Section 4: Additional Considerations

⇒ Resident refusal of medications
⇒ Altering medications
⇒ PRN medications
⇒ Medication errors
Refusal

A resident cannot be forced to take any medication. Steps will be taken to avoid missed or refused doses of medications and related adverse reactions.

⇒ Missed/refused medications are documented in the resident’s MAR and the prescriber is notified of the refusal based on the community’s policy and procedure.
⇒ Prescriber’s directions regarding refused/missed medications are followed.
⇒ The community nurse evaluates the resident and notifies the prescriber if the resident repeatedly refuses a medication.

Although a resident has the right to refuse medications at any time, this does not mean that there is nothing the caregiver can do when a resident refuses. If a resident refuses a medication, ask him/her why. Oftentimes there is a simple solution that will satisfy the resident. The following is a list of common reasons for refusal with interventions that can be taken.

<table>
<thead>
<tr>
<th>Reason for refusal</th>
<th>Intervention</th>
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<tr>
<td>Pills are difficult to swallow.</td>
<td>Request a liquid if available. Find out if the medication can be crushed.</td>
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<td>The side effects are too disruptive/severe.</td>
<td>Consult prescriber for a different medication or a different dosing schedule.</td>
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<td>Manipulative behaviors—this may be the way for the resident to gain control or power.</td>
<td>Allow greater resident control in other areas with other decisions.</td>
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<td>The resident is confused, agitated, or has dementia.</td>
<td>Reattempt several minutes later. Do not draw attention to the issue. Remove environmental distraction such as noise or other residents.</td>
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<td>The resident may not have been informed/consulted regarding changes to medications (for example, “Why am I getting this blue pill instead of my two white ones? I don’t want it.”)</td>
<td>Consult ALL residents regarding changes to medications or dosing schedules. Avoid overly complex explanations.</td>
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Altering Medications

Sometimes a resident is unable to take an oral medication as a whole pill. Perhaps it is difficult to swallow; maybe it gets stuck. Sometimes a resident prefers the medication be altered and mixed with applesauce, pudding, yogurt, or ice cream.

Medication assistance rules allow for an unlicensed staff person to alter a medication in order to assist a resident to take his medications. Be sure not to touch the medication with your bare hands when altering.

WAYS TO ALTER A MEDICATION
- Crushing
- Opening a capsule and putting the contents in food or a beverage
- Pricking a gel cap with a needle or lancet and squeezing the liquid contents of the gel cap into food or a beverage
- Splitting a tablet in half
- Dissolving a tablet in a beverage

Some medications cannot be crushed! It is important to have a pharmacist or other practitioner knowledgeable in medications determine which medications can be crushed and which ones cannot.

Residents who need or prefer to have their medications altered must have this documented somewhere—this can be on the MAR, directly on the medication label from the pharmacy, or in the resident’s health record.

THE RESIDENT MUST KNOW THAT A MEDICATION HAS BEEN ALTERED. YOU CANNOT “HIDE” A MEDICATION IN FOOD OR BEVERAGE! IN ADDITION, THE RESIDENT MUST STILL BE ABLE TO PUT THE MEDICATION INTO HIS MOUTH INDEPENDENTLY. IF THE MEDICATION MUST BE “FED” TO THE RESIDENT, THIS IS CONSIDERED ADMINISTRATION AND MUST BE DONE BY A PROPERLY TRAINED STAFF MEMBER WITH RN OVERSIGHT
PRN Medications

PRN is an acronym for the Latin term “Pro Re Nata” which loosely translates to “as needed.” Medications that are taken on a PRN basis do not follow a routine daily regimen. Rather, they are taken when they are needed. Tylenol taken as needed for a headache would be a common example.

<table>
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<tr>
<th>EXAMPLES OF COMMON PRN USES</th>
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<tbody>
<tr>
<td>Tylenol for fever</td>
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<tr>
<td>Albuterol (inhaler) for shortness of breath</td>
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<tr>
<td>Advil for arthritis pain</td>
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<tr>
<td>Aspirin for headaches</td>
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<tr>
<td>Sublingual nitroglycerin for chest pain</td>
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<tr>
<td>Tums for “heart burn”</td>
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</table>

Key points when handling PRN medications:

⇒ Verify that the resident is able to request the PRN medication.
⇒ Check the prescriber’s orders for parameters indicating the reason for the medication, the exact dose, the minimum time between doses, and the maximum dose in a 24-hour period of time.
⇒ Be cautious not to give an overdose of a medication. Again, adhere to the prescriber’s instructions regarding the minimum time between doses (such as “every 4 hours”) and the maximum dose in 24 hours.
⇒ Always document that you gave a PRN medication to a resident, as well as the response to the medication. Approximately 30—45 minutes after you give a PRN medication, check back with the resident and see if the medication is working, and document its effectiveness. This helps to identify trends in medication usage as well as whether or not the medication is helpful in treating the symptoms.
⇒ Residents do not need to know the name of the medication they are requesting, but they do need to know that they have to request it. For example, a resident can say, “I’d like the pill that helps my back pain.”
Medication Errors

Medication errors can occur within the assisted living community, just like they can occur in the nursing home or hospital. However, all medication errors can be prevented with appropriate protocol and procedures for medication assistance. Medication errors tend to occur when the staff member assisting with medications is in a hurry, or is not paying close attention to what she is doing.

Situations that can lead to medication errors:
⇒ Hurrying to get medications passed in a short period of time.
⇒ Preparing all of the medications for several residents at one time—this can lead to confusion, and end with giving medications to the wrong resident.
⇒ Preparing medications without proper lighting can prevent you from seeing the label clearly.
⇒ Preparing medications in a cluttered location can lead to confusion and errors.
⇒ Preparing medications from memory. This is dangerous! While many residents remain stable for long periods of time, medication orders can change without your knowing it.

Examples of medication errors:

- Giving the wrong medication
- Giving too much of a medication
- Not giving enough of a medication
- Giving a medication at the wrong time
- Not giving a medication at all
- Giving a medication to the wrong resident
Preventing Medication Errors
There are many things a caregiver can do to avoid medication errors. These practices include:

1. Question the use of multiple tablets to provide a single dose of a medicine.
2. Question any changes in the color, size, or form of a medicine.
3. Always read the label three times.
4. Beware of and look up trade names and generic names.
5. Refer to medication reference materials before giving an unfamiliar or new medication.
6. NEVER assist with medications prepared by another person.
7. Always prepare medications in a quiet, well-lit place.
8. Follow the six rights EVERY TIME you prepare a medication.
9. Follow existing medication assistance policies and procedures.

If a medication error occurs:

1. Do not panic and do not be embarrassed; do not give a medication at the wrong time if you missed a dose; do not attempt to fix the situation on your own.
2. Contact your supervisor/community nurse immediately.
3. Contact the prescriber to inform him that a medication error has occurred. Be sure to inform him of the resident’s name, the name and dosage of the medication, and the type of error that has occurred (i.e. too much, wrong medication, etc.).
4. Carefully follow whatever instructions the prescriber gives you.
5. Carefully document the medication error, including what the prescriber told you to do, the condition of the resident, and your actions.
6. Assist your supervisor in completing an incident report or other form required by your community.
7. If the medication error causes an emergency situation contact 911 before doing anything else.
8. If a resident is harmed or potentially harmed due to a medication error, contact the complaint hotline at 1-800-562-6078 and report the incident.