MEDICATION ADMINISTRATION PROCEDURES HANDBOOK

POLICY STATEMENT

Section:	**Client Services**	**Policy #:**	**CS0024**
	Medication Administration	**Page:**	1 of 2

Effective Date: June 22, 2016

Replaces: CS0024 – 09/23/2009
CS0025 – 03/2004
CS0026 – 03/2004

Rationale:

Springboard Centre wants to ensure safe and responsible practices when administering medication.

Policy Statement

General Guidelines:

Administration of medications at Springboard Centre is viewed as an important responsibility.

Medication will only be administered by staff that possess current certification in an approved Medication Administration course. These staff must also complete an in-house practicum before delivering medications to clientele, which includes an orientation of Springboard Centre's Medication Administration Policies and Procedures. Staff will maintain documentation of Medication Administration on a daily basis. The only exception to this will be in the event that medications must be prepacked for outings. Other staff may be responsible for administering but only after the staff has received training on how to administer the medication and what to do in the event of an error.

A review of the medication policies and procedures will occur annually.

Clients/parents/guardians/residential caregivers are advised of Springboard Centre's requirements for the administration of medications at time of admission or as policy amendments occur.

All prescription medications must be identified with a pharmacy label in sealed packaging from the pharmacy, a copy of physician's orders and written consent from the legal guardian of the client. A copy of the physician's order may not always be available. In these circumstances, the pharmacy label will be accepted as the physician's order. Over the Counter medications will not require physician's orders but must be in original packaging and must have signed guardian consent before administration can occur.

Medications must be secured at all times at Springboard Centre. This may include being stored behind a locked door, or carried on the employee's person, where it is not accessible by any other person.

Guardians are responsible to ensure that any non-prescribed medications (e.g., over the counter or herbal remedies) will not have any contraindications with each other or any prescribed medication that the client is taking.

EPI-PENS:

Springboard Centre staff are not allowed to administer injection medication with the exception of EPI-PENs (epinephrine) for allergies. All staff will receive training on how to recognize the symptoms of anaphylaxis and the administration procedure for an EPI-PEN.

The EPI-PEN must be carried with the client at all times through the use of a fanny pack or back pack that has easy accessibility for staff only.

Client Self Administration:

All clientele whom express an interest in becoming self-administered for medications must be assessed for competency. Based upon this assessment, a training tool will be developed in order to help the client reach his/her goal. This assessment will occur on an annual basis.

Self-administration of medication will be monitored and documented by Springboard Centre staff to ensure that stated administration procedures are correctly adhered to.

The Basics

NB – Medication administration can happen within a one-hour leeway period of the prescribed time (one half hour before and one half hour after).

Pills will be packaged in one of three ways:
1. bubble packs
2. prescription bottle
3. multi-dose packet

Liquids will be packaged in the prescription bottles.

No matter what kind of container it is in, the container should be clearly labeled with:
1. Client name
2. Physician's name
3. Drug Name and Strength
4. Dosage of medication
5. Route of administration (this may not be always present if the medication is meant to be given orally)
6. Time of administration

Medications that are purchased over the counter by guardians and sent in to Springboard Centre, will be labeled by staff, with the client's name.

Prescription medications can only be given with a copy of the original prescription written by the physician (or approved pharmacy label) and with signed consent from the guardian.

1.0 Procedure for Medication Administration

NOTE: THIS PROCEDURE SHOULD BE FOLLOWED FROM BEGINNING TO END FOR ONE CLIENT ONLY AT A TIME.

1.1 Gather all needed supplies for medication administration (water, pudding, spoon, medication cups).

1.2 Wash hands.

1.3 Locate client's medication from locked cabinet.

1.4 Complete check #1. Compare **Prescription Label** to **Dr. Orders** and **Medication Administration Record (MAR)** sheet to all information is correct. Check for:
- 1.4.1 Client Name
- 1.4.2 Drug Name
- 1.4.3 Dosage
- 1.4.4 Route
- 1.4.5 Time
- 1.4.6 Physician's Name

1.5 Dispense medication (pop pills, measure liquids with syringe).

1.6 Complete second check (see step 1.4).

1.7 Administer medication appropriately.

1.8 Complete third check (see step 1.4)

1.9 Complete MAR sheet. If the medication is for seizures or behaviours, a count is maintained. Insure that the appropriate boxes are completed.

1.10 Return all medication and equipment to designated locked area.

Medication administration is the same for PRN over the counter medication and PRN Prescription Medication. The only difference is that when you are completing the MAR sheet you need to ensure that:

1. You have noted the date and time of administration (dosage if applicable)
2. You ensure that you are using a separate line or column for each time a medication is administered.

2.0 Pre-packaging Medications

NOTE: THIS PROCEDURE SHOULD BE FOLLOWED FROM BEGINNING TO END FOR ONE CLIENT ONLY AT A TIME.

2.1 Gather all needed supplies for medication administration (water, applesauce, spoon, medication cups).

2.2 Wash hands.

2.3 Locate client's medication from locked cabinet.

2.4 Complete check #1. Compare **Prescription Label** to **Dr. Orders** and **Medication Administration Record (MAR)** sheet to all information is correct.

2.5 Label brown envelope with:

- 2.5.1 Client Name
- 2.5.2 Drug Name
- 2.5.3 Dosage
- 2.5.4 Route
- 2.5.5 Time
- 2.5.6 Physician's Name
- 2.5.7 Pharmacy Name and Number
- 2.5.8 Initials of the person's prepacking medication

If pre-packing liquid medications, place white label with the above information on a plastic Ziploc.
A multi-dose packet is considered labeled, so there is no need to do so. Initial the package to show that you are the person passing it on.

2.6 Dispense medications into envelope. If pre-packing a liquid medication, keep medication in the syringe and use the plastic stopper to keep it from leaking. Place the syringe in the Ziploc bag. A second option is to measure the medication with a syringe, and then place it into an empty transfer bottle (labeled).

2.7 Complete Check #2.

2.8 In the top box of the medication administration place a 'P' and your initials. The bottom box is for the medication giver to initial.

2.9 Give to the person who will be administering the med and ensure they store it in a safe place where only they can access it.

2.11 Administer Medication at indicated time. Do not throw away the envelope or Ziploc bag.

2.12 Upon return to Springboard, complete Check #3.

2.13 Complete the MAR sheet.

2.14 Attach the envelope from the pre-packed medication to the MAR sheet with a paperclip for the medication checker to confirm.

2.15 If you are pre-packing medication for another person, ensure that they know how to give the medication correctly. Ensure they know where to sign on the MAR sheet. Insure they are aware that they are solely responsible for the medication administration and are to report back to you upon completion.

3.0 Medication Checker Procedures

3.1 At specified times, check the appropriate medications to verify they were administered.

- 3.1.1 Check MAR sheet to see if completed.

3.2 Initial the Med Checker spot on the MAR sheet to indicate that the each of the medications have been checked for each client.

3.3 If medications have been pre-packed:

- 3.3.1 Ensure pre-packing documentation was completed. Place a checkmark by the client's name in the Med Checker spot to indicate that you have confirmed that the med was prepacked.
- 3.3.2 At the end of the day, ensure that the MAR sheet was completed for administration. Initial in the Med Checker box name to indicate that you have done the final check.
- 3.3.3 Dispose of pre-packed envelope upon completion.

4.0 Client Absence

4.1 If a client is not present on a day that medication is required to be given, either due to illness or holidays, the following procedure will be followed.

4.1.1 On the MAR, in the top box of the medication administration place an 'A' and do not initial.

5.0 Contaminated Medications

5.1 If a medication has been contaminated as to be unfit for administration, do not administer that particular pill. A contaminated pill is one that has visible dirt or been partially dissolved in water other than the client's saliva. Dispose of the medication appropriately. See Step 9.0 – Disposal of Medication.

5.2 Locate a second pill for administration and follow procedures.

5.3 If a second pill is not available, contact the pharmacy and follow his/her orders.

5.4 If a second pill can be administered, fill out the MAR sheet as normal. If a second pill cannot be administered, place a 'NG' in the top box to indicate the medication was not administered that day. Initial beside the NG.

5.5 Fill out the back of the MAR. Under 'Results' state that a medication was disposed of and whether another pill was administered or not.

5.6 Complete incident report. Contact guardians and caregivers as required. Inform Designated Coordinator.

6.0 Medication is Refused by Client

If the client refuses to take his medications, initially:

6.1 Every 5-10 minutes, offer the medications. Continue until the client either takes the medication or the one-hour leeway has elapsed. Discard contaminated medication appropriately.

6.2 After the one-hour leeway, contact the pharmacy and follow his/her orders as directed.

6.3 If the pill is to be administered by orders of the pharmacist, in the top box on the MAR state the time that the medication was administered and initial in the bottom box. If the pill cannot be administered then place a 'NG' in the top box to indicate the medication was not administered that day. Initial beside the NG.

6.4 Fill out the back of the MAR. Under 'Description' state that client refused. Under 'Results' state whether another pill was administered or not.

6.5 Complete incident report. Contact guardians and caregivers as required. Inform Designated Coordinator.

7.0 Late Medications

In the event that medications have been forgotten or the one-hour leeway period has elapsed:

7.1 Contact the pharmacy and explain the situation to him. Follow the orders that are stated by the pharmacist.

7.2 If the pill is administered by orders of the pharmacist, in the top box on the MAR state the time that the medication was administered and initial in the bottom box. If the pill cannot be administered then place a 'NG' in the top box to indicate the medication was not administered that day. Initial beside the NG.

7.3 Fill out the back of the MAR. Under 'Description' state that late medication administration. Under 'Results' state whether pill was administered or not.

7.4 Complete incident report. Contact guardians and caregivers as required. Inform Designated Coordinator.

8.0 Regurgitation of Medication

If a client should vomit during the medication procedure or shortly after the medication has been administered.

8.1 Contact the pharmacist, making note of the exact time that the medication was administered and the exact time that the vomiting occurred.

8.2 Follow the pharmacist's orders.

8.3 If a second pill is administered by orders of the pharmacist, in the top box on the MAR state the time that the medication was administered and initial in the top box since the bottom box should be signed due the original medication given.

8.4 Fill out the back of the MAR. Under 'Description' state that client vomited the medication up. Under 'Results' state whether pill was administered or not.

8.5 Complete incident report. Contact guardians and caregivers as required. Inform Designated Coordinator.

9.0 Medication Disposal/Returning Medication to the Home

9.1 If a medication has to be disposed, place medication in a marked medication disposal bottle. This is kept in a locked cabinet. All medications are placed into this, including liquids. Ensure the back of the MAR sheet is completed to indicate this.

9.2 When the bottle is finished, return it to a pharmacy for disposal.

9.3 If a medication is being sent home, it is sent home in its original packaging. Ensure the back of the MAR is completed to indicate that the medication has been sent home.

10.0 Procedure in case of Medication Error

A medication error is defined as any discrepancy involving:

1. Time of medication administered
2. Route of medication
3. Medication administered
4. Client given medication
5. Dosage of medication
6. Purpose of medication
7. Documentation

10.1 Med Giver will identify the medication error and inform a manager immediately
  - 10.1.1 Date and time of occurrence
  - 10.1.2 Client involved

10.2 Client involved will immediately be closely monitored for any untoward signs and symptoms that may be related to the drug that was administered.

10.3 Manager or Med Checker will immediately notify the pharmacy, the Client's Family Doctor, Designated Coordinator or Chief Executive Officer in emergency situations (i.e. overdose, wrong client).

10.4 If the situation warrants, the Manager or Med Checker will call 911 and have the client transported to the hospital for further evaluation and management.

10.5 The Manager or Med Checker will contact guardian and/or residence.

10.6 The Med Giver will complete an incident report within 24 hours.

Guide to writing an incident report:

1. Tick off the box if it is either a Medication Error (or a Medication Incident) based on the above criteria.
2. Identify the date and time of occurrence.
3. Identify the first and last name of the client involved. The client can then be referred to by the first name throughout the report.
4. Identify the staff involved. This will include the medication giver and the manager who prepacked the medication, if applicable.

If it is an error that was identified by the medication checker, all staff involved in prepacking and administration will be identified.

5. In as much detail as possible, outline the circumstances that could have led to the error including the role of the med giver or pre-packer and the reasons why the medication was not administered as outlined. Attach extra sheets if needed. In addition, attach supporting documentations such as in cases of seizures or behaviors.
6. Document adverse reactions observed if there are any.
7. If the pharmacy and/or family doctor need to be contacted, identify and document the name of the pharmacy, the pharmacist that was spoken to and the directions that were relayed. If the error does not warrant a contact with the pharmacist, please put an N/A beside the "pharmacy contacted" line.
8. Identify if there are any external medical services that were accessed due to the error. This will include but is not limited to Emergency Medical Services, physician, emergency room staff, and poison control.
9. The writer will print and sign his/her name and the date on the report.
10. Submit the report on the same day to the Manager or Med Checker.

10.7 The Manager or Med Checker will conduct a review of the Medication Error Incident with the concerned Med Giver.

10.8 The Manager or Med Checker will submit the Med Error Report to the Coordinator.

10.9 The Coordinator will file the Report on the Medication Error Folder and Database and will notify the CEO and submit the Medication Error Report to PDD if warranted.

10.10 The Coordinator will conduct regular medication administration evaluation and monitoring for the agency. This includes but is not limited to:

1. Reviewing the medication error reports on a semi-annual basis or more frequently as needed.
2. Identifying possible causes which led to the medication errors
3. Reviewing the guidelines of proper medication administration with all staff annually.

4. Reinforcing precautionary steps if needed and adding to the current medication administration guidelines to avoid recurrence
5. Filing a copy of the report in the med giver's supervision file
6. Filing of all Medication Error Reports in a specific folder (Medication Error Report Folder)
7. Conducting an annual evaluation and review or as frequently as needed of medication errors with the leadership team and reviewing to staff to ensure that they will be competent in medication administration.
8. Monitoring and Updating the Medication Administration Certification of all staff

11.0 Procedure for Signing in Medications – Everyday Prescription Medication

When medications are sent in for our administration, the following procedure will be followed.

11.1 The medication is immediately removed from the client's bag.

11.2 Take the medication to the medication cabinet.

11.3 Check medication label against Dr. Orders and MAR to ensure correct medication is sent in.

11.4 Once it is certain the correct medication has been sent in, place the medication into the appropriate basket and initial on the MAR sheet that you have received the medication.

12.0 Procedure for Signing in Medications – PRN Prescription Medication for Seizures and Behaviors

12.1 The medication is immediately removed from the client's bag.

12.2 Take the medication to the medication cabinet or medication room.

12.3 Check Medication label against the doctor's order and MAR to ensure correct medication is sent in.

12.4 Make an initial count of the medication being signed. A second person must verify that the number is correct.

12.5.1 On the MAR sheet fill column labeled 'Amount of Medication Signed In'.

12.6 Take that amount signed in and add to the amount of the medication still on hand. Take that total and fill the section labeled 'Total Amount Before Med Admin'.

12.7 Store medication away in locked cabinet.

13.0 Out of Medication

13.1 When there is about 3 days worth of medication remaining, contact the client's residence to inform that the medication is needed.

13.3 When the medication is sent in follow the procedures for signing in of medication (Step 11 and 12)

14.0 Responsibilities of Non-med Givers on a Team

14. 1 All members of the team are responsible for knowing the medication regime for the client's on their team.

14.2 All members may be required to administer pre-packed medications. They should know exactly how the medication is given and when as they are responsible for ensuring that medication has been given. Once that medication has been given directly to them to be responsible, they must ensure follow through with the commitment. It cannot be passed on to other members.

14.3 If a non-med giver notices that a medication has not been administered they are to notify their Assistant Manager, Manager or the Designated Coordinator immediately so that administration can occur.

15.0 Starting New Medication

Frequently there are changes to a client's medication. This could either be by discontinuation of meds or change in dosages. A physician can only do changes and discontinuation of meds. Physician's orders are needed for all medication changes.

If a medication is discontinued, the medication will be safely sent home for disposal. The MAR sheet will be removed and filed or a line drawn through the remainder of the month for that Medication with the words D/C to show that is discontinued. On the back of the MAR sheet, state that the medication has been sent home due to discontinuation of the medication.

If a medication changes in dosage, the previous medications will be sent home for disposal. On the front of the MAR sheet, a line will be drawn across with the words D/C to show that is discontinued. On the back of the MAR sheet, state that the medication has been sent home due to change of dosage of the medication.

A new MAR sheet will be made up for the new dosage so as to avoid confusion over what medication is actually being given. On the MAR sheet there is a section for MEDICATION START DATE. This will be filled out so that staff are aware when a new medication has taken effect.

The Designated Coordinator will be informed of all medication changes so that he/she can ensure proper documentation.

At times, a Guardian may ask that an over the counter herbal, or natural, medication be administered. This can be done with only signed consent by the guardian. A physician's orders will not be needed. It however should be explained to the guardian that there may be reactions to the prescription and herbal medication and that Springboard will not be held responsible for such drug interactions. It shall also state that Springboard recommends that such herbal medications should only be introduced with consultation with a licensed physician.

Process for the Documentation of Client Medication Incident/Error Reports

Springboard Centre takes the documentation and preventative strategies around any “incident” involving a client very seriously. It is because of this that so much work goes into the related documentation, review, and follow-up.

Our current processes involve:

1. A detailed account by a designated writer (Refer to page 22)
2. A summary to be completed by the Designated Coordinator that outlines the effectiveness of the interventions used, and what is to occur to address the issue on a long-term basis (Refer to page 23, section 09)

The processes have been created to allow effective documentation and follow-up, from the time of the initial incident to the completion of an effective, long-term, preventative solution.

Client Medication Incident/Error Report
~Writer Guide~

Medication Incident/Error Reports are to be completed for client medication incidents only. Additional forms are available for:

- Client incidents
- Staff incidents

This form shall be used for the following:

- **Medication Error** – Discrepancy regarding client, time, route, and dosage
- **Medication Incident** – Situations that are beyond the Medication Giver's control such as client refusal, regurgitation, and failure to receive medications from residence for administration
- **PRN Medication Use** – Use of prescribed PRN's for seizures or behaviors.

Writer Outline:

1. **Section 1 (Error/Incident Identification)**
   Check off either Medication Error or Medication Incident based upon the criteria set forth on the front page.

2. **Section 2 (Persons Involved)**
   a. Identify the date and time that the Incident/Error occurred. Be specific and accurate.
   b. Identify the first and last name of the client involved. Hence forth the client can be referred to by the first name throughout the rest of the report.
   c. Identify the staff involved. This will include the medication giver and the person whom prepacked the medication, if applicable. If it is an error that was identified by the medication checker, this staff member will also be identified.

3. **Section 3 (Description of Incident/Error)**
   In as much detail as possible outline what happened during the incident. Make note of whom was responsible to give the medication, why the medication was not administered as outlined, and actions taken to correct the incident/error. Attach another

sheet if required. Also attach supporting documentation is used for seizures or behaviors.

4. **Section 4 (Pharmacy Contact and Orders)**
   If the pharmacy needed to be contacted note the pharmacy that was called, the pharmacist that was spoken to and his/her directions to be followed. If the pharmacy did not need to be contacted, please identify with an N/A beside the "Pharmacy contacted" line.

5. **Section 5 (Adverse Reactions)**
   Note if there were any adverse reactions to the incident/error. Mark N/A if not applicable.

6. **Section 6 (External Medical Services Utilized)**
   Identify any external medical services that were accessed due to the incident/error. This would include but not limited to ambulance, physician, emergency ward, and poison control.

7. **Section 7 (Notification)**
   Notification must be made to the residence and guardian each time a medication incident or error occurs. This is especially important if the directions given by a medical professional (pharmacy or physician) effect medication delivery at home. An effort should be to call the residence and guardian first. If they cannot be reached then a note in the communication book will suffice.

8. **Section 8 (Signature)**
   The name and signature of the person writing this report will occur in this section.

9. **Section 9 (Office Use Only)**
   This section is for the use of the Designated Coordinator to make comments on follow up strategies to ensure that the incident/error does not occur again. Copies of Medication Incidents are placed on file and also provided to PDD.