: Sinus infection	
Medication/Treatment Orders: DC Amoxil EES 666mg three times daily for 10 days by mouth	
Instructions: Call HCP if temperature remains elevated above 100.3 for more than 48 hours.	
Follow-up visit:	**Lab work or Tests:** None today
Signature: Richard Black, MD	**Date:** March 3, yr

Posted by: Date: Time: Verified by: Date: Time:

Pharmacy Label

Rx # 156 Greenleaf Pharmacy 111-222-3434
20 Main Street
Treetop, MA 09111 3/3/yr

David Cook
Erythromycin 333mg
IC EES Qty.60
Take 2 tablets by mouth three times daily for 10 days

Dr. Black
Lot # 14239 ED: 3/3/yr Refills: 0

Month and Year: **MEDICATION ADMINISTRATION SHEET** **Allergies:**

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Name: **Site:**	**CODES**	**CODES**			**Signature**
	DP-day program/day hab	**A-absent**			
	LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**			
	P-packaged	**OSA-off site administration**			
	W-work	**MNA-medication not administered**			
	H-hospital, nursing home, rehab center		**Signature**		
	S-school				
	V-vacation				

Accuracy Check 1 __________________ Date ___________ Time __________ Accuracy Check 2 __________________ Date __________ Time __________

To transcribe a new medication order, you will be using the HCP order, the pharmacy label, and the medication sheet.

Abbreviations

An abbreviation is a shortened form of a word or phrase. There are many abbreviations used in the health care profession. However, there are only a few abbreviations you are allowed to use at a MAP site. When transcribing onto a medication sheet, the following abbreviations are acceptable for use:

- Cont.- continue
- DC - discontinue
- am - morning
- pm - afternoon or evening
- cap - capsule
- tab - tablet
- gm - gram
- mg - milligram
- mcg - microgram
- IU or units - international unit
- mL - milliliter
- mEq - milliequivalent
- PRN - as needed
- IM - intramuscular
- ODT - orally dissolving tablet
- Subcut - subcutaneous

True (T) or False (F)

1. ___ Only acceptable abbreviations may be used on the medication sheet.
2. ___ Each site may create their own list of acceptable abbreviations.
3. ___ The abbreviation pm can indicate either afternoon or evening.
4. ___ The abbreviation for milligram is mL.
5. ___ PRN is the abbreviation for as needed.

Medication Sheet

The medication sheet is an essential component of the Medication Record. The medication sheet is a document that tracks the administration of medications. All HCP orders must be transcribed onto a medication sheet.

Each time you administer a medication, you will document your initials on the medication sheet. This means you have administered the medication as ordered. At the end of each month:

- The completed medication sheets are removed from the medication book.
    - These medication sheets are filed in the person's health record.
- The new month's medication sheets are inserted.

Other terms used for a medication sheet include:

- Med sheet
- Medication administration sheet
- Medication administration record (MAR) and/or
- Medication log.

Month and Year **MEDICATION ADMINISTRATION SHEET** **Allergies:**

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strengt	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strengt	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strengt	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strengt	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

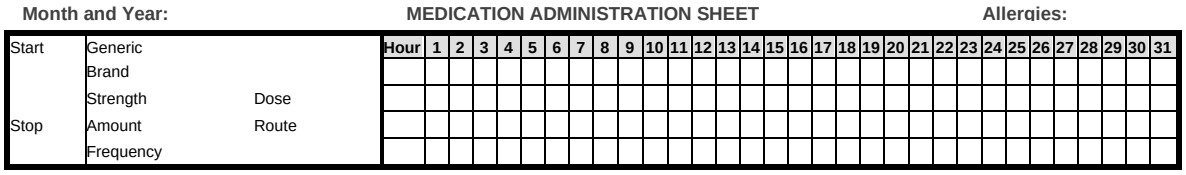
	CODES	**CODES**			**Signature**
Name:	**DP-day program/day hab**	**A-absent**			
	LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**			
Site:	**P-packaged**	**OSA-off site administration**			
	W-work	**MNA-medication not administered**			
	H-hospital, nursing home, rehab center		**Signature**		
	S-school				
	V-vacation				

Accuracy Check 1 __________________ Date ___________ Time __________ Accuracy Check 2 __________________ Date __________ Time __________

A Detailed View of the Medication Sheet

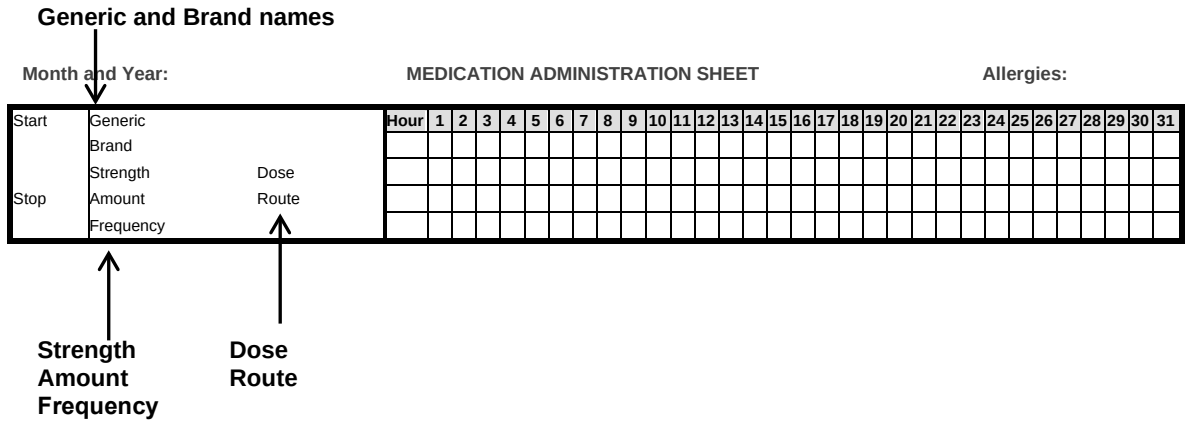
The top of the medication sheet includes the:

- Current month and year
- Allergies



The left side (medication block) of the medication sheet has an area to write:

- Generic and brand medication names
- Strength of the medication
- Amount of medication to administer
- Frequency or how often the medication is to be administered
- Dose of the medication
- Route by which the medication is to be administered
- Start date
- Stop date

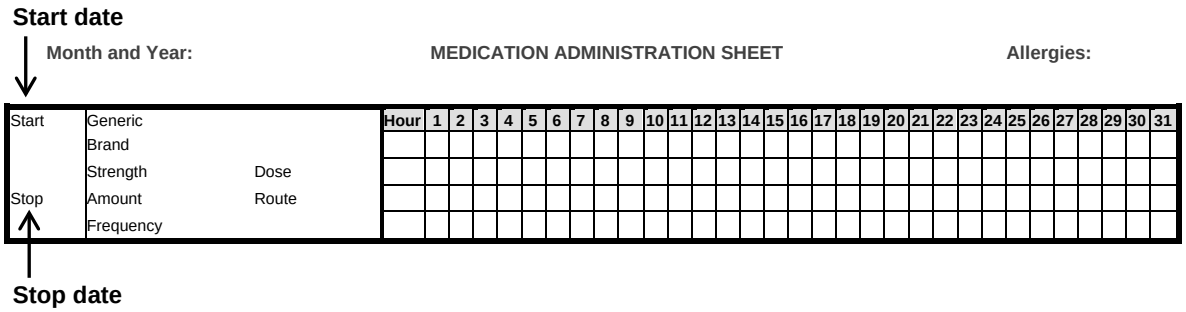


Start Date and Stop Date

A start date is the date the person receives the first dose of a medication. Start dates are used to monitor how long a person has been receiving a medication without any changes to the HCP order. If a person has been receiving a medication for a long time, without the HCP order changing, the start date may be several years old.

A stop date is used to identify the date when:

- The last dose of a time-limited medication is administered, such as an antibiotic that is administered for only 7 days or
- If the medication is not time-limited and will be given on an ongoing basis, the stop date can be documented as 'Cont.' (continue).

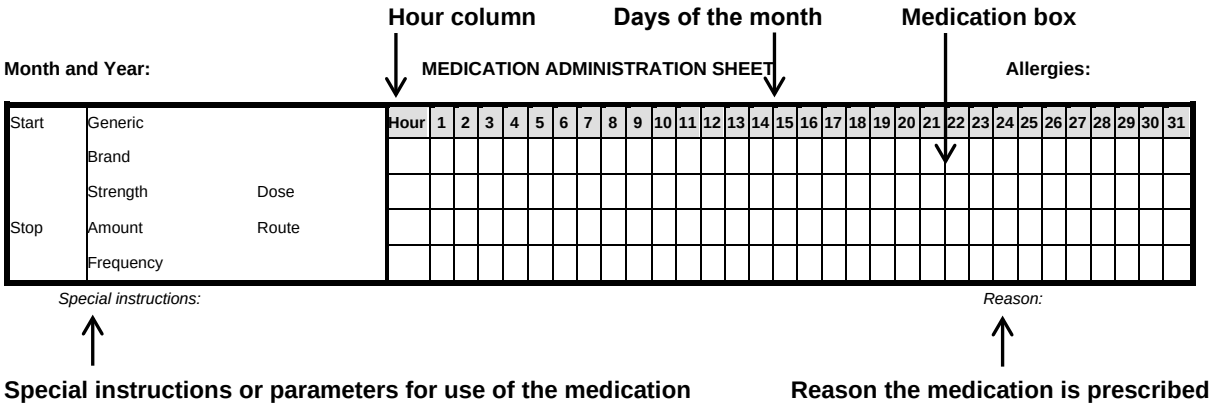


Medication Grid

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 prepared and administered the medication as ordered.

Across the top of the grid are the numbers 1-31. These are the days of the month. Specific times will be written in the hour column to indicate when the medication is to be administered.

The reason for the medication (as noted in the HCP order) and/or any special instructions, are written under the medication grid.



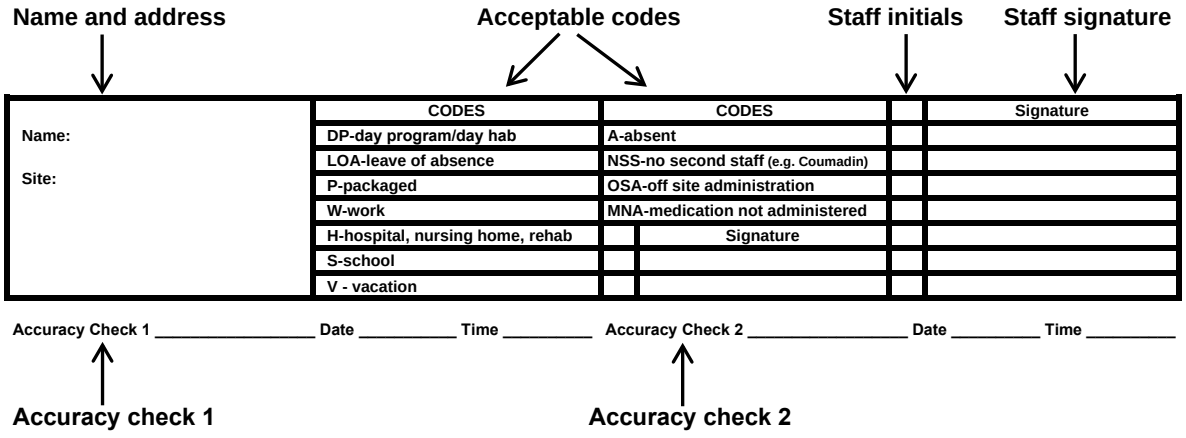

The reason a medication is ordered must be documented on the order by the prescribing HCP. If the reason does not change, historical HCP documentation stating the reason for the medication is acceptable.

The bottom of the medication sheet includes the:

- Person's name
- Address
- List of acceptable 'codes' for use on the medication sheet
- Signature list
    - Each staff must initial and sign the signature list. This identifies their initials with their full name anytime initials are used on a medication sheet.
        - For example:
            - You will initial and sign the signature list once for the month the first time you administer medication or
            - If you make any changes to the medication sheet, such as when discontinuing a medication.

- Accuracy Checks
    - Prior to the first medication administration of the new month, 2 staff (preferably together):
        - Check the new month's medication sheets for accuracy
            - Using the HCP orders and pharmacy labels
            - To make sure that the orders were transcribed correctly onto the new month's medication sheets
            - To make sure other information that is part of the medication sheet is also transcribed correctly e.g., allergies, month, year etc.
        - During the accuracy check, if you see incorrect information copied from the HCP order or the pharmacy label onto the medication sheet
            - The entire transcription must be marked through as an error and rewritten.
        - Also review the current month's medication sheets
            - To make sure all ongoing transcriptions were copied onto the new medication sheets.
    - Documentation of a completed accuracy check includes:
        - Your full signature
        - The date
        - The time completed.

Accuracy check documentation indicates that the new medication sheets are complete and correct. Accuracy checks are a critical medication-related task.



Accuracy checks may be completed several days prior to the start of the new month. Staff must double check before the first medication administration of the new month to make sure no changes occurred after the checks were completed.

Acceptable Codes on a Medication Sheet

A code is a set of letters created as an acceptable abbreviation of a longer phrase or sentence. The code describes:

- A specific medication responsibility
- A change in medication responsibility
- The responsibility for the medication administration to be done away from the person's home
- When a medication is not administered.

The following is the list of Acceptable Codes:

- A - **a**bsent from site (Used when medication is not administered due to unauthorized reasons beyond staff's control. This is used if the person left the program without agreement or supervision. Or, if the person did not return as planned without agreement or supervision during medication administration time.)
- DP - **d**ay **p**rogram/day habilitation (Used when a person's medication responsibilities are transferred to a day program or a day habilitation program.)
- H - **h**ospital, nursing home, rehab center, respite (Used when a person's medication responsibilities are transferred to a hospital, nursing home, rehabilitation center, respite, etc.)
- LOA - **l**eave **o**f **a**bsence (Used when medication is transferred to family/guardian/responsible party for administration while on leave of absence.)
- MNA - **m**edication **n**ot **a**dministered (Used when medication is not administered at the scheduled time. Examples include if the medication is not available, the medication is held when ordered parameters are met, the person refuses the medication, etc. A medication progress note must be documented when MNA is used to explain why the medication was not administered and any follow up actions taken.)
- NSS - **n**o **s**econd **s**taff (Used specific to a medication that requires dose verification[28] prior to administration by a second staff, such as Warfarin sodium. This indicates there is no second staff available.)
- OSA - **o**ff-**s**ite **a**dministration (Used when medication is administered by Certified staff at an off-site location, such as the movies, a community outing, etc.)
- P - **p**ackaged (Used when a person packages or administers their own medication under Certified/licensed staff supervision. This code is used when a person is learning to self-administer their medication.)
- S - **s**chool (Used when a person's medication responsibilities are transferred to a school or after school program.)

[28] Double-checking the dose.

- V - **v**acation (Used when medication is to be administered by Certified staff when the staff accompanies a person on a planned vacation.)
- W - **w**ork (Used when medication is to be administered by Certified staff at a person's work location.)

Only acceptable codes may be used on the medication sheet to identify when:

- A medication is administered at a location other than the person's home
- The person is learning to self-administer their medication
- The person is not present during the medication administration time
- A medication is not administered.

When the person leaves day program to go to work during the scheduled medication administration time:

- Day program staff document 'OSA' on the medication sheet.
- Residential staff document 'W' on the medication sheet.

Based on each scenario, fill in the acceptable code that you would use on the medication sheet.

You are a day program staff with medication administration duties:

1. ____A person did not attend day program because they are on vacation.
2. ____A person is scheduled to receive medication at their off-site work location.

You are a residential site staff with medication administration duties:

1. ____A person is with staff at the beach.
2. ____A person is at day program.
3. ____A person is at their family's home over the weekend.
4. ____A person is not in their home during medication administration time because the person left the site without supervision.
5. ____One person is away in Florida for the week with another Certified staff.
6. ____A person is at work.

 If you use an acceptable code on a medication sheet, the code and its meaning must be listed on that medication sheet.

Recorded Information on a Medication Sheet: Transcription

Before you administer a medication, the information from the HCP order and the pharmacy label must be transcribed onto the medication sheet.

The following information must be transcribed onto the medication sheet:

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

 Whether or not a person has allergies, the allergy section on the medication sheet must be completed. This is so that HCPs and other staff will know this section was not overlooked.

Use the list of terms on the previous page to complete this exercise. Write the number of the term (1-14) next to the information that has to be transcribed below.

Month and Year: **MEDICATION ADMINISTRATION SHEET** **Allergies:**

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

	CODES		**CODES**			**Signature**
Name:	**DP-day program/day hab**		**A-absent**			
	LOA-leave of absence		**NSS-no second staff (e.g. Coumadin)**			
Site:	**P-packaged**		**OSA-off site administration**			
	W-work		**MNA-medication not administered**			
	H-hospital, nursing home, rehab center		**Signature**			
	S-school					
	V-vacation					

Accuracy Check 1______________ Date_______ Time________

Accuracy Check 2 ______________ Date_______ Time________

Depending on the pharmacy used by your work location, you may see 'pharmacy generated medication sheets.' The pharmacy pre-prints all of the information from the HCP order and pharmacy label onto the medication sheets.

- If your site uses pharmacy generated medication sheets, you are still responsible for:
    - Verifying that all information is accurate.
        - You must compare the HCP order and pharmacy label
            - to what is pre-printed on the medication sheet.
    - Transcribing a new HCP order when received during the month
        - Using a blank space on the medication sheet.
            - You cannot rely on the pharmacy to provide a pre-printed medication sheet for the new order.

Frequency

'Frequency' and the word 'time' are used interchangeably. Most HCPs will not order an actual time to administer the medication. Instead, the HCP will order how many times per day a medication is to be administered or the time between doses. For example:

- Twice daily
- Three times daily
- Once daily before bedtime
- Three times daily after meals
- Every 6 hours
- Every 12 hours
- PRN every 12 hours

Based on a person's daily schedule, specific medication administration times are chosen by your supervisor. Times will vary from site to site or person to person. Each site must have a medication administration time schedule. In general, unless otherwise indicated by the HCP, medication dose times should be scheduled at least 4 hours apart.

Ask your supervisor what the medication administration time schedule is specific to your work location.

HCP orders for ‘once daily’ medications must be further clarified. The order must include which portion of the day the medication should be administered. For example:

- Once daily in the am (morning)
- Once daily after lunch
- Once daily before bedtime
- Once daily in the pm (afternoon or evening)

This is to make sure that ‘once daily’ medications are given at an appropriate time of day. For example, some medications may cause sleepiness. Administering a medication that may cause sleepiness in the evening is a safer option than administering it in the morning.

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.

Once daily at 4pm

Hour
4pm

Twice daily

Hour
8am
8pm

Three times daily

Hour
8am
4pm
8pm

Four times daily

Hour
8am
12pm
4pm
8pm

PRN every 12 hours

Hour
P
R
N

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.

For example:

Sally’s HCP writes an order for Depakote 250mg daily at bedtime by mouth. Sally's typical bedtime is 9pm. When transcribing the HCP order, remember that you must assign the medication administration time. The time is documented in the hour column on the medication sheet. In this example, 9pm is documented in the hour column to indicate Sally’s preferred bedtime using the bottom ‘pm’ hour box.

Hour
9pm

1. Tim's HCP writes an order for Depakote 500mg daily at bedtime by mouth. His typical bedtime is 10pm. Document the time chosen in the hour column using the appropriate hour box.

Hour

2. Andrew's HCP writes an order for Omeprazole 20mg daily thirty minutes before breakfast by mouth. His typical breakfast time is 8am. Document the time chosen in the hour column using the appropriate hour box.

Hour

Sometimes, the HCP may want a medication to be administered at a specific time. In is the case, the HCP will order the specific time, such as:

- Once daily at 6:30pm
- Twice daily at 10am and 7pm

When the HCP orders a specific time, it is transcribed in the hour column on the medication sheet. The time the HCP has chosen must be used, even if this time varies from the site's medication administration time schedule.

1. Kevin's HCP writes an order for Aspirin 81mg daily at 4pm by mouth. Document the time in the hour column using the appropriate hour box.

Hour

2. Mary Alice's HCP writes an order for Depakote 250mg twice daily, at 8am and 8pm by mouth. Document the times in the hour column using the appropriate hour boxes.

Hour

Medications ordered as PRN do not have a specific time in the hour column. Instead, PRN is documented in the hour column.

1. Joe's HCP writes an order for Tylenol 650mg every 6 hours by mouth PRN headache. What will you document in the hour column?

Hour

Match the term(s) to the corresponding definition.

1.	___	Start Date	A	Used when a medication is not administered
2.	___	Special Instructions	B	Placed in a medication box to indicate you have administered the medication as ordered
3.	___	Hour Column	C	The days of the month
4.	___	Numbers 1-31	D	Why the medication was ordered
5.	___	Reason	E	The date the person is scheduled to receive the first dose of a medication
6.	___	Stop Date	F	Location of the specific time a medication is to be administered
7.	___	Staff Initials	G	Guidelines or parameters specific to administration of the medication
8.	___	Acceptable Codes	H	The date when the last dose of a time limited medication is scheduled to be administered

Transcribing a New HCP Order

When transcribing a new HCP order onto the medication sheet, always start with the first order written. Complete each new order without skipping orders in the process. This will help to make sure all orders are transcribed.

David Cook was seen by the HCP. Orders were written and medication obtained from the pharmacy. The date is March 3rd, yr. The time is now 1pm. Review the following example of how the information from the HCP order and pharmacy label is transcribed onto the medication sheet.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** March 3, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states his "head hurts" and he has had a runny nose for 2 days, temperature is 100.3.	
Current Medications: Amoxil 500mg three times daily for 10 days by mouth Also, see attached medication list.	
Staff Signature: Sam Dowd	**Date:** March 3, yr
Health Care Provider Findings: Sinus infection	
Medication/Treatment Orders: DC Amoxil EES 666mg three times daily for 10 days by mouth	
Instructions: Call HCP if temperature remains elevated above 100.3 for more than 48 hours.	
Follow-up visit:	**Lab work or Tests:** None today
Signature: Richard Black, MD	**Date:** March 3, yr

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

The first HCP order states, 'DC Amoxil.'

Discontinuing a Medication
When the HCP orders a medication or treatment to be stopped, it is called discontinuing. The process is usually abbreviated as D/C or DC.
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. A series of xxxxx's or a straight line ——— may be used.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic **Amoxicillin**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2/28/yr	Brand **Amoxil**		8am	SW	4S	SW	—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **250mg**	Dose **500mg**																															
Stop	Amount **2 tabs**	Route **Mouth**	4pm	TM	JS		—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3/10/yr	Frequency **Three times daily**		8pm	TM	JS		—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **for 10 days** *Reason:* **sinus infection**

2. Draw a diagonal line through the left side, written portion, of the medication sheet and document: DC, the date, and your initials.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic **Amoxicillin**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2/28/yr	Brand ~~**Amoxil**~~ DC 3/3/yr SD		8am	SW	4S	SW	—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **250mg**	Dose **500mg**																															
Stop	Amount **2 tabs**	Route **Mouth**	4pm	TM	JS		—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3/10/yr	Frequency **Three times daily**		8pm	TM	JS		—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **for 10 days** *Reason:* **sinus infection**

3. Draw a diagonal line through the right side, grid section, of the medication sheet and document: DC, the date, and your initials.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic **Amoxicillin**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2/28/yr	Brand ~~**Amoxil**~~ DC 3/3/yr SD		8am	SW	4S	SW	—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **250mg**	Dose **500mg**					DC 3/3/yr SD																										
Stop	Amount **2 tabs**	Route **Mouth**	4pm	TM	JS		—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3/10/yr	Frequency **Three times daily**		8pm	TM	JS		—	—	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **for 10 days** *Reason:* **sinus infection**

The next order you transcribe is the new medication, EES.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** March 3, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states his "head hurts" and he has had a runny nose for 2 days, temperature is 100.3.	
Current Medications: Amoxil 500mg three times daily for 10 days by mouth Also, see attached complete medication list.	
Staff Signature: Sam Dowd	**Date:** March 3, yr
Health Care Provider Findings: Sinus infection	
Medication/Treatment Orders: DC Amoxil → EES 666mg three times daily for 10 days by mouth	
Instructions: Call HCP if temperature remains elevated above 100.3 for more than 48 hours.	
Follow-up visit:	**Lab work or Tests:** None today
Signature: Richard Black, MD	**Date:** March 3, yr

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

Rx # 156 **Greenleaf Pharmacy** **111-222-3434**
20 Main Street
Treetop, MA 09111 **3/3/yr**

David Cook

Generic → **Erythromycin 333mg**

Brand → **IC EES** **Qty.60**

Take 2 tablets by mouth three times daily for 10 days

Dr. Black

Lot # 14239 **ED: 3/3/yr** **Refills: 0**

When transcribing information onto the medication sheet, it is important to copy the dose from the HCP order. The strength and amount must be copied from the pharmacy label.

The dose from the HCP order is copied next to the word dose on the medication sheet.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** March 3, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states his 'head hurts' and he has had a runny nose for 2 days, temperature is 100.3	
Current Medications: Amoxil 500mg three times daily for 10 days by mouth Also, see attached complete medication list.	
Staff Signature: Sam Dowd	**Date:** March 3, yr
Health Care Provider Findings: Sinus infection	
Medication/Treatment Orders: DC Amoxil Start EES 666mg three times daily for 10 days by mouth	
Instructions: Call HCP if temperature remains elevated above 100.3 for more than 48 hours	
Follow-up visit:	**Lab work or Tests:** None today
Signature: Richard Black, MD	**Date:** March 3, yr

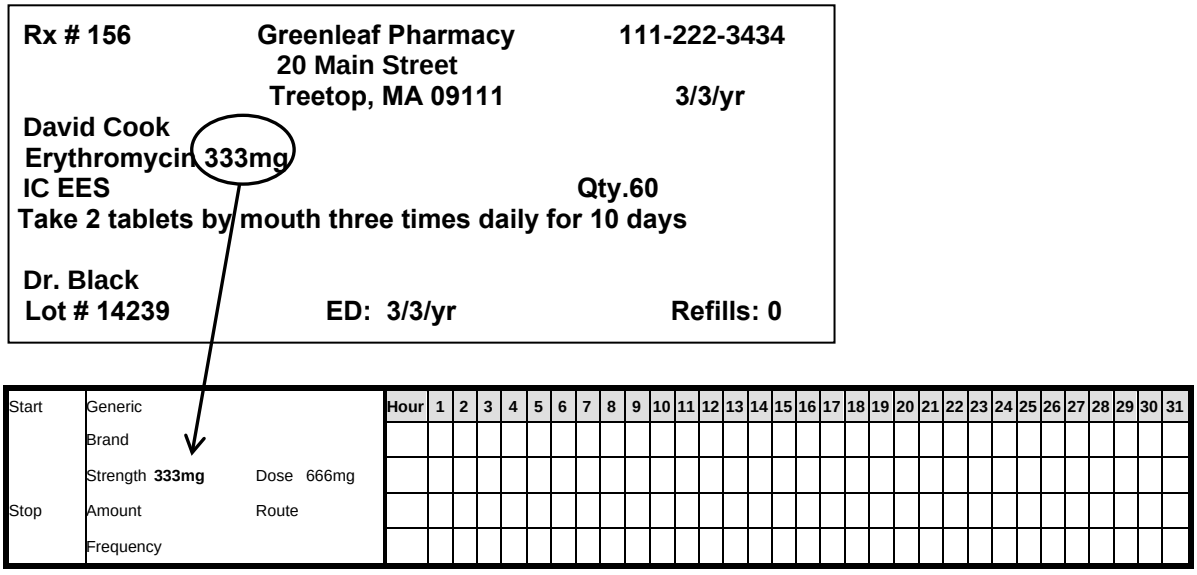
Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time**

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose 666mg																																
Stop	Amount	Route																																
	Frequency																																	

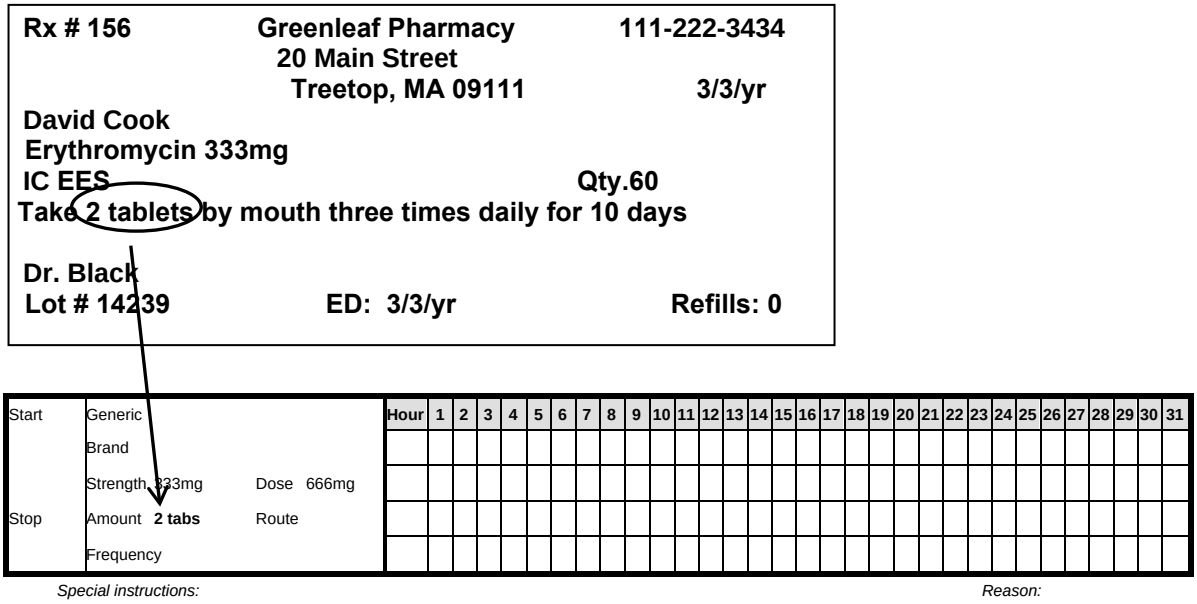
Special instructions: *Reason:*

The strength and amount are copied from the pharmacy label.

The strength on a pharmacy label is usually next to or underneath the name of the medication. Copy this number next to the word 'strength' on the medication sheet.



The amount on a pharmacy label is in the label directions and is copied next to the word amount on the medication sheet.



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.

Start	Generic **Erythromycin**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand **EES**																																	
	Strength **333mg**	Dose **666mg**																																
Stop	Amount **2 tabs**	Route **Mouth**																																
	Frequency **Three times daily**																																	

Special instructions: **for 10 days** *Reason:* **Sinus infection**

If the medication name on the HCP order is written as a:

- Generic medication, and the pharmacy supplies the generic medication,
    - then only the generic name of the medication is required to be transcribed onto the medication sheet.
- Brand name medication, and the HCP includes ‘brand only, no substitutions’ on the prescription,
    - the pharmacist will prepare the brand name medication and not the generic form. In this situation, there will only be a brand name listed on the pharmacy label. Only the brand name (as listed on the HCP order and pharmacy label) will be transcribed onto the medication sheet.

The number of times per day the medication is ordered is copied next to the word ‘frequency’ on the medication sheet.

If a specific number of days is also ordered:

- This information may also be written next to the word ‘frequency’ on the medication sheet if space allows and the information is legible.
- If there is not enough space to print clearly, the specific number of days ordered may be copied in the special instructions area.

To complete the grid, follow these steps:

- Assign times in the hour column; times assigned should be at least 4 hours apart.
    - For David, the HCP ordered the frequency as
        - Three times a day for 10 days.
    - Three ‘times’ are chosen and written in the hour column. 8am, 4pm and 8pm are examples of times often chosen.

- Think about the date and time to determine when the first dose can be administered.
    - For David, based on the date and time, March 3, yr at 1pm:
        - The March 3rd 8am dose cannot be administered. The March 3rd 8am medication box is crossed (X) out, as are all boxes before it.
        - The medication can be administered March 3rd at 4pm. This medication box is left open, and all boxes before it are crossed (X) out.
        - The medication can be administered March 3rd at 8pm. This medication box is left open, and all boxes before it are crossed (X) out.

Start	Generic **Erythromycin**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand **EES**		**8am**	X	X	X																											
	Strength **333mg**	Dose **666mg**																															
Stop	Amount **2 tabs**	Route **Mouth**	**4pm**	X	X																												
	Frequency **Three times daily**		**8pm**	X	X																												

Special instructions: **for 10 days** *Reason:* **Sinus infection**

Next,

- If the medication is ordered to be administered for a certain number of days, the days must be counted.
    - For David, the HCP ordered the medication to be administered for 10 days.
        - For each scheduled time (8am, 4pm and 8pm), ten medication boxes are counted and left open. The remaining medication boxes are crossed (X) out.
- Write the 'start' and 'stop' dates:
    - A start date is the date the first dose is scheduled to be administered.
    - A stop date is the date the last dose is scheduled to be administered.

Start	Generic **Erythromycin**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
3/3/yr	Brand **EES**		**8am**	X	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **333mg**	Dose **666mg**																															
Stop	Amount **2 tabs**	Route **Mouth**	**4pm**	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3/13/yr	Frequency **Three times daily**		**8pm**	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **for 10 days** *Reason:* **Sinus infection**

This is the completed transcription of David Cook's HCP order and pharmacy label onto a medication sheet:

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic **Amoxicillin**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2/28/yr	Brand ~~Amoxil~~ DC 3/3/yr SD		8am	SW	AS	SW							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **250mg**	Dose **500mg**																																
Stop	Amount **2 tabs**	Route **Mouth**	4pm	LW	JS								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3/10/yr	Frequency **Three times daily**		8pm	LW	JS								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

DC 3/3/yr SD

Special instructions: **for 10 days** *Reason:* **Sinus infection**

Start	Generic **Erythromycin**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
3/3/yr	Brand **EES**		8am	X	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **333mg**	Dose **666mg**																																
Stop	Amount **2 tabs**	Route **Mouth**	4pm	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3/13/yr	Frequency **Three times daily**		8pm	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **for 10 days** *Reason:* **Sinus infection**

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Name: David Cook

Site: 45 Shade Street

CODES		CODES		Signature
DP-day program/day hab	**A-absent**	SD	Sam Dowd
LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**	AS	Amanda Smith
P-packaged	**OSA-off site administration**	LW	Linda White
W-work	**MNA-medication not administered**	S	Serena Wilson
H-hospital, nursing home, rehab center	**Signature**	JS	Jenna Sherman
S-school			
V-vacation			

Accuracy Check 1 *Linda White* Date 2/28/yr Time 8pm Accuracy Check 2 Jenna Sherman Date 2/28/yr Time 8pm

Review the completed EES transcription and answer the following questions.

1. What is the date and time of the first scheduled dose of EES? _____
2. What is the 'start' date? _____
3. What is the date and time of the last scheduled dose of EES? _____
4. What is the 'stop' date? _____
5. What is the frequency? _____
6. What are the times the medication is scheduled to be administered? _____

7. What is the dose of the new medication? _____
8. What is the amount to administer? _____
9. What is the strength of the tablet supplied? _____
10. What is the name of the staff that transcribed the order? _____

Electronic health records are another method of recording medication administration. If this method is used at your work location, ask your supervisor when you will receive training.

If anything about an existing HCP order changes (frequency, dose, parameters for use, etc.), it is considered to be a new HCP order. The old HCP order must be discontinued on the medication sheet and the new HCP order transcribed.

Posting and Verifying

After an HCP order is transcribed onto a medication sheet, the HCP order is Posted and Verified. This is one of the critical medication-related tasks that helps to make sure you administer medications safely. Posting and Verifying is completed by two Certified and/or licensed staff. Posting is documentation by the staff that completed the transcription.

After all orders are transcribed, the first staff documents:

- 'Posted'
  - On the HCP order form
  - Under the HCP's signature
- Date
- Time
- Staff signature

To verify an order, the second staff must review the transcription completed by the first staff. This is to make sure the HCP order and pharmacy label information was accurately transcribed onto the medication sheet.

The second staff documents:

- 'Verified'
    - On the HCP order form
    - Under the HCP's signature
- Date
- Time
- Staff signature

'Posting and Verifying' helps make sure all medication orders are transcribed accurately onto medication sheets. This is so that medication is administered as ordered.

All HCP orders must be posted and verified. This includes when the HCP notes, "No new orders" or "No medication changes."

If two Certified and/or licensed staff are not available when the medication is due 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.

Staff must document that there was a new HCP order in the person's health record.

Note the HCP order has been posted and verified under the HCP signature.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** March 3, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David states his "head hurts" and he has had a runny nose for 2 days, temperature is 100.3.	
Current Medications: Amoxil 500mg three times daily for 10 days by mouth Also, see attached complete medication list.	
Staff Signature: Sam Dowd	**Date:** March 3, yr
Health Care Provider Findings: Sinus infection	
Medication/Treatment Orders: DC Amoxil EES 666mg three times daily for 10 days by mouth	
Instructions: Call HCP if temperature remains elevated above 100.3 for more than 48 hours.	
Follow-up visit:	**Lab work or Tests:** None today
Signature: Richard Black, MD	**Date:** March 3, yr

Posted by: Sam Dowd **Date: 3/3/yr Time: 1:15pm Verified by:** Linda White **Date: 3/3/yr Time: 2pm**

Tanisha has returned from an HCP appointment and medication has been obtained from the pharmacy. The date is February 5th, yr. The time is 1pm. Use the HCP order, pharmacy label and medication sheet to transcribe the new orders. Remember to post the HCP order after completing the transcription.

HEALTH CARE PROVIDER ORDER

Name: Tanisha Johnson	**Date:** Feb. 5, yr
Health Care Provider: Dr. Chen Lee	**Allergies:** No known medication allergies
Reason for Visit: Continues to complain of soreness in the back of her mouth.	
Current Medications: Phenobarbital 64.8mg once daily in the evening by mouth Clonazepam 1mg twice daily at 8am and 4pm by mouth Amoxil Suspension 500mg every 12 hours for seven days by mouth	
Staff Signature: Sam Dowd	**Date:** Feb. 5, yr
Health Care Provider Findings: Increased inflammation of gum-line on left side of mouth	
Medication/Treatment Orders: DC Amoxil Suspension Cleocin HCL 300mg three times a day for 10 days by mouth	
Instructions: Notify HCP if Tanisha continues to complain of mouth soreness after 72 hours.	
Follow-up visit: February 16, yr	**Lab work or Tests:** None
Signature: Dr. Chen Lee	**Date:** Feb. 5, yr

Posted by: **Date:** **Time:** **Verified by:** **Date:** **Time:**

Rx #178	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3434** **2/5/yr**

Tanisha Johnson

Clindamycin 100mg **Qty. 90**
IC Cleocin HCL

Take 3 tablets by mouth 3 times a day for 10 days
Take with 8 ounces of water

Dr. Lee

Lot# 352 **ED: 2/5/yr** **Refills: 0**

Month and Year: February, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Phenobarbital		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand Luminal																																	
	Strength 32.4mg	Dose 64.8mg																																
Stop	Amount 2 tabs	Route Mouth																																
Cont.	Frequency Once daily in evening		**8pm**	TM	TM	TM	**JS**																											

Special instructions: *Reason:* seizures

Start	Generic Clonazepam		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand Klonopin		**8am**	KM	AS	KM	KM	AS																										
	Strength 1mg	Dose 1mg																																
Stop	Amount 1 tab	Route Mouth	**4pm**	TM	TM	TM	**JS**																											
Cont.	Frequency Twice daily 8am and 4pm																																	

Special instructions: *Reason:* seizures

Start	Generic Amoxicillin suspension		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
2/2/yr	Brand Amoxil suspension		**8am**	X	X	KM	KM	AS					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength 250mg/5mL	Dose 500mg																																
Stop	Amount 10mL	Route Mouth																																
2/9/yr	Frequency every 12 hours for 7 days		**8pm**	X	TM	TM	**JS**					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: *Reason:* gum

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Name: Tanisha Johnson

Site: 45 Shade Street
Treetop MA 00000

CODES	**CODES**		**Signature**
DP-day program/day hab	**A-absent**		Kay Mathers
LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**	AS	Amanda Smith
P-packaged	**OSA-off site administration**	TM	Timothy Miller
W-work	**MNA-medication not administered**	SW	Serena Wilson
H-hospital, nursing home, rehab center	**Signature**	JS	Jenna Sherman
S-school		SD	Sam Dowd
V-vacation	JC John Craig	KM	Kay Mathers

Accuracy Check 1 Sam Dowd Date 1/31/yr Time 9pm

Accuracy Check 2 John Craig Date 1/31/yr Time 9pm

Answer the following questions by choosing the best response.

1. Sam Dowd has written his initials and signed his full name on the signature list of a person's medication sheet. This is done

A. __ every time he administers a medication
B. __ once each month to identify his initials with his full name
C. __ at the beginning of each shift
D. __ only when he administers a PRN medication

2. Sam Dowd documented 'DP' in a medication box on the medication sheet. This indicates that the person

A. __ received their daily pills
B. __ refused all afternoon medications
C. __ was at the day program when the medication was due
D. __ is at a doctor's appointment and is unable to take medication

3. When transcribing the dose onto the medication sheet

A. __ copy it from the pharmacy label
B. __ multiply the amount sent by the pharmacy
C. __ locate it on the HCP order
D. __ divide the strength of the tablet by the amount to give

4. The start date for a medication

A. __ will always be the date the medication was ordered
B. __ is located on the HCP order
C. __ is the date a person receives the first scheduled dose
D. __ is listed on the pharmacy label

5. The allergy information on a medication sheet

A. __ only needs to be filled in if a person has an allergy
B. __ must be completed, if the person has no allergies list "none"
C. __ must be written in red, highlighted, and initialed by the supervisor
D. __ can be written under special instructions

Medication Information Sheets

The last section of the medication record typically contains the medication information sheets. Medication information sheets can be:

- Obtained from the pharmacy
- Accessed from a reputable online resource
- Found packaged with the medication as an insert.

Remember you must learn about a medication before administering it.

Let's Review

- A medication sheet is a document used to track the administration of a person's medication.
    - If you use an acceptable code on a medication sheet, the code and its meaning must be listed on that medication sheet.
- The HCP order, pharmacy label, and medication sheet are needed to complete a transcription.
    - The dose is copied from the HCP order.
    - The strength and amount are copied from the pharmacy label.
    - The dose, strength, and amount are copied onto the medication sheet.
- A specific time must be transcribed in the hour column on the medication sheet.
- The start date is the date a person is scheduled to receive the first dose of a medication.
- The stop date is the date a person is scheduled to receive the last dose of a medication.
- Transcriptions must be completed accurately to ensure safe medication administration.
- All HCP orders must be 'Posted and Verified'. This critical medication-related task is to make sure HCP orders are accurately transcribed onto the medication sheet.
    - 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.
- Accuracy checks must be completed, by two staff, prior to the start of the new month's medication sheets.
- Accuracy checks are a critical medication-related task.
- Medication information sheets are a valuable medication information resource.

Unit 7

Administering Medications

Responsibilities you will learn

- The difference between regularly scheduled and as needed (PRN) medications
- The medication administration process
- How to use liquid medication measuring devices
- How to manage various scenarios if a medication is not administered

Some medications are administered regularly. Some medications are administered only if needed. It is important to know the difference.

Regularly scheduled medications are administered for various health conditions, such as high blood pressure, or high cholesterol. They are usually taken every day at routine times to work as intended.

Other medications are only administered as needed for specific health issues when they occur, such as chest pain, seasonal allergies, cold symptoms, or constipation. These medications are administered on an 'as needed' or 'PRN' basis.

Regularly Scheduled Medications

Regularly scheduled medications are administered routinely, on a continuing basis.

For example: Colace 100mg twice daily by mouth

In the example, the medication will be administered twice daily at two specific times, as listed under the hour column on the medication sheet.

Start	Generic **Docusate Sodium**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Colace**		**8am**	WS	AM	JC	WS																															
	Strength **100mg**	Dose **100mg**																																			
Stop	Amount **1 tab**	Route **Mouth**																																			
Cont.	Frequency **Twice daily**		**8pm**	**SD**	**SD**	**KM**	**KM**																														

Special instructions: *Reason:* **constipation**

Sometimes data collection, such as vital signs or bowel tracking, is required for medication administration. This data must be recorded on the medication sheet

above or below the medication to be administered. This data can also be electronically tied to the medication to be administered.

Review the medication sheet. What is the data being recorded? _______

Start	Generic		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Check blood pressure (BP)**		**8am**	WS	AS	JC	WS																											
	Strength	Dose	**BP**	120/64	134/66	130/62	132/60																											
Stop	Amount	Route																																
Cont.	Frequency **Daily in the morning**																																	

Special instructions: **Hold Zestril if systolic (top) blood pressure (BP) reading is below 100 and notify HCP** *Reason:*

Start	Generic **Lisinopril**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Zestril**		**8am**	WS	AS	JC	WS																											
	Strength **20mg**	Dose **40mg**																																
Stop	Amount **2 tabs**	Route **Mouth**																																
Cont.	Frequency **Daily in the morning**																																	

Special instructions: **Hold Zestril if systolic (top) blood pressure (BP) reading is below 100 and notify HCP** *Reason:* **high BP**

Certified staff must be trained in vital sign (VS) monitoring as it relates to medication administration. An HCP, RN, LPN, pharmacist, paramedic or EMT must conduct Vital Signs training.

Ask your supervisor if there are people who have HCP orders requiring vital sign monitoring at your work location. If so, ask when you will be trained.

PRN Medications

Medications that are administered only ‘as needed’ are known and abbreviated as ‘PRN.’ In addition to including the 5 Rights of medication administration, PRN medication orders must also include the following details:

- The specific target signs and symptoms for use such as:
    - Complaint of headache
    - No bowel movement in 3 days
    - Complaint of right knee discomfort

- Measurable objective criteria, if needed, such as:
    - Head slapping for more than 5 minutes
    - Seizure lasting more than 1 minute
    - Temperature of 101 or more
- A PRN frequency:
    - How many hours apart the doses may be administered such as:
        - ‘Every 8 hours PRN’ or
        - Three times daily PRN, must separate doses by at least 6 hours or
        - How many hours apart are required between a PRN dose and a Regularly scheduled dose of the same medication, such as
            - ‘Do not give within 4 hours of a regularly scheduled dose.’
- Parameters for use
    - How many doses of medication may be administered before the HCP must be notified such as:
        - ‘If 4 doses are administered within 24 hours, notify the HCP.’
    - What to do if the medication is administered and is not effective such as:
        - ‘If complaints of right knee pain continues longer than 2 hours after PRN medication is administered, notify the HCP.’

A PRN medication may only be administered for the target signs and symptoms ordered by the HCP. Remember, target signs and symptoms ordered by the HCP indicate ‘when’ you should administer a PRN medication. A reason is ‘why’ a medication is ordered by the HCP. For example, Tylenol is ordered for fever (reason). It is administered if temperature is over 101 (target sign/symptom).

PRN medication orders must include:

- Specific target signs and symptoms
- Instructions for use,
    - including what to do if the medication is given and is not effective.

For example, Tanisha has an order for:

Milk of Magnesia 1200mg by mouth PRN every 3rd evening if no bowel movement (BM). Contact HCP if no BM by the next morning.

On the medication sheet under the hour column, you will see the abbreviation 'PRN.' In this example, to follow the order as written, BM data must be cross-referenced. This includes during day program or work hours. You will look for the BM data documented on the medication sheet to determine whether the medication must be administered.

Based on the bowel data tracking entered (which includes day program data), does the Milk of Magnesia require administration on the evening of the 5th? _____

Start	Generic **Monitor and record number**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
6/1/yr	Brand **of bowel movements (BM)**		**7-3**	0	1	0	0	0																									
	Strength	Dose	**3-11**	1	1	0	0	0																									
Stop	Amount	Route	**11-7**	0	0	0	0	0																									
Cont.	Frequency **Every shift**																																

Special instructions: **Check daily Monday-Friday with day program and record** *Reason:*

Start	Generic **Magnesium hydroxide**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
6/1/yr	Brand **Milk of Magnesia**		**P**																														
	Strength **400mg/5mL**	Dose **1200mg**	**R**																														
Stop	Amount **15mL**	Route **Mouth**	**N**																														
Cont.	Frequency PRN every 3rd evening if no BM																																

Special instructions: **Contact HCP if no bowel movement by the next morning.** *Reason:* **Constipation**

A PRN medication is documented on a medication sheet by:

- Writing your initials and the time administered, in the same medication box
  - Across from the medication administered
    - under the correct date.
  - If the medication is administered in the morning, use one of the top two medication grid boxes on the medication sheet.
  - If administered in the afternoon or evening (as ordered in the example above), document using one of the two bottom medication grid boxes.
- You will also write a medication progress note including:
  - The date and time
  - Medication and dose administered
  - The reason administered
  - Your signature
    - After enough time has passed, document the results and/or response to the medication.
      - Use a new line in the progress notes, if needed.

Example of PRN medication documentation:

Start	Generic **Ibuprofen**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Motrin**		**P**																															
	Strength **400mg**	Dose **400mg**	**R**																															
Stop	Amount **1 tab**	Route **Mouth**	**N**	3pm AS																														
Cont.	Frequency **Every 8 hours as needed**																																	

Special instructions: **for complaint of right knee pain. Notify HCP if pain continues after 48 hours** *Reason:* **right knee pain**

Name David Cook **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
3/1/yr	3pm	Ibuprofen	400mg	X				David says, 'my right knee hurts'.	——	*Amanda Smith*
3/1/yr	4pm	At 4pm David says, 'It still hurts to bend my knee.'							——————	*Amanda Smith*

Review the HCP order for David Cook and answer the questions.

Health Care Provider Order

Motrin 400mg every 8 hours as needed by mouth for complaints of right knee pain. Notify HCP if symptoms continue for more than 48 hours. Reason: Right knee pain.

1. Is the Motrin ordered as a regularly scheduled or PRN medication? _____
2. What is the reason the medication is ordered? _____
3. Are you allowed to administer the Motrin if he complains of a headache? _____
4. If administered at 9am, what is the earliest time it may be administered again? __
5. If the medication has been administered as ordered for 48 hours and David still complains of right knee pain, what should you do? _____

The 5 Rights of Medication Administration

The 5 Rights of medication administration are the:

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

Right Person

The person's name on the HCP order, the pharmacy label and the medication sheet must agree. You must also make sure you have identified the right person with that name.

- If you do not know who the person is, you can identify the right person by:
  - Asking a staff who knows the person or
  - Looking at a current picture of the person.

If you are not sure who the person is, never ask their name as a way to identify them. For example, 'Are you David Cook?' The reason is because someone who is not David may respond 'yes' to your question.

Medication records usually include a person's Emergency Fact Sheet (EFS). The EFS has a picture that can be used to identify the right person.

David Cook						Nickname: Dave		
Current Address: 45 Shade Street, Treetop MA 00000								
Former Address: 25 Smith Street, Oldtown MA 00000								
Sex	Race	D.O.B.	Age*	Height*	Weight*	Build	Hair	Eyes
M	Cauc.	3-15-64	52	6'1"	196		Br	Bl
Distinguishing Marks: Mole on right shoulder								
Legal Competency Status: Presumed Competent								
If Legal Guardian, Name: NA						Phone		
Address						Work		
Family Address (if different): 25 Smith Street, Oldtown MA 00000						Phone: 617-000-0000		
Training / Work Program: Amercare Services			Address: 13 Main Street Treetop MA 00000					Phone: 617-000-0000
Relevant Emergency Medical Information: (Allergies, Medications, etc.) Allergies-none Diagnoses-High blood pressure, osteoarthritis right knee, GERD								
Physician's Name: Dr. Richard Black			Address: 504 Lyman Street, Treetop MA 00000					Phone: 617-000-0000
Language / Communication: Speaks and understands English. Minimal ability to read and write						Ability to protect self w/o assistance: yes		
Significant Behavior Characteristics: none						Likely Response To Search Efforts: good		
Pattern of Movement (if lost previously)			Places Frequented					
Relevant Capabilities: Independent with ADL's			Limitations:			Preferences: Enjoys riding on buses		
Probable Dress*								
Where and When the person was last seen						Date*		Time*
Emergency Contacts: FAMILY / GUARDIAN: David Cook, Sr. (father)						DDS: Sky Johnson, Service Coordinator		
RESIDENCE: Linda White, Program Manager								
Note: Asterisked (*) items are left blank on the original and filled in on copy if and when the individual is lost. Except age, height, and weight which must be recorded at all times on the form.								
NAME: David Cook			COMMONWEALTH OF MASSACHUSETTS			AREA: Anywhere Area Office		

Right Medication

The medication name on the HCP order, the pharmacy label, and the medication sheet must agree. You must make sure you have identified the right medication with that name.

Read each medication name to ensure it matches letter for letter. Each medication usually has a brand and a generic name.

- When identifying the right medication:
  - If a brand name medication is written on the HCP order, it will be substituted by the pharmacy with the generic medication.
- You will see:
  - The brand name on the HCP order
  - Both the brand and generic names on the pharmacy label
  - Both the brand and generic names on the medication sheet.

Right Dose

The dose identified on the HCP order, the pharmacy label, and the medication sheet must agree. The dose is how much medication the HCP orders for the person each time the medication is scheduled to be administered. You must make sure you have the right dose of the medication.

- When identifying the right dose, you will see the:
  - Dose on the HCP order
    - The number is most often written in milligrams, 'mg.'
  - Strength of the tablet and the amount of tablets to administer on the pharmacy label
  - Dose, strength, and amount on the medication sheet.

The strength of the tablet supplied by the pharmacy can be:

- The same as the dose ordered or
- A different number
  - when multiplied by the amount to administer, it will equal the dose ordered.

Dose = Strength X Amount

The HCP orders the dose of a medication.

Health Care Provider Order

Name:	**Date:**
Health Care Provider:	**Allergies:**
Reason for Visit:	
Current Medications:	
Staff Signature:	**Date:**
Health Care Provider Findings:	
Medication/Treatment Orders:	
Instructions:	
Follow-up visit:	**Lab work or Tests:**
Signature:	**Date:**

Dose ordered is 100mg

The pharmacy supplies the strength of the tablet and label directions for the amount to give to equal the dose ordered. The strength supplied and the amount to give can change. The dose ordered remains the same.

Dose		Strength	Amount
100mg	=	 25mg 25mg 25mg 25mg	4 tablets
100mg	=	 50mg 50mg	2 tablets
100mg	=	 100mg	1 tablet
100mg	=	 200mg, ½ tablet	½ tablet

Review the dose of medication ordered by the HCP and the strength of the tablet supplied by the pharmacy. Fill in the amount of tablet(s) or capsule(s) to administer that you would expect to see printed in the pharmacy label directions.

	Dose	**Strength**	**Amount**
1.	100mg	50mg tablet	
2.	150mg	75mg tablet	
3.	500mg	250mg capsule	
4.	375mg	125mg tablet	
5.	500mg	500mg capsule	
6.	4mg	1mg tablet	
7.	10mg	2mg tablet	
8.	60mg	30mg capsule	
9.	600/200mg	300/100mg tablet	
10.	25mg	12.5mg tablet	
11.	12.5mg	25mg tablet	

Right Time

To be sure you have the right time, the time written on the HCP order, the pharmacy label, and medication sheet must agree. The words 'frequency' and 'time' are interchangeable[29].

- When identifying the right time, the:
  - HCP will order how many times throughout a day a medication is to be administered
  - Pharmacy label directions will include the frequency
  - Medication sheet includes the frequency as ordered by the HCP and
    - The specific times chosen are written under the hour column on the medication sheet.

All medications must be administered 'on time.' On time is defined as one hour before the time chosen in the hour column on the medication sheet up to one hour after the time chosen in the hour column on the medication sheet.

The one-hour window does not apply to PRN medication. PRN medication is administered when the target signs and symptoms are met, based on the frequency ordered. If you are unsure, contact a MAP Consultant.

[29] Either word can be used to mean the same thing.

Right Route

The route written on the HCP order, the pharmacy label, and the medication sheet must agree. You must make sure you have the right route. The route is the way medication enters the body.

- When identifying the right route, the:
  - HCP order will include the route
  - Pharmacy label directions will include the route
  - Medication sheet will include the route.

Routes Other Than Oral: Medication administered orally (by mouth) is the focus of this training. If a person is unable to take medications by mouth, or if the medication is not available in oral form (tablets, capsules, liquids), medications can enter the body by other routes. Other routes include, but are not limited to:

Route	Definition
Buccal	Placed in the cheek
Enteral	Administration into the stomach or intestines by g tube or j tube
Inhalable	Inhaled orally or nasally
Intramuscular	Administration in a muscle
Nasal	Administration in the nose by spray or pump
Ophthalmic	Administration in the eye
Otic	Administration in the ear
Rectal	Administration to or in the rectum
Subcutaneous	Administration between the skin and the muscle
Sublingual	Placed under the tongue
Topical	Applied directly to the skin
Transdermal	Administration through the skin
Vaginal	Administration to or in the vagina

Never administer a medication by a route for which you have not received training. Your supervisor will arrange for an RN, an LPN, or a MAP Trainer to conduct additional route training, when needed.

Specialized training is required if a person receives:

- Medication through enteral routes, i.e., a gastrostomy or jejunostomy (g/j) tube.
- Auto injectable epinephrine, such as an EpiPen or an Auvi-Q through the intramuscular route.

You are newly Certified. You know a person in your work location has an order for an EpiPen. Before you are assigned medication administration duties, you should:

1. ___ Ask a coworker to show you how it is administered.
2. ___ Call the pharmacy and ask for instructions.
3. ___ Read the medication information sheet so you will know how to use it.
4. ___ Ask your supervisor to arrange a specialized training for EpiPen use.

Ask your supervisor when you will receive training on all other routes medications are administered at your work location.

Safe Medication Administration

There are critical medication-related tasks that must be completed prior to the Medication Administration Process. Accurate completion of these tasks plays a key role in helping to make sure you administer medications safely.

You have learned that the critical medication-related tasks are to:

- Make sure the correct medication is received from the pharmacy
- Post and verify an HCP order
- Complete monthly accuracy checks.

Confirm the HCP Order

You must confirm that there is an HCP order for each medication to be administered.

Before confirming the HCP order, critical medication-related tasks were completed. These tasks help to make sure that the 5 Rights of medication administration on the HCP order agree with the pharmacy label and the medication sheet. Check all the tasks that apply.

1. ____ The pharmacy label on a medication refill was compared to the HCP order and the medication sheet.
2. ____ The HCP order, pharmacy label, and medication sheet were reviewed during posting and verifying.
3. ____ The HCP order, pharmacy label, and medication sheet were reviewed during the monthly accuracy checks.

The 2 Checks of Medication Administration

After the HCP order is confirmed, you must compare the 5 Rights of medication administration between the pharmacy label and the medication sheet.

Check 1 - Pharmacy label and the medication sheet
Check 2 - Pharmacy label and the medication sheet

Confirm the HCP order(s)

Health Care Provider Order

Name:	**Date:**
Health Care Provider:	**Allergies:**
Reason for Visit:	
Current Medications:	
Staff Signature:	**Date:**
Health Care Provider Findings:	
Medication/Treatment Orders:	
Instructions:	
Follow-up visit:	**Lab work or Tests:**
Signature:	**Date:**

- The reason(s) to confirm the HCP order(s) 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
  - The order has not changed since the last time you administered medication
  - The HCP order has not been discontinued.

Check 1 is a comparison of the 5 Rights between the pharmacy label and the medication sheet:

Medication Sheet

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

	CODES		**CODES**		**Signature**
Name:	**DP-day program/day hab**		**A-absent**		
	LOA-leave of absence		**NSS-no second staff (e.g. Coumadin)**		
Site:	**P-packaged**		**OSA-off site administration**		
	W-work		**MNA-medication not administered**		
	H-hospital, nursing home, rehab center		**Signature**		
	S-school				
	V-vacation				

- The reason(s) for Check 1 is to make sure:
  - The strength of each tablet and the amount of tablets to administer is the same on the pharmacy label and the medication sheet
  - That you focus on the number of tablets needed.
- After Check 1, you place the correct number of tablets in the medication cup

Check 2 is a comparison of the 5 Rights between the pharmacy label and the medication sheet:

Medication Sheet

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions: *Reason:*

	CODES	CODES		Signature
Name:	**DP-day program/day hab**	**A-absent**		
	LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**		
Site:	**P-packaged**	**OSA-off site administration**		
	W-work	**MNA-medication not administered**		
	H-hospital, nursing home, rehab center	**Signature**		
	S-school			
	V-vacation			

- The reason for Check 2 is to make sure:
  - You placed the correct number of tablets in the medication cup
    - According to the pharmacy label directions and
    - The amount transcribed on the medication sheet.
- After Check 2, you administer the medication.

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

Fill in the blanks using the terms ‘HCP order,’ ‘pharmacy label’ and/or ‘medication sheet.’

1. To administer medications safely, you will first confirm that there is an _____.
2. Check 1 is comparing the 5 Rights between the _____ and the_____.
3. Check 2 is comparing the 5 Rights between the _____ and the_____.

Match the step of the medication administration process to its corresponding reason.

Confirm	____	A. To verify that the amount of medication that you prepared agrees with the pharmacy label and medication sheet
Check 1	____	B. To make sure the instructions and amount to administer on the pharmacy label agree with what is transcribed onto the medication sheet
Check 2	____	C. To make sure the HCP order has not changed since the last time you administered medication

Special Instructions

Look at the entire pharmacy labeled container to see if there are special instructions you must follow when preparing, administering, or storing the medication. For example, 'do not crush,' 'shake well,' or 'refrigerate.'

Some people have difficulty swallowing a whole tablet with water. In these cases, you must report this to the HCP. The HCP will determine if it is acceptable for you to change the form of a medication.

An HCP order is required to:

- Place the whole tablet or capsule in applesauce, yogurt, or pudding, etc.
- Crush the tablet and mix with applesauce, yogurt, or pudding, etc.
- Open the capsule and mix the contents with applesauce, yogurt, or pudding, etc.
- Mix two liquid medications together
- Mix crushed medication and liquid medication together
- Dissolve the medication in water
- Give the medication with a liquid other than water.

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.

True (T) or False (F)

1. ____ You must contact the HCP to obtain an order if a person requests apple juice with their medication if no order exists.

2. ____ A tablet may only be halved or quartered by the pharmacy.

3. ____ You may place whole pills in applesauce, yogurt or pudding without an HCP order.

4. ____ Liquid medications may be mixed together if ordered by the HCP.

5. ____ An HCP order is not required to open a capsule and mix the contents with applesauce.

Medication Administration Process

Administering medication is part of a larger process called the Medication Administration Process. The medication administration process includes what happens before, during, and after you:

- Confirm there is an HCP order for each medication to be administered and
- Complete the 2 Checks of the 5 Rights.

The process includes what you will do to:

- **Prepare**
- **Administer**
- **Complete**

Medication is prepared and administered to one person at a time.

Prepare

- Wash:
  - The area
    - If a tabletop surface is used, make sure you wipe it clean before starting to prepare medication.
  - Your hands
    - Proper hand washing includes wetting your hands with clean, running water and applying soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Rub your hands for at least 20 seconds. Rinse thoroughly and dry.
- Unlock the storage area.
- Review the medication administration sheet specific to any medication due to be administered.
  - Take out the medication(s) to be administered.

Before you prepare, make sure to gather all necessary supplies and equipment. For example, a glass of water, spoons, medication cups and proper liquid measuring devices, etc.

Administer

- Confirm the HCP order(s):
    - Make sure there is an HCP order for each medication to be administered.
- Check 1:
    - Compare the 5 Rights on the pharmacy label to the 5 Rights on the medication sheet.
- Place the correct number of tablets in the medication cup:
    - When removing a tablet from a
        - Blister pack
            - always start with the highest numbered ‘bubble.’ Place the medication cup underneath firmly. Push the tablet through the backing directly into the medication cup.
        - Bottle
            - the cap may have instructions to push down then turn or there may be arrows you must line up to remove the cap. Tap the number of tablets needed into the bottle cap then place directly into the medication cup.
- Check 2:
    - Compare the 5 Rights on the pharmacy label to the 5 Rights on the medication sheet.
- Administer the medication:
    - The medication is given directly from you to the person.
    - Stay with the person until the medication is swallowed.
- Look Back:
    - Review the pharmacy label and medication sheet to make sure that what the person just swallowed is what you intended to administer.
        - If you realize you made a mistake, notify a MAP Consultant immediately.

Complete

- Document:
    - In the Medication Record
        - Place your initials on the medication sheet
            - across from the medication administered
            - next to the correct time
            - under the correct date.
    - If it is the first time you are administering the medication for the month, sign your full name and initial the signature list.

    - In the Count Book (if the medication is countable)
        - Use the index to locate the correct person, medication, and count sheet page number, then
            - turn to the correct count sheet page
            - subtract the number of tablets you removed from the package. Pay attention to your math. Make sure the number you document in the amount left column is the same as the number of tablets left in the package.

- Secure the medication.

- Wash your hands.

- Observe the person for the effects of the medication.

If you are administering multiple medications due at the same time, to the same person, confirm the HCP order for each medication you are administering then complete Checks 1 and 2 for each medication. All medication due at the same time, for the same person, may be given together and placed in the same medication cup. Liquid medication is measured and placed in a separate medication cup.

If you are administering more than one liquid medication, due at the same time, to one person, each liquid medication is measured and placed in a separate medication cup.

Medication Administration Process List

Prepare

Wash the area and your hands.
Look at the medication sheet to identify the medication to administer.
Unlock and remove the medication you are administering.

Administer

Confirm there is an HCP order for the medication you are administering. *
Check 1 - compare the 5 Rights between the pharmacy label and the med sheet. *
Prepare the medication.
Check 2 - compare the 5 Rights between the pharmacy label and the med sheet. *
Give the med.
Look back (silent comparison between pharmacy label and med sheet).

Complete

Document:

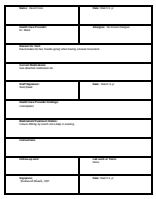
1. Medication Record
2. Count Book, if needed.

Secure the medication.
Wash your hands and observe.

* During medication administration training and testing, you must verbalize and demonstrate (show) when you:

- Confirm the HCP order
- Perform Check 1
- Perform Check 2.

Medication Administration Process Visual

WASH **Area & Hands** 	**LOOK FOR** **Medication** **Record** 	**UNLOCK** **Medication** **Area** 	**Prepare**
CONFIRM  **HCP Order**	 **1** **Pharmacy Label** **to** **Medication Sheet**	**PREPARE** 	**Administer**
 **2** **Pharmacy Label** **to** **Medication Sheet**	**GIVE** 	**SILENT** **Look Back** 	
DOCUMENT 1. Medication Sheet 2. Count Sheet, if needed 	**LOCK** **Medication** **Area** 	**WASH HANDS**  **OBSERVE** 	**Complete**

Glove Use: In addition to hand washing, there may be times when wearing gloves is necessary. For example, when applying an ointment to a skin rash, or when administering a rectal medication.

To put the gloves on:

- Wash your hands as described in the 'Prepare' section of the medication administration process, then
- Put on each glove to cover your entire hand and wrist.

To take the gloves off:

- With one gloved hand, take hold of the other glove at the wrist.
- Turn the glove inside out as you peel it off your hand.
- Roll the removed glove in your hand still wearing a glove.
- With your ungloved hand, insert your index finger down the wrist of your still gloved hand. Pull the glove down and inside out over the rolled glove.
    - At this point both gloves are off with one glove tucked inside the other glove
- Throw away the used gloves into the trash.
- Wash your hands.

Do not administer medication if

- You cannot read the HCP order
- There is no HCP order
- You cannot read the pharmacy label
- There is no pharmacy label
- You have any concern that the 5 Rights do not agree between the
    - HCP order
    - Pharmacy label
    - Medication sheet
- A medication seems to be tampered (altered)
- The medication was prepared by someone else
- The person
    - Has a serious change
    - Has difficulty swallowing
    - Refuses to take the medication
- The pharmacy supplied a liquid form of medication, you have been giving the tablet form and there is no change in the HCP order
- The medication was ‘pre-poured’.

In addition, never use another person’s medication to give to someone else for any reason. This is not allowed, even if they have the same medication and dose ordered.

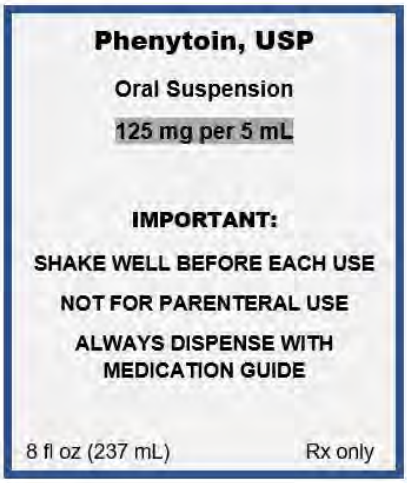
Liquid Medication

When the medication is in a liquid form, the same medication administration process is followed. Liquid medications are products you may see labeled as a solution, suspension, syrup, or an elixir. Some medications are only available as liquids. Liquid medications must be measured.

Liquid medications are usually measured in milliliters. The abbreviation for milliliter is 'mL.' If abbreviations are used on the pharmacy label, read them carefully.

The label on a liquid medication includes the strength of the medication. The strength is based on how many milligrams (mg) per milliliters (mL) are measured.

The strength on the Phenytoin label tells you that every 5mL of liquid equals 125mg of the medication.



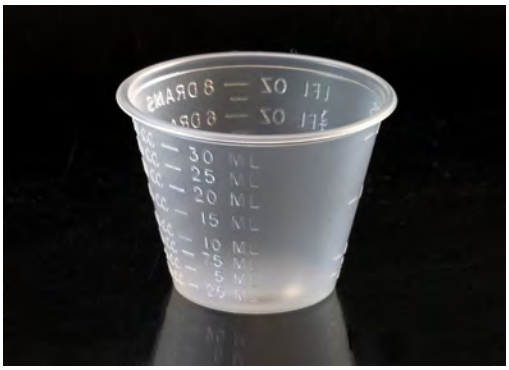
If you measure 10mL, how many milligrams of medication do you have? ____

Remember, whenever a medication has a pharmacy label, the pharmacist will indicate the strength supplied and the amount to administer on the label.

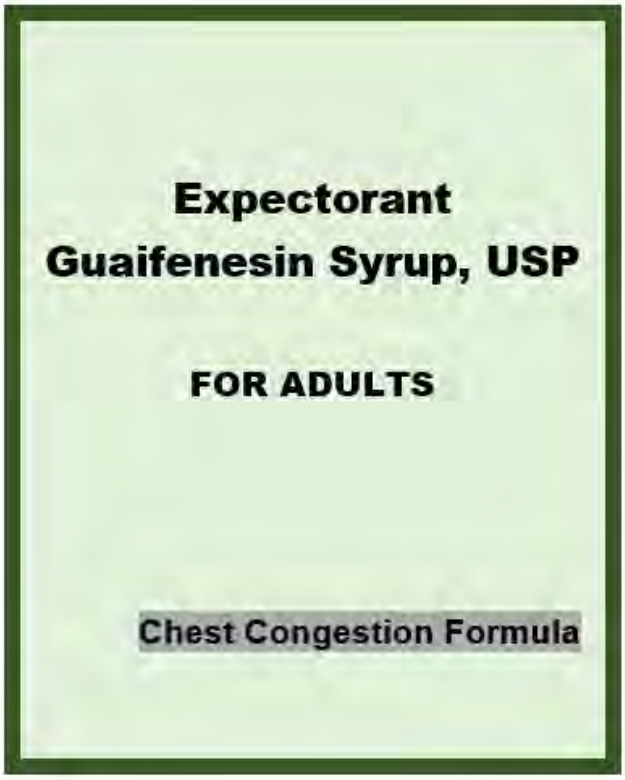
For the purposes of this exercise, review the labels and write the strength of each medication.

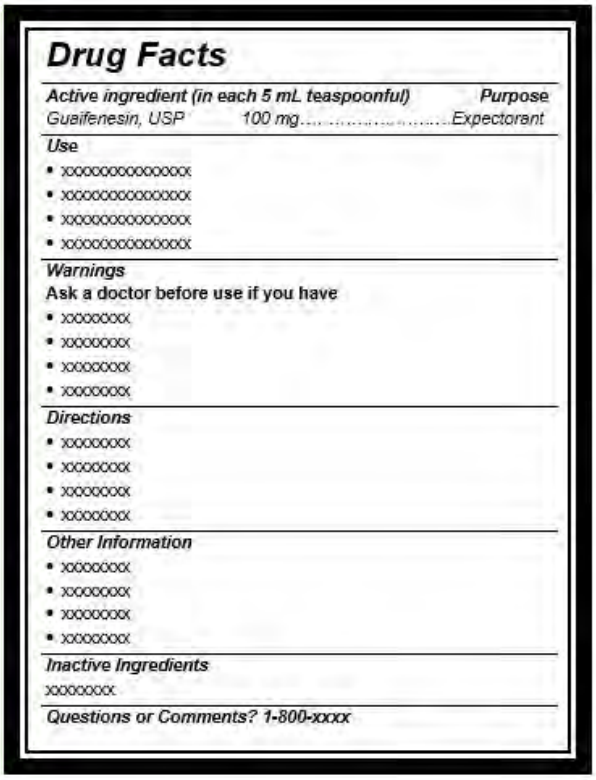
1. Oral Saline Laxative strength _____mg per _____mL

If the dose ordered by the HCP is 2400mg, using the measuring device below, shade in the amount to administer based on the dose ordered and the strength supplied.

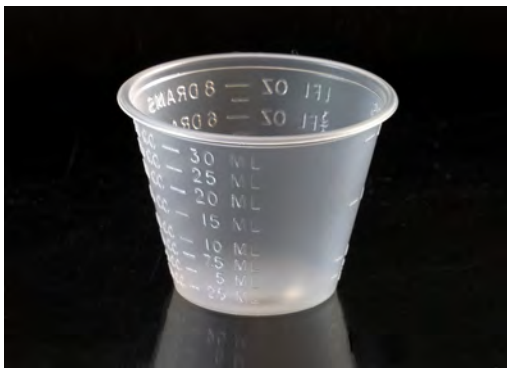


2. Expectorant Guaifenesin Syrup strength _____mg per _____mL



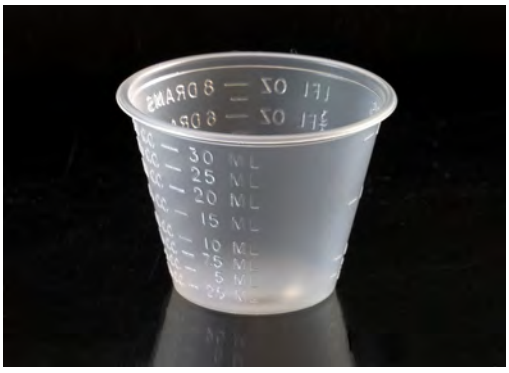


If the dose ordered by the HCP is 200mg, using the measuring device below, shade in the amount to administer based on the dose ordered and the strength supplied.



3. Bismuth Subsalicylate strength _____mg per _____mL

If the dose ordered by the HCP is 262mg, using the measuring device below, shade in the amount to administer based on the dose ordered and the strength supplied.



Liquid Measuring Devices

Always use a proper measuring device. Use the device that comes with the medication. If one is not provided, you must ask the pharmacist for an appropriate measuring device. Types of liquid measuring devices include a medication cup, oral syringe, a dropper, and dosing spoon.

Some oral liquid measuring devices include a combination of markings (measurements) such as, milliliter (mL), teaspoon, or tablespoon. If you are unsure which marking to use, contact the MAP Consultant.

If teaspoons are confused with tablespoons, this could result in a three times overdose or underdose. If milliliters are confused with teaspoons, this could result in a five times overdose or underdose.

Medication Cup

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

- Shake the medication container, if needed.
- Remove the cap and place it upside down.
    - This will help to keep the medication free of germs.
- Place the medication cup on a flat surface, at eye level.
    - Do not hold it in your hand.
- Locate the correct measurement on the medication cup.
    - Find the marking on the cup that agrees with the amount you need for the dose ordered.
- Hold the bottle so that your hand covers the pharmacy label.
    - This keeps the label from becoming soiled.
- Pour slowly.
    - If you pour too much, do not pour back into the bottle.
    - Use a second medication cup to pour into and measure again.
    - 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.

If two liquid medications are due at the same time, each liquid medication must be measured using a different medication cup.

Sometimes the amount of liquid medication to be administered is too small to use a medication cup. The medication can only be measured accurately using an oral syringe, a dropper or a dosing spoon.

Oral Syringe

Oral syringes come in different sizes. The most common sizes are 1mL, 2.5mL and 5mL syringes, but there also are 10mL and larger syringes. Find the measurement on the oral syringe that agrees with the amount you need for the correct dose.

Many times, a pharmacy will provide an alternative bottle cap or an adapter that fits on the top of the bottle. This allows the liquid to be withdrawn directly from the container with an oral syringe.

When preparing a liquid medication based on the dose ordered, you determine the amount of liquid to be measured into the oral syringe. Then make sure you do the following:

- Shake the medication container, if needed.
- Remove the lid and
    - Push the adapter firmly into the top of the bottle or
    - Screw the alternative cap on the bottle.
- Push the tip of the oral syringe into the hole
    - In the adapter or
    - An alternative cap.
- Turn the bottle upside down.
    - Pull the plunger of the syringe back so that the medicine is drawn from the bottle into the syringe.
    - Continue to pull the plunger back to the marking that corresponds to the dose.

- If you are unsure about how much medication to draw into the syringe, contact the MAP Consultant.
- Remove any large air bubbles from the syringe.
    - Air bubbles within an oral syringe can give an inaccurate measurement.
    - If there are air bubbles, empty the syringe back into the bottle and try again.
- Turn the bottle back the right way up.
- Remove the syringe.
- After use, wash with warm water and dish soap and leave apart to dry.

Dropper

A dropper is a glass or plastic tube that is narrow at one end and has a rubber bulb at the other end that is squeezed in order to measure and sometimes administer medication. Droppers come in different sizes with different markings and are used for different reasons. There are droppers used to administer liquid oral medication, eye drops and ear drops. If a dropper comes with the medication, always use the dropper included.

When preparing a liquid medication based on the dose ordered, you determine the amount of liquid to be measured into the dropper. Then make sure you do the following:

- Hold the dropper upright.
    - Do not pull the medication up into the rubber end (bulb) of a dropper or turn the dropper upside down.
- Squeeze the bulb of the dropper.
    - This will squeeze excess air out of the dropper and prepare the dropper to suck up the medication.
- Place the dropper into the bottle.
- Slowly let pressure off of the bulb.
    - You will see the medication being pulled up into the dropper.
    - Measure at eye level.

- When you get the medication pulled up to the mark of the amount needed
    - Squeeze the bulb into the container to either remove extra medication or to pull up more medication if needed.
- Let go of the rubber end.
    - This will cause an air bubble to pop up. It will look like the medication is off measurement, but you have the correct amount in the dropper.

Some droppers are made to be taken apart and cleaned after use. If you are using this type of dropper, remove the bulb from the dropper and wash both pieces with warm water and dish soap, rinse well and let the parts air dry.

Dosing Spoon

Dosing spoons come in different sizes with different markings.

When preparing a liquid medication based on the dose ordered, you determine the amount of liquid to be measured into the dosing spoon. Then make sure you do the following:

- Hold the dosing spoon upright.
- Find the marking for the amount needed based on the dose ordered.
- Slowly pour the medication from the bottle into the spoon at eye level.
- After use, wash the spoon with warm water and dish soap, rinse and let it air dry.

Never measure liquid medications with household utensils or measuring spoons. They are not consistent in size and will result in either too much or too little medication administered.

Look at the dose ordered by the HCP and the strength of the liquid medication supplied by the pharmacy. Fill in the amount to administer you would expect to see printed in the pharmacy label directions.

	Dose	**Strength**	**Amount**
1.	150mg	75mg/10mL	
2.	100mg	50mg/6mL	
3.	100mg	50mg/2mL	
4.	150mg	75mg/4mL	
5.	200mg	100mg/5mL	
6.	150mg	50mg/3mL	
7.	100mg	25mg/2mL	
8.	500mg	250mg/10mL	
9.	100mg	100mg/15mL	
10.	500mg	500mg/30mL	
11.	500mg	125mg/5mL	

You are preparing Tanisha's liquid medication. It comes with its own special dropper. After completing your first check in the medication administration process, you are now ready to measure the medication. The amount is listed as 4mL. You cannot find the dropper. Check what you should do next.

1. ___ Get a teaspoon from the kitchen drawer. Pour just a little less since a teaspoon is equal to 5mL.

2. ___ Borrow the special dropper that comes with Juanita's liquid medication.

3. ___ Call the pharmacy and request an appropriate measuring device.

4. ___ Use a medication cup that has markings for 2.5mL and 5mL. Pour just a little less than the 5mL marking.

Match the following terms with the corresponding letter.

1. ___ Medication cup	A. Must be held upright and at eye level for measuring
2. ___ Oral syringe	B. Squeeze the bulb to draw up medication
3. ___ Dropper	C. Place on a flat surface at eye level
4. ___ Dosing spoon	D. Pull the plunger back to the correct measurement

True (T) or False (F)

1. ___ If a household teaspoon is used as a liquid measuring device, this could result in an overdose or underdose.
2. ___ Whether preparing liquids or tablets, the same medication administration process is followed.
3. ___ When pouring liquid medication from a bottle, your hand should cover the label.
4. ___ Two different liquid medications may be measured in the same medication cup.
5. ___ Air bubbles within an oral syringe can give an inaccurate measurement.
6. ___ An oral syringe may be washed and reused for the same person.

How to Document if a Medication is Not Administered

There are times when you may have to document that a medication was not administered, such as when a medication:

- Is refused
- Order includes parameters for when to hold (not give) a medication
- Is held prior to testing
- Is not available to administer.

Medication Refusals

Sometimes a person may not want to take their medication. This is called a medication refusal. When a person refuses, ask them why. Their answer is important. If the person you are working with does not speak, notice if they keep their lips sealed and turn away from you or seem to frown as they try to swallow the medication before spitting it out, etc.

Your subjective and objective observations are important when reporting the refusal to the prescribing HCP and may result in the HCP changing the current medication order. The HCP may prefer to consult with a Behavior Specialist as well as other team members and develop a plan to manage refusals.

Medication refusals are defined as when the person:

- Says ‘No’
- Spits the medication right back out or never takes the medication from you
- Spits the medication out later, even though when you administered it, the person seemed to swallow it
- Vomits the medication on purpose within one half hour of taking it.

If the person says no or never takes the medication from you, secure it, wait 15-20 minutes, and offer the medication again. When offering the medication a second time, if the person still refuses, secure it, and wait another 15-20 minutes. Then offer the medication a third time. When offered a third time, if the person still refuses the medication, this is considered a final refusal. A person has up to three times to refuse a medication before you are to consider it a final refusal.

All refusals must be reported immediately to the prescribing HCP. It is very important that the prescribing HCP be notified that the person is refusing to take the medication as ordered.

The prescribing HCP must be notified every time a person refuses a medication. If the prescribing HCP would prefer to be notified less often than the requirement, an HCP order is needed. For example, ‘Notify HCP after two refusals within a week.’

When medication is refused, document this on the medication sheet by:

- Writing the acceptable code MNA (medication not administered) in the medication box and
- Writing a medication progress note including:
    - The date and time
    - The medication involved
    - Why the medication was not administered
    - Your observations
    - Who was notified
        - The prescribing HCP
        - Your supervisor
            - Include first and last names
    - What you were instructed to do
    - Your signature

Here is a documentation example of a refused medication on the medication sheet and corresponding medication progress note:

Month and Year: February, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Clonazepam		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand Klonopin		**8am**	JS	JS	MNA																												
	Strength 1mg	Dose 1mg																																
Stop	Amount 1 tab	Route mouth																																
cont	Frequency twice daily 8am and 4pm		**8pm**	TM	TM																													

Special instructions: *Reason: seizures*

Name **Tanisha Johnson** **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature

2-3-yr 9:15am Tanisha refused her morning Clonazepam 1mg. I attempted to administer it 3 times. Dr. Lee was notified. He recommended to skip this dose and to administer the next dose when it is due. Linda White, supervisor was also notified. Jenna Sherman

You are responsible for medication administration on March 4, yr. You prepare David's 4pm medication. As you enter the room with his Prilosec, he is pacing back and forth and states, "I don't want that medication." You should:

1. ___ Tell David he must take his medication
2. ___ Dispose of the medication since he doesn't want it
3. ___ Ask David why he does not want to take the medication
4. ___ Consider the medication refused

David tells you he does not like the purple color of the tablet. You should:

1. ___ Hide the pill in his food so he cannot see the color purple
2. ___ Insist he take the medication because it's ordered by the doctor
3. ___ Leave the pill with David and hope that he will take it
4. ___ Secure the medication, return in 15 minutes, and offer it again

After 3 attempts, David still refuses the medication. You should first:

1. ___ Notify your supervisor and coworkers of the refusal
2. ___ Wait one more hour and offer the medication a fourth time
3. ___ Save the medication for the next scheduled administration time
4. ___ Notify Dr. Black of the refusal

Using the medication sheet and corresponding progress note, document the medication refusal.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic **Omeprazole**	**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Prilosec**																																
	Strength **20mg** Dose **20mg**																																
Stop	Amount **1 tab** Route **Mouth**	**4pm**	WS	WD	JC																												
Cont.	Frequency **Once daily before supper**																																

Special instructions: *Reason:* **GERD**

Name David Cook **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature

Class Discussion

Scott Green's HCP prescribed Zyprexa to manage his schizophrenia. Zyprexa is an antipsychotic medication that can help calm 'racing thoughts.' In the past, Scott has been hospitalized for his safety and the safety of others when his symptoms were severe. Scott recently began refusing his Zyprexa. He refused it three times in the last week. Each time staff notified the prescribing HCP of the refusal, they included the recent refusals.

1. Why is it important to report each refusal to the prescribing HCP?
   _____
   _____
2. Why is it important to report the previous refusals? _____
   _____
   _____
3. What could occur if the prescribing HCP is not notified of all recent refusals?
   _____
   _____

Scott Green recently refused his medication for management of his schizophrenia. He refused it on Monday, Tuesday, and Thursday. You are working on Friday and prepare the medication. Scott refuses the medication even after you attempt to administer it three times.

The most complete information to report to the prescribing HCP is:

1. ___ Scott refused his antipsychotic medication on Friday, even though you attempted to administer it 3 times.
2. ___ Scott refused his antipsychotic medication on Friday and previously on Monday, Tuesday, and Thursday.
3. ___ Scott has a history of refusing his medication. He refused his antipsychotic medication on Friday. It is his right to refuse medication.

Parameters

Parameters are a set of rules that tell you how something should be done. Another word for parameters is guidelines. HCP orders may include parameters that tell you exactly what to do before or after you administer a medication. They will also tell you when to notify the HCP, if needed.

This is an example of an HCP order that includes a parameter telling you when to give a medication:

- Give Milk of Magnesia 1200mg by mouth as needed every 3rd evening if no bowel movement.

This is an example of an HCP order that includes a parameter telling you when to hold (or not give) a medication:

- Take pulse daily before Lisinopril administration, if pulse is less than 60 do not give Lisinopril.

These are examples of HCP orders that include a parameter telling you when to notify the HCP:

- If no bowel movement within 24 hours after PRN Milk of Magnesia is administered, notify the HCP.
- If pulse is less than 60, hold Lisinopril and notify the HCP.
- If complains of a sore throat, notify the HCP.
- If temperature is 100 or greater, notify the HCP.

When parameters to hold the medication are met and the medication is not administered, document this on the medication sheet by:

- Writing the acceptable code MNA (medication not administered) in the medication box and
- Writing a medication progress note including:
    - The date and time
    - The medication involved
    - Why the medication was not administered
    - Your observations
    - If required, who was notified
        - MAP Consultant (typically the HCP)
        - Your supervisor
            - Include first and last names
        - What you were instructed to do
    - Your signature.

The parameters in a person's HCP order are written on the medication sheet next to special instructions. The parameters below are to hold Zestril if the systolic (top) blood pressure (BP) reading is below 100 and notify the HCP. On March 5th at 8am the BP reading you obtain is 90/50. Use the medication sheet to document the BP reading and the held dose. Use the medication progress note to document what happened and who you notified.

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand **Check blood pressure (BP)**		**8am**	WS	AS	JC	WS																											
	Strength	Dose	**BP**																															
Stop	Amount	Route	**S**	120	134	**130**	**132**																											
Cont.	Frequency **Daily in the morning**		**D**	**64**	**66**	**62**	**60**																											

Special instructions: **Hold Zestril if systolic (top) blood pressure (BP) reading is below 100 and notify HCP** *Reason:*

Start	Generic **Lisinopril**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand **Zestril**		**8am**	WS	AS	JC	WS																											
	Strength **20mg**	Dose **40mg**																																
Stop	Amount **2 tabs**	Route **mouth**																																
Cont.	Frequency **Daily in the morning**																																	

Special instructions: **Hold Zestril if systolic (top) blood pressure (BP) reading is below 100 and notify HCP** *Reason:* **high BP**

MEDICATION PROGRESS NOTE

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature

Medication Ordered to be Held Before a Medical Test

There are some medical tests that require restrictions of food, drink and/or medication prior to testing. An HCP order will specify:

- If medication is to be held before a medical test
- Whether to give the medication after the test is completed or
- To resume the next regularly scheduled dose as ordered.

When medication is ordered to be held (not administered) prior to a medical test, document this on the medication sheet by:

- Writing the acceptable code MNA (medication not administered) in the medication box and
- Writing a medication progress note including
    - The date and time
    - The medication involved
    - Why the medication was not administered
        - Reference the HCP order to hold the dose of medication prior to testing.
    - Your signature.

The instructions in a person's HCP order state to hold the Omeprazole on March 4, yr at 4pm prior to a scheduled test and to resume the next dose when it is due. Document the held medication dose on the medication sheet and write a medication progress note.

Start	Generic **Omeprazole**																																							
8/31/yr	Brand **Prilosec**																																							
	Strength **20mg**	Dose **20mg**																																						
Stop	Amount **1 tab**	Route **Mouth**																																						
Cont.	Frequency **Once daily before supper**																																							

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
4pm	WS	WD	JC																												

Special instructions: *Reason:* **GERD**

MEDICATION PROGRESS NOTE

Date	Time	Medication	Dose	Given	Not	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature

If a Medication is Not Available to Administer

At times a medication may not be available to administer even though you have attempted to obtain the medication from the pharmacy, such as when:

- Prior authorization is required from the person's prescription insurance company
    - Follow up by immediately contacting the prescribing HCP and obtain an HCP order about what you are to do until the medication can be obtained.
- The medication is 'too soon to refill'
    - Follow up by contacting the pharmacist and asking when the medication will be available and what you are to do until the medication is obtained.
- No refills remain on the prescription
    - Follow up by immediately contacting the prescribing HCP and request a new prescription be sent to the pharmacy.
        - Follow up with the pharmacy to ensure the prescription is received.
        - Confirm a date and a time the medication will be obtained.
            - If you cannot obtain the medication for the dose that is due, obtain an HCP order about what you should do.

When medication is not available to be administered, document this on the medication sheet by:

- Writing the acceptable code MNA (medication not administered) in the medication box and
- Writing a medication progress note including:
    - The date and time
    - The medication involved
    - Why the medication was not administered
    - What you have done to obtain the medication
    - Your observations
    - Who was notified
        - Pharmacist and/or HCP
        - Your Supervisor
            - Include first and last names
    - What you were instructed to do
    - Your signature.

There is no Prilosec available for you to administer at 4pm on March 4th, yr. You call and speak to Forrest Greenleaf, the pharmacist at Greenleaf Pharmacy. You are told the medication will be delivered by 7:30pm. You then ask the pharmacist what to do about the 4pm dose that will be missed. The pharmacist's recommendation is to omit the 4pm dose on March 4th, yr. and to give the next regularly scheduled dose when due. Document the missed dose on the medication sheet and write a medication progress note.

Start	Generic **Omeprazole**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Prilosec**																																							
	Strength **20mg**	Dose **20mg**																																						
Stop	Amount **1 tab**	Route **Mouth**	**4pm**	WS	WD	JC																																		
Cont.	Frequency **Once daily before supper**																																							

Special instructions: *Reason:* **GERD**

MEDICATION PROGRESS NOTE

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature

When a medication is not available and as a result is omitted (not given), it is a medication occurrence. You must contact a MAP Consultant immediately and submit a medication occurrence report.

Let's Review

- Some medications are administered on a continuous basis.
- Some medications are administered on a PRN, as needed basis.
    - PRN medication orders must have:
        - Target signs and symptoms
        - A specific reason for use
        - Parameters or instructions
            - including what to do if the medication is given and has no effect.
- There are 5 Rights of Medication Administration:
    - Person
    - Medication
    - Dose
    - Time
    - Route
- The 5 Rights must agree between the:
    - HCP order
    - Pharmacy label
    - Medication sheet.
- Safe Medication Administration includes:
    - Confirmation there is an HCP order
    - Check 1 - Pharmacy label and medication sheet
    - Check 2 - Pharmacy label and medication sheet
        - The 5 Rights must be checked 2 times before any medication is administered.
- Liquid medication strength will usually have a 'mg' per 'mL.'
- Liquid measuring devices must always be used to prepare liquid medication.
- There are many different routes that medications can be administered.
    - Routes other than oral require additional training.
- An HCP order is required to change the form of a medication (such as crushing).
- If a person refuses their medication, try to determine why.
- Offer the medication 3 times before considering the medication refused.
- Documentation of a medication not administered includes:
    - An acceptable code on the medication sheet and
    - A progress note.

Unit 8

Chain of Custody

Responsibilities you will learn

- What the 'Chain of Custody' means
- Why the Chain of Custody is necessary
- What can happen if the Chain of Custody is broken
- Your role in the Chain of Custody

The Chain of Custody is a trail of unbroken documentation that ensures the physical security of medication. The Chain of Custody tracks every tablet, capsule, mL, etc. of medication.

This tracking documents medication:

- From the time it is requested from the pharmacy
  - either as a new medication or a medication refill
- Until the time it no longer exists at the site
  - when administered, disposed, transferred, etc.

The Chain of Custody makes sure all medication is accounted for and the integrity of the medication is not compromised. Maintaining the Chain of Custody minimizes the opportunity for medication to be diverted (stolen).

Many documents and methods are used to track medications. These include:

- A Medication Ordering and Receiving Log
  - Documentation of medication that is ordered by a site and when it is received from the pharmacy.

- Pharmacy receipts
  - Documentation from the pharmacy of all medication dispensed to a site
    - Whether delivered to the site or
    - Picked up from the pharmacy by Certified staff.

- Count Book
  - Documentation of countable medication that is
    - Added into the Count Book
    - Subtracted from a Count Book.

- Security of the medication storage area
    - Only staff assigned to administer medication may access the medication storage area.

- Medication sheet
    - Documentation of medication that is administered and (if) not administered.

- Medication release documents (Transfer or LOA form)
    - Documentation of medication that is moved from one location to another location.

- Disposal Record
    - Documentation of medication that is disposed.

- Blister Pack Monitoring
    - A medication tracking method. Blister pack monitoring is not a MAP requirement. If used at your site, documentation must be completed by staff on the back of the blister pack. Each time a tablet or capsule is removed from the package, staff must document their initials, the date, and the time.

Ask your supervisor if blister pack monitoring is required at your work location.

Medication Ordering and Receiving Log

All sites must maintain a record of when a prescription is requested to be filled by the pharmacy. Sites must also maintain a record of the quantity of medication received. The quantity of medication requested, and the quantity of medication received must be compared. This process is usually documented using a Medication Ordering and Receiving Log. You must document in the Medication Ordering and Receiving Log each time you:

- Request a medication refill from the pharmacy, document the:
  - Person's name
  - Name of medication and strength
  - Quantity (total number of tablets, capsules, mL, etc. requested)
  - HCP's name
  - Your signature and the date the medication refill was requested.
- Receive a medication refill from the pharmacy, document the:
  - Prescription (Rx) number
  - Strength of medication received
    - Double check that the strength ordered is the same as the strength received.
  - Quantity (total number of tablets, capsules, mL, etc. received)
  - remaining refills
    - If '0', contact the HCP to request another prescription be sent to the pharmacy.
  - Your signature and the date the medication refill was received.

Sample Medication Ordering and Receiving Log

Provider **Site Address** **Pharmacy**

Name	Medication	Strength Ordered/ Expected	Quantity Ordered/ Expected	Health Care Provider	Ordered by- Signature/Date	Rx#	Strength Received	Quantity Received	Refills Left	Action Taken	Received by- Signature/Date

You have received a delivery of medication from the pharmacy. As you document that the medication is received onto the Medication Ordering and Receiving Log, you notice that one of the medications received has '0' refills.

What should you do next? _____

Anytime a medication refill was ordered but not received as expected, immediately contact the pharmacy. Document any action taken on the Medication Ordering and Receiving Log.

Pharmacy Receipts

The pharmacy will provide a receipt for every medication dispensed. The pharmacy receipt usually includes the:

- Person's name
- Medication name
- Strength of medication
- Total number of tablets, capsules, or mL dispensed
- Rx (prescription) number

When medication is received from the pharmacy you must compare the:

- Medication received from the pharmacy to the pharmacy receipt
  - ensuring you received what the pharmacy has documented they sent.
- Medication Ordering and Receiving Log to the medication obtained
  - ensuring you received what was ordered/expected by your site.

The pharmacy manifests (receipts of medication dispensed) must be kept at the site for a minimum of 90 days.

Some sites use the pharmacy manifests as documentation for the site's receiving system. If so, the pharmacy manifests must be kept on site for two years.

Ask your supervisor if the pharmacy supplies automatic refills or online orders for your work location. If the answer is yes, you still need to cross check the medication you are expecting to receive to what the pharmacy delivers. Ask your supervisor what system is used to do this.

Countable Controlled Substance Book

The Countable Controlled Substance Book is typically known as the Count Book. All countable controlled (schedule II - V) medication must be documented and tracked in a Count Book. There are many requirements surrounding countable medication because these medications may be stolen and abused.

The Count Book must have a binding with no loose pages. The binding is the adhesive on the edge of the book that holds the pages together and protects them. The book must be preprinted with consecutively[30] numbered pages.

Usually, a Count Book will have a page in the front with lines to write in the site address and the book number. If there are no spaces labeled as such, the information may be written on a blank page in the front of the Count Book.

Count Books are consecutively numbered for the site, i.e., Count Book 1, Count Book 2, Count Book 3, etc.

A Count Book has 3 basic sections, including the:

- Index
- Count Sheets
- Count Signature Sheets

[30] Numbered in order.

Index

The beginning of the Count Book contains the index. The index identifies the:

- Name of each person prescribed a countable medication
- Medication name and strength
- Count sheet page number of the countable medication
- Signature space if the medication is removed from count.
    - Only a supervisor may remove a medication from count. The reasons for removal include (but are not limited to):
        - The medication was discontinued and disposed
        - The medication was disposed after a person died
        - The person moved and medication was transferred to a new home.

In the above examples, the 'amount left column' on the count sheet page will be marked as '0.' This shows that the medication is physically no longer at the site to count.

Index

Name	Medication and Strength	Page Number				Person responsible for removing medication from count
David Cook	Phenobarbital 32.4mg	1	2			
Tanisha Johnson	Clonazepam 1mg	3				
Tanisha Johnson	Phenobarbital 32.4mg	4				
Ellen Tracey	Lorazepam 0.5mg	5				
Juanita Gomez	Tramadol 50mg	6				
David Cook	Tramadol 25mg	7				

A Count Book index also identifies the count sheet pages that are currently in use. The index must be updated when transferring from an old count sheet page to a new count sheet page. As the index is updated, the preceding page number is not crossed out. The index is used as a guide when conducting a 'Shoulder to Shoulder' count of all medication.

Looking at the sample index below, you know that:

- Sarah Brown's Phenobarbital is no longer in the double locked area to count because Linda White, the supervisor, signed as removing it from count. If the medication was discontinued, it would have remained on count and double locked until disposed. Only after its disposal would a supervisor sign as 'Person Responsible for Removing Medication from Count.' If you turned to the corresponding count sheet page 7, the 'amount left' column would have a '0' as there is no longer medication physically present to count.

- Mike Stone has Ativan 1mg tablets to be counted on page 5 (because page 2 became full).

- When the four boxes next to Joseph Smith's Ativan were full, a supervisor wrote 'see below' with their initials to indicate the Ativan was started on a new row in the index. Joseph Smith's Ativan is currently found on count sheet page 11.

- William Mitchell has Percocet to be counted on count sheet page 8.

According to the index below, there are three count sheet pages currently in use, count sheet page numbers 5, 8 and 11.

Name	Medication and Strength	Page Number				Person responsible for removing medication from count
Sarah Brown	Phenobarbital 97.2mg	1	4	7		*Linda White*
Mike Stone	Ativan 1mg	2	5			
Joseph Smith	Ativan 0.5mg	3	6	9	10	*See below LW*
William Mitchell	Percocet 5mg/325mg	8				
Joseph Smith	Ativan 0.5mg	11				

Index

Count Sheets

The heading of each count sheet must be completed when:

- A new medication is added into the count
- The balance of medication is transferred from a completed count sheet page to a new count sheet page.

The heading of each count sheet must be completed with the information from the pharmacy label, including the:

- Person's name
- Medication name
- Strength of medication
- Directions to administer the medication
- HCP's name
- Pharmacy name
- Prescription (Rx) number
- Prescription date

The first line of the count sheet must indicate the:

- Date and time
    - Amount of medication received from the pharmacy and added into the count, or
    - Amount of medication transferred from a completed count sheet page to a new count sheet page
- Signatures of the two Certified staff verifying the amount of new medication added into the count, or the amount of medication transferred to the new page.

The count sheet tracks the amount of each countable medication when:

- Added as
    - A new medication
    - A medication refill
    - Transferred from a previous page
    - Received from another site
    - Received from the pharmacy after repackaging and/or relabeling

- Subtracted as
    - Administered, including the

        - Date and time
        - Route by which the medication was administered
        - Amount on hand (the amount you started with)
        - Amount used
        - Amount remaining (the amount you are left with after subtracting what you removed from the package)
        - Your signature
    - Packaged
        - The total amount of tablets packaged into a pill organizer by a person learning to self-administer
    - Transferred
        - To another site, such as the day program
        - On an LOA
        - To the pharmacy for repackaging or relabeling
    - Disposed
        - If the medication is
            - refused
            - expired
            - discontinued
            - dropped on floor, etc.

Each tablet, capsule or mL of medication must be accounted for.

The amount used column must be documented in word form, not in numerical form. For example, 'one' must be written and not documented as the number '1.' This will help prevent someone from altering your documentation.

Name: David Cook __X__ Original Entry or
Doctor: Dr. Black _____Transferred from page___
Pharmacy: Greenleaf Prescription Number: N671
Medication and Strength: Phenobarbital 32.4mg Prescription Date: Feb. 17, yr
Directions: Take 3 tablets by mouth once daily in evening

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
2/17/yr	9am	Received 42 from Pharmacy			42	Linda White/Sam Dowd
2/17/yr	8pm	Mouth	42	Three	39	Jenna Sherman
2/18/yr	8pm	Mouth	39	Three	36	Jenna Sherman
2/19/yr	8pm	Mouth	36	Three	33	Amanda Smith
2/20/yr	8pm	Mouth	33	Three	30	Amanda Smith
2/21/yr	8pm	Mouth	30	Three	27	Amanda Smith
2/22/yr	8pm	Mouth	27	Three	24	Jenna Sherman
2/23/yr	8pm	Mouth	24	Three	21	Jenna Sherman
2/24/yr	8pm	Mouth	21	Three	18	Amanda Smith
2/25/yr	8pm	Mouth	18	Three	15	Amanda Smith
2/26/yr	8pm	Mouth	15	Three	12	Amanda Smith
2/27/yr	8pm	Mouth	12	Three	9	Jenna Sherman
2/28/yr	8pm	Mouth	9	Three	6	Jenna Sherman
3/1/yr	8pm	Mouth	6	Three	3	Amanda Smith
3/2/yr	8pm	Mouth	3	Three	0	Amanda Smith

Amount left _0__ transferred to page __2___
Signature _____Amanda Smith__
Signature _____Jenna Sherman___

Count Signature Sheets

The last section of the Count Book contains the count signature sheets. Countable controlled medication must be counted:

- With two Certified staff
- Every time the medication storage keys change hands
    - Including when placing the medication storage keys into or removing them from the combination lock box.
        - This can happen when
            - there is no staff coming on duty as you are leaving or
            - there is no staff present when you arrive.

Count Signature Sheet

Date	Time	Count correct yes/no	Incoming Staff	Outgoing Staff
3/1/yr	3:10pm	Yes	*Amanda Smith*	Sam Dowd
3/1/yr	11:06pm	Yes	**Jenna Sherman**	*Amanda Smith*
3/2/yr	8:56am	Yes	**single person count**	**Jenna Sherman***
3/2/yr	3:04pm	Yes	Sam Dowd	*Linda White (witness)* **
3/2/yr	11:17pm	Yes	*Amanda Smith*	Sam Dowd

***** On 3-2-yr at 8:56am, Jenna Sherman was the only MAP Certified staff on duty. When it was time for her to leave, there was no MAP Certified staff coming on duty. Jenna conducted a single person count before securing the medication storage keys.

****** On 3-2-yr at 3:04pm, a two-person count was conducted by Sam Dowd and Linda White. Sam was assigned medication administration duties for the shift. When

documenting, Linda wrote the word ‘witness’ next to her signature because she and Sam were working the same shift. Outgoing staff had left earlier that morning.

‘Shoulder to Shoulder’ Count Procedure

When conducting[31] a two-person count of the countable controlled medication, follow the ‘Shoulder to Shoulder’ count procedure:

- The outgoing staff (giving up the keys) holds the Count Book and leads the count.
    - Using the index as their guide, the outgoing staff:
        - Reads the information of the first medication to be counted including:
            - the person’s name,
            - medication name and strength,
        - And then turns to the appropriate count sheet page.

- The incoming staff (receiving the keys) locates the corresponding tamper resistant package of medication.
    - The incoming staff then reads aloud the label information
        - The person’s name, medication name, strength, and directions for use.
    - Then the staff counts and states the number of pills, syringes, etc. seen in the package.

- The outgoing staff (giving up the keys) verifies that the:
    - Directions listed on the count page agree with the direction on the pharmacy label.
    - The number of pills, syringes etc. in the ‘amount left’ column is the same as the number counted by the incoming staff.

- Both staff look at and verify that the number of pills, syringes etc. remaining in the tamper resistant package and in the ‘amount left’ column are the same.

- Both staff inspect the integrity of the package to ensure there has been no tampering.

- This process is completed for each countable medication.

- After all countable medications have been counted, both staff must sign the count signature sheet. This documents that the count was conducted, and all countable medication is accounted for. When documenting the time the count is

[31] the action of doing or carrying out a task or process

completed, look at a clock and document the exact time to the minute. The medication storage keys are now transferred to the incoming staff.

Countable medications must be counted each time the medication storage keys change hands. This includes when the storage keys are placed into or removed from a lock box. The person assigned medication administration duties must carry the medication storage keys for the shift.

All counts must be conducted by two Certified and/or licensed staff. The required count may be conducted by a single Certified and/or licensed staff, but only if the following conditions are met:

- The required two-person count has been conducted within the previous 24 hours and
- A second Certified/licensed staff person is not scheduled to be at the site when the responsibility of the control of the medication key needs to be passed.

The required two-person count must be conducted:

- At the first opportunity and
- No later than 24 hours after the last two-person count was conducted.

True (T) or False (F)

1. __ When conducting a two-person medication count, it is acceptable for one staff to conduct the count and have a second staff verify the count later.
2. __ All countable medications must be counted every time the medication storage keys change hands.
3. __ After counting the medications and accepting the medication storage keys, you are accepting responsibility for the security of the medication.
4. __ The medication storage keys are carried by the Certified staff assigned medication administration duties for the shift.
5. __ Maintaining the Chain of Custody makes it harder for medication to be stolen.

Review the scenario and select the best action.

You arrive at work and are assigned medication administration duties for the shift. A 'Shoulder to Shoulder' count is completed, the medication storage keys are handed to you, and you have accepted responsibility for the medication. During your shift, another Certified staff asks for the medication storage keys to get the drug reference book from the medication storage area. You must:

1. __ Give the keys to the Certified staff with instructions to return them as soon as they have what they need.
2. __ Unlock the medication storage area for the Certified staff and instruct them to lock it back up when they are done.
3. __ Unlock the medication storage area, obtain the drug reference book for the Certified staff and relock.

Mark yes (Y) or no (N) if you may give the medication keys to:

1. __ The VNA nurse who needs to access insulin stored in the medication area.
2. __ An Administrator or supervisor that is not MAP Certified and requests to do an audit.
3. __ Maintenance personnel for needed repairs to the medication closet.

Answer the following questions:

1. What happens to the 'Chain of Custody' if unauthorized staff have access to the medication storage area? _____

2. When and to who are you allowed to give the medication storage keys?
   _____

   _____

You are one of two Certified staff conducting a 'Shoulder to Shoulder' count. Review count sheet page 9 below and the corresponding blister pack (see next page). Is the count correct? _____

Name: Scott Green _X_ Original Entry or
Doctor: Dr. S. Pratt ____Transferred from page__
Pharmacy: Greenleaf Prescription Number: N588
Medication and Strength: Zolpidem 5mg Prescription Date: Mar. 3, yr
Directions: Take 1 tablet by mouth once daily PRN at bedtime per Scott's request for difficulty sleeping

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/3/yr	9am	Received 30 from pharmacy			30	Linda White/Sam Dowd
3/3/yr	9pm	mouth	30	One	29	Jenna Sherman
3/4/yr	9pm	mouth	29	One	28	Jenna Sherman
3/8/yr	9:30pm	mouth	28	One	27	Amanda Smith
3/10/yr	9pm	mouth	27	One	26	Amanda Smith
3/11/yr	9:15pm	mouth	26	One	25	Jenna Sherman
3/13/yr	9pm	mouth	25	One	24	Jenna Sherman
3/14/yr	10pm	mouth	24	One	23	Jenna Sherman
3/18/yr	10pm	mouth	23	One	22	Amanda Smith
3/22/yr	9:30pm	mouth	22	One	21	Amanda Smith

If the tablets in a blister package are accidentally removed out of order, you cannot rely on the numbered blisters. Instead, you must count each tablet.

When and Why 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 into the count.
    - Why?
        - To verify the total amount of new medication received from the pharmacy is:
            - correct
            - added to the count
            - not stolen.

- Adding a medication refill from the pharmacy into the count.
    - Why?
        - To verify the total amount of medication received from the pharmacy is
            - correct
            - added to the count
            - not stolen.

- Disposing medication.
    - Why?
        - To verify the total amount of medication to be disposed
            - is rendered useless
            - cannot be used
            - is not stolen.

- A count sheet page is transferred, including both the bottom of the completed page and the top of the newly transferred page.
    - Why?
        - To verify the amount (number of tabs, caps, mL's etc.) of medication at the bottom of the completed page
            - is the same as the amount of medication at the top of the new page
                - to make sure the medication has not been stolen.

- The medications are counted each time the medication storage keys change hands.
    - Why?
        - To verify all medication is secure, accounted for and is not stolen.

Sometimes there are no countable medications, or ‘high-risk Schedule VI’ medication stored at your work location. When this is the case, there must be a documentation procedure to identify the Certified or licensed staff responsible for control of the Medication Storage Key.

Name: Tanisha Johnson ___ Original Entry or
Doctor: Dr. C. Lee X__ Transferred from page_4__
Pharmacy: Greenleaf Prescription Number: N347
Medication and Strength: Phenobarbital 32.4mg Prescription Date: Mar. 3, yr
Directions: Take 2 tablets by mouth once daily in evening

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/17/yr	9pm		Page Transfer*		32	Jenna Sherman/*Amanda Smith*
3/18/yr	8pm	Mouth	32	Two	30	Jenna Sherman
3/19/yr	8pm	Mouth	30	Two	28	Jenna Sherman
3/20/yr	8pm	Mouth	28	Two	26	*Amanda Smith*
3/21/yr	8pm	Mouth	26	Two	24	*Amanda Smith*
3/22/yr	8pm	Mouth	24	Two	22	*Amanda Smith*
3/23/yr	8pm	Mouth	22	Two	20	Jenna Sherman
3/24/yr	8pm	Mouth	20	Two	18	Jenna Sherman
3/25/yr	8pm	Mouth	18	Two	16	*Amanda Smith*
3/26/yr	8pm	Mouth	16	Two	14	*Amanda Smith*
3/26/yr	9pm		Received 60 from pharmacy**		74	Jenna Sherman/*Amanda Smith*
3/27/yr	8pm	Mouth	74	Two	72	*Amanda Smith*

*The 3/17/yr 9:00pm entry is an example of a count sheet page transfer. If you looked back at count sheet page 4 at the bottom, you would see 32 in the amount left column and the signatures of Jenna Sherman and Amanda Smith.

**The 3/26/yr 9:00pm entry is an example of adding a medication refill into count when two MAP Certified staff are working at the same time and a pharmacy delivery arrives.

Security of the Medication Storage Area and Medication Administration Responsibilities

Only MAP Certified staff may know the locked box combination to access the medication storage keys. Access to the medication storage area must be limited to staff assigned to administer medication. Once you are assigned medication administration duties, you are responsible for the inventory (supply) of medication during your assigned shift.

Often countable controlled medications are part of the inventory. When they are, a two-person, 'Shoulder to Shoulder' count of the medication is conducted. The count is done with the incoming and outgoing responsible staff every time the medication storage keys change hands.

Once you have conducted the count and have accepted the keys:

- Only you should have access to the medication storage area
- The medication keys are kept with you as long as you are at the site
- At the end of your shift, before handing the keys over
    - You must conduct a 'Two-Person Count' with the incoming staff who will be responsible for the medication.

A count must be conducted every time medication responsibilities change.

If no Certified staff will be at the site during the next shift, the keys must be kept locked at the site. Medication storage keys are usually secured in a combination locked box.

A count must be completed:

- Before placing the keys into the locked box
- After removing the keys from the locked box.

Certified or licensed staff assigned medication administration responsibilities and the security of the medication storage area must keep the keys on their person[32] during their entire assigned shift or assignment.

- If the assigned Certified or licensed staff needs to leave their work location and
    - There is another Certified or licensed staff available to remain at the work location
        - A 'Two-Person Count' must be conducted and documented in the Count Book.
    - If the Certified or licensed staff returns to the work location and

[32] Carried by the person.

        - They will resume medication administration responsibilities
            - another count must be completed.
- If the assigned Certified or licensed staff needs to leave their work location and
    - There is no other Certified or licensed staff available to conduct a 'Two-Person Count'
        - Then a 'Single Person Count' must be conducted
            - document in the Count Book
                - your signature and 'single person count'.
        - The medication storage area keys are then placed in the designated locked container, such as a realtor box.
    - If the Certified or licensed staff returns to the work location and
        - They will resume medication administration responsibilities
            - another count must be completed.
- If the assigned Certified or licensed staff needs to leave the work location
    - Along with all other scheduled Certified or licensed staff
        - A 'Two-Person Count' must be conducted and documented in the Count Book.
            - The medication storage keys will then be placed in the designated locked container, such as a realtor box.
    - The second Certified or licensed staff will sign the Count Book in the role of a 'witness' to the count.
        - If either or both Certified or licensed staff return to the work location, and
            - One of them will resume medication administration responsibilities
                - another count must be completed.

When you are assigned the task of medication administration, you must keep the keys on your person during your entire shift.

Ask your supervisor if a Biometrics medication security system is used at your work location. If so, ask how it works.

Medication Sheets

Medication sheets are tracking forms that are part of the Chain of Custody. All HCP medication orders must be transcribed onto a medication sheet. After a medication is administered, you write your initials in the medication box on the medication sheet. Your initials in a medication box means that you administered the medication at the site. If the medication was not administered at the site because the person was at another location, an acceptable code is used.

If the person is at the site but the medication is not administered, document this on the medication sheet by

- Writing the acceptable code MNA (medication not administered) in the medication box and
    - Writing a progress note explaining
        - Why the medication was not administered and
        - Who was notified

Documentation example of a medication missed (omitted), on the medication sheet and corresponding medication progress note:

Month and Year: June, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: Bactrim**

Start 2/1/yr	Generic Phenytoin Brand Dilantin																																				
	Strength 100mg	Dose 200mg																																			
Stop	Amount 2 tabs	Route Mouth																																			
cont.	Frequency twice daily																																				
Hour	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**						
8am	JS	JS	JS	JS	JS	AS	AS	AS	AS	JS	JS	JS	JS	JS	AS	AS	AS	AS	JS	JS	JS	JS	MNA														
8pm	TM	TM	SD	SD	SD	SD	SD	TM	TM	TM	TM	SD	SD	SD	SD	SD	TM	TM	TM	TM	SD	SD															

Special instructions: *Reason: seizures*

Name Juanita Gomez **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
6-23-yr	9:30am	Juanita's morning dose of Phenytoin 200mg was omitted. The refill was not included in this morning's delivery. The pharmacy was contacted and said the medication will be delivered by 2pm today. I spoke to the pharmacist, Forrest Greenleaf who told me to skip this morning's dose and give the 8pm dose as ordered. He also recommended notifying the neurologist. I notified Dr. Jones who had no further recommendations. I also reported the information to Linda White, Supervisor.	Jenna Sherman							

When a medication is not available and is omitted (not given) as a result, it is a medication occurrence. This requires you to contact a MAP Consultant immediately and submit a medication occurrence report.

Medication Release Documents

A medication release document is used to track medication. When medication is moved from one location to another location, a dated medication release document (transfer or LOA form) must be completed.

Medications may be transferred to or from a residential site and:

- The day program/day habilitation[33]
- Family for an LOA
- A different residential site
- The pharmacy for repackaging or re-labeling
- The hospital because a specific medication prescribed for the person is not supplied by the hospital's pharmacy.

A medication release document must include:

- The name of the person whose medication is being moved
- Where the medication is being transferred from
- Where the medication is being transferred to
- Medication name and strength
- Total amount of medication (tablets, capsules, mL, etc.) transferred
- Signature of person transferring medication
- Signature of person receiving medication.

[33] A site similar to a day program except medications are only given by nurses.

Sample Medication Transfer Form

I, _____, am transferring the following medication
For (Name), _____
From _____
To _____
Date _____

Medication	Strength	Quantity

Signature of staff receiving medications _____ Date _____

Signature of staff transferring medications _____ Date _____

Medications are transported only by MAP Certified or licensed staff:

- For the people residing at their work location and
- Only during work hours.

MAP Certified staff may not transport medications:

- For people living outside of the staff's work location or
- On the staff's own time.

Medication Administration at Locations other than the Residential Site

Whenever possible, schedule medication to be administered at the residential site. However, if a person requires medication at locations other than the residential site, it may be administered.

Medication administration at locations other than the residential site may include:

- Day Program
- Off-Site Medication Administration
- Leave of Absence
- Certified/Licensed Staffed Vacation

Day Program Medication and Residential Site Staff Responsibilities

Sometimes a person routinely receives medications at more than one location. For example, they may receive medication at their residential site, as well as at their day program. In this case, you must ask the pharmacy to 'split-package' or divide the medication into two containers, one for the residential site and one for the day program.

For example, if Juanita attends her day program five days a week, the pharmacy will prepare and package her day program medication separately from medication she receives at her residential site. If Juanita's monthly supply of medication is delivered in full to the residential site:

- Before you send it to the day program:
  - Document the medication as received in the residential site's Medication Ordering and Receiving Log
    - If the medication is a countable medication, add it to the Count Book.
    - Complete a transfer form for the split-packaged day program medication including:
      - Name of person
      - Medication name and strength
      - Amount of tablets, capsules or mLs released

        - if the medication is a countable medication, it must be subtracted from the residential site's Count Book
    - Address the medication is being released from
    - Address the medication is being released to
    - Your signature, as the person releasing the medication
    - Date

- At the day program:
    - Obtain signature and date of the person accepting the medication.
        - If the medication is a countable medication, day program staff must add it to the Count Book
        - Make a copy of the signed and dated transfer form
            - the residential site keeps the original as documentation of medication released and
            - the day program keeps the copy as documentation of medication received.

Day program staff usually receive their supply of medication from residential site staff. In this instance, a day program will not be able to meet the MAP requirement of having 90 days' worth of pharmacy receipts in the program. Instead, a day program will have transfer forms which are kept on site for 2 years.

The residential site staff are responsible for making sure the day program staff have everything required for medication administration, including:

- A copy of the HCP order and
- Pharmacy labeled split-packaged medication.

Communication between residential site staff and day program staff is essential for safe medication administration.

Class Discussion

Juanita has a medication ordered four times daily, scheduled for 8am, 12pm, 4pm and 8pm. The 12pm dose is administered at the day program 5 days a week. At Juanita's last HCP visit, Dr. Jones discontinued the medication. The residential staff discontinued the order on the medication sheet, posted and verified the HCP order and disposed of the discontinued medication, per service provider policy. However, no one notified the day program. What do you think happened? What should have happened?

Ask your supervisor what the communication system is between the day program and your work location.

Day Program Staff Responsibilities

Day programs must have a system in place to make sure a complete set of current HCP orders are received from the residential site for each person. This includes PRN medication orders that may be needed during day program hours.

Day program staff transcribe only the medications scheduled during day program hours onto the medication sheet. They must also transcribe PRN medications that may be needed during day program hours.

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

Residential site staff informs day program staff that David Cook has a new order for Amoxicillin 500mg every 8 hours for 10 days by mouth because he has bronchitis. The times chosen by residential site staff were 6am-2pm-10pm. His first dose was at 10pm on May 2, yr.

After resting at home for several days, David has received medical clearance to return to the day program on Monday, May 8, yr.

Using the copy of the HCP order and the pharmacy labeled medication package (see following two pages) supplied by residential site staff, day program staff will transcribe the order onto a medication sheet.

HEALTH CARE PROVIDER ORDER

Name: David Cook	**Date:** May 2, yr
Health Care Provider: Dr. Black	**Allergies:** No Known Allergies
Reason for Visit: David has had a cough since yesterday. He is complaining of a sore throat and says he 'feels tired'. His temperature was 100 at 9am today.	
Current Medications: See attached medication list.	
Staff Signature: Sam Dowd	**Date:** May 2, yr
Health Care Provider Findings: Bronchitis	
Medication/Treatment Orders: Amoxicillin 500mg every 8 hours for 10 days by mouth	
Instructions:	
Follow-up visit:	**Lab work or Tests:**
Signature: Richard Black, MD	**Date:** May 2, yr

Posted by: Sam Dowd **Date:** 5/2/yr **Time:** 1:15pm **Verified by:** Linda White **Date:** 5/2/yr **Time:** 2pm
Posted by: Tom Cash **Date:** 5/8/yr **Time:** 8:10am **Verified by:** Sara Green **Date:** 5/8/yr **Time:** 9am

After transcribing, day program staff must post and verify the HCP order under the post and verify section that was completed by residential site staff.

Rx #210	**Greenleaf Pharmacy** **20 Main Street** **Treetop, MA 00000**	**111-222-3443** **5/2/yr**
David Cook		
Amoxicillin 500mg **IC Amoxil**		**Qty. 30**
Take 1 tablet by mouth every 8 hours for 10 days		**Dr. Black**
Lot# 436	**ED: 5/2/yr**	**Refills: 0**

At the day program, when transcribing you must use and copy all the times chosen by the residential staff. This includes the times the medication is administered at the residential site.

Only the medication boxes for the times and days of the week when the medication will be given at the day program are left open. Day program staff will initial in these boxes after medication administration.

All medication boxes for times and/or days of the week that do not apply to day program hours (Saturday, Sunday, holidays, etc.) are marked with an 'X' in the medication box.

Month and Year: May, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Amoxicillin																														
5/2/yr	Brand Amoxil																														
	Strength 500mg	Dose 500mg																													
Stop	Amount 1 tab	Route mouth																													
5/12/yr	Frequency Every 8 hours for 10 days																														

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2pm	X	X	X	X	X	X	X						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
10pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special Instructions: *Reason: bronchitis*

How many Amoxicillin tablets should be split-packaged by the pharmacy and transferred to the day program staff by the residential site staff? _____

When medication administration is scheduled during school hours, residential site staff must maintain all Chain of Custody documentation. Documentation includes the use of a transfer form and the acceptable code 'S' in the appropriate boxes on the medication administration sheet.

Off-Site Medication Administration (OSA)

Off-site medication administration is medication administered to a person at an off-site location:

- By you or a licensed staff
- During the hours they would usually receive medication at
    - Home or
    - Day program.

Examples include, but are not limited to:

- A person leaves their home for a community outing, the movie theater or the mall. You will administer their medication while they are attending the activity.
- A person leaves the day program to go to their work location or to attend an activity. You will administer their medication during work or while they are attending the activity.

Preparation of Off-Site Medication

The medication must be prepared by the pharmacy when the person will be off-site for more than 24 hours.

You may prepare the medication if:

- The pharmacy cannot prepare the medication and
- The off-site time period is less than 24 hours.

When you prepare the off-site medication, you must also administer the medication. Each medication strength must be:

- In a separate container
    - Marked directly on the container with the information from the original pharmacy label including the:
        - Person's name
        - Medication name
        - Strength of medication
        - Amount to administer
        - Frequency (including specific time(s) to administer)
        - Name of ordering HCP
        - Directions for medication administration
        - Date prepared
        - Amount of medication in the OSA container (number of tablets, capsules or mLs).

After Preparation of Off-Site Medication

After you prepare the OSA medication, you must document. You must write a medication progress or narrative note that includes the location of where you will administer the OSA medication. You must leave the corresponding medication box open.

See the documentation example below after preparation of an OSA medication.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Clonazepam	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
3/1/yr	Brand Klonopin	8am	SD	SD	SD	SD	SD																										
	Strength 1mg Dose 1mg																																
Stop	Amount 1 tab Route mouth	4pm	JS	AS	AS	AS																											
cont.	Frequency twice daily at 8am-4pm																																

Special instructions: *Reason: seizures*

Name Tanisha Johnson **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
3/5/yr	2:10pm	I prepared Tanisha's 4pm dose of Clonazepam 1mg for an OSA. I will administer the medication to her while she is attending an outing to watch a movie followed by dinner.								
										Amanda Smith

If medication prepared for the off-site medication administration is a countable controlled medication, when subtracting, it must be noted as OSA in the Count Book.

Below is a documentation example after preparation of an OSA countable controlled medication in the Count Book:

3| P a g e

Name: Tanisha Johnson _X_Original Entry or
Doctor: Dr. Chen Lee ___Transferred from page___
Pharmacy: Greenleaf Prescription Number: N236
Medication and Strength: Clonazepam 1mg Prescription Date: March 3, yr
Directions: Take 1 tablet by mouth twice daily at 8am and 4pm

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/3/yr	9am	Received from pharmacy			60	Sam Dowd/Linda White
3/3/yr	4pm	Mouth	60	One	59	Jenna Sherman
3/4/yr	8am	Mouth	59	One	58	Sam Dowd
3/4/yr	4pm	Mouth	58	One	57	Amanda Smith
3/5/yr	8am	Mouth	57	One	56	Sam Dowd
3/5/yr	2pm	OSA	56	One	55	Amanda Smith

During Off-Site Medication Administration

At the time the medication is due, you will administer it to the person. During the off-site administration time, you must have a copy of your current MAP Certification Letter.

The staff responsible for medication administration at the residential site when the person is away will document by writing 'OSA' in the medication box at the scheduled administration time.

Return from Off-Site Medication Administration

When you return with the person to their home or day program, you must write a second progress or narrative note. The note is to indicate that the medication was administered.

Below is a documentation example of the second medication progress note. This note was written after returning to the person's home.

Name Tanisha Johnson **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
3/5/yr 2:10pm I prepared Tanisha's 4pm dose of Clonazepam 1mg for an OSA. I will administer the medication to her while she is attending an outing to watch a movie followed by dinner.										
										Amanda Smith
3/5/yr 7:27pm I administered Tanisha's Clonazepam 1mg at 4:10pm										
										Amanda Smith

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Clonazepam	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
3/1/yr	Brand Klonopin	8am	SD	SD	SD	SD	SD																										
	Strength 1mg Dose 1mg																																
Stop	Amount 1 tab Route mouth	4pm	JS	AS	AS	AS	OSA																										
cont.	Frequency twice daily at 8am-4pm																																

Special instructions: *Reason: seizures*

If for any reason the medication was not administered as ordered off-site, you must complete all necessary follow up. The follow up must include writing a medication progress or narrative note.

Unused Off-Site Oral Medication

Any unused OSA oral medication that you prepared may not be used after returning from the OSA. It must be disposed and documented in the disposal log.

Any unused OSA oral medication that the pharmacy prepared in tamper-resistant packaging may be returned to the medication storage area for use. If it is a countable medication, it must be added back into the count.

See the MAP Policy Manual for details of staffed vacation requirements.

Leave of Absence

Leave of absence (LOA) is when medication is released from a person's home and given to a family member or a responsible friend to administer. They are not required to be MAP Certified or licensed staff.

Preparation of LOA Medication

For any leave of absence, contact the pharmacy to package the LOA medication.

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

- Scheduled ahead of time or
- Greater than 72 hours.

You may prepare the medication if the pharmacy is unable to and only if the LOA is:

- Unplanned (not scheduled ahead of time) and
- Less than 72 hours.

Knowing the date and time the person will be leaving on the LOA and the date and time the person will be returning from the LOA will help to determine the amount of medication to prepare.

If staff prepares the LOA medication, each medication strength must be:

- Prepared in a separate container
    - Marked directly on the container with the information from the original pharmacy label including the:
        - Person's name
        - Medication name
        - Strength of medication
        - Amount to administer
        - Frequency (including specific time(s) to administer)
        - Name of ordering HCP
        - Directions for medication administration (specific dosing and time)
        - Date prepared
        - Amount of medication in the LOA container (number of tablets, capsules or mLs).

All medication sent on the LOA must be documented on a Leave of Absence form.

The Leave of Absence form must include the:

- Person's name
- Destination
- Date and time of departure
- Estimated date and time of return
- Allergies
- Medication name
    - Strength of tablet, capsule or mL
    - Frequency
    - Amount to administer
    - Route
    - Directions or special instructions, if any
- Amount of medication placed into the container
- Who prepared the medication
    - Pharmacy name or
    - Staff name
- Signature(s) of the
    - Second staff, if available, who double checked the prepared LOA medication
    - Staff releasing the medication and
    - Family member or responsible friend accepting the medication.

Written instructions and medication information should also be available to the person who is responsible for medication administration during the LOA.

If staff prepare medication for off-site administration or a leave of absence, a coin envelope may be used for each medication.

Sample Leave of Absence Form

Name _____ Allergies _____ Date _____
Site address _____ Site Phone _____
Destination address _____
Date and time of departure _____
Date and time of expected return _____

Medication	Strength	Amount	Frequency	Route	Special Instructions	# Pills Provided

Medications Packaged By: Check one

☐Pharmacy Name of Pharmacy _____ Date ____
☐Staff Name of Staff _____ Date ____

Name of Staff who double-checked** preparation of medication: ** (if available)
_____ Date ____

I understand the above information regarding medication and its administration. My questions have been answered. I understand I may call the staff if any further questions.

Name of Person entrusted with medication _____
Signature _____ Date ____

Name of Staff releasing medication _____
Signature _____ Date ____

The original, signed LOA form is part of a person's health record.

When the LOA medication is a countable controlled medication, it must be subtracted in the Count Book as an LOA medication.

*On 2-24-yr at 10am, Amanda Smith subtracted nine tablets from the count sheet when those medications were released to David's sister for a leave of absence (LOA). Because the LOA was greater than 72 hours, the pharmacy prepared the medication.

Name: David Cook __X__ Original Entry or
Doctor: Dr. Black _____Transferred from page___
Pharmacy: Greenleaf Prescription Number: N671
Medication and Strength: Phenobarbital 32.4mg Prescription Date: Feb. 17, yr
Directions: Take 3 tablets by mouth once daily in evening

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
2/17/yr	9am	Received from Pharmacy			42	Linda White/Sam Dowd
2/17/yr	8pm	Mouth	42	Three	39	Jenna Sherman
2/18/yr	8pm	Mouth	39	Three	36	Jenna Sherman
2/19/yr	8pm	Mouth	36	Three	33	Amanda Smith
2/20/yr	8pm	Mouth	33	Three	30	Amanda Smith
2/21/yr	8pm	Mouth	30	Three	27	Amanda Smith
2/22/yr	8pm	Mouth	27	Three	24	Jenna Sherman
2/23/yr	8pm	Mouth	24	Three	21	Jenna Sherman
2/24/yr	10am	LOA	21	nine*	12	Amanda Smith
2/27/yr	8pm	Mouth	12	Three	9	Amanda Smith

Documentation of the LOA

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

After the LOA

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

Any unused LOA oral medication may not be returned for use. The person’s family or responsible friend may keep the medication for future LOAs. If not kept by the person’s family or responsible friend, the LOA oral medication must be disposed and documented.

Items such as inhalers and topical ointments, etc. may be returned for use.

Ask your supervisor to review the procedure regarding staff responsibilities when a person returns home from an LOA specific to your work location.

Disposal

All controlled and countable controlled medication to be disposed must be documented. The required form for disposal is the Controlled Substance Disposal Record.

Disposals of OTC medication and dietary supplements may also be documented using the Controlled Substance Disposal Record.

The disposal record is a consecutive, chronological[34] documentation of medications disposed. This means, each time a medication is disposed, it is assigned an 'item' number and dated. For example, the first disposal to take place in a new site would be documented as item #1 (year), followed by item #2 (year), item #3 (year) etc. Typically, a site will start each new calendar year with item #1 and the current year.

When documenting a medication disposal on the disposal record, do not leave blank spaces. Complete the:

- Heading of the form including the:
  - Service provider name
  - Site address
  - DPH MAP Registration number
- Item #
- Date of disposal
- Person's name
- Date the prescription was last filled
- Medication name
- Strength of medication
- Amount disposed
- Reason for disposal
- Count Book information
  - If the medication was a countable medication, include the
    - Count Book number and
    - Count Book page number.
  - If the medication was not a countable medication
    - write 'n/a' (not applicable) in the space.
- Rx number
- Pharmacy name

[34] Arranged in the order of the time the disposal happened.

- Signature of MAP Certified supervisor
- Your signature

When countable medications are disposed, the Disposal Record and the Count Book documentation must agree. The documentation in both places must include the reason for disposal.

Possible reasons for medication disposal include:

- The medication was
  - Refused
  - Dropped on the floor
  - Discontinued
  - Expired (outdated)
  - Prepared incorrectly
- The person died
- The supply of medicine at the site is more than allowed
- Unused LOA oral medication was returned to the site.

Medication disposals must be completed 'shoulder to shoulder' with two Certified staff. One of the staff must be a MAP Certified Supervisor.

The following exceptions are allowed if your supervisor is not available, and the service provider policy permits it. Two Certified staff may dispose of the medication if the medication was

- Refused
- Dropped
- Prepared incorrectly.

Ask your supervisor if the service provider policy requires that the supervisor participate in all medication disposals. DPH requires that the medication to be disposed is rendered unusable. This means that once you have prepared the medication for disposal, no one is able to still use it. Look for specific disposal instructions on the medication information sheet. If you find any, follow them.

To render a medication unusable, you:

- Remove the medication from the pharmacy packaging
- Put the medication into a sealable bag (do not crush)
- Add an unappealing substance such as:
    - Dirt
    - Kitty litter
    - Coffee grounds
    - Etc.
- Seal the bag and put it into an airtight, non-descript container
- Place it in the trash.

Make sure all identifying personal information (pharmacy label) is removed from the empty pharmacy packaging before placing it in the trash.

Medication may not be returned to the pharmacy for disposal. There are community 'Take Back' medication disposal options.

On March 3, Amanda Smith accidentally dropped one tablet of Tanisha Johnson's Clonazepam 1mg on the floor and disposed of the tablet with Linda White. In this example, disposal documentation was completed in the Count Book and on the disposal form. (The pharmacy label is used to complete a disposal form.) Notice the entry fifteen minutes later when another tablet was removed for administration.

Name: Tanisha Johnson __X__ Original Entry or
Doctor: Dr. Chen Lee _____Transferred from page__
Pharmacy: Greenleaf Prescription Number: N236
Medication and Strength: Clonazepam 1mg Prescription Date: March 3, yr
Directions: Take 1 tablet by mouth twice daily at 8am and 4pm

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/3/yr	9am	Received from Pharmacy			60	John Craig/Sam Dowd
3/3/yr 4:00pm during preparation a tablet was dropped on the floor. The one tablet was disposed leaving 59 tablets. See Item#2 on disposal record. Amanda Smith/Linda White						
3/3/yr	4:15pm	mouth	59	One	58	Amanda Smith

Rx # N236 Greenleaf Pharmacy 111-222-3434
20 Main Street
Treetop, MA 00000 3/3/yr
Tanisha Johnson

Clonazepam 1mg Qty. 60
IC Klonopin

Take 1 tablet by mouth twice daily at 8am and 4pm
Dr. Lee

Lot # 365-792 ED: 3/3/yr Refills: 3

Controlled Substance Disposal Record

Service Provider: Amercare

MAP Registered Site: 45 Shade St.

MAP MCSR No.: MAP 00001

Item #: 1-yr			Date: 02/18/yr	Item #:			Date:
Individual's Name: David Cook			Date Last Filled: 05/5/yr	Individual's Name:			Date Last Filled:
Medication: Tramadol			Strength: 50mg	Medication:			Strength:
Amount Disposed: twenty tabs	Take Back ☐		Reason: DC'd	Amount Disposed:	Take Back ☐		Reason:
Countable Controlled Substance Book Number: 1		Page Number: 7	Rx Number: N125 Pharmacy: Greenleaf	Countable Controlled Substance Book Number:		Page Number:	Rx Number: Pharmacy:
Signatures: Staff: Sam Dowd			Site Supervisor: Linda White	Signatures: Staff:			Site Supervisor:
Item #: 2-yr			Date: 03/3/yr	Item #:			Date:
Individual's Name: Tanisha Johnson			Date Last Filled: 03/3/yr	Individual's Name:			Date Last Filled:
Medication: Clonazepam			Strength: 1mg	Medication:			Strength:
Amount Disposed: one tab	Take Back ☐		Reason: fell on floor	Amount Disposed:	Take Back ☐		Reason:
Countable Controlled Substance Book Number: 1		Page Number: 3	Rx Number: N236 Pharmacy: Greenleaf	Countable Controlled Substance Book Number:		Page Number:	Rx Number: Pharmacy:
Signatures: Staff: Amanda Smith			Site Supervisor: Linda White	Signatures: Staff:			Site Supervisor:
Item #:			Date:	Item #:			Date:
Individual's Name:			Date Last Filled:	Individual's Name:			Date Last Filled:
Medication:			Strength:	Medication:			Strength:
Amount Disposed:	Take Back ☐		Reason:	Amount Disposed:	Take Back ☐		Reason:
Countable Controlled Substance Book Number:		Page Number:	Rx Number: Pharmacy:	Countable Controlled Substance Book Number:		Page Number:	Rx Number: Pharmacy:
Signatures: Staff:			Site Supervisor:	Signatures: Staff:			Site Supervisor:

All expired or discontinued medications must be rendered unusable per MAP Policy Section 15. According to Regulations at 105 CMR 700.003I(3)I: Disposal occurs in the presence of at least two witnesses and in accordance with any policies at the Department of Public Health (DPH). DPH Policy requires disposal to occur in the presence of two Certified and/or licensed staff of which one of the two is supervisory staff (i.e., Site Supervisor). If the Site Supervisor is unavailable when an individual refuses a prepared medication, or a pill/tablet/capsule, etc. is inadvertently dropped, then two Certified and/or licensed staff may render these medications unusable in accordance with acceptable MAP disposal practices. Disposal of all prescription medications in Schedule II–VI shall be documented on the DPH approved *Disposal Form*. This *Disposal Form* may also be used for OTC medications and Dietary Supplements. Each disposal page number should be updated sequentially (e.g., page 1, page 2, etc.). Item numbers are to be separate and unique and may not be repeated. When turning to the next page, the item number should also continue to be updated sequentially (e.g., item 7, item 8, item 9, etc.).

Failure to maintain complete and accurate records of medication disposal could result in potential Drug Diversions and revocation of the MAP Registered site's MCSR.

Page No. 1

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

After the medication is disposed you may subtract the medication from the count.

Fill in the blanks.

1. Medication disposal must take place with _____ Certified staff.

2. When a countable medication is disposed, it must be documented on a disposal record and in the _____ _____

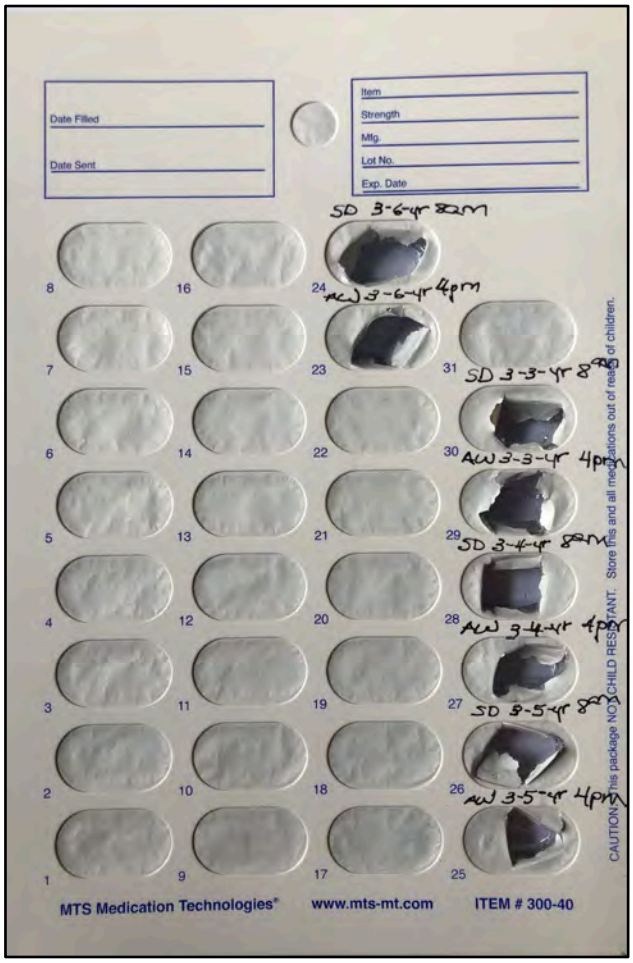
3. On a disposal record, the _____ _____ is the chronological numbering of medications disposed.

4. A MAP Certified _____ must be present when disposing of expired or discontinued medications.

Blister Pack Monitoring

Although not a MAP requirement, if used at your site you will:

- Document medication was removed from a blister pack by writing your
  - Initials, the date and the time on the back of the blister pack
    - For each tablet removed.



When blister pack monitoring is used at your work location, you should look at the set of documentation before yours. If you notice there is no documentation for an earlier dose of medication that should have been administered by a previous staff, contact a MAP Consultant immediately.

In addition, your supervisor or a designee will periodically review the documentation on the back of the blister package to ensure medication was given as prescribed.

Medication Supply Discrepancy

Suspicious

A suspicious count discrepancy[35] 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. They are serious and can result in potential criminal prosecution.

- Loss is when a medication is unaccounted for, either at the site or a pharmacy.
- Diversion (theft) is taking from a person's medication for a use other than the person.
- Tampering is altering or substituting a medication or the packaging of a medication.
- Documentation inconsistencies specific to this subject include, but are not limited to:
    - Medication documented as disposed and later discovered as not disposed
    - Altered legal documents (HCP orders, medication sheets, etc.)
    - A disposal record
        - That contains only one staff signature

Prescription medication losses (schedules II-VI) must be reported to the Drug Control Program (DCP). The loss must be reported within 24 hours of discovery. The Drug Incident Report (DIR) is submitted via the DCP online reporting system.

If tampering is suspected:

- Call the person's HCP and the local police
- Submit a DIR
- Follow any instructions given to you by the HCP, the police or the DCP.

In addition, the suspected tampered medication must be removed from the medication storage area. A suspected tampered countable medication must be removed from the count. The documentation for removing it from the count must include the reason why. The medication should be secured in an area or container on site that only your supervisor can access.

[35] When the amount of medication in the package does not match the amount on the count sheet page.

Do not remove the medication from the home. Doing so breaks the Chain of Custody.

If the medication is transferred to the police or a DCP investigator, complete a transfer form.

If the medication is not transferred to the police or a DCP investigator, the medication may be disposed once the investigation is complete.

If loss, theft, or documentation inconsistencies are suspected, your supervisor must be contacted. A DIR must be submitted.

Remember, documentation tells a story from beginning to end. If a suspicious discrepancy is noted in the Count Book, it must be documented accurately. Use as

many lines as you need to 'tell the story' of what happened. Make sure your documentation includes that the discrepancy was reported to the DCP and your supervisor.

Name: Ellen Tracey _X_ Original Entry or
Doctor: Dr. Glass ___Transferred from page__
Pharmacy: Greenleaf Prescription Number: N448
Medication and Strength: Lorazepam 0.5mg Prescription Date: April 15, yr
Directions: Take 2 tablets by mouth twice daily and 1 tablet by mouth once daily PRN, anxiety. Give PRN dose at least 4 hours apart from scheduled dose. See Support Plan.

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
4/15/yr	9am	Received from Pharmacy			18	Linda White/Sam Dowd
4/15/yr	8pm	mouth	18	two	16	Amanda Smith
4/16/yr	8am	mouth	16	two	14	Sam Dowd
4/16/yr	3pm	mouth	14	one	13	Sam Dowd
4/16/yr 3:51pm there are 12 tabs in the package. Blister pack monitoring review shows documentation is completed for the last dose administered. There is one empty bubble after the 4/16/yr 3pm dose for anxiety. There are no initials, date or time documented near the empty bubble. Linda White, Supervisor notified. Amanda Smith						
4/16/yr	8pm	mouth	12	two	10	Amanda Smith
4/16/yr 9pm Drug Incident Report submitted to DPH. Linda White						

Count Signature Sheet

Date	Time	Count correct yes/no	Incoming Staff	Outgoing Staff
4/15/yr	7:19am	yes	*Amanda Smith*	Sam Dowd
4/15/yr	3:10pm	yes	**Jenna Sherman**	*Amanda Smith*
4/15/yr	11:06pm	yes	**single person count**	**Jenna Sherman**
4/16/yr	10:12am	yes	Sam Dowd	*Linda White (witness)*
4/16/yr	3:57pm	no	*Amanda Smith*	Sam Dowd
4/16/yr 9pm Drug Incident Report submitted to DPH. Linda White				
4/16/yr	11:07pm	yes	**Jenna Sherman**	*Amanda Smith*

In the event of a countable medication loss, the count signature sheet must reflect that the count is incorrect. You must document 'no' in the column on the count signature sheet. When noting that the count is incorrect, you must also include the corresponding count sheet page number where the loss was discovered.

Non-suspicious

A non-suspicious count discrepancy is when the count is off. However, it 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. Use as many lines as you need to 'tell the story' of what happened. Make sure your documentation also includes that you reported the discrepancy and correction to your supervisor.

Name: David Cook __X__ Original Entry or
Doctor: Dr. Black _____Transferred from page___
Pharmacy: Greenleaf Prescription Number: N671
Medication and Strength: Phenobarbital 32.4mg Prescription Date: Feb. 15, yr
Directions: Take 3 tablets by mouth once daily in evening

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
2/15/yr	9am	Received from Pharmacy			42	*Linda White*/Sam Dowd
2/15/yr	8pm	Mouth	42	Three	39	Jenna Sherman
2/16/yr	8pm	Mouth	39	Three	36	Jenna Sherman
2/17/yr	8pm	Mouth	36	Three	33	*Amanda Smith*
2/18/yr	8pm	Mouth	33	Three	30	*Amanda Smith*
2/19/yr	8pm	Mouth	30	Three	27	*Amanda Smith*
2/20/yr	8pm	Mouth	27	Three	24	Jenna Sherman
2/21/yr	8pm	Mouth	24	Three	21	Jenna Sherman
2/22/yr	10am	LOA	21	nine*	12	*Amanda Smith*
2/25/yr	8pm	Mouth	12	Three	9	*Amanda Smith*
2/26/yr	8pm	Mouth	9	Three	5	Jenna Sherman
2-27- yr 10am When counting I noticed the amount left says 5 but the number in the medication package is 6. The math of the 2-26-yr at 8pm entry is incorrect. I notified Linda White, Supervisor. Correct count is 6						
_____			_____	_____	6	Sam Dowd

Your role in the Chain of Custody is necessary to ensure the security of the medication. The 'Chain of Custody' documentation that tracks medication received into or transferred out of the site must always be completed.

Let's Review

- All medications and dietary supplements must be accounted for and tracked.
- Medications are tracked using these documents and methods:
    - Pharmacy Ordering and Receiving Log
    - Pharmacy receipts
    - Medication sheets
    - Count Book
    - Security of the medication storage area
    - Medication release documents
        - Transfer form
        - LOA form
    - Disposal Record
    - Blister Pack Monitoring (if used at your agency)
- Always:
    - Complete the appropriate tracking document
    - Include your signature and date.
- If releasing medication to another person, make sure to obtain their signature as accepting the medication.
- Countable medication must be reconciled (counted) every time the medication storage keys change hands.
- Diversion (theft) of prescription medication may result in potential criminal prosecution.
- Prescription medication losses must be reported to DCP within 24 hours of discovery of the loss.
- You play an important role in maintaining the Chain of Custody.

Unit 9

Medication Occurrences

Responsibilities you will learn

- The definition of a medication occurrence (error)
- What you do if you make or discover a medication occurrence
- When and how to report a medication occurrence
- How to help reduce medication occurrences

To administer medication safely, the process must be completed from beginning to end. Most medication occurrences are due to not following the steps of the medication administration process.

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

- Wrong
    - Person
    - Medication
    - Dose
    - Time
        - Omission (a subcategory[36] of wrong time)
    - Route

A Medication Occurrence Report (MOR) is used to track each time one of the 5 Rights goes wrong during medication administration.

A **hotline medication occurrence** is when the occurrence is followed by

- medical intervention including but not limited to:
    - Lab work
    - Tests
    - Emergency Room visit
    - HCP visit, etc.
- Illness
- Injury
- Death

[36] A type.

Ask your supervisor how MORs are submitted at your work location.

Procedure Following a Medication Occurrence

As soon as a medication occurrence is identified (whether you make it or discover it) you must do the following:

- Check to see if the person is okay.

- If the person is not okay, call 911.
    - You must know your
        - Provider's emergency procedures and
        - Where emergency contact information is located.

- Call a MAP Consultant.
    - When speaking to the MAP Consultant, make sure you
        - Tell the MAP Consultant exactly what happened, including
            - the medication(s) involved
            - the total number of doses involved
            - what type of occurrence happened
            - date and time of occurrence.

- Follow all recommendations given to you by the MAP Consultant.

- Notify your supervisor.

- Document in medication administration record:
    - What happened
    - Who you notified
        - include the MAP Consultant's full name
        - your supervisor's full name
    - The MAP Consultant's recommendations
    - What you did (the MAP Consultant's recommendations)
    - Sign your name
    - Date/time

- Complete a Medication Occurrence Report (MOR).
    - If the medication occurrence is not a hotline medication occurrence
        - Submit the MOR to the MAP Coordinator within 7 days of discovery.
    - If the medication occurrence is a Hotline Medication Occurrence
        - It must be reported within 24 hours of discovery of the medication occurrence to
            - DPH
                - notify DPH via the online DPH Hotline Reporting System
            - The MAP Coordinator
                - notify the MAP Coordinator via electronic submission.

Documentation Example

Scenario: David Cook has an HCP order for Phenobarbital 97.2mg by mouth daily in the evening. The pharmacy has been supplying 32.4mg strength tablets. However, today's refill contains 97.2mg strength tablets. The transcription is rewritten. To equal the dose ordered, 1 tablet is now administered.

On 9-19-yr, Timothy Miller is assigned medication administration duties. He remembers the last time he worked he administered three tablets of David's Phenobarbital. He pops 3 Phenobarbital 97.2mg strength tablets. When initialing the medication sheet, he sees the rewritten transcription and realizes he gave too much medication. Timothy checks to see if David is okay. David is changing into his pajamas and getting ready to watch his favorite TV show.

Timothy calls Dr. Black's office. The answering service notifies Dr. Black. Timothy explains to Dr. Black that David Cook has an HCP order for Phenobarbital 97.2mg by mouth daily in the evening. Instead, David was given 291.6mg at 8:15pm. Dr. Black recommends that David be evaluated in the emergency room. Timothy calls 911 as directed by Dr. Black. Emergency staff arrive and Timothy explains what happened. The emergency staff take David to Treetop Hospital emergency room. Timothy calls his supervisor, Linda White, and reports what happened.

Timothy must now write a medication progress note to explain what happened.

Name David Cook **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
9-19-yr	9:00pm							At 8:15pm David received Phenobarbital 291.6mg instead of 97.2mg. I checked on David. He was changing into his pajamas getting ready to watch his favorite TV show. I called Dr. Black and reported what happened. Dr. Black recommended that David be sent to the emergency room. I called 911 and David was taken to Treetop Hospital emergency room. I called Linda White, Site Supervisor, and reported what happened.		Timothy Miller

Timothy will complete a Medication Occurrence report (MOR). He will notify DPH and the MAP Coordinator.

Medication Administration Program (MAP)
MEDICATION OCCURRENCE REPORT (MOR) Form

Service Provider		Date of Discovery	
Individual's Name		Time of Discovery	
Site Address (street)		Date(s) of Occurrence	
City/Town Zip Code		Time(s) of Occurrence	
MAP Site Telephone No.		MAP MCSR No.	MAP

A) Type Of Occurrence (As per regulation, contact MAP Consultant)

1 ☐ Wrong Individual
2 ☐ Wrong Dose
3 ☐ Wrong Route
4 ☐ Wrong Medication (includes medication given without an order)
5 ☐ Wrong Time (includes medication not given in appropriate timeframe)
☐ Omission (subgroup of 'wrong time'--medication not given or forgotten)

B) Medication(s) Involved

	Medication Name	Dosage	Frequency/Time	Route
As Ordered:				
As Given:				
As Ordered:				
As Given:				
As Ordered:				
As Given:				

C) MAP Consultant Contacted (Check all that apply)

Type	Name	Date Contacted	Time Contacted
☐ Registered Nurse			
☐ Registered Pharmacist			
☐ Health Care Provider			

D) Hotline Events

Did any of the events below follow the occurrence? ☐ Yes ☐ No

If ***yes***, 'check all that apply below', and **within 24 hours** of discovery notify DPH through the online DPH Hotline Reporting System, and notify the applicable DDS, DMH, DCF, or MassAbility MAP Coordinator. If *no*, notify your DDS, DMH, DCF, or MassAbility MAP Coordinator within 7 days of discovery. See 'page 2' for contact information.

☐ Medical Intervention (*see Section E below*) ☐ Illness ☐ Injury ☐ Death

E) MAP Consultant's Recommended Action and/or Events Following the Occurrence

Medical Intervention ☐ Yes ☐ No If Yes, 'Check all that apply'.

☐ Health Care Provider Visit	☐ Lab Work or Other Tests	☐ Clinic Visit
☐ Emergency Room Visit	☐ Hospitalization	

☐ Other: Please describe

F) Supervisory Review/Follow-up

Contributing Factors: 'Check all that apply' and complete 'Narrative' below:

1 ☐ Failure to Properly Document Administration
2 ☐ Medication not Available (Explain Below)
3a ☐ Medication Administered by Non-Certified Staff (includes instances of expired or revoked Certification)
3b ☐ Medication Administered by a licensed nurse, employed on-site. LPN ☐ RN ☐
3c ☐ Medication Administered by a licensed nurse, not employed on-site (e.g., VNA)
4 ☐ Non-compliant Procedure
5 ☐ Failure to Accurately Record and/or Transcribe an Order
6 ☐ Failure to Accurately Take or Receive a Telephone Order
7 ☐ Medication Had Been Discontinued
8 ☐ Other-(Narrative Required)

Narrative: (If additional space is required, continue in box F-1)

Supervisor (Print Name)	**Print Title**	**Date**
Contact phone number	**Email address**	

Medication occurrences can be used to improve medication administration procedures. When medication occurrences are reviewed, the focus is on what contributed to the occurrence. The cause of the occurrence is more important than who made the mistake.

Every staff member can and should learn from someone else's mistake. If you make a mistake, remember that the safety of the person must always be your primary concern. Your job is to report the occurrence to the MAP Consultant immediately.

Follow the same process each time you administer medication to decrease the chances of making a mistake.

Ask your supervisor what the follow up process is for a medication occurrence at your work location. If you discover or make an occurrence, your supervisor will need the details about what happened. This is to determine if the:

- Occurrence was reported promptly to the MAP Consultant
- MAP Consultant responded in a timely manner
- Recommendation was followed.

In addition, a supervisor reviews:

- If there was an impact on the person
- The completed medication occurrence report
    - Which of the 5 Rights of medication administration were violated
        - right person
        - right medication
        - right dose
        - right time
            - omission
        - right route
- That the form was forwarded to the office, if necessary.

It is important for a supervisor to know:

- Was the HCP order current?
- Was the HCP order clearly understood?
- Was the HCP order posted and verified before the medication was given?
- Was the proper procedure used to assure the identity of the person?
- Was it confirmed that the medication agreed with the HCP order?

- Were the 2 Checks of the 5 Rights conducted before the medication was administered?
- Was the medication transcribed correctly?
- Was the medication sheet filled out correctly?
- Was the pharmacy label legible and clearly understood?
- Was the correct medication available to be given?
- Was the prepared medication kept secure until the intended person swallowed the medication?

Gathering this information will help a supervisor determine the reason for an occurrence. Reasons for an occurrence may be:

- Failure to follow the medication administration process
- Failure to follow the correct process in ordering and receiving medication
- Contributing environmental[37] factors such as a:
    - Snowstorm
- Documentation errors such as a:
    - Transcription error
- Other contributing factors such as:
    - Noise.

Gathering this information helps a supervisor determine corrective action that could include:

- Reviewing procedures with the staff (retraining specific to what went wrong)
- Reviewing regulations and/or policy with the staff (retraining specific to what went wrong)
- Requiring complete formal retraining such as:
    - Repeating a full MAP Certification training
- Providing 1:1 supervision until the supervisor is satisfied of correct practice such as:
    - Supervised medication passes.

When the cause of the medication occurrence included a pharmacy error, an HCP error, etc., in addition to staff error, other responses may be necessary.

[37] The conditions, objects, and circumstances that surround you.

Number the steps (1-7) in the order they must be completed if you make or discover a medication occurrence.

A. __ Complete a Medication Occurrence Report

B. __ Follow all recommendations given to you by the MAP Consultant

C. __ Notify your supervisor

D. __ Call 911, if needed

E. __ Document what you did and who you notified

F. __ Call a MAP Consultant

G. __ Check to see if the person is okay

A **wrong person** medication occurrence means the medication was administered:

- to the wrong person, either by
    - Misidentification
    - Distraction
    - The medication was left unattended or not secured and someone else ingested it.

To minimize the chances of a medication occurrence involving a wrong person, always:

- Remain mindful.
    - Think about what you are doing as you prepare medication. Do not rush or skip steps to save time.
    - If possible, bring the person to the medication area.
    - If you are unsure of who the person is
        - Ask another staff who is familiar with the person or
        - Look at the Emergency Fact Sheet picture.
    - Do not try to do more than one task at the same time.
        - For example:
            - Do not prepare medication while talking on your cell phone.
    - Never leave medication unattended.
        - If the medication is refused, secure it until you attempt a second or third administration.
    - Never pre-pour medication.

You and your coworker Jim will be working together. Jim is assigned medication administration duties, and you are assigned morning ADL's. To save time, Jim decides to 'pre-pour' all of the medications.

Just as Jim finishes preparing all of the medications, he hears you call for 'Help!' Jim goes to help you, leaving the prepared medication unattended. When Jim returns to the medication area he finds one of the people living in the home with the empty pill cups.

1. What category of medication occurrence was made? _____
2. What should Jim do first? _____
3. How could this medication occurrence have been prevented? _____
4. What if Jim had correctly prepared only one set of medication and he heard the call for help? _____

A **wrong medication** occurrence means the medication was administered:

- Without an HCP order
    - Including administering a medication
        - Using an expired HCP order
        - That had been discontinued
        - Past the stop date of a time limited medication order
        - Administering one medication instead of another
            - Tegretol is ordered/Tylenol is administered instead.

To minimize the chances of a medication occurrence involving a wrong medication, always:

- Look at the HCP order
    - To ensure
        - It is valid; signed and dated by the HCP
        - The medication order has not been changed or was discontinued
        - What is printed on the pharmacy label is what the HCP ordered.
- Call a MAP Consultant if you have a question regarding an HCP order.

Janet is assigned medication administration duties. She remembers from the last time she worked that Tanisha has an HCP order for Kenalog 0.1% cream to be applied to the bottoms of both feet at bedtime.

Janet helps Tanisha get ready for bed. She gets the cream from the medication storage area and applies it to the bottom of Tanisha's feet. Janet then washes her hands and starts to prepare Tanisha's oral medications.

Janet reviews Tanisha's HCP orders and medication sheets. She notices that the order for the Kenalog cream was discontinued yesterday.

1. What category of medication occurrence was made? _____
2. What should Janet do first? _____
3. How could Janet have prevented this medication occurrence? _____

A **wrong dose** medication occurrence means:

- Too much or
- Too little
    - of the medication was administered at the scheduled time.

To minimize the chances of a medication occurrence involving a wrong dose, always:

- Look at the
    - HCP order to find the dose of the medication
    - Pharmacy label to find the strength of the tablet and the amount to give to equal the dose
    - Medication you have prepared in the cup to ensure the amount is correct
    - Blister pack (if used) to ensure the tablet was popped out and did not 'stick' to the foil seal
    - OPUS cassette (if used) to ensure the tablet was removed and did not 'stick' in the corner.
- Call a MAP Consultant if the strength of the tablet and amount to give does not equal the dose ordered by the HCP.

Tanisha Johnson has an HCP order for Phenobarbital 64.8mg once daily in the evening. The pharmacy had been supplying a 32.4mg tablet with directions to take 2 tablets. When the new refill was obtained, it was supplied as a 64.8mg tablet with directions to take 1 tablet.

At 8pm, Serena starts to prepare Tanisha's medications. Serena remembers that Tanisha always receives 2 tablets of Phenobarbital. She then gets the blister pack of Phenobarbital, pops 2 tablets and administers them.

As Serena starts to document on the medication sheet and Count Book, she notices that the strength of the tablet and amount to give has changed.

1. What category of medication occurrence was made? _____
2. What should be done first? _____
3. How could this medication occurrence have been prevented? _____

A **wrong time** medication occurrence means the medication was administered:

- Too early (more than 1 hour before the scheduled time)
- Too late (more than 1 hour after the scheduled time), or
- Parameters or instructions for use of the medication were not followed.

A subcategory of wrong time is:

- **Omission**
  - Meaning the medication was not administered; either it was
    - forgotten or
    - not available to administer

To minimize the chances of a medication occurrence involving a wrong time or omission, always:

- Use the top two boxes on the medication sheet to schedule ‘am’ medication times and the bottom two boxes to schedule ‘pm’ medication times
- Administer medication within one hour before and up to one hour after the time listed on the medication sheet
- Administer PRN medication at the exact frequency ordered keeping in mind the last time it was administered
  - There is no 1-hour window for PRN medication.
- Call a MAP Consultant if you have questions about the frequency of a medication
- Always document after administering the medication
  - This is because if a second staff sees a ‘blank space’ on the medication sheet, and it is within the hour time window, they might give the medication again.
- Follow the instructions and/or parameters for use of the medication as ordered by the HCP
  - Such as checking the person’s blood pressure before giving the medication
    - If the medication is administered without obtaining the blood pressure, it is a ‘wrong time’ medication occurrence.
- Make sure that the medication is obtained from the pharmacy
  - Order refills from the pharmacy at least one week before the medication runs out.
  - When the last remaining refill is ordered, notify the HCP that a prescription is needed.

Obtaining medication may take several phone calls. The process is not complete until the medication is obtained.

If a medication is not received from the pharmacy because:

- It is out of stock
- A prescription is needed
- Prior authorization is needed, etc.

contact the HCP for instructions about what to do until it is available.

If no HCP instructions are obtained, MORs must be submitted for the omitted doses. A MAP Consultant must be contacted following each omission of the medication.

You are assigned medication administration duties. You wash your hands and unlock the medication storage area. You look in the medication book and see that the person has Tegretol 400mg due at 4pm. However, when you locate the blister pack of Tegretol, you find the blister pack is empty.

You check the medication storage area for a backup supply, and none is found. You call the pharmacy, but the pharmacist tells you there are no refills left.

1. What should you do next? _____
2. If no medication is obtained, who should you call? _____
3. What category of medication occurrence was made? _____
4. How could this medication occurrence have been prevented? _____

When ordering a refill, if you are told it is too soon to obtain the medication, contact your supervisor. The Supervisor will compare medication administrations to the quantity of medication received from the pharmacy. This is to determine if too much medication was administered**.**

A **wrong route** medication occurrence means the medication was administered:

- By a way (route) not ordered by the HCP.

To minimize the chances of a medication occurrence involving a wrong route, always:

- Look at the
  - HCP order to see the route of administration ordered
  - Pharmacy label and medication sheet to ensure the route of administration is listed and is the same as the HCP order
- Separate medications by their route, in the person's medication storage area
- Remain mindful
  - To ensure you administer the medication by the correct route
  - Call a MAP Consultant if you have questions about the way a medication is to be administered.

Ellen Tracey has an HCP order for Debrox eardrops, 4 drops to each ear at bedtime and a second HCP order for Saline eye drops, 4 drops to each eye at bedtime.

As Joe is preparing Ellen's medications, another staff is talking to Joe about the new 'app' he installed on his phone. Joe is very interested in the new 'app' and stops paying attention to what he is doing. Instead of reaching for the Saline eye drops, he takes the Debrox eardrops.

Joe proceeds to administer the Debrox eardrops into Ellen's eyes. Joe realizes what he has done as he is completing a 'look back' while signing the medication sheet.

1. What category of medication occurrence was made? _____
2. What should Joe do next? _____
3. How could this medication occurrence have been prevented? _____

Match the term to the corresponding example.

1.___	Wrong dose	A	Ear drops ordered for the right ear were administered into the right eye
2.___	Wrong person	B	A morning dose of medication was administered in the evening
3.___	Wrong route	C	Klonopin 2mg was ordered and Klonopin 1mg was administered
4.___	Wrong medication	D	A discontinued medication was administered
5.___	Wrong time	E	Medication ordered was not administered
6.___	Omission	F	Medication was left unattended and then was ingested by another person

Let's Review

- A medication occurrence is when one of the 5 Rights goes wrong.
- You must know your provider's emergency procedures and where emergency contact numbers are listed.
- If you make or discover a medication occurrence, speak to a MAP Consultant immediately.
    - Follow all recommendations
    - Document recommendations
- The safety of the person must always be your first concern. Call 911 if needed.
- Medication occurrences should be viewed as 'teachable moments'
    - Learn from yours and/or 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.
- Medication occurrences must be reported to the MAP Coordinator within 7 days of discovery.
- Hotline medication occurrences must be reported to DPH and the MAP Coordinator within 24 hours of discovery.

Appendix

This section includes sample documentation of common issues that you may see at your work location.

Health Care Provider Order
Certified and/or licensed staff cannot alter (change) any information recorded on an HCP order. When applicable, in the margin of the HCP order you may document:

- When a medication has been discontinued, or
- Verification of an OTC medication or dietary supplement without a pharmacy label.

Pharmacy Label
Certified and/or licensed staff cannot alter (change) the information printed on a pharmacy label. When criteria have been met, a 'directions change' sticker may be applied next to the pharmacy label directions.

Medication Sheet
On the medication sheet, all medication boxes for scheduled times must be initialed in real time. If documentation is completed accurately, all medication boxes will be initialed by the end of the month. There will be no blank spaces.

Late Entry Documentation
A late entry is an acceptable method of correcting documentation. A late entry is a progress note completed after the time when documentation should have been done. It tells the story of what happened earlier. A late entry includes, but is not limited to:

- Current date and time
- Date and time of actual event
- Explanation
- Your signature

Never post-date[38] your documentation.

Real Time
Real time is the actual time, to the minute (what you see on the clock). Real time documentation should occur when documenting on a:

- Medication progress note
- Narrative note
- Count signature page
- Etc.

[38] Document a date later than the actual date.

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 must 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 show the correct order 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 right away.
Use a 'late entry' to clear up information written earlier. Also use a 'late entry' to explain a task that was not documented when it should have been.	Never skip or leave a blank space for another staff to document later. Never post-date an entry.	Late entries 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 opinions.	Documentation must be factual and correct. This is to make sure 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.'	Doing so can be viewed as an attempt to hide something.
Spell out words when documenting. Only use acceptable codes or abbreviations.	Never create your own documentation short cuts.	Doing so prevents others from understanding what you write.
Only document and sign for a task you do. For example, when participating in a 'shoulder to shoulder' count or a disposal, etc.	Never sign your signature on a count signature sheet or disposal form, etc. if you were not part of the process.	Doing so protects you. You are responsible for the information you write.
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.

Requirement: All HCP orders must be posted and verified. This includes when the HCP writes, 'No new orders' or 'No medication changes.'

Scenario: You have returned from an HCP visit with Juanita. The HCP wrote 'No medication changes' on the HCP order form.

Responsibility: You will post the HCP order, document the visit in her health record and communicate the information to others. A second staff will verify the order.

HEALTH CARE PROVIDER ORDER

Name: Juanita Gomez	**Date:** June 22, yr
Health Care Provider: Dr. David Jones	**Allergies:** Bactrim
Reason for Visit: Follow up visit after upper respiratory infection	
Current Medications: Colace liquid 200mg by mouth twice daily Dilantin 200mg by mouth twice daily Ultram 50mg by mouth twice daily	
Staff Signature: Sam Dowd	**Date:** June 22, yr
Health Care Provider Findings:	
Medication/Treatment Orders: No medication changes	
Instructions:	
Follow-up visit:	**Lab work or Tests:**
Signature: *Dr. David Jones*	**Date:** June 22, yr

Posted by: Sam Dowd **Date: 6/22/yr Time: 1:15pm Verified by:** Linda White **Date: 6/22/yr Time: 2pm**

Requirement: An HCP discontinues a medication or changes a medication dose or frequency. The HCP writes the change on a different order form. The different order form does not include all the current medication orders. Certified staff must document that the medication was discontinued or changed. The change is documented on the HCP order form that includes all the current medication orders.

Scenario: You have received a fax HCP order on 12-1-yr for Juanita to D/C Colace liquid 200mg by mouth twice daily.

Responsibility: You will mark the Colace as discontinued (D/C) on the medication sheet. You will post and verify the fax order. On the HCP order form that lists current medications, you will write 'D/C', your initials and the date in the margin next to the Colace.

HEALTH CARE PROVIDER ORDER

Name: Juanita Gomez	**Date:** Sept. 29, yr
Health Care Provider: Dr. David Jones	**Allergies:** Bactrim
Reason for Visit:	
Current Medications:	
Staff Signature: Sam Dowd	**Date:** Sept. 29, yr
Health Care Provider Findings:	
Medication/Treatment Orders: Colace liquid 200mg by mouth twice daily Dilantin 200mg by mouth twice daily Ultram 50mg by mouth twice daily	
Instructions:	
Follow-up visit:	**Lab work or Tests:**
Signature: *Dr. David Jones*	**Date:** Sept. 29, yr

D/C'd 12/1/yr SD

Posted by: Sam Dowd **Date:** 9/29/yr **Time:** 3:15pm **Verified by:** Linda White **Date:** 9/29/yr **Time:** 5pm

Requirement: The medication box is initialed after medication is administered. A countable medication is subtracted from a count sheet page after removal.

Scenario: A single person count is done, and the count is incorrect. The count sheet page has no documentation that the medication was given earlier. There is also a blank box on the medication sheet. The staff responsible for medication administration earlier has left work for the day.

Responsibility: You call the MAP Consultant who recommends that you check the blister package. When checking, you find an empty bubble. The empty bubble is marked with initials, a date, and a time by the staff responsible for giving the medication earlier. You also call your supervisor. You write a medication progress note and a progress note on the count sheet. You explain what you saw, who you contacted and what you did.

The staff who did not document after medication administration must write a 'late entry' on the medication progress note and on the corresponding count sheet the next time they are working. The medication box stays empty.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Clonazepam																																							
8/31/yr	Brand Klonopin																																							
	Strength 1mg	Dose 1mg																																						
Stop	Amount 1 tab	Route Mouth																																						
Cont	Frequency twice daily 8am and 4pm																																							

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8am	JS	JS	JS	JC	JC	JS	JS	JS	JS		JS	JS																			
4pm	TM	SD	SD	AS	AS	SD	SD	SD	AS	SD	AS																				

Special instructions: *Reason: seizures*

Name Tanisha Johnson **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
3-10-yr 3:45pm The medication box for Tanisha's 3-10-yr 8:00am dose of Clonazepam is blank. I contacted Rebecca Long, RN, MAP Consultant. Rebecca recommended checking the blister pack and count book. Documentation on the blister pack was checked. The empty bubble is initialed with the date and time on the back of the blister pack. It was not subtracted in the count book. Linda White, Supervisor was notified.										Sam Dowd
3-11-yr 10:30am Late entry. Tanisha's 3-10-yr 8:00am dose of Clonazepam was given as ordered. It was not documented at that time.										*Jenna Sherman*

Name: Tanisha Johnson ____ Original Entry or
Doctor: Dr. Chen Lee __X__ Transferred from page 3
Pharmacy: Greenleaf Prescription Number: N236
Medication and Strength: Clonazepam 1mg Prescription Date: March 3, yr
Directions: Take 1 tablet by mouth twice daily at 8am and 4pm

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/9/yr	9am		Page Transfer		60	John Craig/Sam Dowd
3/9/yr	4pm	Mouth	60	one	59	Amanda Smith
3/10/yr 3:51pm The morning dose was not subtracted when it was removed. I contacted Linda White, Supervisor and told her the amount left says 59 however the amount left is 58.						
						Sam Dowd
3/10/yr	4pm	Mouth	58	One	57	Sam Dowd
3/11/yr 7:06am Late entry for 3-10-yr 8am med was given and not subtracted at that time.						Jenna Sherman
3/11/yr	8am	Mouth	57	One	56	Jenna Sherman
3/11/yr	4pm	Mouth	56	One	55	Amanda Smith
3/12/yr	8am	Mouth	55	One	54	Jenna Sherman

Requirement: Two Certified staff must verify a countable medication refill.

Scenario: A countable medication is delivered. You are the only Certified staff present.

Responsibility: You add the medication into the count when delivered. The second Certified staff verifies the amount delivered when they arrive to work.

Name: David Cook ____ Original Entry or
Doctor: Dr. Black _X_ Transferred from page 1
Pharmacy: Greenleaf Prescription Number: N671
Medication and Strength: Phenobarbital 32.4mg Prescription Date: Feb. 17, yr
Directions: Take 3 tablets by mouth once daily in evening

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/3/yr	9am		Page Transfer		0	Amanda Smith/Jenna Sherman
3/3/yr	10am		Received from pharmacy		30	Sam Dowd/John Craig
3/3/yr	8pm	Mouth	30	Three	27	Jenna Sherman
3/4/yr	8pm	Mouth	27	Three	24	Amanda Smith
3/5/yr	8pm	Mouth	24	Three	21	Amanda Smith
3/6/yr	8pm	Mouth	21	Three	18	Amanda Smith
3/7/yr	8pm	Mouth	18	Three	15	Jenna Sherman
3/8/yr	8pm	Mouth	15	Three	12	Jenna Sherman
3/9/yr 9:45am Received 60 tabs from pharmacy 72						John Craig
3/9/yr 2:30pm Verifying 60 tabs received						Sam Dowd
3/9/yr	8pm	Mouth	72	Three	69	Jenna Sherman

Requirement: Two Certified staff must verify a countable medication received from the pharmacy.

Scenario: You notice on a count sheet there is an increase in the 'amount left column' with no explanation.

Responsibility: You check the countable medication. You document what you find and notify the Supervisor.

The Supervisor will speak to the staff who added the medication into the count without an explanation.

5| P a g e

Name: Ellen Tracey
Doctor: Dr. Glass
Pharmacy: Greenleaf
Medication and Strength: Lorazepam 0.5mg
Directions: Take 2 tablets by mouth twice daily and 1 tablet by mouth once daily PRN, anxiety. Give PRN dose at least 4 hours apart from scheduled dose. See Support Plan.

__X__ Original Entry or
____Transferred from page __
Prescription Number: N458
Prescription Date: March 3, yr

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/3/yr	9am		Received from pharmacy		30	Linda White/Sam Dowd
3/3/yr	8pm	mouth	30	two	28	Amanda Smith
3/4/yr	8am	mouth	28	Two	26	John Craig
3/4/yr	8pm	mouth	26	Two	24	Sam Dowd
3/5/yr	8am	mouth	24	Two	112	John Craig
3/5/yr	8pm	mouth	112	Two	110	John Craig
3/6/yr 7:09am The amount left column increases from 24 to 112. See the 3-5-yr 8am entry. There is a second blister pack of ninety Lorazepam 0.5mg tabs that accounts for the increased number minus the dose that was administered after the medication was received. Linda White, Supervisor notified.						Jenna Sherman
3/6/yr	8am	mouth	110	Two	108	Jenna Sherman

Requirement: Discontinued (or expired) countable controlled medication must remain on count until disposed with a supervisor present.

Scenario: A countable controlled medication is discontinued. You are working with another Certified staff, but your supervisor will not be present until the next day.

Responsibility: You mark the medication as discontinued on the medication sheet. You write a progress note that the HCP discontinued the medication. When your supervisor is available, the medication is disposed. The reason for disposal and the 'Item #' from the disposal form is included. The amount left column is 'zeroed out' to show the medication is no longer physically present to count. Your supervisor will update the index to show the medication is no longer on count.

Name: Scott Green ___ Original Entry or
Doctor: Dr. S. Pratt _X_ Transferred from page 9
Pharmacy: Greenleaf Prescription Number: N558
Medication and Strength: Zolpidem 5mg Prescription Date: Apr. 2, yr
Directions: Take 1 tablet by mouth once daily PRN at bedtime per Scott's request for difficulty sleeping

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
4/3/yr	9am	Page Transfer			30	Linda White/Sam Dowd
4/6/yr	9:38pm	mouth	30	One	29	Jenna Sherman
4-21-yr 2pm Scott told the HCP at today's appointment he is sleeping well. A year of sleep data and the number of times Scott requested Zolpidem was given to the HCP. The HCP wrote an order to discontinue Zolpidem. Linda White, Supervisor notified that med needs to be disposed. _____						Sam Dowd
4/22/yr 9:17am twenty-nine Zolpidem tabs discontinued by Scott's HCP on 4/21/yr were disposed. See Item #37-yr. _____					0	Linda White/Sam Dowd

Requirement: Countable controlled medication that is dropped must be kept on count until disposed in the presence of two Certified staff.

Scenario: A countable controlled medication is dropped. You are working alone or with another staff who is not MAP Certified.

Responsibility: You write a progress note that the medication was dropped on the day it happened. When a second Certified staff or your supervisor is available, the medication is disposed. The reason for disposal is included.

Name: Tanisha Johnson ___ Original Entry or
Doctor: Dr. Chen Lee _X_ Transferred from page 4
Pharmacy: Greenleaf Prescription Number: N538
Medication and Strength: Phenobarbital 32.4mg Prescription Date: Apr. 2, yr
Directions: Take 2 tablets by mouth once daily in evening

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
4/3/yr	9pm		Page Transfer		60	John Craig//Sam Dowd
4/3/yr	8pm	mouth	60	two	58	Amanda Smith
4/4/yr 7:43pm Med cup holding two tablets knocked off table and fell on floor. Placed in med cup and locked waiting for disposal. Linda White, Supervisor notified. _____ Amanda Smith						
4/4/yr	8pm	mouth	58	Two	56	Amanda Smith*
4/5/yr 3:06pm The 8pm dose (two tabs) on 4/4/yr was dropped. The two tabs are now disposed. See Item #10-yr. 54						Sam Dowd/John Craig
4/5/yr	8pm	mouth	54	Two	52	Amanda Smith

* The 4-4-yr 8pm entry indicates that after Amanda Smith documented the dropped medication, she then removed two additional tablets in preparation for the medication to be administered as scheduled.

Requirement: Documentation errors must be properly corrected.

Scenario: You write incorrect documentation in the Count Book.

Responsibility: You correct the error. The original entry must remain legible.

20| P a g e

Name: Tanisha Johnson ____ Original Entry or
Doctor: Dr. Chen Lee __X__ Transferred from page 10
Pharmacy: Greenleaf Prescription Number: N236
Medication and Strength: Clonazepam 1mg Prescription Date: March 3, yr
Directions: Take 1 tablet by mouth twice daily at 8am and 4pm

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/9/yr	9am		Page Transfer		60	John Craig//Sam Dowd
3/9/yr	4pm	Mouth	60	one	59	Amanda Smith
3/10/yr	8am	Mouth	59	One	58	Sam Dowd
3/10/yr	4pm	Mouth	58	One	57	Jenna Sherman
3/11/yr	8am	Mouth	57	One	56	Amanda Smith
3/11/yr	4pm	Mouth	56	One	55	Sam Dowd
3/12/yr	8am	Mouth	55	One	54	Jenna Sherman
3/12/yr	4pm	Mouth	54	One	~~54~~ error ~~AS~~ 53	Amanda Smith
3/13/yr	8am	Mouth	53	One	52	John Craig
3/13/yr	4pm	Mouth	52	One	51	Sam Dowd
~~3/13/yr~~	~~8am~~	~~Mouth~~	~~51~~	~~One~~	~~50~~	~~John Craig~~ error JC
3/14/yr	8am	Mouth	51	One	50	John Craig

Requirement: Two Certified staff are required to complete a count sheet page transfer.

Scenario: A count sheet page transfer is required. You are working alone or with another staff who is not MAP Certified.

Responsibility: You are the only Certified staff present. A count sheet page transfer is required. You document the transfer of medication from the bottom of the old count sheet page to the top of the new count sheet page. The next Certified staff on duty will verify the amount you transferred. They will compare the amount of medication on the bottom of the old count sheet page with the amount on the top of the new count sheet page. They will document the verification.

Below is the bottom of the old count sheet page (page 10), followed by the new page.

3/8/yr	4pm	Mouth	62	One	61	Amanda Smith
3/9/yr	8am	Mouth	61	One	60	John Craig

Amount left 60 Transferred to page 20
Signature John Craig
Signature single transfer

20| P a g e

Name: Tanisha Johnson
Doctor: Dr. Chen Lee
Pharmacy: Greenleaf
Medication and Strength: Clonazepam 1mg
Directions: Take 1 tablet by mouth twice daily at 8am and 4pm

____ Original Entry or
__X__ Transferred from page 10
Prescription Number: N236
Prescription Date: March 3, yr

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/9/yr	8am		Page Transfer		60	John Craig//single transfer
3/9/yr	4pm	Mouth	60	one	59	John Craig
3/9/yr	8pm	Page transfer amount verified.				Sam Dowd
3/10/yr	8am	Mouth	59	One	58	Jenna Sherman
3/10/yr	4pm	Mouth	58	One	57	Amanda Smith

Requirement: An HCP order must be copied as written when transcribing.

Scenario: The HCP orders a generic medication. The pharmacy supplies the generic medication.

Responsibility: You will transcribe only the generic name of the medication. 'NA,' which means 'not applicable,' is written in the space next to the word 'brand.'

Month and Year: August, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic **Erythromycin**			**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/3/yr	Brand **NA**			**8am**	X	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength **333mg**	Dose **666mg**																																
Stop	Amount **2 tabs**	Route **Mouth**		**4pm**	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
8/13/yr	Frequency **Three times daily**			**8pm**	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **for 10 days** *Reason:* **Sinus infection**

Requirement: An HCP order must be copied as written when transcribing.

Scenario: The HCP orders a topical generic medication. The pharmacy supplies the topical generic medication.

Responsibility: You will transcribe the topical generic medication. The percentage of a topical medication is part of the medication name. The dose, the strength and the amount are the specific amount (which may be compared to a coin size and/or a 'pea' size, etc.) as written in the HCP order.

Month and Year: April, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic hydrocortisone cream 0.05%			**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
4/1/yr	Brand NA																																	
	Strength dime size	Dose dime size																																
Stop	Amount dime size	Route topical																																
Cont	Frequency daily in the evening			**8pm**																														

Special instructions: apply to right elbow *Reason:* dermatitis

Requirement: An HCP order must be copied as written when transcribing.

Scenario: The HCP orders a generic name medication. The generic name of the medication is supplied by the pharmacy. The medication ordered is in the form of an inhalation aerosol. The aerosol is inhaled by mouth via an inhaler device.

Responsibility: You will transcribe the generic name medication. The strength per 'actuation' is found on the pharmacy label. The word 'actuation' and the word 'puff' are the same. The dose is based on the number of puffs ordered each time. The amount is the number of puffs ordered by the HCP.

Month and Year: May, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Albuterol sulfate	**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
5/1/yr	Brand NA	P																															
	Strength 90mcg/puff Dose 180mcg	R																															
Stop	Amount 2 puffs Route Inhalable by mouth	N																															
Cont	Frequency Every 6 hours PRN																																

Special instructions: PRN wheezing and shortness of breath *Reason:* asthma

Requirement: An HCP order must be copied as written when transcribing.

Scenario: The HCP orders a generic name medication. The generic name of the medication is supplied by the pharmacy. The medication ordered is in the form of an inhalation solution. The solution is inhaled by mouth via a nebulizer. The solution is supplied in premixed single use vials.

Responsibility: You will transcribe the generic name medication. The percentage of the inhalation solution inhaled by mouth via a nebulizer is part of the medication name. The dose, strength and amount are 1 vial as written in the HCP order and on the pharmacy label directions.

Month and Year: May, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic	Albuterol sulfate 0.083% 2.5mg/3mL NS			**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
5/1/yr	Brand	NA			**8am**																															
	Strength	1 vial	Dose	1 vial																																
Stop	Amount	1 vial	Route	Inhalable by mouth	**4pm**																															
Cont	Frequency	Three times a day			**8pm**																															

Special instructions: via nebulizer treatment *Reason:* asthma

Requirement: A copy of a prescription may be used as an HCP order.

Scenario: The HCP gives you a copy of a prescription for a generic name medication. The generic name medication is supplied by the pharmacy. The pharmacy label includes the generic name, strength, amount, frequency with specific medication times, and the route. The dose equals strength X (times) amount.

Responsibility: You will transcribe the medication using the prescription and the pharmacy label. You will post the order. A second staff will verify the order.

The Lee Corporation
101 North St. Treetop, MA 000000000
Tel: 222-333-4343 Fax: 888-777-8765
Prepared By: MALDONADO, KATIE
Trans id: 23102610565056915177020

Chen Lee, MD
Internal Medicine

PRINTED PRESCRIPTION

Johnson, Tanisha
45 Shade Street, Treetop, MA 00000
DOB: xx/xx/xxxx, Phone: xxx-xxx-xxxx

Date: 05-15-xxxx

Pharmacy: Greenleaf Pharmacy, 20 Main Street, Treetop, MA 00000 Tel. 111-222-3434, Fax: xxx-xxx-xxxx

Rx

Clonazepam Tablet 1mg Orally
Disp: ***60*** (SIXTY)
Sig: take 1 tablet twice daily at 8am and 4pm Twice daily 30 days
Diagnosis: (E00.0) Seizure Disorder

Refills: ***1*** (ONE)
DEA#: ab0000000
NPI#: 0000000000
LIC.#: 000000

Chen Lee, MD

Interchange is mandated unless the practitioner writes the words "No Substitution" in the space above.

Chen Lee, MD

For Opioids: Partial fill upon patient request.

Posted Linda White 05/15/yr 1:20pm Verified Amanda Smith 05/15/yr 3:30pm

Month and Year: May, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Clonazepam		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
5/15/yr	Brand NA		**8am**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X																
	Strength 1mg	Dose 1mg																																
Stop	Amount 1 tab	Route by mouth	**4pm**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X																
Cont	Frequency Two times a day																																	

Special instructions: give at 8am and 4pm

Reason: seizures

Requirement: When a medication occurrence happens or is discovered, you must begin the 'Procedure following a Medication Occurrence' (see Unit 9).

Scenario: You are doing blister pack monitoring. You see that a medication was not administered, but there are initials in the medication box. The medication is not documented as subtracted on the count sheet. The count is correct.

Responsibility: You begin the 'Procedure following a Medication Occurrence.' You care for the person and follow the procedure. Then you write a medication progress note. The note includes the date and time it was discovered that the medication was not administered. You also write who was notified and what you were instructed to do. You do not circle the initials.

The staff who initialed will write a late entry medication progress note.

Month and Year: March, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Clonazepam																															
8/31/yr	Brand Klonopin																															
	Strength 1mg	Dose 1mg																														
Stop	Amount 1 tab	Route mouth																														
Cont	Frequency twice daily 8am and 4pm																															

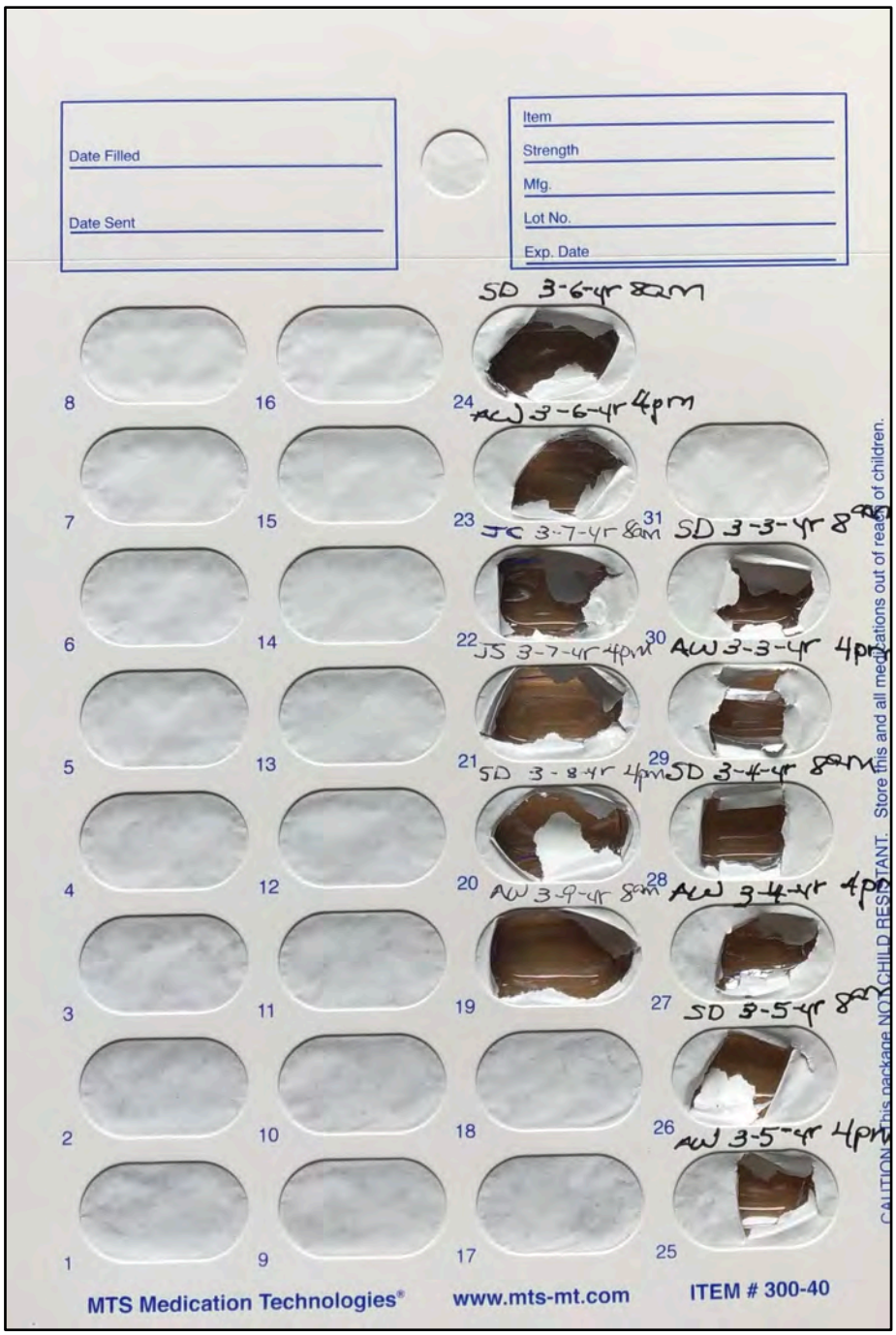
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8am	TM	TM	SD	SD	SD	SD	JC	JC	AW																						
4pm	JS	SD	AW	AW	AW	AW	JS	SD																							

Special Instructions: *Reason: decrease seizures*

Name Tanisha Johnson **MEDICATION PROGRESS NOTE**

Date	Time	Medication	Dose	Given	Not Given	Refused	Other	Reason (for giving/not giving)	Results and/or Response	Staff Signature
3-9-yr 11:15am During routine blister pack monitoring it was noted there are no initials, date, time indicating that a Clonazepam tablet was removed for the 3-8-yr 8am dose. The medication box for Tanisha's 3-8-yr 8:00am dose of Clonazepam is initialed. I contacted Forrest Greenleaf, pharmacist, MAP Consultant. Mr. Greenleaf recommended continuing to administer medication as prescribed. Linda White, Supervisor										
3-11-yr 9:49am Late entry - the 3-8-yr 8am Clonazepam entry is initialed as administered, however, was not.									———————	John Craig

See next page for the corresponding blister pack that was reviewed by the Supervisor.



In addition, a medication occurrence report must be submitted (per state agency guidelines) to the MAP Coordinator within 7 days of the discovery.

Requirement: When a medication occurrence happens or is discovered, you must begin the 'Procedure following a Medication Occurrence' (see Unit 9).

Scenario: You realize you administered medication to the wrong person. You begin the 'Procedure following a Medication Occurrence.' After checking to see if the person is okay, you contact the MAP Consultant. They recommend that the person be brought to the emergency room.

Responsibility: After the person is cared for, you complete all necessary documentation. This includes the count sheet page of the housemate's medication that was administered to the wrong person. Then submit the medication occurrence report per state agency guidelines.

6| P a g e

Name: Juanita Gomez
Doctor: Dr. Jones
Pharmacy: Greenleaf
Medication and Strength: Tramadol 50mg
Directions: Take 1 tablet by mouth twice daily

__X__ Original Entry or
____ Transferred from page___
Prescription Number: N569
Prescription Date: March 2, yr

Date	Time	Route	Amount on Hand	Amount Used	Amount Left	Signature
3/3/yr	9am		Received from pharmacy		60	Linda White//Sam Dowd
3/3/yr	8pm	Mouth	60	one	59	Amanda Smith
3/4/yr	8am	Mouth	59	One	58	Sam Dowd
3/4/yr	8pm	Mouth	58	One	57	Amanda Smith
3/5/yr	8am	Mouth	57	One	56	John Craig
3/5/yr 8:43am One Tramadol 50mg tablet was removed and administered to housemate.				———	55	John Craig

Medication Administration Program (MAP)
MEDICATION OCCURRENCE REPORT (MOR) Form

Service Provider	Amercare	Date of Discovery	3-5-yr
Individual's Name	Tanisha Johnson	Time of Discovery	8:51am
Site Address (street)	45 Shade Street	Date(s) of Occurrence	3-5-yr
City/Town Zip Code	Treetop MA 00000	Time(s) of Occurrence	8:43am
MAP Site Telephone No.	000-000-0000	MAP MCSR No.	MAP 00001

A) Type Of Occurrence (As per regulation, contact MAP Consultant)

1 ☒ Wrong Individual
2 ☐ Wrong Dose
3 ☐ Wrong Route
4 ☐ Wrong Medication (includes medication given without an order)
5 ☐ Wrong Time (includes medication not given in appropriate timeframe)
☐ Omission (subgroup of 'wrong time'--medication not given or forgotten)

B) Medication(s) Involved

	Medication Name	Dosage	Frequency/Time	Route
As Ordered:	not ordered for this individual			
As Given:	Tramadol	50mg	8:43am	Mouth
As Ordered:	not ordered for this individual			
As Given:	Phenytoin	200mg	8:43am	Mouth
As Ordered:	not ordered for this individual			
As Given:	Docusate liquid	200mg	8:43am	mouth

C) MAP Consultant Contacted (Check all that apply)

Type	Name	Date Contacted	Time Contacted
☐ Registered Nurse			
☐ Registered Pharmacist			
☒ Health Care Provider	Dr. Chen Lee	3-5-yr	8:53am

D) Hotline Events

Did any of the events below follow the occurrence? ☒ Yes ☐ No

If ***yes***, 'check all that apply below', and **within 24 hours** of discovery notify DPH through the online DPH Hotline Reporting System, and notify the applicable DDS, DMH, DCF, or MassAbility MAP Coordinator. If *no*, notify your DDS, DMH, DCF, or MassAbility MAP Coordinator within 7 days of discovery. See 'page 2' for contact information.

☒ Medical Intervention (*see Section E below*) ☐ Illness ☐ Injury ☐ Death

E) MAP Consultant's Recommended Action and/or Events Following the Occurrence

Medical Intervention ☐ Yes ☐ No If Yes, 'Check all that apply'.

☐ Health Care Provider Visit	☐ Lab Work or Other Tests	☐ Clinic Visit
☒ Emergency Room Visit	☐ Hospitalization	

☐ Other: Please describe

F) Supervisory Review/Follow-up

Contributing Factors: 'Check all that apply' and complete 'Narrative' below:

1 ☐ Failure to Properly Document Administration
2 ☐ Medication not Available (Explain Below)
3a ☐ Medication Administered by Non-Certified Staff (includes instances of expired or revoked Certification)
3b ☐ Medication Administered by a licensed nurse, employed on-site. LPN ☐ RN ☐
3c ☐ Medication Administered by a licensed nurse, not employed on-site (e.g., VNA)
4 ☐ Non-compliant Procedure
5 ☐ Failure to Accurately Record and/or Transcribe an Order
6 ☐ Failure to Accurately Take or Receive a Telephone Order
7 ☐ Medication Had Been Discontinued
8 ☒ Other-(Narrative Required)

Narrative: (If additional space is required, continue in box F-1) Staff answered the telephone while preparing medications. Staff then administered a housemates' medication to Tanisha. Tanisha's 8am medication had been administered earlier as prescribed; Luminal 64.8mg by mouth and Klonopin 1mg by mouth. Tanisha was observed in the emergency room for 4 hours and then was released with no new HCP orders. Retraining planned for the involved staff and all other staff will include topic of mindfulness during medication administration and having someone else answer telephone.

Supervisor (Print Name)	Linda White	**Print Title**	Supervisor	**Date**	3-5-yr
Contact phone number	121-121-1212	**Email address**	lw@aol.net		

Requirement: When a medication occurrence happens or is discovered, you must begin the 'Procedure following a Medication Occurrence' (see Unit 9).

Scenario: The medication system in your work location is under review by your supervisor and you are assisting. Your supervisor asks you about a recently obtained HCP order for a cough medication for Juanita. She was admitted from the emergency room to the hospital for a worsening cough.

The order was for dextromethorphan hydrobromide liquid 30mg by mouth every 8 hours for 7 days. The pharmacy label strength was printed as 15mg per 15mL. The directions were to give 30mL. You explain to your supervisor that all staff used household spoons to measure the medication. This was the first liquid medication ever ordered in this home. There are no liquid measuring devices on site as paper medication cups are used for tablets. Juanita had 3 doses administered before the hospitalization.

Responsibility: Your supervisor begins the 'Procedure following a Medication Occurrence' after identifying the 3 wrong doses. Your supervisor completes all necessary documentation, including submitting the medication occurrence report per state agency guidelines. All staff will be trained in using an appropriate measuring device (see Unit 7).

Medication Administration Program (MAP)
MEDICATION OCCURRENCE REPORT (MOR) Form

Service Provider	Amercare	Date of Discovery	5-14-yr
Individual's Name	Juanita Gomez	Time of Discovery	9:11am
Site Address (street)	45 Shade Street	Date(s) of Occurrence	5-13-yr to 5-14-yr
City/Town Zip Code	Treetop MA 00000	Time(s) of Occurrence	5-13-yr 3pm-11pm 5-14-yr 7am
MAP Site Telephone No.	000-000-0000	MAP MCSR No.	MAP 00001

A) Type Of Occurrence (As per regulation, contact MAP Consultant)

1 ☐ Wrong Individual
2 ☒ Wrong Dose
3 ☐ Wrong Route
4 ☐ Wrong Medication (includes medication given without an order)
5 ☐ Wrong Time (includes medication not given in appropriate timeframe)
☐ Omission (subgroup of 'wrong time'--medication not given or forgotten)

B) Medication(s) Involved

	Medication Name	Dosage	Frequency/Time	Route
As Ordered:	dextromethorphan hydrobromide liquid	30mg (30mL)	Every 8 hours for 7 days	Mouth
As Given:	dextromethorphan hydrobromide liquid	Unknown	5-13-yr 3pm, 11pm 5-14-yr 7am	Mouth
As Ordered:				
As Given:				
As Ordered:				
As Given:				

C) MAP Consultant Contacted (Check all that apply)

Type	Name	Date Contacted	Time Contacted
☐ Registered Nurse			
☐ Registered Pharmacist			
☒ Health Care Provider	Dr. Richard Black	5-14-yr	9:47am

D) Hotline Events

Did any of the events below follow the occurrence? ☒ Yes ☐ No

If ***yes***, 'check all that apply below', and **within 24 hours** of discovery notify DPH through the online DPH Hotline Reporting System, and notify the applicable DDS, DMH, DCF, or MassAbility MAP Coordinator. If *no*, notify your DDS, DMH, DCF, or MassAbility MAP Coordinator within 7 days of discovery. See 'page 2' for contact information.

☒ Medical Intervention (*see Section E below*) ☒ Illness ☐ Injury ☐ Death

E) MAP Consultant's Recommended Action and/or Events Following the Occurrence

Medical Intervention ☒ Yes ☐ No If Yes, 'Check all that apply'.

☐ Health Care Provider Visit	☒ Lab Work or Other Tests	☐ Clinic Visit
☒ Emergency Room Visit	☒ Hospitalization	

☒ Other: Please describe Chest x-ray

F) Supervisory Review/Follow-up

Contributing Factors: 'Check all that apply' and complete 'Narrative' below:

1 ☐ Failure to Properly Document Administration
2 ☐ Medication not Available (Explain Below)
3a ☐ Medication Administered by Non-Certified Staff (includes instances of expired or revoked Certification)
3b ☐ Medication Administered by a licensed nurse, employed on-site. LPN ☐ RN ☐
3c ☐ Medication Administered by a licensed nurse, not employed on-site (e.g., VNA)
4 ☐ Non-compliant Procedure
5 ☐ Failure to Accurately Record and/or Transcribe an Order
6 ☐ Failure to Accurately Take or Receive a Telephone Order
7 ☐ Medication Had Been Discontinued
8 ☒ Other-(Narrative Required)

Narrative: (If additional space is required, continue in box F-1) All staff involved used household spoons. Paper medication cups are used for tablets. Juanita's cough worsened after 3 doses of cough medication, and she had difficulty breathing. The HCP was contacted, and an ER visit followed. Lab work and a chest x-ray were completed. She was admitted to the hospital diagnosed with pneumonia. Retraining is planned for all staff regarding the use of an appropriate liquid measuring device.

Supervisor (Print Name)	Linda White	**Print Title**	Supervisor	**Date**	5-14-yr
Contact phone number	121-121-1212	**Email address**	lw@aol.net		

PRN Health Care Provider (HCP) Medication Orders

All HCP orders must include the 5 Rights of medication administration. In addition to the 5 Rights, an HCP order for PRN medication must include, but is not limited to:

- Reason for use
- Specific target signs and symptoms
- Instruction(s) for use
- Time between PRN and scheduled doses of the same medication
- When the HCP wants to be notified
- 'Not to exceed' instructions only when less than maximum daily dose is warranted.

This is an example of Scott Green's PRN medication order:

Tylenol 650mg by mouth PRN every 6 hours as needed for complaint of headache. Must give 6 hours apart from scheduled dose. Notify HCP if not effective after 24 hours. Not to exceed 3 doses in 24 hours. Reason: headache.

Below are the PRN medication order requirements and the parts of Scott Green's order that meet each requirement.

PRN Medication Order Requirements	Parts of Scott Green's PRN Order
Reason for use	Headache
Specific target signs and symptoms	Complaint of headache
Instruction(s) for use	PRN every 6 hours as needed
Time between PRN and scheduled doses of the same medication	Must give 6 hours apart from scheduled dose
When the HCP wants to be notified	Notify HCP if not effective after 24 hours
'Not to exceed' instructions	Not to exceed 3 doses in 24 hours

Supervisor Responsibilities

The site supervisor has the responsibility to:

- Assign the task of administering medications
- Be present and sign as a witness for all disposal of expired and/or discontinued medications
- Make sure that the ‘index’ of the countable controlled substance book is current
- Provide supervisory review of all medication occurrences.

Prohibited Activities for MAP Certified Staff Working at a MAP Registered Site

Certified staff may not do any of the following:

1. Altering or falsifying documents or documentation. This includes:
   - Altering Health Care Provider (HCP) Orders after the orders have been signed and dated by the HCP.
   - Signing or initialing for a task that the staff did not do or witness.
   - Correcting another staff's documentation error.
   - Forging another staff's signature, name, initials, etc.
2. Accepting an HCP order that has dose and/or frequency ranges.
3. Pre-pouring medication(s).
   - 'Pre-pouring' includes:
     - Preparing more than one person's medication at a time.
     - Packaging of medication for a person who is learning to self-administer their medication.
4. Splitting a tablet, capsule, pill, etc. to equal a dose ordered.
5. Administering medication prepared by another staff.
6. Administering one person's medication to another person who has an order for the same medication.
7. Administering medication via any route other than oral without first receiving training.
8. Administering medication with food (for example, apple sauce, pudding, etc.) or altering the formulation (for example, crush, dissolve, etc.) of the medication without an HCP Order stating to do so.
9. Preparing and administering medication by memory.
10. Packaging medication into a pill-organizer.
11. Administering a PRN medication for symptoms other than for the PRN target signs and symptoms ordered by the HCP.
12. Administering a PRN medication without follow-up documentation of the effectiveness of the PRN medication.
13. Returning a medication back into its container or package once it has been removed.
14. Combining multiple prescriptions of the same medication into a single container.

15. Measuring liquid medication with a measuring device that does not have the specific amount marked to measure the dose ordered.
16. Measuring more than one liquid medication into the same measuring device at the same time.
17. Disposing of medication alone (by yourself).
18. Accepting a pharmacy delivery without verifying and securing the medication.
19. Writing or highlighting on a pharmacy label.
20. Highlighting on a Medication Administration Record (MAR).
21. Covering a pharmacy label with a 'directions change sticker' or using a 'directions change sticker' on a MAR.
22. Altering medication packaging (for example, cutting, gluing, stapling, taping, etc.).
23. Sharing medication administration responsibilities between more than one staff at the same time.
24. Accepting or obtaining the Medication Storage Keys without first conducting a Two Person count or a Single Person Count if alone.
25. Transporting medication for people they do not work with and/or during non-work hours.
26. Releasing (i.e., transferring) medication without completing the required Medication Release (e.g., Leave of Absence [LOA] Form or Transfer Form) documentation.
27. Delay in reporting medication occurrences once discovered.
28. Documenting in the 'past' or 'future'.
29. Using an 'Items List'
30. Administering medications that are not labeled per MAP Policy
31. Using generic 'Standing Orders', i.e., PRN HCP orders that have not been individualized.

Words You Should Know

Abbreviation - A shortened form of a word or phrase.

Acceptable Codes - A set of letters created as an acceptable abbreviation of a longer phrase or sentence.

Accuracy check - A review of HCP orders compared to the new month's medication sheets completed by two Certified and/or licensed staff. This is to make sure that all information on the medication sheets is complete and correct.

Administration - The process of giving medications to the people you support.

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. This is an adverse response.

Allergies - A list of known medications, food, substances, etc. that the person's immune system reacts to as if they were a foreign substance.

Amount - The number of tablets, capsules or mLs 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 – In this training, an authorized prescriber is the same as a Health Care Provider (HCP). This is the person who prescribes medication.

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

Chain of Custody - A trail of unbroken documentation that ensures the physical security of medication.

Communication - The sharing or exchanging of information.

Confidentiality - Keeping information about the people you support private. For example, health information.

Controlled (Schedule VI) Medication - Medication which requires an HCP prescription to obtain it from the pharmacy.

Countable Controlled Medication (Schedule II-V) - Medication which requires an HCP prescription to obtain it from the pharmacy. These medications are at high risk of being stolen and abused. For these reasons, they must have additional security measures in place.

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.

Count Sheets - 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 to document when responsibility for the countable medications is transferred.

Critical Medication-Related Tasks - tasks that must be completed prior to the Medication Administration Process to make sure medications are administered safely. The 3 critical medication-related tasks are: 1) Make sure the correct medication is received from the pharmacy, 2) Post and verify an HCP order, and 3) Complete monthly accuracy checks.

Day Program Medication and Residential Staff Responsibilities - The tasks that must be completed by the residential staff when medication is scheduled to be administered during Day Program hours.

Day Program Staff Responsibilities - The tasks that must be completed by the day program staff when medication is scheduled to be administered during Day Program hours.

Desired Effect - When a medication does exactly what it was intended to do.

Dietary Supplements - Products that contain dietary ingredients such as vitamins, minerals, herbs, or other substances. Other substances are other ingredients listed on the back of a manufacturer's label.

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

Disposal - To render a medication unusable and discard it.

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

Documentation - To record information by writing it down.

Documentation Error - A mistake when writing on a medication sheet, medication progress note, count sheet page, etc.

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

Drug Loss - When a medication is unaccounted for at either a site or a pharmacy.

Emergency Contact List - A single page list of telephone numbers of emergency contacts. This includes MAP Consultants, Poison Control, and other emergency numbers (911, fire, police).

Exhausting Current Supply - Using an existing supply of medication to administer a newly ordered dose or frequency of the same medication under certain conditions.

Emergency Fact Sheet (EFS) - A single document for each person that includes their picture and lists important contact and medical information.

Everyday Reporting - The exchange of information between staff about routine, day-to-day matters.

Expiration Date - The last date a medication may be administered. The date is printed on the pharmacy label.

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.

Five Rights of Medication Administration - The right person, the right medication, the right dose, the right time, and the right route.

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

Generic name medication - A medication known by its chemical name.

HCP Encounter/Consult/Order Form - The form used by the HCP to write orders. HCP Encounter Form, HCP Consult Form and HCP Order Form are different names used for the same form.

Health Care Provider (HCP) - A person who is registered in the state of Massachusetts to prescribe medication. Health care providers can be a doctor, dentist, nurse practitioner, etc.

Health Care Provider Order - A set of detailed orders/instructions written by the HCP for each person. Many times, HCP orders are medication related, but not always.

Health Care Provider Visit - A medical appointment scheduled for a person with an HCP.

Health-Related Questions - Communication initiated by the person or staff in which answers are obtained from the HCP specific to a person's current health status.

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

Identifier - A special marking on a package of countable controlled medication that identifies it as a countable controlled medication.

Immediate Reporting - The exchange of information as soon as a change in a person is observed.

Index - The first section of the Count Book.

Leave of Absence (LOA) - Used when medication is transferred to family/guardian/responsible party for administration while on leave of absence.

Leave of Absence Form - The document used to track medication when medication is released to family/guardian/responsible party for an LOA.

Liquid Medication - Medication dispensed by a pharmacy as a solution, syrup, suspension, or elixir, etc.

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 (RPh) or Health Care Provider (HCP).

MAP Policy Manual - The single, organized source of MAP information and policies.

MAP Recertification - The process of retesting every 2 years to maintain your MAP Certification.

MCSR - Massachusetts Controlled Substances Registration.

Measuring Devices - Used to measure various forms (such as powder or liquid, etc.) of medication. Examples include a marked medication cup, oral syringe, dropper, dosing spoon, etc.

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

Medication Administration - The process of giving medications to the people you support.

Medication Administration Process - What you must do to prepare, administer, and complete medication administration.

Medication Administration Sheet - The tracking form for documenting the administration of medication.

Medication Categories - There are three categories. Controlled, Countable Controlled, and Over-the-Counter (OTC) medication.

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

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

Medication Information Sheet - A printed resource for medication information usually provided by the pharmacy.

Medication Interaction - A mixing of medications in the body.

Medication not Administered - When a medication is not given for various reasons.

Medication Occurrence - When one of the 5 Rights goes wrong during medication administration.

Medication Occurrence Report (MOR) - Used to track each time one of the 5 Rights goes wrong during medication administration.

Medication Ordering and Receiving Log - The documentation of medication that is ordered by a site and when it is received from the pharmacy.

Medication Outcome - The result a medication produces after it is administered.

Medication Reconciliation - The process of generating the most complete and accurate list of the person's currently prescribed medications.

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.

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

Medication Security - Requirements that protect medication from unauthorized access, tampering, loss, etc.

Medication Sheet - The document used to track the administration of each person's medication.

Medication Storage - Requirements that maintain medication effectiveness and security while storing them.

Medication Supply Discrepancy - When the medication count is off due to medication loss, diversion (theft), tampering, documentation inconsistencies or documentation errors in addition or subtraction.

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

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

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

Observing and Reporting - Watching a person carefully and sharing the information about the changes you notice.

Obtaining Medication - The process of getting medication and Dietary Supplements from the pharmacy.

Omission - Occurs when the medication is not administered. A type of medication occurrence.

Oral - When a medication is taken by mouth.

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

Over-the-Counter (OTC) Medication - Medications that do not require a prescription from the HCP.

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

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

Pharmacy Label - The label attached to a medication container by the pharmacy.

Pharmacy Receipt - A document received from the pharmacy listing how many tablets, capsules or mLs of each medication was dispensed to the site (also called a Pharmacy Manifest).

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

Prescription - Instructions submitted from the HCP to the pharmacist for all controlled and countable controlled medication ordered.

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

Principles of Medication Administration - The basis of medication administration.

Prior Authorization - Approval from an insurance company, required prior to the pharmacy being able to fill a prescription.

PRN - An abbreviation meaning 'as needed.'

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

Protocol - A detailed HCP order that includes instructions on when, how, and why to give a medication.

Regularly Scheduled Medication - Medication administered routinely, on a continuing basis.

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

Respecting a Person's Rights - In relation to medication administration, people have the right to know what their medications are and the reasons they are taken, know the risks and benefits of taking the medication, to refuse medication, and be given medication only as ordered by the HCP.

Responsibilities - Tasks required as part of job duties for which you are accountable.

Responsibilities in Action - A set of responsibilities done accurately by MAP Certified staff for safe medication administration.

Route - The way a medication enters the body.

Rx - An abbreviation for a prescription number. The Rx number appears on a pharmacy label.

Sensitivity to Medication - Being unable to tolerate medication when the medication is ordered at a usual dose or less.

Shoulder to Shoulder Count - The procedure for transferring responsibility for the safety and security of the medications, from one staff to another staff. This is only required for Countable Medications, like a prescription pain reliever or anti-anxiety medication.

Side Effect - A result from a medication that is not wanted or intended.

Special Instructions - Guidelines or parameters on the HCP order and/or pharmacy label specific to the administration of a medication.

Specialized Training - Additional training required for medication routes other than oral, High-Alert medication, etc.

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.

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

Subjective Information - When a person who speaks or signs tells you how they are feeling.

Support Plan - A detailed HCP order that includes instructions on when, how, and why to give a medication.

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

Tamper Resistant Packaging - A way the pharmacy packages a medication to make it obvious the package has been opened. For example, a blister pack.

Telehealth Health Care Provider Order - Documentation of instructions given by an HCP during a telehealth appointment.

Telephone Health Care Provider Order - Documentation of instructions given by an HCP over the telephone.

Toxicity - When a medication builds up in the body and the body cannot handle it anymore.

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

Transcription - The process of copying information from the HCP order and the pharmacy label onto the medication sheet. Also, the completed document after the information has been recorded.

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.

When Not to Administer Medication - Instances when you cannot administer medication.

When to Request a Medication Refill - When there is no less than a seven-day supply of medication remaining.

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

Wrong Medication - When medication is administered without an HCP order. This 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.

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.

Answer Key

Unit 1

Page 17

1. F
2. F
3. T
4. F
5. T
6. F
7. T

Page 19

1. Juanita is able to nod her head ‘yes’ and ‘’no’ to respond to a question or she may ‘make a face’ to show if she liked (smiled) or did not like (frowned) a flavor when tasting the pudding.
   Related principle-communication
2. Allow Ellen to fill her own glass of water for medication administration
   Related principle- supporting abilities
3. Often switch the order of who you administer the medications to
   Related principle-mindfulness

Page 21

1. Anxiety defined as biting hands for more than 4 minutes and head slapping for longer than 30 seconds or more than 5 times in 4 minutes
2. No
3. Notify HCP

Unit 2

Page 24

1. O
2. O
3. S
4. O
5. S

Page 28

4. _√_ David states he has, 'sharp pain' when he bends his right knee. He frowns getting off the van and is limping. His right knee is now red, warm to touch and swollen. He has received Ibuprofen 400mg for right knee pain and his symptoms continue.

Unit 3

Page 33

Lisinopril Omeprazole Ibuprofen

Page 43

1. T
2. T
3. F
4. T

Page 46

~~Sample Medication Information Sheet~~

Interactions: Tell your HCP of all the medications you are taking. Do not use with St. John's Wort. Using tramadol together with alcohol may increase side effects such as dizziness, drowsiness, confusion, and difficulty concentrating.

Page 48

1. B
2. C
3. G
4. L
5. K
6. E
7. F
8. J
9. H
10. I
11. A
12. D

Unit 4

Page 56

1. Dr. Black
2. Burning in throat after eating
3. Sam Dowd
4. No known allergies
5. Gastroesophageal reflux disease
6. Prilosec
7. Remain upright 30 minutes after eating

Page 57

HEALTH CARE PROVIDER ORDER

Name: Tanisha Johnson	**Date:** Feb. 2, yr
Health Care Provider: Dr. Chen Lee	**Allergies:** No known medication allergies
Reason for Visit: Complaining of soreness in back of mouth.	
Current Medications: √ Phenobarbital 64.8mg once daily in the evening by mouth √ Clonazepam 1mg twice daily at 8am and 4pm by mouth	
Staff Signature: Sam Dowd	**Date:** Feb. 2, yr
Health Care Provider Findings: Inflammation of gum-line on left side of mouth	
Medication/Treatment Orders: Amoxil Suspension 500mg every 12 hours for seven days by mouth	
Instructions: Notify HCP if Tanisha continues to complain of mouth soreness after 72 hours.	
Follow-up visit: Feb. 16, yr	**Lab work or Tests:** None
Signature: Dr. Chen Lee	**Date:** Feb. 2, yr

1. Circle the new medication order-see above
2. 500mg
3. Every 12 hours for seven days
4. Place a checkmark next to Tanisha's current medications-see above
5. No

Page 63

1. Yes

2. Document the order word-for-word on an HCP Order form. Read back the information given to you by the HCP to confirm you recorded it accurately. If you have trouble understanding the HCP, ask another staff to listen in as you take the order. Then have 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 on the order form.

3. 72 hours

4. Yes

Page 66

3 tablets

Unit 5

Page 73

1 Rx # C201 2 Greenleaf Pharmacy 20 Main Street Treetop, MA 00000 3 111-222-3434

5 3/4/yr

4 David Cook

6a Tramadol 7 50mg

6b IC Ultram Qty. 21 8

Take 9 1 tablet 10 by mouth 11 every 8 hours for 7 days

12 Take with water

13 Dr. Black

14 Lot # 776-5433 15 ED: 3/4/yr 16 Refills: 0

Page 74

1. C
2. C
3. D
4. All

Page 77

No. Aspirin EC is ordered. Aspirin was supplied.

Page 78

No. The frequency listed on the HCP order is ‘daily in the evening.’ The frequency listed on the pharmacy label is ‘every evening at 8 PM.’ Note: if the HCP order is not time specific, the label should include the time of day ordered, not a specific time.

Page 79

1. You could give an incorrect dose of four 100mg tablets.
2. It is a different color.

Page 81

1. 120
2. 32
3. 28
4. no
5. a day too early
6. 28
7. to ensure medication is available to administer as ordered

Unit 6

Page 88

1. T
2. F
3. T
4. F
5. T

Page 95

Day Program Staff

1. V
2. OSA

Residential Program Staff

1. OSA
2. DP
3. LOA
4. A
5. V
6. W

Page 97

Write the number on the medication sheet of the term (p. 97) that corresponds with information to be transcribed, listed as numbers 1-14.

Month and Year: month, yr **1** MEDICATION ADMINISTRATION SHEET Allergies: **3**

Start	Generic	**4**		
11	Brand	**5**		
	Strength	**7**	Dose	**6**
Stop 12	Amount	**8**	Route	**10**
	Frequency	**9**		

Hour	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

Special instructions: **13** *Reason:* **14**

Start	Generic			
	Brand			
	Strength		Dose	
Stop	Amount		Route	
	Frequency			

Hour	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

Special instructions: *Reason:*

Start	Generic			
	Brand			
	Strength		Dose	
Stop	Amount		Route	
	Frequency			

Hour	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

Special instructions: *Reason:*

Start	Generic			
	Brand			
	Strength		Dose	
Stop	Amount		Route	
	Frequency			

Hour	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**

Special instructions: *Reason:*

Name: **2**

Site:

CODES	**CODES**		**Signature**
DP-day program/day hab	**A-absent**		
LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**		
P-packaged	**OSA-off site administration**		
W-work	**MNA-medication not administered**		
H-hospital, nursing home, rehab center	**Signature**		
S-school			
V-vacation			

Accuracy Check 1______________ Date_______ Time________

Accuracy Check 2 ______________ Date_______ Time________

Page 100

1.

Hour
10pm

2.

Hour
7:30am

Page 101

1.

Hour
4pm

2.

Hour
8am
8pm

1.

Hour
P
R
N

Page 102

1. E
2. G
3. F
4. C
5. D
6. H
7. B
8. A

Page 110-111

1. 3/3/yr at 4pm
2. 3/3/yr
3. 3/13/yr at 8am
4. 3/13/yr
5. 3 times daily for 10 days
6. 8am, 4pm, 8pm
7. 666mg
8. 2 tabs
9. 333mg
10. Sam Dowd

Page 114

HEALTH CARE PROVIDER ORDER

Name: Tanisha Johnson	**Date:** Feb. 5, yr
Health Care Provider: Dr. Chen Lee	**Allergies:** No known medication allergies
Reason for Visit: Continues to complain of soreness in back of mouth	
Current Medications: Phenobarbital 64.8mg once daily at 8pm by mouth Clonazepam 1mg twice daily by mouth Amoxil Suspension 500mg every 12 hours for seven days by mouth	
Staff Signature: Sam Dowd	**Date:** Feb. 5, yr
Health Care Provider Findings: Increased inflammation of gum-line on left side of mouth	
Medication/Treatment Orders: DC Amoxil Suspension Cleocin HCL 300mg three times a day for 10 days by mouth	
Instructions: Notify HCP if Tanisha continues to complain of mouth soreness after 72 hours.	
Follow-up visit: February 16, yr	**Lab work or Tests:** None
Signature: Dr. Chen Lee	**Date:** Feb. 5, yr

Posted by: ***Full Signature*** **Date:** ***2/5/yr*** **Time:** ***1pm*** **Verified by:** **Date:** **Time:**

Page 115

Month and Year: February, yr **MEDICATION ADMINISTRATION SHEET** **Allergies: none**

Start	Generic Phenobarbital	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand Luminal																																
	Strength32.4mg Dose 64.8mg																																
Stop	Amount 2 tabs Route mouth																																
Cont.	Frequency Once daily at 8pm	**8pm**	TM	TM	TM	JS																											

Special instructions: *Reason:* seizures

Start	Generic Clonazepam	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand Klonopin	**8am**	KM	AS	KM	KM	AS																										
	Strength1mg Dose 1mg																																
Stop	Amount 1 tab Route mouth	**4pm**	TM	TM	TM	JS																											
Cont.	Frequency Twice daily 8am and 4pm																																

Special instructions: *Reason:* seizures

Start	Generic Amoxicillin suspension	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2/2/yr	Brand Amoxil suspension	**8am**	X	X	KM	KM	AS	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength250mg/5mL Dose 500mg																																
Stop	Amount 10mL Route																																
2/9/yr	Frequency every 12 hours for 7 days	**8pm**	X	TM	TM	JS	—	—	—	—	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

D/C 2/5/yr initials

D/C 2/5/yr initials

Special instructions: *Reason:* gum

Start	Generic Clindamycin	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2/5/yr	Brand Cleocin HCL	**8am**	X	X	X	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength 100mg Dose 300mg																																
Stop	Amount 3 tabs Route mouth	**4pm**	X	X	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2/15/yr	Frequency 3 times daily for 10 days	**8pm**	X	X	X	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: Take with 8 ounces of water *Reason:* gum

Name: Tanisha Johnson

Site: 45 Shade Street
Treetop MA 00000

CODES	CODES		Signature
DP-day program/day hab	**A-absent**	KM	Kay Mathers
LOA-leave of absence	**NSS-no second staff (e.g. Coumadin)**	AS	Amanda Smith
P-packaged	**OSA-off site administration**	TM	Timothy Miller
W-work	**MNA-medication not administered**	SW	Serena Wilson
H-hospital, nursing home, rehab center	**Signature**	JS	Jenna Sherman
S-school		SD	Sam Dowd
V-vacation	JC John Craig		

Accuracy Check 1 Sam Dowd Date 1/31/yr Time 9pm

Accuracy Check 2 John Craig Date 1/31/yr Time 9pm

Page 116

1. B
2. C
3. C
4. C
5. B

Unit 7

Page 119

Blood pressure

Page 121

Yes

Page 122

1. PRN medication
2. For complaints of right knee pain
3. No
4. 5PM
5. Notify HCP

Page 127

Amount
1. 2 tablets
2. 2 tablets
3. 2 capsules
4. 3 tablets
5. 1 capsule
6. 4 tablets
7. 5 tablets
8. 2 capsules
9. 2 tablets
10. 2 tablets
11. ½ tablet

Page 130

4. _√_ Ask your supervisor to arrange a specialized training for EpiPen® use.

Page 131

All

Page 135

1. HCP Order
2. pharmacy label and medication sheet
3. pharmacy label and medication sheet

Match the step of the medication administration process to its corresponding reason.

Confirm C

Check 1 B

Check 2 A

Page 137

1. T
2. T
3. F
4. T
5. F

Page 145

250mg

Page 146

1. 1200mg/15mL
   You should have filled to the 30mL line

Page 147

2. 100mg/5mL
   You should have filled to the 10mL line

Page 148

3. 262mg/15mL
   You should have filled to the 15mL line

Page 153

Amount
1. 20mL
2. 12mL
3. 4mL
4. 8mL
5. 10mL
6. 9mL
7. 8mL
8. 20mL
9. 15mL
10. 30mL
11. 20mL

Page 154

3. _√_Call the pharmacy and request an appropriate measuring device.

Match the terms with the corresponding letter.

1. C
2. D
3. B
4. A

Page 154 continued

True (T) or False (F)

1. T
2. T
3. T
4. F
5. T
6. T

Pages 157

You should:

3. _√_ Ask David why he doesn't want to take the medication

David tells you he doesn't like the purple color of the tablet. You should:

4. _√_ Secure the medication, return in 15 minutes, and offer it again

After 3 attempts, David still refuses the medication. You should first:

4. _√_ Notify Dr. Black of the refusal

Page 158

Using the medication sheet and corresponding progress note, document the medication refusal.

Start 8/31/yr	Generic **Omeprazole**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Brand Prilosec																																
	Strength 20mg	Dose 20mg																															
Stop	Amount 1 tab	Route mouth	**4pm**	WS	WD	JC	MNA																										
cont	Frequency **Once daily before supper**																																

Special instructions: *Reason: GERD*

MEDICATION PROGRESS NOTE

3/4/yr 4:45pm David refused his 4pm dose of Prilosec. David was pacing; he stated, "I don't like purple". I attempted to administer the medication 3 times. Dr. Black and (your supervisor's name) notified. _____Your signature

Page 159

Class Discussion

1. So that the HCP will have enough information to make a decision about medication changes.
2. So that the HCP will be able to determine if the refused doses of medication may lead to the medication being less effective.
3. Scott could experience racing thoughts. In his history, this led Scott to being a safety risk to himself and others in the community.

The most complete information to report to the prescribing HCP is:

2._√_ Scott refused his antipsychotic medication on Friday and previously on Monday, Tuesday and Thursday.

Page 161

Your initials ↓

Start	Generic		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand **Check blood pressure (BP)**		**8am**	WS	AS	JC	WS																											
	Strength	Dose	**BP**																															
Stop	Amount	Route	**S**	120	134	**130**	**132**	**90**																										
Cont.	Frequency **Daily in the morning**		**D**	**64**	**66**	**62**	**60**	**50**																										

Special instructions: **Hold Zestril if systolic (top) blood pressure (BP) reading is below 100 and notify HCP** *Reason:*

Start	Generic **Lisinopril**		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
8/31/yr	Brand **Zestril**		**8am**	WS	AS	JC	WS	MNA																										
	Strength **20mg**	Dose **40mg**																																
Stop	Amount **2 tabs**	Route **mouth**																																
Cont.	Frequency **Daily in the morning**																																	

Special instructions: **Hold Zestril if systolic (top) blood pressure (BP) reading is below 100 and notify HCP** *Reason:* **high BP**

MEDICATION PROGRESS NOTE **March, yr**

3/5/yr 8am Blood Pressure 90/50. Zestril 40mg held. (Name of HCP) notified. _____Your full signature

Page 162

Start	Generic **Omeprazole**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Prilosec**																															
	Strength **20mg**	Dose **20mg**																														
Stop	Amount **1 tab**	Route **mouth**	**4pm**	WS	WD	JC	MNA																									
Cont.	Frequency **Once daily before supper**																															

Special instructions: *Reason:* **GERD**

MEDICATION PROGRESS NOTE **March, yr**

3/4/yr 4PM Omeprazole 20mg held per HCP order to hold before scheduled test ----------Your full signature

Page 164

Start	Generic **Omeprazole**		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
8/31/yr	Brand **Prilosec**																															
	Strength **20mg**	Dose **20mg**																														
Stop	Amount **1 tab**	Route **mouth**	**4pm**	WS	WD	JC	MNA																									
Cont.	Frequency **Once daily before supper**																															

Special instructions: *Reason:* **GERD**

MEDICATION PROGRESS NOTE **March, yr**

3/4/yr 4PM Prilosec was unavailable. Spoke to Forrest Greenleaf at the Greenleaf Pharmacy. He stated medication will be delivered by 7:30pm. He stated to omit 4pm dose and give the next scheduled dose when due. (Name of your Supervisor) also notified _____Your full signature

Unit 8

Page 168

Call the prescribing HCP to request a new prescription be submitted to the pharmacy.

Page 178

1. F
2. T
3. T
4. T
5. T

Page 179

3._√_ Unlock the medication storage area, obtain the drug reference book for the Certified staff and relock.

1. N
2. N
3. N

1. The ‘Chain of Custody’ is broken and medications could be stolen.

2. To MAP Certified and/or licensed staff after conducting a two person count with them.

Page 180

Yes, (the tablets were popped out of order)

Page 192 Class Discussion

Day program staff continued to give the discontinued medication. Residential staff should have faxed or sent a copy of the new order over to the day program.

Page 194

5 tablets

Page 210

1. two
2. Count Book
3. item number
4. Supervisor

Unit 9

Page 226

Number the 'Procedure Following a Medication Occurrence' in the order to be completed if you make or discover a medication occurrence

7 Complete a Medication Occurrence Report

4 Follow all recommendations given to you by the MAP Consultant

5 Notify your supervisor

2 Call 911, if needed

6 Document what you did

3 Call a MAP Consultant

1 Check to see if the person is okay

Page 227

1. Wrong Person
2. Check to make sure the person is okay. If not, call 911. If okay, contact MAP consultant for recommendation.
3. Medications should never be pre-poured and never left unattended.
4. Jim could have secured the medication before assisting with the emergency or taken the medication with him.

Page 228

1. Wrong Medication
2. Check to see that Tanisha is okay. If not call 911. If okay, contact MAP Consultant for recommendation.
3. By confirming the HCP order

Page 229

1. Wrong Dose

2. Check to see that Tanisha is okay. If not, call 911. If okay, contact MAP Consultant for recommendation.

3. By comparing the strength of the medication ordered with the strength of the medication received during the medication ordering and receiving process.

Page 231

1. Call the HCP for a refill.

2. MAP Consultant

3. Omission

4. During the ordering and receiving process, when it was documented that there were no refills left, the HCP should have been contacted for a new prescription.

Page 232

1. Wrong Route

2. Check to make sure Ellen is okay. If not, call 911. If okay, contact MAP Consultant for recommendation.

3. Joe should have instructed the other staff to stop talking with him until he finished administering medications.

Page 233

Match the term to the corresponding example

1. C
2. F
3. A
4. D
5. B
6. E

Glossary of Terms

Accommodations - changes made to the environment so the person can access treatment.
Antibiotics - medications that treat bacterial infections.

Antidepressants - medications that treat depression.

Antipsychotics - medications that treat mental illness.

Authorization - approval

Chronological - arranged in the order of the time the disposal happened.

Conducting: the action of doing or carrying out a task or process.

Consecutively - numbered in order.

Crisis Stabilization - short-term treatment for a mental health disorder.

Day habilitation - a site similar to a day program except medications are only given by nurses.

Discrepancy - when the amount of medication in the package does not match the amount on the count sheet page.

Documentation - to record information by writing it down.

Dose verification - double-checking the dose.

Effectiveness - the process of determining how well the product works.

Electronically - through the computer.

Environmental - the conditions, objects and circumstances that surround you.

Identifier - an identifier is a special marking on the package.

Inconsistencies - documentation that says different or conflicting things.

Independently - by themselves; without support staff.

Interchangeable - either word can be used to mean the same thing.

Investigated - a formal examination of facts to find out what happened and who did it.

Medication Administration - the process of giving medications to the people you support.

Medication Reconciliation - the process of generating the most complete and accurate list of the person's currently prescribed medications.

Multivitamins - supplements that contain different vitamins and minerals.

Nonprescription Medication - medication that does not require a prescription from the HCP.

On their person - carried by the person.

Participation - being involved in the appointment.

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

Post-date - document a date later than the actual date.

Recommendation - an instruction or order or referral.

Refrigerated - medication that must be kept in the refrigerator.

Rehabilitation - short-term care to improve abilities or recover from physical injuries.

Responsibility - tasks required as part of job for which staff are accountable.

Self-administering - when the medication is under the complete control of the person.

Sensitivity to Medication – being unable to tolerate medication when the medication is ordered at a usual dose or less.

Subcategory - a type.

Suspicious count discrepancy - when the amount of medication in the package does not match the amount on the count sheet page.

Symbols and Abbreviations - a shortened form of a word or phrase.

Transcription - the process of copying information from the HCP order and the pharmacy label onto the medication sheet.

Verification - confirmation that the product purchased is what the HCP ordered.

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.

Ask Your Supervisor these Questions Specific to Your Work Location

1. Where is the MAP MCSR found in the medication area?
2. Where is the MAP Policy Manual found?
3. Where is the Emergency Contact List found?
4. Who is responsible for contacting the HCP to report changes in the people I support?
5. How is information shared between shifts? For example, how are new HCP orders communicated if there is no staff present when I arrive for my shift?
6. Does anyone have HCP orders for 'high alert' medication? If so, how are they tracked?
7. Does anyone have HCP orders for 'high risk' medication? If so, how are they tracked?
8. How does the pharmacy identify countable controlled medication?
9. Where is the current (less than 2 years old) drug reference book or the current (less than 2 years old) medication information sheets found?
10. What HCP visit forms are required specific to the people I support?
11. After becoming MAP Certified, will I receive training in the Transcription of Medication Management System (TMM System)?
12. Am I allowed to take a telehealth/telephone order? If yes, where are the telehealth/telephone order forms kept?
13. What method is used to obtain medication refills from the pharmacy?
14. Which pharmacy is used to obtain medication if the usual pharmacy is closed?
15. Does anyone have HCP orders for antipsychotic medications requiring a Rogers Decision?
16. Where are medications requiring refrigeration stored?

17. How is the backup set of keys accessed, if needed?

18. What is the medication administration time schedule?

19. When will I receive training on all other routes medications are administered?

20. Is blister pack monitoring required?

21. Does the pharmacy supply automatic refills or online orders? What system is used to compare the medications that are expected with what the pharmacy delivers?

22. How are the new month's medication sheets generated?

23. What is the communication system between the day program and the residential site?

24. What is the procedure regarding staff responsibilities when a person returns from an LOA?

25. Is the supervisor required for all medication disposals?

26. How are MORs submitted?

27. What is the follow up process for medication occurrences?