Medication by Mouth........................................................................................................... 49
Sublingual (SL) Medication................................................................................................. 49
Liquid Medication ............................................................................................................... 49

EYE MEDICATION ............................................................................................................. 49
Eye Drops .......................................................................................................................... 49
Eye Ointment ..................................................................................................................... 50

EAR MEDICATION ............................................................................................................ 50

RECTAL MEDICATION .................................................................................................. 51
Suppository ....................................................................................................................... 51
Enema ............................................................................................................................... 51

VAGINAL MEDICATION .................................................................................................. 52
Cream ................................................................................................................................. 52
Suppository ....................................................................................................................... 52

TRANSDERMAL / TOPICAL MEDICATION .................................................................. 53
Transdermal (Patch) ......................................................................................................... 53
Topical (Cream, Ointment, Etc.) .................................................................................... 53

NASAL / INHALER MEDICATION ................................................................................. 54
Nasal Spray ....................................................................................................................... 54
Nasal Inhaler .................................................................................................................... 54
Respiratory Inhaler .......................................................................................................... 54
Nebulizer .......................................................................................................................... 54

OSTOMY CARE ................................................................................................................ 55
Summary ............................................................................................................................ 55
Definitions ........................................................................................................................ 55
Assistance ......................................................................................................................... 55
Emptying Pouch ............................................................................................................... 55
Changing Pouch ............................................................................................................... 56

OBSERVING AND REPORTING ..................................................................................... 57

OXYGEN ASSISTANCE ................................................................................................ 58
Summary ............................................................................................................................ 58
Procedure .......................................................................................................................... 58

FIRST AID FOR WOUNDS ............................................................................................... 59
Summary .......................................................................................................................... 59
Procedure .......................................................................................................................... 59

INSULIN ADMINISTRATION AND MONITORING .............................................................. 60
Capillary Blood Glucose Monitoring ................................................................................. 60
Preparing Insulin For Administration .............................................................................. 61
Rules For Insulin Storage .................................................................................................. 61
Procedure For Preparing Insulin For Administration ...................................................... 62
Procedure For Giving A Subcutaneous Insulin Injection .................................................. 63
Preparing Two Types Of Insulin ...................................................................................... 64
Preparing Insulin Injection Pen For Administration ....................................................... 65

SECTION V: OTHER MED TECH RESPONSIBILITIES ...................................................... 66

HEALTH CARE AGENCY ................................................................................................. 66
Summary .......................................................................................................................... 66
Procedure .......................................................................................................................... 66

FIRST AID / EMERGENT SITUATIONS .......................................................................... 67
Summary .......................................................................................................................... 67
Requirements .................................................................................................................... 67
Procedure .......................................................................................................................... 67

RESIDENT MEDICAL EMERGENCY .............................................................................. 69
Summary .......................................................................................................................... 69
Medical Response ............................................................................................................ 69
CPR Action ....................................................................................................................... 69
Procedure .......................................................................................................................... 69

DECEASED RESIDENT .................................................................................................... 71
Summary .......................................................................................................................... 71
Procedure for Hospice Resident ....................................................................................... 71

REFRIGERATOR MONITORING ....................................................................................... 73
Summary .......................................................................................................................... 73
Procedure .......................................................................................................................... 73

CBG MACHINE TESTING (Delegate Task) ..................................................................... 74
Summary .......................................................................................................................... 74
**SECTION VI: FORMS**

<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Occurrence Report and Investigation</td>
<td>76</td>
</tr>
<tr>
<td>Resident Photograph</td>
<td>79</td>
</tr>
<tr>
<td>Community / Physician Communication</td>
<td>80</td>
</tr>
<tr>
<td>Medication Receipt Log</td>
<td>81</td>
</tr>
<tr>
<td>Medication Disposal Log</td>
<td>82</td>
</tr>
<tr>
<td>Shift Count Narcotics Verification</td>
<td>83</td>
</tr>
<tr>
<td>Individual Narcotic Record</td>
<td>84</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>85</td>
</tr>
<tr>
<td>Outside Healthcare Agency</td>
<td>86</td>
</tr>
<tr>
<td>Record of Resident Death</td>
<td>87</td>
</tr>
<tr>
<td>Refriferator Temperature Control Log</td>
<td>88</td>
</tr>
<tr>
<td>Medication Error Report</td>
<td>89</td>
</tr>
<tr>
<td>House Stock Policy</td>
<td>90</td>
</tr>
<tr>
<td>House Stock Formulary</td>
<td>91</td>
</tr>
<tr>
<td>CBG Machine Testing Log</td>
<td>92</td>
</tr>
<tr>
<td>Alert Charting Log</td>
<td>93</td>
</tr>
</tbody>
</table>
SECTION I: MEDICATION RULES & GUIDELINES

PROGRAM OVERVIEW

The purpose of the Med Tech training manual is to review with designated staff how to safely administer medications authorized by law. This program is not intended to replace any state approved Medication Administration Certification Course. Med Tech shall be responsible for tasks assigned to support effective implementation of community health services systems according to company policy and all regulations that apply. This training content includes instruction for direct assistance to residents, preparation of required documentation and the system support tasks usually designated to Med Tech staff, primarily, management of resident medications and treatments.

STATE REGULATIONS

The law specifically identifies the settings, i.e. Assisted Living Communities, Alzheimer’s Communities, etc. under which a qualified staff person can administer medications and the limits to what duties can be performed and what has to be carried out by a licensed practitioner. It is always best practice to get clarification from the nurse or executive director, if in doubt as whether you can perform a medication administration task or not.

In Washington State the task of administering medications must be delegated by the LN in the community. There are very detailed steps involved in the delegation process. Additionally, the state requires staff to be credentialed and there are state approved classes that must be completed and passed before the delegation process can begin.

In Oregon State most of the process of administering medications is a trained task and only a few duties are delegated. The decision for when a duty must be delegated is determined by the LN in the community and company policy.

It may be helpful to review the definitions below to become familiar with what the various terminologies are used throughout this training manual.

DEFINITIONS

Independent self-administration - when a resident is independently able to directly apply a legend drug or controlled substance by ingestions, inhalation, injection or other means. Self-administration may include situations in which an individual cannot physically self-administer medications but can accurately direct others to do so.

Medication Assistance - the assistance that is rendered by a non-licensed staff member, to a resident to assist the individual’s self-administration of medication. This assistance can include: reminding, coaching, handing the medication container to the resident, opening the medication container, using an enabler, or placing the medication in the resident’s hand. The resident must be able to put the medication into his/her mouth or apply or instill the medication. The resident does not necessarily need to state the name of the medication, intended effects, side effects, or other details, but must be aware that they are receiving medications. Assistance with injecting medications is prohibited under medication assistance, with the exception of insulin.
Medication Administration - when a resident is not able to independently ingest or apply a medication and they must have the medication administered by a person legally authorized and trained to do so. This includes the ingestion, application, rectal or vaginal insertion of medication of both prescription and non-prescription drugs, according to the written or printed directions of a licensed physician or other authorized practitioner.

Medication Reminder Boxes or Systems - a customized resident medication box or system is a device that is compartmentalized and designed to house medications according to time element (day, time of day, week, etc.). The filling of a medication system by any other person other than the resident or a resident (non-staff) designee, is considered the process of dispensing medications, therefore, can only be done by the LN under the direction of the pharmacy.

Enablers - are physical devices used to facilitate an individual's/resident's self-administration of a medication. Physical devices include, but are not limited to, a medicine cup, glass, cup, spoon, bowl, prefilled syringes, syringes used to measure liquids, specially adapted table surface, straw, piece of cloth or fabric. An individual's hand may also be an enabler. The practice of "hand-over-hand" administration is not allowed. Medication administration with assistance includes steadying or guiding an individual's hand while he or she applies or instills medications such as ointments, eye, ear and nasal preparations.

Delegation - means that a registered nurse authorizes an unlicensed person to perform tasks of nursing and medication administration in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a resident in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and re-evaluating the task at regular intervals. All State delegation requirements must be met by any staff in order to be delegated.

Carrier – means a substance (applesauce, pudding etc) that is used to help the resident swallow an oral medication more easily. To use a carrier you must have a physician orders to do so.

MEDICATION SERVICE

Our healthcare industry regulators recognize that individuals residing in community based care settings may need assistance self-administering their prescribed drugs and controlled substances, due to physical or mental limitations.

The community’s responsibility is to perform a thorough assessment of the resident’s ability to manage his or her medications. This assessment is completed with the resident, the resident’s representative, and the resident’s health care practitioner. Once the level of independence, assistance, or need for administration has been determined and agreed upon, the resident’s medication service level will be documented in the resident’s service plan/negotiated service agreement and staff will be alerted. Periodic re-evaluations will be performed by the community nurse to determine if a new level of medication service needs to be assigned.

Regulations vary between states making it critical for staff members assisting with medications to always check with the nurse if in doubt of whether they can perform a specific task.
## DELEGATED OR TRAINED TASK GUIDELINE

<table>
<thead>
<tr>
<th>Task</th>
<th>Oregon</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administration of non-injectable medication</td>
<td>trained</td>
<td>trained</td>
</tr>
<tr>
<td>2. Blood Sugar Testing</td>
<td>taught task</td>
<td>delegated</td>
</tr>
<tr>
<td>3. Insulin Injections</td>
<td>delegated</td>
<td>delegated</td>
</tr>
<tr>
<td>4. Subcutaneous Injections</td>
<td>delegated</td>
<td>delegated</td>
</tr>
<tr>
<td>5. Ostomy Care</td>
<td>delegated</td>
<td>delegated</td>
</tr>
<tr>
<td>6. Basic Wound Care</td>
<td>LN determination of trained/delegated</td>
<td>LN determination of trained/delegated</td>
</tr>
</tbody>
</table>
SECTION II: RESOURCES AND TOOLS

CLASSIFICATION OF MEDICATIONS RELATED TO BODY SYSTEMS AND COMMON ACTIONS

A. Antimicrobial:
   i. Controls or prevents growth of bacteria, fungus, virus, or other microorganisms.

B. Cardiovascular:
   i. Corrects an irregular, fast, or slow heart rate
   ii. Prevents blood from clotting
   iii. Lowers blood pressure

C. Dermatological
   i. Anti-infective
   ii. Anti-inflammatory

D. Endocrine
   i. Anti-diabetic
   ii. Reduces inflammation
   iii. Hormones

E. Gastrointestinal
   i. Promotes bowel movements
   ii. Antacids
   iii. Anti-diarrheal
   iv. Reduces gastric acid

F. Musculoskeletal
   i. Relaxes muscles

G. Neurological
   i. Prevents seizures
   ii. Relieves pain
   iii. Lowers body temperature
   iv. Anti-Parkinsonian
   v. Antidepressants
   vi. Promotes sleep
   vii. Relieves anxiety
   viii. Antipsychotics
   ix. Mood stabilizer

H. Nutrient/Vitamin/Mineral(s)
   i. Replaces chemicals missing or low in the body

I. Respiratory
   i. Decreases mucus production
   ii. Bronchodilation
   iii. Cough depressant/expectorant
   iv. Decongestant

J. Sensory
   i. Anti-glaucoma
   ii. Artificial tears
   iii. Earwax emulsifiers

K. Urinary
   i. Increases water loss through kidneys
MEDICATION ROUTES

There are various routes by which a qualified Medication Tech is authorized to administer medications. The proper route for administration should be specified in the physician order. The authorized routes of administration are as follows:

- Oral = swallowed by mouth
- Sublingual = dissolved under the tongue
- Topical = applied to the skin
- Eye = drops or ointments applied to the eye
- Ear = drops placed in the ear
- Rectal = inserted in the rectum
- Vaginal = inserted in the vagina
- Inhalant = taken in through mouth or nose by breathing in or inhaling
- Transdermal = absorbed through skin through application of a patch
COMMON ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ac</td>
<td>before meals</td>
</tr>
<tr>
<td>pc</td>
<td>after meals</td>
</tr>
<tr>
<td>bid</td>
<td>twice a day</td>
</tr>
<tr>
<td>tid</td>
<td>three times a day</td>
</tr>
<tr>
<td>qid</td>
<td>four times a day</td>
</tr>
<tr>
<td>HS</td>
<td>hour of sleep</td>
</tr>
<tr>
<td>po</td>
<td>by mouth</td>
</tr>
<tr>
<td>q</td>
<td>every</td>
</tr>
<tr>
<td>qd</td>
<td>every day</td>
</tr>
<tr>
<td>qh</td>
<td>every hour</td>
</tr>
<tr>
<td>q6h</td>
<td>every 6 hours</td>
</tr>
<tr>
<td>qod</td>
<td>every other day</td>
</tr>
<tr>
<td>DC</td>
<td>discontinue</td>
</tr>
<tr>
<td>ml</td>
<td>milliliter</td>
</tr>
<tr>
<td>Gm</td>
<td>gram</td>
</tr>
<tr>
<td>kg</td>
<td>kilogram</td>
</tr>
<tr>
<td>OU</td>
<td>both eyes</td>
</tr>
<tr>
<td>OS</td>
<td>left eye</td>
</tr>
<tr>
<td>OD</td>
<td>right eye</td>
</tr>
<tr>
<td>PRN</td>
<td>as needed</td>
</tr>
<tr>
<td>tsp</td>
<td>teaspoon</td>
</tr>
<tr>
<td>Tbsp</td>
<td>tablespoon</td>
</tr>
<tr>
<td>oz</td>
<td>ounce</td>
</tr>
<tr>
<td>tab</td>
<td>tablet</td>
</tr>
<tr>
<td>cap</td>
<td>capsule</td>
</tr>
<tr>
<td>SL</td>
<td>sublingual</td>
</tr>
<tr>
<td>EC</td>
<td>enteric coated</td>
</tr>
<tr>
<td>meq</td>
<td>milliequivalent</td>
</tr>
<tr>
<td>otic</td>
<td>ear</td>
</tr>
<tr>
<td>oint</td>
<td>ointment</td>
</tr>
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<td>supp</td>
<td>suppository</td>
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<td>solution</td>
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<td>s</td>
<td>without</td>
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<td>p</td>
<td>post</td>
</tr>
<tr>
<td>c</td>
<td>with</td>
</tr>
<tr>
<td>x</td>
<td>times</td>
</tr>
</tbody>
</table>

**NOTE:** You may see abbreviations on communication from Health Care professionals, however, refrain from using abbreviations on any internal communication.
COMMON DRUG MEASUREMENTS

**METRIC** — decimal system of weights and measures using the gram, meter, and liter

LIQUID: cubic centimeter (cc) = milliliter (ml)

SOLID: 1 gram (gm) = 1,000 milligrams (mg)

**HOUSEHOLD** — system based on common, though not standard, measuring devices

tsp = teaspoon

Tbsp = tablespoon

oz = ounce

1 tsp = 5 cc

3 tsp = 1 Tbsp = 15 cc

2 Tbsp = 30 cc = 1 oz
SIX COMPONENTS OF A PHYSICIAN ORDER

There must be a written physician’s order for prescription and non-prescription medications. To have a complete order, the following six items must be included:

1. The client’s full name
2. The date of the order
3. Name of the medication
4. Dosage and administration information
5. Route of administration
6. Physician’s signature
SOURCES OF INFORMATION ABOUT DRUGS

There are a variety of reference books available that provide information about specific medications, including the therapeutic effect, uses, side effects, and special administration instructions. Each community should have such a reference guide for use by staff.

Some examples of such reference books include:

- Physician Desk Reference (PDR)
- Mosby’s Nursing Drug Reference

Other sources of drug information include:

- Your local or consulting pharmacist
- Medication inserts
- Various internet sites

NOTE: Reference books should be no older than 3 years and kept in the Med Room. Most pharmacies supply these books yearly for no charge if using their pharmacy.
EFFECTIVE HAND WASHING TIPS TO PREVENT THE SPREAD OF DISEASE

Effective hand washing is one of the most important means of preventing infections that are spread through direct contact between people or between people and infected substances they might come in contact with, and for preventing contamination.

Hand Washing Technique

1. Remove jewelry.
2. Prepare paper towel before washing by pushing dispenser handle for amount needed.
3. Use warm running water.
4. Wet hands — apply soap or anti-microbial agent with hands lower than elbows.
5. Wash all surfaces of both hands — between the fingers, tops of the fingers, finger nails, and the backs of the hands for a minimum of 20 seconds.
6. Rinse under warm running water, letting water drip from fingers.
7. Dry hands with paper towels.
8. Use dry paper towel to turn off faucet.
9. Apply hand lotion if necessary, but do not apply right after washing or before giving direct care. Hand lotion can interfere with cleansing action or an anti-microbial agent.

When to Hand Wash

1. When you arrive at or leave work
2. Between contacts with different residents
3. Before putting gloves on and after removing gloves — gloves do not replace hand washing
4. Before contact with people who may be susceptible to infections such as older people and babies
5. After coughing, sneezing, or blowing your nose
6. After using the bathroom
7. After smoking cigarettes
8. Before and after food preparation
9. Before and after eating

Studies have shown that the best way to get others to wash their hands is to be a role model. When your residents and staff observe you washing your hands, they are more inclined to do the same.

Disinfect Other Common Surfaces in Your Community

Throughout the day, people in your community may come into contact with the telephone, doorknobs, sink handles, toilet handles, countertops, and appliances. Be sure to disinfect these surfaces on a regular basis by wiping them with anti-bacterial cleaners or common household products such as chlorine bleach.

A note of caution: Store disinfectants in safe areas that provide only limited access by staff. You do not want your residents to be injured by the inappropriate use of such products. Also, state regulations prohibit the storage of disinfectants, bleach, household cleaning supplies, etc., with food products or medications.
SECTION III: MEDICATION DOCUMENTS & PROCESSING

Initial training for QMAR is done in QMAR University online prior to completion of hands on training. (This can be found in the Ageia Health Services under medication administration) Med Techs must complete the medication Modules in IPCED within the first thirty days of hire.

The Community must maintain accurate documentation for each administration of medication (including over-the-counter medication) if staff assists with administration.

The Community has established a Medication Assistance Record (MAR) system to serve the need for documentation. Paper documentation will be used only if electronic record keeping is unavailable. (See emergency procedures)

Photograph Page

- When using Quick MAR on-line, download a photograph of each resident into the Quick MAR system.
- Take resident photos at the time of move-in and at least semi-annually thereafter, or when a resident undergoes significant change in appearance, i.e. significant weight loss or gain.
- Retain used photo sheets in the resident's record.

MARS

MARs are individual for each resident and always current to indicate the following information:

1. Name and telephone number contact for the primary care or prescribing physician or nurse practitioner.
2. Current month, day, year.
3. Allergies and sensitivities, if any.
4. Diet specifications.
5. Description/parameters for the medication or treatment, in layman’s terms.
6. Resident-specific parameters and instructions for PRN (as-needed) medication or treatment.
7. Initials of the person assisting with administration of a medication.
8. Name of reviewer and date of review.
9. Diagnosis
MAR GENERAL INSTRUCTION

Summary

This document presents a general instruction about using resident MARs and addresses the following:

- Preparing medication
- Documentation
- Resident rights

Preparing Medication

BEFORE administering medications, or assisting with administration of medication, check each medication three (3) times every time it will be given:

- Check the Medication Administration Record (MAR)
- Check the pharmacy or manufacturer label on the medication packaging
- Check the MAR again to assure all information is the same before giving (administering.) Notify LN if a discrepancy is found.

ALWAYS: Read It – scan it – Read It – pop it – Read it - re store the medication card/bottle

Record signature after passing medications

- Bubble pack or medication label must match the MAR. If it does not, notify LN immediately for clarification. You can never change the MAR elements on a label.

- Give PRN (as needed) medication only for the reason specified on the medication sheet and label or as clarified by the LN. Follow physician order instruction about discontinuing the medication for non-use or after a condition is resolved.

- The Med Tech who prepares medication must also pass the medication.

- When a Med Tech has prepared medications and an emergency prevents them from passing those medications, the medications must be destroyed and prepared again by the Med Tech that will be passing those medications.

- When medications are poured/prepared as the “new” set referred to above, staff must order replacement doses immediately.

- Unless regulations specify otherwise (see below), the Med Tech should pour/prepare medications prior to the scheduled time for the medication pass, but cannot have more than one (1) med pass poured at a time.

NOTE: In Washington State, the Med Tech must NOT pour/prepare medication in advance.
• The Med Tech must visually witness the medication being taken. If the resident is not willing to take the medication at that time, the Med Tech should label the med cup with the resident's name and apartment number and lock the cup in the designated compartment of the med cart. The Med Tech should explain to the resident that they will return in 30-60 minutes. If the resident is still not ready re-approach two more times then destroy the medication and document, and report as a refused medication.

MAR DOCUMENTATION

• Each time a Med Tech prepares medication; the Med Tech must initial the MAR that corresponds to the resident, the medication, and the day and time indicating the medication was given.

• Document assistance/administration at the time a medication is removed from its container, unless regulation specifies otherwise.

RESIDENT RIGHTS (7 rights of Medication)

Community staff who participates with a medication pass must respect the seven (7) rights of medication assistance/administration, as follows:

1. Right Resident

The resident name on the bubble pack or the vial (pill bottle) must match that on a Medication Assistance Record (MAR) designated for the resident and the correct resident must be identified to receive it.

2. Right Medication

The label on the medication must match the name and dose of the medication on the MAR.

3. Right Route

Directions on the medication must match those on the MAR for the correct route, e.g., by mouth, in eyes, topically, rectally, etc.

4. Right Dose

The dosage written on the medication label must match the dosage written in the MAR and the dosage dispensed and given.

5. Right Time

The administration time frame must coincide with the directions on the label and can be given 1 hour prior or 1 hour after the time. Always follow specific state guidelines.

6. Right to Refuse

The resident always has the right to refuse a medication. The Med Tech must document the reason for refusal, after re-approach and notify management.
ROUTINE MEDICATION PASS

Summary

- Staff shall carry out all medication and treatment orders as prescribed.
- Staff shall not allow medication prescribed for one resident to be administered to another.
- Staff shall NOT cut pills unless the pills are scored (i.e., intended for cutting) and the purpose for cutting is only to make a pill smaller and easier to swallow. Staff shall not cut pills to meet a dosage order. Only the pharmacy can cut pills to create a proper dose and provide the pills to the Community.
- Staff shall NOT crush medications unless directed by a physician and the medication is crushable. Staff shall NOT mix medication in a carrier without letting the resident know their medications are in there.

NOTE: Some medications cannot be altered or diluted.

Procedure

1. Read the Resident specific medication administration (MAR). We use the electronic medication record of recording medications.

2. Check the drug name, strength, dosage, time and day.

3. Read the prescription label on the medication. Information on the label must match the information on the MAR for medication name, dose, time, resident and frequency.

4. Check the expiration date and, if the medication is expired, do not administer.
   a. Contact the pharmacy immediately to request a refill
   b. Notify the MD and community nurse if any doses are not given.

5. Read the medication sheet and the prescription label again. For questions or when the medication label and the MAR medication do not match, contact the community nurse, physician and/or the pharmacist before giving the medication.

6. Without touching the pills, unless wearing a clean pair of gloves, place the medication into an individual container (e.g. a soufflé cup) labeled with the resident’s initials or Apt #. (See above about putting medication in food.)

7. Initial the appropriate place on the MAR to document that you have prepared the medication.
   NOTE: if resident refuses or med is not given, select an exception tab and document appropriately the reason the medication was not taken. i.e.: “Resident out of community”, etc.

8. The MAR may be signed as the medications are set-up or poured. Medications must not be set up in advance for more than one administration at a time. If a medicine cup or other individual container is used to set up medications it must be placed in a closed compartment labeled with the resident’s name. Changes to the MAR that occur after the medication is delivered must be documented by the same staff person who administered the medication.

EXAMPLE DOCUMENTATION

<table>
<thead>
<tr>
<th>Medication Hour</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Docusate Sodium 250mg. 2 tablets (125 mg ea) by mouth every morning to prevent constipation. Hold</td>
<td>8am</td>
<td>YI</td>
<td>YI</td>
<td>YI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Revised 12-2016
for loose stool or diarrhea and notify MD.
PRN MEDICATIONS

Summary
- Staff shall carry out all medication and treatment orders as prescribed.
- All PRN medications must be clarified in the MAR, to provide specific information about when it should be administered (or offered) to a resident, with resident specific parameters. Give/offer PRN medication ONLY according to direction for its use and administration.

Procedure
1. When a resident requests the PRN medication, confirm that the resident’s complaint is included/described in the orders for that medication and that the resident’s request is appropriate.
2. Review the MAR for frequency and when last given.
3. Initial on MAR, per example below. (i.e.: “YI” = the Med Techs initials.)
5. Give the medication.
6. Unless otherwise specified, 1-2 hours after giving a PRN medication, document in the prn follow up sections of the MAR, the results/effectiveness, after asking the resident or determining otherwise.
7. If medication is not effective, follow parameters on the MAR and notify the LN and MD if applicable.

EXAMPLE DOCUMENTATION

| Day of the month | PLN Medication | Hour | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
|------------------|----------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|
| Tylenol 650 mg. 2 tabs (325 mg. each) every 4 hours as needed for resident temp above 99.0, headache, or resident complaint of “arthritis pain”. Do not exceed 8 tablets in 24 hours. | PRN | YI | 10pm |
| effective | | | | | | | | | | | | | | | | | | |

Back of MAR

<table>
<thead>
<tr>
<th>Date</th>
<th>Hour</th>
<th>Medication</th>
<th>Reasons/Comments</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/10/2012</td>
<td>10 pm</td>
<td>2 tabs Tylenol</td>
<td>Resident complains of headache/headache resolved</td>
<td>YI</td>
</tr>
</tbody>
</table>
REFUSED MEDICATION

Summary

- Staff shall administer all medication and treatment orders as prescribed.
- A resident has the right to refuse medications and/or treatments.
- Staff shall re-approach resident two more times and attempt to administer the medication.
- Staff to obtain information regarding why the refusal; i.e.: “makes me sick”, “makes me dizzy”, too hard to swallow”, etc.
- Staff shall notify the prescribing physician when a resident refuses ordered medication or treatment and follow direction about reporting subsequent refusals. If prescribing physician has given specific reporting parameters concerning refusals of medications or treatments, these orders will be followed.
  o NOTE: Follow notification preferences from MD, listed on the residents’ admission orders.

Procedure

1. Chose med refused in the MAR for the dose refused. (See example below)
2. FAX the physician when a resident refuses medication.
3. Notify Licensed Nurse about the refusal.
4. NOTE: If the resident is refusing more than one, be clear about whether refusal and notification apply only for a specific medication or for others also.
5. On the MAR describe the refusal situation and document notification to the MD.

EXAMPLE DOCUMENTATION

<table>
<thead>
<tr>
<th>Day of the month</th>
<th>1</th>
<th>2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
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<td>Docusate Sodium</td>
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<td>bowels. Hold for</td>
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<td>diarrhea and</td>
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<td>notify MD.</td>
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<td></td>
</tr>
</tbody>
</table>

Comment Sheet (On back of MAR)

<table>
<thead>
<tr>
<th>Date</th>
<th>Hour</th>
<th>Medication</th>
<th>Reasons/Comments</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/3/2010</td>
<td>8am</td>
<td>Docusate Sodium</td>
<td>Resident refused. Loose stool today. MD notified.</td>
<td>YI</td>
</tr>
</tbody>
</table>
DISCONTINUED MEDICATION

Summary

- Staff shall document a date on the MAR each time a medication or treatment is discontinued.

Procedure

1. Find the appropriate MAR and document immediately after receiving notice/order to discontinue the medication.
2. QMAR will record as a discontinued med.
3. Make a notation on the discontinue order to state “noted on MAR” with the date and your initials.
4. FAX the noted discontinue order to notify the specified pharmacy.
5. If the resident uses another pharmacy, make and send a copy of the discontinue order to the pharmacy providing medical records, after writing on the copy: “for medical records only”.
6. Make a notation on the original discontinue order to state “faxed to pharmacy” and the date and your initials.
7. Immediately pull the medication from the medication cart or drawer and put the medication in a designated, double locked area for Discontinued Meds for either return or destroy. **NOTE:** Narcotics must continue to be counted until destroyed or returned.

EXAMPLE DOCUMENTATION

<table>
<thead>
<tr>
<th>Medication</th>
<th>Hour</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Docusate Sodium 250mg. 2 tablets, 125 mg. each, by mouth every day to regulate bowels. Hold for loose stool or diarrhea and notify MD.</td>
<td>8am</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>DC’d</td>
<td>2/9/10</td>
<td>Dr. Parker</td>
<td>YI</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**NOTE:** Shaded content represents “highlighting.”

NEW MEDICATION ORDERS

Revised 12-2016
Summary

- Staff shall be timely for processing all new medication and treatment orders to facilitate delivery of the medication/treatment.
- Staff should become familiar with commonly used abbreviations that might apply for medication or treatment orders received for residents. Staff should use the layman term indicated when transcription involves reference to any abbreviations.

Procedure

1. FAX the order to the pharmacy specified in the residents’ chart
2. For any questions or clarifications, contact the community licensed nurse.
3. Verify that Pharmacy has entered the order into QMAR
4. If Pharmacy not available for order entry transcribe the order into QMAR – notify the Pharmacy of the entry.
5. If this becomes a duplicate order, merge or discontinue the staff entered order and preserve the Pharmacy entry. (Community sees the orders that Pharmacy enters, Pharmacy does not see the orders entered from the community)

NOTES:

a) If an order will be needed before the next routing delivery, make a specific note to indicate urgency and, in addition, telephone the pharmacy about the order.

b) If the resident uses an alternate pharmacy, make a copy of the order and send it to the pharmacy that provides medical records so the next set of MARs sheets will be accurate.

c) all antibiotics and pain medications are to be STAT ordered

6. The staff member who processes the order should make a note on the order to itemize actions taken (e.g., “faxed to pharmacy, noted on MAR”). Use provided stamp and initial as indicated.

7. If a new order indicates need to place the resident on alert charting, the staff member who processes the order must initiate alert charting and add resident to alert charting log. (Refer to Alert Charting policy and procedures.)

8. After transcribing an order
   A. Place the original in the Med Tech to verify tab awaiting a second verification. (The oncoming Med Tech must review the transcription as a double check for accuracy)
   B. After the second verification place in the binder under the RN to check tab.
   C. The RN must verify the Order in QMAR for accuracy, sign the order and file it in the residents chart.

9. An order cannot be accepted unless the physician has signed the order and it includes all the necessary ingredients for safe administration:

   *Resident Name
   *Prescription Name
   *Dosage of medication to be given
*Frequency, Duration and Route of administration
*Condition/Symptom for which it is being given

If a physician directs verbal communication orders, politely inform him/her that the pharmacy will not fill a prescription or change a resident’s prescription without a signed order. Provide the physician with the community fax number or explain to the physician that they can call the pharmacy directly, but the pharmacy will still require a signature before they can process the order. If the new medication arrives and you still have not received a faxed order, contact the pharmacy and request a copy to be sent as soon as possible.

Based on the medication, resident need for it, and the expected delivery time (but not longer than 24 hours after a planned deliver time), initiate the procedure for “medication not available” if necessary.

- When notified that the pharmacy will not deliver a special order medication as requested, OR
- When a medication is not received as planned in the regularly scheduled delivery, or as requested;
- Always notify the community LN and/or Executive Director as soon as it is discovered that a medication is not available.

CHANGE IN MEDICATION ORDERS

There will be times when a physician may want to make adjustments in the dosage or frequency of a medication. The same rules apply as are outlined in the section titled, “New Medication Orders”.

Once you have the order, fax to the Pharmacy for entry into QMAR. Verify that the previous order is discontinued and the new order has been entered, and follow procedure for new medication order.

**Remember**, only appropriate health care practitioners can change medication orders. Never alter or change an order without a written, signed order from the physician.

**EXAMPLE DOCUMENTATION**

<table>
<thead>
<tr>
<th>Medication</th>
<th>8am</th>
<th>9am</th>
<th>10am</th>
<th>11am</th>
<th>12pm</th>
<th>1pm</th>
<th>2pm</th>
<th>3pm</th>
<th>4pm</th>
<th>5pm</th>
<th>6pm</th>
<th>7pm</th>
<th>8pm</th>
<th>9pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Docusate Sodium 250mg. 2 tablets, 125 mg. each, by mouth every day to regulate bowels. Hold for loose stool or diarrhea and notify MD.</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>NB</td>
<td>DC’d</td>
<td>2/9/12</td>
<td>Dr. Parker</td>
<td>Your Initials</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

(New Order) 
Revised 12-2016
TIME OR DAY LIMITED MEDICATION

Summary

- Staff shall administer all medication and treatment orders as prescribed. There may be times when medications are only given for short periods, before or after an event, or a few times a month.

Procedure

1. Fax order to the Pharmacy.
2. Verify the order in QMAR with the limitations or Stop date
3. MAR will reflect the days the medication is to be given and the days it is not to be given
4. Follow procedure for new medication order.

EXAMPLE DOCUMENTATION

<table>
<thead>
<tr>
<th>Day of the month (Time Limited)</th>
<th>Medication</th>
<th>Hour</th>
<th>1</th>
<th>2</th>
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<th>13</th>
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<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/06/10 YI Cipro 250 mg.</td>
<td>8am</td>
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<td>1 tablet, by mouth, every</td>
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<td>12 hours for urinary tract</td>
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<td>infection for 5 days.</td>
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</tbody>
</table>

New Order: 2/9/12

YI

Dr. Parker

Your initials

Auto Stop 2/11/17 YI
**Medication**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Hour</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coumadin 2.5 (1 tab), by mouth, M, W, F, SA, to prevent blood clots. Report bruising, bleeding gums to LN</td>
<td>5 pm</td>
<td>YI</td>
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<td>YI</td>
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<td>YI</td>
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<td>YI</td>
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<td>YI</td>
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<td>YI</td>
<td>__</td>
<td>YI</td>
<td>__</td>
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</tbody>
</table>

Revised 12-2016
MEDICATION ERROR

Procedure

1. Staff shall document each medication error found on the MAR, as it is discovered, using MAR Audit Tool.
2. In addition, the person who identifies the error shall follow the medication error reporting process to document the error and initiate management review.

**NOTE:** The Executive Director should provide the medication error report to the nurse as applicable to support staff re-training if needed in correction/response to the error.

3. Notify the Community nurse and the Executive Director.
4. Community nurse and/or Executive Director will determine who and how the family and Physician will be notified and communicate to the Med Tech. Med Tech can notify the family and Physician if directed. Family is to be called. Physician is to be faxed and called if necessary and directed to do so.
5. Place the resident on alert charting with direction to observe for side effects or adverse reactions.
6. The LN or Executive Director will take appropriate steps as necessary to correct the error or prevent recurrence.

EXAMPLE DOCUMENTATION

<table>
<thead>
<tr>
<th>Day of the month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Docusate Sodium</td>
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<td>8am</td>
<td>ST</td>
<td>ST</td>
<td>ST</td>
<td>ST</td>
<td>YI</td>
<td></td>
</tr>
<tr>
<td>250mg. 2, 125 mg. tablets by mouth every day to regulate bowels.</td>
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</tr>
</tbody>
</table>

Comment Sheet (On back of MAR)

<table>
<thead>
<tr>
<th>Date</th>
<th>Hour</th>
<th>Medication</th>
<th>Reasons/Comments</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/4/2012</td>
<td>5pm</td>
<td>Docusate Sodium</td>
<td>Medication given in error.</td>
<td>YI</td>
</tr>
</tbody>
</table>
MEDICATION NOT AVAILABLE

Summary

- Staff shall administer all medication and treatment orders as prescribed.
- When medication is not available for a scheduled time pass, staff shall take necessary steps to obtain the medication and notify the Executive Director and nurse, as required.

Procedure

1. Staff to assure the medication is not in the community.
2. FAX and call the pharmacy (and/or notify the family, if a possible source for delivery), about a plan to deliver the medication.
3. Notify the Executive Director and the Community nurse about the status of medication delivery.
4. If medication will not arrive in time for next dose, alert the physician about unavailability and ask for an order to hold the medication until the planned delivery, if not already on standing orders.
5. Document missed dose in QMAR
6. Document in QMAR what you have done, the plan for delivery and notification to the MD.
7. Place the resident on alert charting to observe for changes in condition related to the missed medication and indicate the expected delivery time.
8. **REPEAT steps 2 through 6 EACH TIME a dose is missed**, omitting #4 above, if it does not apply each time.
9. If the medication is delivered within 1 hour before or 1 hour after the scheduled time pass, proceed to give the medication immediately. If it arrives outside the indicated two hours of flexibility, proceed to give the medication **ONLY** as directed by the MD or nurse with such direction documented.

**EXAMPLE DOCUMENTATION**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Hour</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paxil 20mg 1 tablet by mouth every day to regulate mood.</td>
<td>5am</td>
<td>YI</td>
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</tbody>
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Revised 12-2016
### ORDERING / REORDERING MEDICATIONS

#### Summary

- Resident medications will be available when needed.
- The Community shall respect a resident’s choice to use a pharmacy other than the Community’s contracted pharmacy if the chosen pharmacy can supply medications in bubble packaging, have a pharmacist available on call 24 hours/7 days a week, and deliver or arrange transportation for medication(s) ordered for the resident.
- Staff should follow the Community policies and procedures that apply for medication ordering and should follow pharmacy policies/procedures as informed by the pharmacy.
- The resident (or resident's representative) shall be responsible to pay for medications not covered through a health insurance plan. See below about pre-authorization.

#### Procedure

- **Order medications BEFORE the medication is down to a 7 day supply.**

- Each shift, determine whether medications need to be ordered/re-ordered, and initiate the order process.

  **Order Process**

  a. Scan the medication bar code on the bubble pack if on Quick MAR.
  b. If there is no tab on the medication; write the medication and resident information on the pharmacy re-order form and fax to pharmacy.
  c. Keep pharmacy reorder form in designated area for shift to shift follow up until med arrives.
  d. When medication arrives check off on the re-order form that medication has arrived.

- After an order is initiated, each subsequent shift follows up on the ordering/re-ordering activity of the previous shift, until the medication arrives.

- If a medication is not available in the Community at the time needed, follow the procedure for “medication not available.”

- **If pre-authorization is needed:** when the Community’s contracted pharmacy notifies that a medication is not covered by the resident’s health plan, staff must act as follows:
  a. The Community nurse (or designee) or medication assistant must notify the resident or resident representative that the medication is not covered.

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Hour</th>
<th>Medication</th>
<th>Reasons/Comments</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/1/2012</td>
<td>8am</td>
<td>Paxil</td>
<td>Called pharmacy. Will deliver today, regular time. MD notified and order received to hold and restart when medication received.</td>
<td>YI</td>
</tr>
<tr>
<td>2/1/2012</td>
<td>5pm</td>
<td>Paxil</td>
<td>Medication arrived. Given per MD</td>
<td>YI</td>
</tr>
</tbody>
</table>
b. The physician must be immediately notified by first faxing a Community/Physician Communication form (Pg. 78 - Attachment C). Follow up the fax with a phone call and report that the medication will be given as soon as it is available.

ORDERING FROM AN “OUTSIDE” PHARMACY

- If a medication is not available in the Community at the time needed, follow the procedure for “medication not available.”
- When a resident uses an “outside” pharmacy, write the business name and telephone number for that pharmacy on the face sheet in QMAR or Real Page and note the following requirements:
  - Write the pharmacy name and delivery method on the resident’s information sheet in the resident health record.
  - On the medication sheet that staff uses, describe the steps to order medication from the outside pharmacy.
  - As specified in the procedure about medication order change, staff also must make sure to send orders to the community’s contracted pharmacy to update medical records for residents who use an alternate pharmacy.
- Follow the process outlined under “Order Process”, obtaining an order form from each specific pharmacy or following their re-order directions.
**PRE-AUTHORIZATION FOR MEDICATION – EXAMPLE**

(Use the Community/Physician Communication form)

This cutout representation shows how to complete the indicated section of the form.

<table>
<thead>
<tr>
<th>Community</th>
<th>Physician’s Response/Orders*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medication, ____________________________ requires a pre-authorization.</td>
<td></td>
</tr>
<tr>
<td>Please mark one of the following options:</td>
<td></td>
</tr>
<tr>
<td>☐ Hold this medication until pre-auth is received</td>
<td></td>
</tr>
<tr>
<td>☐ DC the medication above.</td>
<td></td>
</tr>
<tr>
<td>☐ DC the medication above and replace It with the following:</td>
<td></td>
</tr>
<tr>
<td>________________________________</td>
<td></td>
</tr>
</tbody>
</table>

* These orders are to be in effect for the next 180 days unless otherwise indicated below

<table>
<thead>
<tr>
<th>Information Only</th>
<th>Response Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

NOT 180 days – Orders to be in effect for (circle one) 30 days 60 days 90 days Other ______ days
REFILL MEDICATIONS RECEIVED

Resident medications shall be available when needed.

Procedure

1. When new bubble cards are received from the pharmacy, review them to
   a. Compare against the MAR for accuracy, one card at a time.
   b. Review expiration dates and assure that an adequate supply is available.

2. After confirming accuracy and expiration dates, place new cards in the medication drawer or cart or proceed as necessary to correct any error in the medications received

MEDICATION ALLERGY / ADVERSE REACTION

Summary

- Staff shall notify the LN and MD if recognizing any allergic or adverse reaction to medication.
- Symptoms of drug allergies and adverse reactions can include (but are not limited to) the following:
  - Skin rash
  - Swelling
  - Puffiness
  - Nasal drainage
  - Diarrhea
  - Itchy eyes or skin
  - Wheezing
  - Difficulty breathing
  - Shock
  - Other possible indicator, as identified for a medication or learned for a specific resident/medication combination

Procedure

1. Seek emergency treatment and notify LN any time a resident has difficulty breathing, a change in blood pressure, wheezing, complaint of any swelling or any other significant change in condition possibly related to medication.

2. Immediately notify the resident’s physician about any suspected drug reaction and/or allergy.

3. Initiate Incident Report.

4. Transfer onto the MAR any potential drug allergy stated in physician’s orders.

5. Per Community requirement, place the resident on alert charting each time a new medication is started, for observation of possible adverse reaction to the medication.
MEDICATION STORAGE

Summary

- Staff shall seek to sustain security for the Community medication system by managing medication storage according to regulations, licensing requirements and best practices.

- If apartment storage for medications is requested by a “self-med” resident, the Community shall advise and assist residents in safe storage practices.

Guidelines

Staff should apply the following guidelines at all time for BOTH prescription medications and over-the-counter (OTC) medications (which can include samples if state regulation allows):

- Store an OTC medication with its original label and, in the original container; and mark/label with resident name and apartment number.

- Store prescription medication in the container dispensed by the pharmacy, and maintain the original label intact and legible.

- *Do not write on a medication label.* (Only a pharmacist or licensed physician can do so.)

- Store medications in a locked medication room, container, cart or refrigerator according to the medication label if it indicates direction (e.g., “store in refrigerator,” “store at room temperature,” etc.).

- Separately store topical medications in a sealed compartment (such as a sealed bag) and away from other medications. Label the bag with resident name and apartment number.

- Separately store eye and ear medication in sealed compartments to prevent leakage and keep them separated from other medications.

- For controlled/narcotic substances, store in a secure, double locked container or cabinet, separate from other medications, and count them regularly as required by procedure (See page 38: “Controlled Medications Tracking”).

- Use all medications, including OTC’s within their product “use by” or expiration date and notify the pharmacy for replacement of any medications or supplies that are out of date.
MEDICATION RECEIPT / DISPOSAL

Summary

- When medication is received staff shall use the “Medication Receipt Log” to log receipt of the medication for a resident who receives assistance with medication administration, including narcotic/controlled substances, which is tracked separately.
- Staff shall use the “Medication Disposal Log” to log disposal of medications, including narcotic/controlled substances.

NOTE: Other documents provide separate direction and procedures that apply and “narcotics tracking” processes.

- The established forms are attached & addressed below:
  - Medication Receipt Log (Pg. 79 - Attachment D)
  - Medication Disposal Log (Pg. 80 - Attachment E)

NOTE: Direction here does not indicate “resident-specific use” of the logs but if regulations stipulate such use, the Community shall maintain separate logging as applicable for a resident, and store used logs in individual resident records.

Procedure

1. Keep current Medication Receipt/Disposal Logs in the resident record to track medications received and disposed of in the Community.

2. As the forms indicate, enter complete information for each resident medication as follows:
   a. Medication Receipt Log – when medication arrives, log it to specify
      - Resident name
      - Medication name
      - Prescription number
      - Date received
      - Amount received
      - Staff Initials
   b. Medication Disposal Log – log each medication disposal event, to specify
      - Resident name
      - Medication name
      - Prescription number
      - Disposal date
      - Disposal amount
      - Reason for disposal
      - Method of disposal (see form)
      *Validating signatures/s (as directed)

3. Remove forms from the resident record after they are no longer current, and purge in the resident purged file.

4. Narcotic disposal may only occur between the LN and Med Tech, RCC or Executive Director both witnessing the disposal.
5. Non-narcotic medications may be disposed of by the RCC or Med Techs.

CONTROLLED MEDICATIONS TRACKING AND ADMINISTRATION

Overview

Our company policy requires that narcotics and other designated substances be controlled separately from other medications. This section specifies the processes in place to restrict and monitor access to controlled medications in the community. The community shall establish a double lock storage system as required for narcotics and controlled medications. Additional requirements may be found in the community’s, contracted pharmacy manual.

Receipt of Controlled Medications

Only staff responsible for medication administration should receive medication shipments. The steps outlined below describe the process for properly receiving delivered controlled medications:

1) An itemized shipping record must accompany all deliveries of controlled medications.

2) Signing for the receipt of a medication must include a copy of the Shipment Record. If no “copy” is available, staff should make a second copy for the community to keep and file.

3) The Med Tech should inspect all controlled medications at time of delivery to verify the name of each item delivered and any identifying number or amount of medications on the shipping document.

4) The Med Tech who takes delivery must be the person who signs the shipping invoice, UNLESS the medication is for a resident that self-administers**.

5) Identify any delivery discrepancy, notify the dispensing pharmacy as soon as possible during the shift and note the discrepancy along with your initials on the shipping record.

6) Fax (before the shift ends) the documented and initialed shipping record, outlining the discrepancy, to the dispensing pharmacy and place the original in the nurse’s box for follow up.

**If a Resident who self-administers is not available when the shipment arrives, initiate a tracking system form (Individual Narcotic Record) to note delivery information; and appropriately store the medication (see below). Later, when the resident is available, use the same tracking record to:

a. Count together with the resident to confirm the medication amount shown on the form
b. 2) Obtain the resident’s signature and counter-sign below the resident’s signature.

Recordkeeping

At each change of shift the oncoming and outgoing Medication staff members will, TOGETHER, count all controlled medications, including any designated unwanted and awaiting disposal. The steps outlined below describe the process for properly counting controlled medications:
1) Narcotic count will be recorded in the bound books provided by the Pharmacy. There must be an accurate reconciliation from one shift to the next. The signature page must be signed every shift, every day to ensure accuracy.

2) Each day, at the start of each oncoming shift, staff will initiate a controlled substance count. Both staff members should agree that the actual amount remaining from the previous shift matches the amount present for the beginning of the new shift. When both staff members confirm proper counts for all the controlled medications, each Med Tech should sign the signature page in the bound narcotic book in the appropriate space, OR should address any discrepancy as indicated in the next section.

3) If a medication aid is working two consecutive shifts, they must sign as the off going and oncoming signature and then off going with the next Med Tech to count/sign for verification.

Controlled Medication Discrepancy

If a discrepancy is noted during the narcotics verification process the counting staff must initiate immediate investigation and notification as follows:

1) Recount and reconcile the discrepancy if possible.

2) If the discrepancy is not reconciled, immediately notify the Executive Director and/or the nurse supervisor in charge, who will direct staff not to leave the community, as follows:

   * The staff members who were counting must remain, as well as, all staff members associated with the administration or assistance of medication.

   * Staff directed to remain cannot leave without permission directly from the Executive Director or designated person in charge.

3) The Executive Director (or person in charge) must attempt to reconcile the discrepancy and is responsible for completion of an incident report if reconciliation is not achieved.

4) The Medication Aid reporting off duty will notify the appropriate pharmacy as necessary to obtain replacement medication.

5) The authorities must be notified if a missing narcotic or controlled substance cannot be found.

6) Executive Director must also notify their Supervisor.
RESIDENT LEAVE WITH MEDICATIONS

Allowing a resident to take any medications with them for a temporary or permanent leave from the community is specified by orders written from the prescribing physician and is viewed as a dispensing process, therefore, we encourage the resident to plan the absence, in advance, so that arrangements can be made for the medications to be prepared by the pharmacy. If the absence is unscheduled and would result in the resident not having their medications, the community will provide up to a 72 hour supply of medications, from the resident’s current medication supply, which must be prepared by the Registered Nurse. These medications can be dispensed from the available resident medications in accordance with pharmacy guidelines and company policies regarding repackaging medication by the registered nurse.

Procedure For Medications When A Registered Nurse Is Not Available

Copies of the card? both sign list

Should the LN not be available at the time of departure, or if prior notice was not given of resident leaving, alternative options must be utilized as listed below:

1. Must have order from MD to send medications with resident family.
2. The medication staff may provide the resident/responsible party with the entire medication blister pack (or other original container) as well as a copy of the current medication administration record.
3. Copies of the medication cards must be made and the responsible party sign the copies showing they received the medications. The signed copies are retained at the community.
4. Instruct the resident/responsible party to document on the medication administration record provided, when the resident has consumed the medications as ordered, or document if the resident refused the medications.
5. Upon returning to the community, the resident/responsible party shall return medications and medication administration record to the medication staff; the medication administration record completed by the resident/responsible party becomes a permanent addition to the original medication administration record.
6. Another copy of the medications cards is made and signed by responsible party and med Tech. The cards are checked for inconsistencies in medication administration by comparing with the copy of the returned MAR.
7. When resident is out of the community for an activity, medical appointment or any other outing not lasting overnight, contact community LN for further directions regarding administration of medications.
8. Medication staff should review the returned administration record and take appropriate action as necessary, i.e. the resident refused their medication.
9. If there is a discrepancy in the Controlled Medication Count upon the return, see page 39 “Controlled Medication Discrepancy” Policy.
COMMUNICATION

Overview

The community is responsible for implementing systems to observe and report events that may result in a resident’s need for immediate medical attention, but also more subtle deviations in the resident’s physical, emotional, and mental functioning.

These resident deviations are called a Change of Condition and they can be either short term or significant.

(a) **Short term change of condition** is a change in the residents’ health or functioning that is expected to resolve or be reversed with minimal intervention or occurs in a predictable, cyclical pattern associated with a previously diagnosed condition. An example would be a resident with a diagnosis of bi-polar disorder who exhibits a short period of increased depression or infections that are expected to resolve.

(b) **Significant change of condition** means a major deviation from the most recent evaluation that may affect multiple areas of functioning or health that is not expected to be short term and may impose significant risk to the resident. An example would be a resident who experienced a stroke and now has loss of mobility, speech, bladder control, and cognitive ability.

The following will outline the process and importance of clear, concise, and timely communication between all individuals involved in the resident’s care.

ALERT CHARTING

All services that are provided or available for our residents are derived from the resident’s service plan or negotiated agreement. When the service plan is initially developed it is based on a certain level of functioning and current medical condition. A resident’s condition can change quickly. If this change goes unnoticed by the staff, the resident may not get the care they need. Imagine a resident that can safely ambulate without any assistance, but after developing symptoms of dizziness can no longer walk without losing their balance. This change must be communicated to all staff. It is imperative that all staff assist in communicating information that will contribute to providing the necessary level of support to our residents. Alert Charting (Pg. 83 - Attachment H) can be generated by any staff member, but it is the Med Tech that will typically initiate the first step in determining what type of intervention, management/professional notification, or assistance is needed, as well as notifying the LN about the change or calling 911 as appropriate and then notifying the LN.

The steps outlined below describe the process for properly completing and processing Alert Charting:

**Alert Charting Log Completion**

1) Fill in the resident identification information on a blank line on the Alert Charting Log.

2) Define your concern by describing what you have seen or heard. Include names, dates and list other individuals (by name) who observed the same. Refer to the table titled, *Examples of Resident Observations, Table 1*, (Pg. 43) for guidance in reporting.

3) Print your name, job title, sign and date the entry.
4) If in doubt whether you should include a resident on the Alert Charting Log, error on the conservative side. It is better to over report than to omit communicating information that may be important in keeping our residents safe.

5) Notify the LN and Executive Director.

6) THIS IS NOT AN INCIDENT REPORT! If an incident or accident occurs, i.e., a resident fall, you must still complete a Non-Employee Incident/Occurrence Report (Pg. 84 - Attachment I) in addition to initialing alert charting.

**See notes on ALERT SECTION**

1) A staff member observing a resident change of condition will notify the Med Tech on duty (or 911 if an emergent situation). The Med Tech will ask enough information about what was observed to determine whether the unusual occurrence needs immediate attention. If not, the resident will be added to the Alert Charting Log with observable information for staff to report immediately by the Med Tech.

2) The alert Charting Log is kept in the 24 hour book under the Alert Charting tab. All staff has access to the Alert Charting Log.

3) Floor staff is to document on the 24 hour communication form any observable information regarding the resident on the Alert Charting Log.

4) The Med Tech is to document in the resident progress notes any observable information for all residents on the Alert Charting log for each shift.

5) If an incident report is also generated it should be completed and placed in the 24 hour book under the incident report tab for the LN and executive director review.

6) After the LN has evaluated and assessed the resident’s condition they will decide whether a modification to the resident’s current services needs to be made. This could include anything from a slight adjustment of medication to a new approach in providing care. Typically, when a change in service is made; monitoring needs to be initiated for observation of condition changes. If the Nurse decides that this monitoring needs to be done by staff, the Nurse will document information that needs to be observed and reported for that resident on the Alert Charting Log located in the 24 Hour Communication Book. This document (alert charting log) will always be placed in the 24 Hour Communication Book and will provide a quick, at-a-glance overview of the residents that require monitoring.

7) The expectation with monitoring is that the Med Tech will only document what the LN has asked them to observe and report on the Alert Charting Log. The Med Techs shall review the care staff notes about the resident from the 24 hour report form. The Med Tech’s responsibility is to document factual observations that will alert/assist the LN in assessing the resident for supportive, follow-up care and services, omitting any opinions or diagnosis.

8) The Med Tech will continue to document change of condition occurrences until they are directed by the LN to stop and the resident has been removed from the Alert Charting Log.

- The Alert Charting Log will be updated by the LN, final outcome documented by the LN in each resident’s progress notes, and filed in the Resident Chart under Progress Notes tab.
If there are multiple matters related to the same resident, but for different issues, the Med Tech may be documenting on separate conditions.

- The Alert Charting Log will be “Highlighted in Yellow” for that resident, indicating condition Resolved.
- Resolved Alert Charting Logs may be destroyed by the RN.
Examples Of Resident Observations-Table 1

Table 1: Resident Observation & Evaluation Report Guidelines

<table>
<thead>
<tr>
<th>Physical</th>
<th>Emotional</th>
<th>Social</th>
<th>Cognitive</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to perform Activities of Daily Living: Mobility, Personal Care, Dressing, Eating, Bathing</td>
<td>Mood Change: withdrawn, anxious, paranoid, tearful, lack of interest, etc.</td>
<td>New interests or relationship development, i.e. attending new activity programs</td>
<td>Unable to find or recognize familiar items, places, or persons</td>
<td>Any occurrence that may support further review by the LN or Management Staff to better care for our residents</td>
</tr>
<tr>
<td>Control of Bladder/Bowel</td>
<td>Physically or verbally aggressive</td>
<td>Excessive use of alcohol</td>
<td>Communication Difficulties: word searching, garbled sentence, low tone</td>
<td></td>
</tr>
<tr>
<td>Balance</td>
<td>Loss of interest in food</td>
<td>Rejection of previous friends or interests</td>
<td>Loss of Safety Recognition: not using walker or demonstrating unsafe behavior</td>
<td></td>
</tr>
<tr>
<td>Hearing, Vision, or Speech</td>
<td></td>
<td>Loss of Family Support</td>
<td>Unable to manage finances</td>
<td></td>
</tr>
<tr>
<td>Swallowing</td>
<td></td>
<td></td>
<td>Refusal to take medications</td>
<td></td>
</tr>
<tr>
<td>Lethargy or Restlessness</td>
<td></td>
<td></td>
<td>Distrustful/paranoid</td>
<td></td>
</tr>
<tr>
<td>Sleep Patterns</td>
<td></td>
<td></td>
<td>Loss of interest in food</td>
<td></td>
</tr>
<tr>
<td>Ability to self-perform duties on service plan: i.e., take care of pet, make bed, launder personal items, take medications, etc.</td>
<td></td>
<td></td>
<td>Refusal of services: housekeeping, personal care, outside agencies</td>
<td></td>
</tr>
</tbody>
</table>

Alert Charting documentation examples: write down changes in the resident’s routine functioning.

<table>
<thead>
<tr>
<th>Physical</th>
<th>Emotional</th>
<th>Social</th>
<th>Cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janet Smith had difficulty with speech, slurring words, within 30 minutes of taking am medications. She started on a new medication, Fentanyl patch today.</td>
<td>Tom Rue refused his am meds, stating that we were trying to poison him. He then was rude to his tablemates at lunch whenever they looked or spoke to him saying “quit looking at me or quit talking to me”. He is usually extremely cordial with his tablemates.</td>
<td>Liz Lehner appeared under the influence when she returned from her 9am shopping trip. She had difficulty walking and talking and had a strong odor of alcohol. Liz Lehner normally only has an occasional glass of wine with dinner.</td>
<td>Jack Tober handed me his checkbook during the administration of his am meds and asked me if I knew how much money he currently had in the bank. He stated, “I do not understand this screwdriver”.</td>
</tr>
</tbody>
</table>
Alert Charting Documentation (Progress noting) Guidelines (Do’s And Don’t’s)

The observations the Med Tech records on the Alert Charting Log are part of a resident’s legal medical record and shall be prepared following the guidelines noted below.

- ALWAYS put the date, time and signature (NOT INITIALS ONLY) on each entry.
- ALWAYS use a black pen.
- ALWAYS write legibly so the notes are clear and as easy to read as possible.
- ALWAYS document completely to “tell a story” with a beginning, a middle and an end.
- DO NOT use slang and try to avoid abbreviations when making entries.
- ALWAYS refer to resident as “resident” not Mr. Smith
- ALWAYS refer to staff by title and not name.
- DO NOT make a diagnosis or present an opinion. REPORT only observations, facts, and steps taken.
- DO NOT scribble through entries. After writing a note in error, draw a single line through the entry, write “error” above and sign the note.
- DO NOT recant an incident and its details.

HEALTH PROFESSION COMMUNICATION AND CHARTING

Various services are available outside of the community to help support a resident’s needs. To ensure that communication and services are integrated between the community and these health professionals, system and procedures must be followed. Typically, the Med Tech is the first, and sometimes only, staff that is aware of a health professional’s visit to a resident. Therefore, the Med Tech serves as a gatekeeper, insuring that the health professional charts their visit and that important information is reported, documented, and forwarded to the community Licensed Nurse.

The information to follow will outline the process and importance of clear, concise, and timely communication between all individuals involved in the resident’s care.

1) There is a separate notebook binder set up for all visiting health professionals, including, Home Health, Hospice, and Physicians. It is titled, Health Professional Communication and it houses the progress notes written after each visit, by each professional.

2) Provide the professional with a quiet place to chart that does not allow access to resident charts, progress notes or other sensitive information.

2) After their visit, the Med Tech should politely direct the health professional to the binder for charting. The Med Tech should uncover if there is any needed direction or action to be taken by the staff and seek clarification if necessary. The community LN will check this binder daily for follow-up, but if a concern is mentioned on evenings or weekends, the Med Tech may need to contact the LN or Executive Director by phone.

3) The LN will use the chart notes to update service plans, treatment sheets, task sheets or notify the kitchen of new diet orders. If there are any issues that need to be addressed the LN will assess the resident as appropriate. The LN is the only staff member that can pull the health professional’s notes from the health professional’s binder as each visit needs to be reviewed by the LN.
PHYSICIAN WRITTEN COMMUNICATION

Keeping the resident’s physician informed of changes of condition, medication or treatment issues, and incidents/accidents is vital to insuring the resident receives the best care possible. The community has an established form titled, Community Physician Communication, for documenting to physicians, resident changes and general information.

The following steps should be followed for communicating to a resident’s physician:

1) Using the identified form, state the reason for notification. For example, this it to notify you that Mrs. Jones had a non-injury fall on 5/1/12 at 11:50pm. She had a dizzy spell and lost her balance getting out of bed to go to the bathroom.

2) It is important to include all information, facts and observations (never opinions), that will assist the physician for making recommendations. For example, along with the information provided above it would have been helpful to include vital sign information taken prior and post the fall. Also, include any steps the community has taken in response to the issues, i.e. placed resident on Alert Charting Log charting, instructed resident to sit up on bedside for 2 minutes prior to standing, place a commode by bedside for night time use, etc.

3) Sometimes the Community Physician Communication form will not require a physician response, but when instruction is needed be clear to state that a response is expected, especially if a time frame is applicable, i.e. need a response before 7:00pm when the pharmacy makes their last medication delivery.

4) Complete and sign the form as applicable and fax the form to the physician. Attach the fax confirmation to the communication sheet. Progress note when applicable that the physician has been notified.

5) When the physician responds with a signed order, fax it to the appropriate pharmacy and treat it as a new/changed order. When completed place original order in the fax binder behind the second verification tab, after completing the second verification place behind the RN to check tab. RN will be the final sign off and will file in resident’s record.
PHYSICIANS ORDERS

Physicians Admission Orders

At move-in, the review of the initial physician signed resident orders and the inclusion of standing orders, must be done by the nurse. After the orders have been faxed to the pharmacy, they will be filed in the residents' chart under the Physician’s Orders tab with “Do Not Purge”. Initial move in orders are to always stay in the resident chart. All ongoing physician orders will also be filed under the Physician’s Orders tab, with the most current order on top. The LN will review and clarify any discrepancies.

Standing Orders

Each resident should have a current Standing Order from their physician. They are typically common interventions that almost all residents can safely have administered, for example, Acetaminophen for mild headache, joint or muscle discomfort, or fever over 100 degrees. These orders are not used very often, but are good to have available immediately if the resident is in need.

90 Day Recapitulation Orders

Physician orders must be part of each resident’s health record every 90-180 days. The contracted pharmacy will requests a recapitation of all resident's medications signed by the physician. Communities can print off the physician orders off of QMAR to have the physician sign and forward to the pharmacy.

1) Print off the physician orders (recap) from QMAR for the resident.
2) The LN is to review the recap to be sure there are no inconstancies
3) Any Nursing orders should be removed from the recap and reprint
4) The LN is to sign the recap and fax to the physician with a cover letter
5) When the signed recap is returned by the physician, the MT/LN is to review for any med changes.
6) Fax the signed orders to the pharmacy
7) Implement any new or changed orders
8) Put the new physician signed recaps in the resident chart under the “orders” tab
9) Remove any previous orders from the resident chart and purge to lessen chance of confusion

Note: The Recapitulation orders may be faxed to the physician for a signature and the signed orders faxed to the pharmacy with a system in place for tracking all returned signed orders.

Procedures

1) When a medication or treatment will be administered, verify the resident’s current physician orders to see if the resident’s physician approved the needed standing order. If they have, transcribe the order onto the MARS and document administration as required.

2) A qualified staff member will periodically review the use of standing orders to monitor a pattern of use and the need for continued use, and shall consult with the physician about concerns identified in the review.
SECTION IV: MEDICATION/TREATMENT ADMINISTRATION

SEVEN RIGHTS OF MEDICATION

Knowledge and adherence to the SEVEN RIGHTS of medication is the foundation to ensuring that medications are given safely. Breaking one or more of the Seven Rights can easily result in a medication error.

THE SEVEN RIGHTS OF MEDICATION INCLUDE:

The Right Resident
The Right Medication
The Right Route
The Right Dose
The Right Time
The Right to Refuse
The Right to Know

Prior to the administration of any medication, the Med Tech must take the time to ensure that they are giving the correct medication to the correct resident at the correct time, in the correct dose and with the proper route, as prescribed by the physician.

The Med Tech who pours the medication must administer the medication. It is the responsibility of the Med Tech who administers the medication must observe the resident taking the medication.

*Remember to wash and sanitize hands prior to and after any medication or treatment assistance.

ORAL MEDICATION

Medication by Mouth

- Give adequate fluid with oral medication.
- Instruct the resident to swallow or chew as the medication label directs.
Sublingual (SL) Medication

- Sublingual tablet is placed under the tongue and allowed to dissolve.
- This is the usual method for giving nitroglycerin tablets for chest pain.

Liquid Medication

- Shake the bottle well before measuring the dosage.
- Measure as you pour the liquid into a plastic medication cup.
- Use an oral syringe provided by the pharmacy if you cannot measure precisely.
- If you pour too much medication, discard it; never return it to the bottle.
- Pour medication away from the bottle label and wipe the label to maintain legibility. (Palm the label and this will assure you always pour away from the label and avoid drips on the label)
- Place the medication at eye level for accuracy.
- If you have any question about label direction, consult with the LN or pharmacist.

EYE MEDICATION

Eye Drops

- Verify which eye to treat by checking the MAR.
- Confirm that the resident has a tissue or provide one.
- Wash hands and put on gloves.
- Have the resident tip back his/her head.
- Gently pull the resident’s lower eyelid, with ring finger, and instill the prescribed number of drops into the pocket (conjunctival sac); and DO NOT touch the dropper on the eye tissue.
- If instilling drops in both eyes be sure to use a different finger to gently pull the lower eyelid down
- After the drops are in, instruct the resident to close the eye gently without squeezing. Have the resident gently roll the eye, this will distribute the medication evenly
- Wait at least one minute between drops of the same medication, and five minutes between different eye medications, or follow Physician order directions.

Eye Ointment

- Verify which eye to treat by checking the MAR.
- Confirm that the resident has a tissue or provide one.
- Wash hands and put on gloves.
• Have the resident tip back his/her head.

• Gently pull the resident’s lower eyelid and squeeze the measured amount of medication into the eye pocket (conjunctival sac); and DO NOT touch the applicator on the eye tissue.

• If instilling in both eyes be sure to use a different finger to gently pull the eyelid down.

• Instruct and encourage the resident to roll the eye after an ointment is applied, to help distribute the medication.

**EAR MEDICATION**

Ear medication is usually drops given for an ear infection or to loosen/soften ear wax (cerumen).

• Verify which ear to treat by checking the MAR.

• Confirm that the resident has a tissue or provide one.

• Have the resident lie on his/her side or tilt his/her head to one side.

• Wash your hands.

• Pull back and lift up the top of the ear.

• DO NOT touch the dropper to the ear, but administer the eardrops and apply a cotton ball so the medication will not run out.

• Encourage the resident to stay on their side for 5 minutes after the drops are in the ear.
RECTAL MEDICATION

Suppository

NOTE: Suppositories should be taken out of the refrigerator and left at room temperature to warm slightly before administering.

- Have the resident lie down on his/her left side with the right knee bent as far into the chest as possible.
- Wash your hands and put on gloves.
- Unwrap the suppository and insert it into the rectum just beyond the sphincter.
  - Lubricant may be necessary.
  - The medication will return if not pushed beyond the sphincter.
  - Notify the LN for any of the following:
    - Meeting any pressure within the rectum
    - Resident expresses discomfort
    - Any abnormality is present (e.g., hemorrhoids)
- After application, encourage the resident to remain lying down for 20 minutes.
- Before leaving the room, check that the call light or staff notification system is within easy reach for the resident.
- Document results on back of MAR.

Enema

- Give only a “Fleet-type” enema
- Protect the bedding with a waterproof pad or towel.
- Have the resident lie down on his/her left side with the right knee bent as far into the chest as possible.
- Wash your hands and put on gloves.
- Gently insert the enema tip into the rectum, but notify the LN for any of the following:
  - Meeting any pressure within the rectum
  - Resident expresses discomfort
  - Any abnormality is present (e.g., hemorrhoids)
- Slowly squeeze the bottle until all the fluid has been inserted into the bowel.
- Encourage the resident to remain lying down for 20 minutes.
- Before leaving the room, check that the call light or staff notification system is within easy reach for the resident.
- Assist with toileting needs as needed.
- Document results on back of MAR.
VAGINAL MEDICATION

Cream

*NOTE: Creams work best when scheduled at bedtime so that the medication will stay in place.*

- Wash your hands and put on gloves.
- If the medication is not pre-filled, fill the applicator with cream by attaching the medication tube to the applicator tip and squeezing the medication tube until the prescribed amount is in the applicator.
- Have the resident lie on her back with legs slightly apart.
- Gently push to insert the plunger into the vagina (as for inserting a tampon), but discontinue insertion and notify the LN if
  - The resident expresses any discomfort.
  - Any abnormality is present.
- After the applicator is inserted, push the plunger until all the medication is delivered.
- If the tube is reusable, wash it with warm soapy water, dry it and replace it in the original container.

Suppository

*NOTE: Suppositories should be taken out of the refrigerator and left at room temperature to warm slightly before administering.*

- Have the resident lie on his/her back with legs slightly apart.
- Wash your hands and put on gloves.
- Unwrap the suppository and insert it into the vagina, but discontinue insertion and notify the LN if
  - The resident expresses any discomfort.
  - Any abnormality is present.
- Encourage the resident to remain lying down for 20 minutes.
- Before leaving the room, check that the call light or staff notification system is within easy reach for the resident.
TRANSDERMAL / TOPICAL MEDICATION

Transdermal (Patch)

Patches are typically applied to a resident’s upper chest or back but the medication label might direct a different site. The skin area selected should be a site with little or no hair.

- Determine where the previous patch was applied and rotate to a different site so that rotation can help minimize skin irritation, and:
  - Document the site used on the medication sheet.
- Wash your hands and put on gloves.
- Unwrap the medication and initial and date the patch.
- Remove the backing from the patch.
- If required, offer the patch so the resident can place it, or assist the resident to place the patch directly on the skin (avoiding hair if possible).
- Press firmly on the patch for 20 seconds.
- Using gloves, fold the used patch and place into a sharps container.
- Document removal of old patch on the MAR. Use narcotic disposal methods.
- Never replace a patch that has fallen off. Always clarify with the Physician if a patch falls off.

Topical (Cream, Ointment, Etc.)

Topical medications are applied on the resident’s skin (or nails or hair) according to the medication label. The site for application will often be an area that can be identified as affected in some way (rash, redness, etc.); but if the label specifies no site, clarify with the resident if able, or LN for the appropriate use.

NOTE: If the site for application is inaccessible for self-application, the resident should direct you to apply the medication.

- Read the medication direction and determine an application site(s)
- Document the site(s) used on the medication sheet.
- Wash your hands and put on gloves.
- Unwrap/open the medication and offer it to the resident for application, or assist the resident to apply the medication directly on the skin (or other site).

NOTE: When the resident applies, guide or remind him/her according to the label directions: where and how to apply, including follow-up if any, to “rub in”, “wash off” or other instruction.
NASAL / INHALER MEDICATION

Nasal Spray

- Wash your hands.
- Instruct the resident to gently blow the nose and tilt back their head.
- Shake the bottle and DO NOT touch the dropper to the nose but administer the ordered number of sprays.
- Rinse the tip of the dropper in warm water.

Nasal Inhaler

- Wash your hands and shake the inhaler and, if necessary, place the canister in the holder.
- Instruct the resident to take a deep breath and then breathe out slowly.
- Use your finger (or the resident’s) to hold down the nostril not receiving medication.
- Instruct the resident to breathe in slowly through the nose.
- Activate the canister as the resident begins to breathe in.
- Instruct the resident not to sneeze or blow their nose just after administering medication. Repeat the medication once if immediate sneezing does happen, but notify the nurse if it happens again or if you have questions.
- Rinse the holder or tip in warm water.

Respiratory Inhaler

- Wash your hands and shake the inhaler and, if necessary, place the canister in the holder.
- Hold the inhaler (or have the resident hold) to the open mouth and instruct the resident to
  - Exhale deeply;
  - Breathe in deeply and slowly through his/her mouth while fully depressing the top of the metal canister with the index finger; and
  - Instruct to close mouth around the inhaler.

Hold his/her breathe as long as comfortable before exhaling.

Proper Use of Metered Dose Inhalers

Medication errors are a common reason for citations in Assisted Living Facilities. Although there are many reasons for medication errors, one may be how a medication is delivered. Licensors will watch medication assistance or administration for different medication delivery routes. Metered dose inhalers are frequently used incorrectly and residents should be given proper instruction to ensure the medication is delivered properly and that the resident receives the correct amount of medication. Those instructions include:

1. Wash hands.

2. Remove the cap and look for any debris that could be lodged in the opening.
3. If the inhaler is new or has not been used for a couple of days it may need to be primed. You will need to check the manufacturer’s instructions as this is specific for different medications.

4. Shake the inhaler well before use (3 or 4 shakes).

5. Encourage the resident to cough if needed.

6. Breathe out through the mouth, away from the inhaler.

7. The resident should be standing up or sitting with head up straight or tipped back slightly.

8. Bring the inhaler to the mouth. The teeth can be gently rested around the inhaler but ensure the resident does not bite down.

9. As the canister is pressed down, instruct the resident to breathe in slowly over 3 to 5 seconds.

10. Rinse the applicator in warm water. Remove the inhaler from the mouth, and have the resident hold breath for about 10 seconds or as long as tolerated, then breathe out.

11. Wait the recommended time between inhalers if any.

12. Instruct the resident to rinse their mouth according to directions on the medication label.

13. Remove the inhaler from the mouth, and have the resident hold breath for about 10 seconds or as long as tolerated, then breathe out.

14. Wait the recommended time between inhalers if any.

15. Instruct the resident to rinse their mouth according to directions on the medication label.

16. Rinse the case as necessary to keep it clean and reapply the cap.

Nebulizer

- Wash your hands and fill the nebulizer cup with the combination of medication and saline, as ordered, or may be pre-mixed.
- Attach the cup to the tubing and mouth piece.
- Turn on the machine and instruct the resident to breathe normally, inhaling and exhaling through the mouthpiece until the medication is gone and no more mist is created.
- Rinse the nebulizer per the manufacturer’s instructions.
OSTOMY CARE

Summary

Unless prohibited by rule, staff can assist with ostomy care as defined below for a resident with a long-standing, stable and predictable ostomy site. Staff should coordinate with a home health agency for oversight and supplies related to overall care of an ostomy site.

Definitions

The terms **ostomy** and **stoma** are often used interchangeably but they have different meanings, as follows.

**Ostomy** – An opening in the body that is surgically created for the discharge of body wastes.

**Stoma** – The actual end of the urethra or bowel seen protruding through an abdominal wall.

Other terms used below:

**Colostomy** – A surgical procedure to remove a portion of the colon or rectum and bring the remaining colon to an opening in the abdominal wall. The portion of the colon involved and/or its permanence can further define it.

**Urostomy** – A surgical procedure to divert urine away from a diseased or defective bladder and, sometimes, remove the bladder. The most common (ileal or cecal conduit) procedures remove a section either at the end of the small bowel (ileum) or at the beginning of the large intestine (cecum) and relocate it as a passageway (conduit) for urine to pass from the kidneys to outside the body through a stoma.

**Continent ileostomy (Kock Pouch)** – An ileostomy variation, this surgery constructs a reservoir pouch with a valve inside the abdomen, from a portion of the terminal ileum, and a stoma is brought through the abdominal wall. A catheter or tube is inserted into the pouch several times a day to drain feces from the reservoir.

Assistance

Following are the types of assistance that might be provided:

- Emptying pouch
- Changing pouch
- Observing and reporting any changes to ostomy/stoma site
- Cleaning and disinfecting pouch

Emptying Pouch

Generally, to keep the weight of the bag/pouch from loosening its seal against the stoma, empty the bag whenever it becomes one-third to one-half full.

1. Gather supplies (gloves, washcloth) and wash/sanitize hands.
2. Have resident sit on or stand over the toilet.
3. Put on gloves.
4. Hold up the end of the pouch and remove the pouch clip or open the spout.
5. Empty the contents into the toilet.
6. With washcloth and warm water, wipe off the end of the pouch/spout inside and outside.
7. Replace the clip on the tail of the pouch or close the spout.
8. Observe the skin area around the pouch for change and, if any is noted, report to the LN and start an Alert Charting Log.
9. Appropriately discard the supplies used.

Changing Pouch
Following are general guidelines for changing an ostomy pouch, but steps should be adapted as necessary to accommodate different pouch systems.

Usually, a pouch will be attached to the body using an adhesive “wafer” that sticks to the skin. One type of system is a wafer and pouch already joined together, but a 2-piece system involves separate components, and the pouch must be fixed to a wafer and unfixed later. Pouch system wafers for application to skin around a stoma can be uncut or pre-cut.

Unlicensed staff assisting for this task must use ONLY pre-cut wafers.

Pouch systems vary for adhesiveness and durability, and, generally, can be expected to last from three to seven days of continuous wear. Changing too frequently or wearing one too long can be damaging to the skin. Itching or burning is a sign that the wafer should be changed, as follows:

1. Gather supplies (gloves, washcloths, new pouch and any adhesive/skin care products indicated in physician orders).
2. Wash or sanitize hands and put on gloves.
3. For a 2-piece system, removed soiled pouch and discard in the garbage can.
4. Remove a wafer from skin by gently pulling on the wafer while pushing on the skin until all areas are loosened; then discard the wafer.
5. Use a washcloth and warm water to clean the stoma and surrounding skin area.
6. Use a second washcloth to pat dry.
7. As treatment orders direct/allows, use adhesive/skin care products or powders before applying a new wafer/pouch system to the skin and invite resident input/preference.
8. Remove paper backing from a pre-cut wafer and apply to skin, with the stoma in the center of the wafer opening, and fix a pouch faceplate onto the wafer if necessary.
9. Gently rub around the wafer to assure removal of any air, especially edges between the wafer and the pouch faceplate.
10. Attach the supporting O-ring around the pouch faceplate collar.
11. Clip the end of the pouch, check the spout, or complete other details as needed.
12. Appropriately discard supplies.

13. Observe the skin area around the pouch for change and, if any is noted, report to the LN and start Alert Charting.

**OBSERVING AND REPORTING**

If you observe any of the following conditions for an “ostomy” resident, notify the LN and the resident’s physician:

- Severe cramps lasting more than 2 to 3 hours
- Any deep cut in the stoma
- Excessive bleeding from the stoma opening (or a moderate amount in the pouch, if ongoing for several emptying’s)
- Continuous bleeding at the stoma/skin junction
- Severe skin irritation or deep ulcers
- Unusual change in stoma size or appearance
- Severe watery discharge lasting more than 5 to 6 hours
- Continuous nausea and vomiting
- No ostomy output for 4 to 6 hours, with or without cramps or nausea
OXYGEN ASSISTANCE

Summary

- A resident receiving oxygen must have physician’s orders for its use, in self-administration or when assisted with its administration.

- Staff who assist with oxygen must receive instruction about safe usage, storage and equipment, as needed, depending on the assisted resident’s use parameters. The Executive Director should know, and provide direction about, any special requirements that apply for storing liquid oxygen containers that differ from those for oxygen gas.

- The name and phone number of the company providing oxygen and oxygen equipment to a resident, along with the detail of the oxygen use shall be entered on the resident’s service plan.

**DO NOT:**

Use oil or grease on the regulator, cylinder or oxygen tank.

Allow smoking within 115 feet of the oxygen. **NO SMOKING** is the rule.

Use hair spray or other flammable aerosol or an electric razor, hair dryer or heating pad around oxygen.

Change the flow rate of a tank without physician order.

Attempt to fill a liquid oxygen tank.

Procedure

- Follow resident-specific directions for the administration of oxygen, which should be stated in the physician’s orders; i.e.
  - When it should be administered – continuously or just part of the time.
  - How it should be administered – through a nasal cannula, humidifier or concentrator.

- Administer the oxygen from a tank or concentrator.

- The amount of oxygen to be delivered at one time to a resident will be written as liters per minute (L/M). For example, 2 L/M or 2 LPM means that the resident should receive 2 liters of oxygen every minute.
  - This “ordered” number should correspond with the oxygen equipment dial.

- Call the company providing the oxygen for questions or concerns about administration or the equipment supplied for the resident.

- Where or how the Oxygen is stored.
FIRST AID FOR WOUNDS

Summary

- Staff providing first aid for resident wounds shall be guided by physician or licensed nurse direction, and such care shall occur only according to state and licensing agency regulations.

- Physician’s orders received at the time of move-in for a resident shall be the general guidance/direction for first aid wound care provided to the resident.

Procedure

- Contact the Community nurse as soon as possible for any question about whether it is appropriate to treat a wound.

- Immediately report any wounds or skin changes to the Community nurse and the Executive Director, including any:
  - Skin redness
  - Bruising
  - Broken skin areas
  - Skin tears
  - Areas of drainage, etc.

- For minor skin tears and abrasions, follow the instructions on the physician’s standing orders for a resident.
  - Identify the injury on Alert Charting for current skin issues, which should prompt checking and treatment as required.
  - Complete an Alert Charting Log.
  - Always wash hands and wear gloves when providing care for minor skin tear/abrasion.

- DO NOT apply any medicated cream, lotion or dressing without a physician’s order.

- Immediately report possible signs of infection to the Community nurse and/or physician:
  - Increased redness
  - Increased swelling
  - Increased pain
  - Increased yellow or green drainage or oozing
  - Increased or changed color
  - Warm to the touch

- Place a resident on Alert Charting Log for charting wound care issues until the Community nurse indicates otherwise.
**All Tasks related to Insulin must be delegated or taught by the RN.**

**INSULIN ADMINISTRATION AND MONITORING**

Capillary Blood Glucose Monitoring

- Review order.
- Wash/sanitize hands.
- Gather equipment needed: alcohol wipes, lancet, lancet device, glucose monitoring machine, strip, sharps container, tissue and gloves.
- Put on gloves.
- Check resident for signs of hyperglycemia or hypoglycemia.
- Prepare the lancing device by inserting a fresh lancet.
- Wipe either side of end of finger with alcohol wipe and allow to dry.
- Turn machine on; look for code number that matches code on bottle of strips. Check expiration date on strips. Wait for display to indicate readiness and insert strip. Wait for display to indicate readiness for the blood sample to be applied.
- Hold lancet device firmly against side of finger, not too close to nail, and press button.
- Wait for a large drop of blood to form and briefly touch hanging drop to center of sample area on the strip. If you have difficulty getting a good drop of blood from the fingertip, try rinsing the resident’s fingers with warm water for a few minutes and then have them shake their hand below their waist. As a last result try milking (squeezing gently) the finger in a downward motion toward the fingertip.
- Have the resident apply pressure to the fingertip site with a clean tissue.
- Note the results displayed on the CBG machine. Discard strip and lancet in the sharps container.
- Record results on the MAR and compare to the acceptable parameters established by the physician.
- If the results are in a trouble zone (too high or low), notify the physician and/or initiate interventions as directed on the MAR.
- Remove gloves and wash hands.
Preparing Insulin for Administration

Prescribed insulin comes in various containers. You may be administering clear or cloudy insulin that comes in a:

- Small glass bottle, also called a vial.
- Disposable pen-like device called an Insulin Pen.
- A cartridge that is loaded into a re-useable insulin pen, or
- A Cartridge that is loaded into a small device called an insulin pump, worn by some people with diabetes.

Whether your resident’s insulin comes in a vial, pen, or pen cartridge, it will always have a prescription label. You need to read and check the prescription label, carefully, in just the same way that you do for other medications. This means that you follow the 7 Rights of Medication Administration before you administer insulin. When administering any medication, always check for the expiration date and never use expired medications. With insulin, there is one more rule to know about the expiration:

**After the first use, a container of insulin can only be used for a maximum of 28 days.** Even if the expiration date printed on a vial is three months away, you must stop using that vial 28 day after opening for first use. The 28-day rule is true for insulin that comes in a vial, an insulin pen or cartridge.

Rules for Insulin Storage

Insulin does not work properly if it gets too hot or cold, so there are several rules for safe insulin storage. Each rule applies to vials, pens, and pen cartridges unless a specific difference is noted.

- New or unused insulin should be stored in the refrigerator.
- Once a vial of insulin is opened or used, it can be stored either in the refrigerator or at room temperature. (Date and initial the insulin when you first use it).
- Once an insulin pen is in use, it must be stored at room temperature
- Do not use hot storage areas such as near a window or cold storage areas like a freezer.
Procedure for Preparing Insulin for Administration

- Review insulin for amount and time to be given.
- Remove selected vial from refrigerator. Check expiration date.
- Gather supplies: Insulin vial, alcohol swabs, retractable syringe for subcutaneous insulin injection marked in units. Wash hands.
- Check order, again, against insulin vial.
- Gently roll vial of insulin between the palms of your hands to mix. (Regular insulin does not need to be mixed.)
- Wipe off top of vial with alcohol wipe. Allow to dry.
- Draw up the desired amount of air into the syringe. (Same units you will be administering of insulin.)
- Insert the syringe into the vial. Insert air into the vial.
- With syringe in still in vial, draw up the desired amount of insulin into the syringe, slowly to prevent getting bubbles into the syringe.
- Recheck the order with the insulin you have drawn up before you withdraw the syringe.
- Remove syringe from vial and do not allow needle to touch any surface to prevent contamination. You should be ready to immediately give the injection. Recheck dose.
- The insulin is now prepared for administration.
Procedure for Giving a Subcutaneous Insulin Injection

- Review medication against MAR for amount to give and time to be given.
- Gather supplies: alcohol swabs, insulin syringe, tissue, gloves and sharps container.
- Wash/disinfect hands and put on gloves.
- For adequate injection site rotation, choose site after reviewing recently used sites indicated on the MAR or administration site map.
- Wipe administration site with alcohol wipe, using a firm, circular motion from the center outward. Allow to dry.
- Recheck medication to be given and time.
- Use your non-dominant hand to pinch gently the area around the injection site (approximately 2 inch fold) to form a cushion.
- Use your dominant hand, holding the syringe the way you would hold a pencil or dart. Insert the needle, quickly at a 90 degree angle. The needle should be completely covered by skin.
- Anchor the syringe or pen with your thumb and index finger of your non-dominant hand at the base. This will prevent the needle from moving below the surface.
- Release your hold on the tissue and slowly push the plunger in using a firm and smooth motion, until all medication is administered.
- Pull the needle straight out at the same angle that it was inserted.
- Immediately, dispose of the syringe in the sharps container. DO NOT put the cap on the needle.
- Gently press the injection site with a cotton ball or gauze. Do not rub or massage the area because this can speed up the action of the insulin.
- Remove gloves and wash hands.
- Document site of injection and administration performed.
- Do not re-cap the needle.
Preparing Insulin Injection Pen for Administration

Some insulin pens come pre-filled with insulin. These pens are disposable and are thrown away when empty. Some pens are re-useable and come with insulin cartridges that you load into the pen and unload when empty.

Insulin pens or their cartridges may contain a single type of insulin or they may contain two types of insulin pre-mixed together. No matter what type(s) of insulin the pen contains, the cartridge comes with a prescription label and an additional medication label on the pen cartridge. The process of checking for expiration dates and verifying the 7 Rights is the same for insulin pens as it is for vials.

Procedures

- Review medication against MAR for amount to give and time to be given.
- Gather supplies: alcohol swabs, insulin pen, needle, cotton ball, gloves and sharps container.
- Wash/disinfect hands and put on gloves.
- For adequate injection site rotation, choose site after reviewing recently used sites indicated on the MAR or administration site map.
- Wipe administration site with alcohol wipe, using a firm, circular motion from the center outward. Allow to dry.
- Recheck medication to be given and time.
- With an alcohol wipe, clean the top of the rubber vial top and place the needle and cap on the syringe.
- Prime the pen by injecting a small sample of insulin into the air (usually 2 units). Priming tells you that the pen is working and it removes air.
- Turn the dose knob to the number of units that is specified on the MAR. This dosage number will appear in the window.
- Recheck the order on the MAR against what the number on the pen is showing.
- Perform the injection process as indicated with a regular insulin needle.
- Use hemostat or needle remover on sharps container to remove and discard needle from pen. DO NOT RECAP.
- Remove gloves and wash hands.
- Document site of injection and administration performed.
SECTION V: OTHER MED TECH RESPONSIBILITIES

HEALTH CARE AGENCY

Summary

Medication Assistants can be designated to coordinate with health care agencies from outside the Community, including those related to home health (physical or occupational therapy, mental health, speech therapy, etc.), hospice care and private duty attendants.

Procedure

Med Tech steps to coordinate can include the following, as designated:

1. Obtain a written physician’s order for the recommended service. (Exception: No order is needed for a private duty attendant.)
2. Have the ordering physician contact the recommended agency if necessary (or confirm contact).
3. Before any service begins, complete and secure signature for the form Outside Health Care Agency Service Acknowledgment (Attachment M), according to its instruction.

NOTES:  
   a. Obtain a supply of forms from the nurse or Executive Director.
   b. DO NOT sign the form; only the Executive Director, the DNS or nurse consultant may sign as the Community representative.

4. Update the service plan for the resident receiving service, to specify the following:
   a. Condition requiring treatment
   b. Service(s) being provided
   c. Name of the agency providing service, with the contact information for day and evening
   d. When the agency should be contacted about the resident’s condition between visits or after hours.

5. When an outside health care agency provider visits the Community:
   a. Verify identification from the provider.
   b. Accompany the provider to the resident’s apartment.
   c. Request the provider to document in the facilities Professional Communication Binder information about the visit, the plan of care for the future, etc.
   d. Notify the nurse about the visit.

NOTE: DO NOT agree to be delegated for any care without approval from the Community LN or the Executive Director.

   Hospice: when a hospice agency is providing service to a resident, the following apply:
   a. Attach with the acknowledgement form the original plan(s) of care provided by hospice.
b. After hospice service begins, always notify the hospice nurse FIRST (not Community staff) about pain issues, change in condition or death, and the appropriate management staff next.

FIRST AID / EMERGENT SITUATIONS

Summary

- The Med Tech assigned for a shift is the person in the Community designated to have primary responsibility for emergency medical services and for assisting residents as needed with administration of medications.

NOTE: All staff should know where to find the Community’s emergency procedures for response to environmental situations. Discussion here is limited to medical conditions.

- Emergency services responsibility (above) is limited to providing first aid or CPR for immediate resident need in a medical or environmental emergency, and seeking other aid as necessary and appropriate. A Med Tech who is assigned this responsibility must be current for First Aid and CPR training.

Requirements

- The Executive Director (or designee) shall confirm that the name of the Medication Assistant is posted in a conspicuous place and made known to all residents and staff, when that Med Tech is responsible for “as needed” assistance to residents for
  - Administration of medication
  - First aid
  - Other emergency medical services support

- Staff shall maintain a complete first aid kit readily available in the medication room, which should be a general type kit approved by the American Red Cross or it must contain the following:
  1. Current edition first aid manual approved by the American Red Cross, the American Medical Association or a state or federal agency.
  2. Sterile first aid dressings
  3. Bandages or roller bandages
  4. Scissors
  5. Tweezers

- For resident not breathing or without a pulse, initiate the procedure elsewhere in the manual: “Resident Medical Emergency.”

- For a deceased resident, refer to the separate procedure document in this manual.

Otherwise, initiate the steps below:

Procedure

1. Stay calm and reassuring to staff and other residents.
2. If in doubt about whether a situation should be considered an emergency, call 911 and determine need for assistance from outside the Community.

**NOTE:** As necessary, refer to the “Resident Medical Emergency” direction in this manual and follow that procedure after calling 911.

3. If necessary, perform appropriate First Aid steps to secure a resident’s injury site.

4. Notify the supervisor and/or the Executive Director and determine who will notify the resident’s family or contact person.

5. Prepare an incident report and an Alert Charting Log form. IR not necessary unless the reason you are sending the resident out is an incident ie fall, broken bone, wound etc. Cardiac arrest, respiratory arrest, infection, increased confusion, behaviors, are not an IR. Chart a progress note and place on ALERT when they return.

6. As required, notify the nurse and observe any First Aid administration to a resident (in addition to #5 requirements above).
RESIDENT MEDICAL EMERGENCY

Summary

- Med Tech staff shall be familiar with Community procedures for handling emergencies and should be timely and efficient in response when a medical emergency occurs.
- Staff shall know that ONLY the resident can decide whether to accept or decline emergency medical treatment and must decline to the Emergency Personnel directly.
- In an emergency that requires a treatment decision (accept or decline), if documentation of legal authority for that decision is not in a resident’s record or readily available for review, staff shall oversee the process described here, to

  Transfer the resident outside the Community for evaluation and treatment.

NOTES:
A “person with legal authority” as a health care representative might be an attorney-in-fact, a “guardian” or designee selected and authorized by the resident to make health care decision, or a court-appointed guardian with authority to make health care decisions.

A financial representative/attorney or someone with general power-of-attorney DOES NOT have the authority to make health care decisions unless a document specifically designates that authority.

Medical Response
- Steps here apply for major medical emergencies. Staff should refer to other direction about First Aid/emergent situations not involving responders from outside the Community.
- For a deceased resident, refer to the separate response procedure in this manual.

Otherwise, initiate the steps below and proceed as applicable for the CPR/First Aid conditions below or other factors.

CPR Action
Med Techs must know the state regulations that apply for a situation when a resident’s heart stops beating or he/she appears to cease breathing (in the Community, on Community grounds or in a Community vehicle.) Note the conditions for each of the following situations.

A. Unless prohibited by regulation, staff should not initiate CPR/First Aid for a resident who has a DNR order on file. Instead, call 911 and wait for emergency personnel to arrive.

B. Where regulation prohibits the process above, staff should call 911 and appropriately trained staff should initiate CPR and continue until emergency personnel arrive to evaluate the resident and take responsibility for applying the DNR order.

C. When a resident is conscious and directly requests CPR, then ignore the DNR order in the resident’s record. (Such a request would be for the present situation only and, as applicable, the Executive Director should assist later for resident review of the directive on file).

Procedure
1. Proceed to #2 except when a resident is not breathing or is without a pulse, which requires action as follows:
a. **Call 911** or have someone else call

b. **Initiate CPR** by trained and authorized staff if indicated on the resident’s CPR document or if resident’s intent (CPR/no CPR) is not known. Do not initiate when resident has directed “no CPR”.

c. **Notify hospice** as soon as possible if the resident is receiving hospice care (CPR or no CPR).

d. **If death occurs** (or has occurred), initiate the Deceased Resident procedure elsewhere in this manual.

2. For other situations, such as listed below, **call 911** if necessary; **AND go back to step #1 if the resident stops breathing**.

   o Resident injury fall
   o Sudden change in resident condition (such as becoming non-responsive to stimuli, severe pain, broken bones, etc.)
   o Any situation perceived as life threatening
   o Other, if directed by the Executive Director, Community LN or a physician

3. **DO NOT leave the resident alone in an emergency. Give First Aid if appropriate.**

4. After any 911 call, prepare copies (or designate someone to prepare) of all the following information, as applicable for the resident, to give to the emergency responders when they arrive:

   a. Medication sheet – both front AND back
   b. Service plan Medical History sheet
   c. CPR directive
   d. All POLST and/or CPR/no CPR sheets (or related state-specific documents)
   e. Medicaid card, if applicable
   f. Any recent Alert Charting notes that might explain the situation

5. Return all documents used for copies to be stored in their proper locations.

6. As possible, dismiss non-essential persons before responders arrive and keep hallways clear.

7. When responders arrive, give them the paperwork copies and direct them to where the resident is located.

8. If the resident is transferred out of the Community or as necessary for any other reason, **notify** as soon as possible all of the following:

   a) Resident primary contact;
   b) Resident’s physician;
   c) Community nurse;
   d) Executive Director

9. **Complete an incident report** to document the emergency incident.

10. List resident “out of community” on the 24 Hour Report.
DECEASED RESIDENT

Summary

- **FIRST**, notify the Executive Director (or designee) and follow any direction provided.

- The Executive Director should know and convey to any staff that needs the information, any regulatory requirements that apply for a resident death in the Community, including whether a “human remains release” form is required.

- Advise the Executive Director (or designee) if the deceased resident’s condition and/or environment indicated anything suspicious or out of the ordinary; and, if necessary, confirm direction to staff about the following:
  - As possible, avoid touching anything.
  - Do not move the resident or any contents in the room.
  - Remember any significant smell, appearance or other indicator.
  - Lock the room.
  - Other measures that seem sensible for the circumstances.

- Determine if the resident was in a hospice program and begin the procedure below at either step #1 or #2.

- Fill out the *Record of Resident Death form* (Pg. 92 - Attachment N). Community staff, not hospice, should complete the form. Make sure that all items left on resident’s body are listed on this form, i.e. jewelry, watch, etc.

- Make a copy of the form to mail to Physician, and put the original in the Resident Records.

Procedure for Hospice Resident

1. If hospice is involved, determine whether the representative is on the premises.

   **Hospice is NOT present**

   a. If hospice is involved, and **not** present in the Community, notify the resident’s hospice attendant or service group and
      - **DO NOT CALL** the family, physician or local authority.

   b. On the Record of Resident Death form, note the hospice representative’s name, the date, and the time of **notification**.

   **Hospice IS present**

   c. If hospice is involved and the resident’s representative is present, use the Record of Resident Death form to document the representative’s name and the date and time for hospice presence at death.

   d. With the hospice representative, determine who will make the contacts indicated in the next step, #2. The calls can be made by
      - Hospice,
ii. Community staff assisting hospice (only after hospice agrees) or
iii. Staff beginning at step #2.
e. If hospice makes any contacts, staff must obtain form information details.

2. If hospice is NOT involved, and if applicable, document notifications indicated on the form as underlined below.

a. Local authority (medical examiner, coroner, etc.): If contact information is not known, the local law enforcement agency or 911 can advise which official should be summoned.

b. The primary contact person named in the resident’s folder on the resident’s information sheet.

   i. If the resident information sheet does not indicate a funeral home, ask the contact person to designate one.

   ii. When the funeral home is decided, ask whether the contact person (or family) will call or would like the Executive Director/designee to do so.

c. The resident’s physician. Document on a “Physician Communication” form.

3. **Before removal of the body**, secure a signature on the Community record form from the coroner, medical examiner, funeral home representative or other person who removes the body.

   NOTE: In addition, the Med Tech (or other staff) signing a “release” form, if any is required, should make and retain a copy of the document after signing.

4. Advise the person in charge for removal to avoid the building’s public areas if possible, and help decide which will be the best route to take.
REFRIGERATOR MONITORING

Summary
- The assigned Med Tech must check daily to confirm that the refrigerator used to store medications maintains temperature between 36° and 40°F.

Procedure
- Each month, retrieve and complete a copy of the Refrigerator Temperature Control Log (Pg. 93 - Attachment O).
- Two refrigerator thermometers must be checked daily to assure temperature is within range. If one thermometer stops working or is out of range, it must be replaced and check again.
- Document results of monitoring on the form, and retain the current log form in the MAR binder.
- Identify any temperature discrepancy (any temperature reading not within the 36-40°F range) and immediately notify the supervisor in charge.
- DO NOT continue to use a refrigerator not functioning at proper temperature; and arrange an alternate area for medication storage if necessary to meet state and pharmacy regulations that apply.
- DO NOT store anything other than medications in the Medication Refrigerator.

Deliver used log forms to the nurse or Executive Director (for the Community QA binder).
CBG MACHINE TESTING (Delegate Task)

Summary
Per the schedule below, staff (usually a designated Med Tech) must check for proper function of the equipment used to monitor resident blood glucose levels. Test as follows:

- Prior to use of new equipment
- After opening a new container of test strips
- Anytime indicated test results are not consistent with resident symptoms
- On suspicion that equipment is not functioning properly
- Weekly unless state regulation or manufacturer directs a different schedule for testing

Additional discussion and training will be presented at the time of RN delegation

Procedure
Each month:

- Retrieve and complete a copy of the attached form CBG Machine Testing Log (Pg. 94 - Attachment P).
- Test the CBG machine as follows:
  - Check the expiration date of the control solution and DO NOT USE outdated solution.
  - Turn on the machine and match the code number displayed on the screen with the code on the test strip container and, if necessary, change the machine code to match.
  - Insert the test strip into the machine and apply to it a small drop of the control solution.
  - Compare the reading displayed on the screen with the chart/information on the test strip container and determine whether test results are within the acceptable range.
    - Because acceptability ranges differ among machines, manufacturer direction must be the basis for determining test results.
  - If results are not within the acceptable range, repeat the testing process.
  - If repeat testing does not indicate an acceptable result, call the number on the back of the machine to contact the manufacturer, identify test results and seek direction about replacement alternatives.
  - Document each functional test on the form and retain a current log form in the MAR binder.
- DO NOT USE equipment if testing indicates it is not functioning properly; and immediately notify the supervisor in charge about the test results.
- Deliver used log forms to the nurse or Executive Director (for the Community QA binder).
SECTION VI: FORMS

TABLE OF CONTENTS

1. Incident Occurrence Report and Investigation — Attachment A
2. Resident Photograph – Attachment B
3. Community/Physician Communication — Attachment C
4. Medication Receipt Log — Attachment D
5. Medication Disposal Log — Attachment E
6. Shift Count Narcotics Verification — Attachment F
7. Individual Narcotic Record — Attachment G
8. Progress Notes – Attachment H
9. Outside Health Care Agency Service Acknowledgment — Attachment I
10. Record of Resident Death — Attachment J
11. Refrigerator Temperature Control Log — Attachment K
12. Medication Error Report – Attachment L
13. Med Room House Sock Formulary – Attachment M
14. CBG Machine Testing Log — Attachment N
15. Alert Charting Log – Attachment O
### Incident - Occurrence Report and Investigation

To be completed by the staff member on Duty who witnessed or found the subject of this Incident Report. **This form must be filled out during the shift the incident occurred**, and submitted to the Community Licensed Nurse or Executive Director, prior to shift end.

Community Name: __________________________ Person Involved: __________________________________________________________________________
Apt. #(if applicable): ______ (Check One) □ Resident □ Visitor □ Staff □ Other: ____________________________________________
Date of Occurrence: ___________ Time of Occurrence: _____am/pm Location of Occurrence: ___________

#### Type of Occurrence:

- □ Fall
- □ Witnessed Fall
- □ Un-witnessed Fall
- □ Found on Floor
- □ Res. To Res.
- □ Res. To Staff
- □ Staff to Res.
- □ Choking/Aspiration
- □ Transfer related
- □ Equipment Failure
- □ Missing Resident
- □ Unknown
- □ Other

#### Nature of Injury:

- □ Abrasion (Size)________________
- □ Pressure Area (Size)________
- □ Skin Tear (Size)______________
- □ Bruise (Size)________________
- □ Laceration (Size)_____________
- □ Burn (Size)__________________
- □ Hematoma (Size)______________
- □ Complaint of Pain (Type & location):

- □ Swelling/soft tissue
- □ No Visible Injury
- □ Unknown
- □ Other (Describe)________________

#### Response to Injury:

- □ First Aid Given (Describe): ____________________________________________
- □ Physical Assessment (ROM): ____________________________________________
- □ Called 911
- □ On Hospice □ Hospice Notified
- □ Sent to Doctor’s office □ Sent to Urgent Care Clinic □ Sent to hospital/ER
- □ Other (Describe): _______________________________________________________

Vital Signs: T ______ P ______ R _____ BP ______

**Description of Occurrence:** (i.e. what was the person doing? What was the environment condition, i.e.: Lighting, floor surface, icy, throw rug, etc. Be factual, don’t speculate. **List names of all staff, residents, visitors, etc., involved or who witnessed the incident.** *(Chart on back of this form if you need more room)*

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What was the victim’s statement as to the cause? **(Please only list exact facts and/or statements – do not speculate):**

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Was there any change in the environment such as foreign object, liquid on the floor, throw rug, etc.
____________________________________________________________________________________

What position was the person found in? Were Supportive devices in use, i.e. cane, walker, eye glasses, etc.
____________________________________________________________________________________

What was the person wearing at the time of the incident including shoes?
____________________________________________________________________________________

Notifications:

☐ Physician: By phone, #: ___________________ By fax, #: ___________________
  Date __________ am/pm

☐ Family/Responsible Party: By phone, #: ___________________
  Date __________ am/pm

☐ Law Enforcement
  Date __________ am/pm

☐ Fax to Home Office
  Date __________ am/pm

☐ Licensed Nurse Notified
  Date __________ am/pm

☐ ED Notified
  Date __________ am/pm

☐ Resident placed on Alert Charting
  Date __________ am/pm

(Report Incidents Listed Below to Home Office)

♦ Outbreaks of illness such as Norwalk-like viruses or food poisoning;
♦ Suspected abuse;
♦ Incidents of violence or threats of violence by residents, visitors, staff, phone calls, written correspondence or others;
♦ Incidents or occurrences involving visitors, guests or vendors;
♦ Investigation of incident by a State Regulatory Authority;
♦ Incidents involving property damage or vehicles.

Action taken to resolve incident and prevent further occurrences?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Examples of health problems that can contribute to an incident: UTI, pain, medications, constipation, incontinence, unstable BP, limited strength or range of motion, sensory impairment, decreased mental functioning, unstable or change in medical condition, acute illness, etc.

Were there any health problems, medications or other conditions that could have contributed to the incident?: _____ NO _____ YES
If “Yes”, explain:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Person Filing Report: ____________________________ Signature ____________________________ Date __________

Executive Director Review: ____________________________ ____________________________ __________

Licensed Nurse Review: ____________________________ ____________________________ __________
To be completed by Executive Director, or Facility Nurse

<table>
<thead>
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<th>Administrative Review and Investigation</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was resident’s service plan being followed at the time of the incident?</td>
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<tr>
<td>Were staff following all/any applicable policy or procedures?</td>
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<tr>
<td>Was resident put on Alert Charting?</td>
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<tr>
<td>Was the incident avoidable?</td>
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<td>Was any policy/procedure or system changed as a result of this incident?</td>
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<tr>
<td>Was there staff training as a result of this incident?</td>
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<tr>
<td>If indicated, was resident’s Service Plan revised?</td>
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<tr>
<td>Medications reviewed?</td>
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<tr>
<td>Has resident had similar incidents?</td>
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<tr>
<td>Is there any reason to suspect abuse or neglect?</td>
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</tbody>
</table>

If there is reason to suspect abuse, was SPD/APS notified? Date: ______________ Time: __________

Summary assessment of contributing factors:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Results of resident and Staff interviews. Include resident mental status, sleeping, alert, behavioral, etc.
________________________________________________________________________
________________________________________________________________________

Has similar incident occurred before? If “Yes”, provide dates and interventions.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What steps are being taken to prevent further occurrence of this incident?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Person Completing Incident/Occurrence Investigation:

_________________________________________________________ Date: __________

Signature Facility Nurse Signature: ___________________________ Date: __________

Executive Director Signature: _______________________________ Date: __________

ATTACHMENT A
RESIDENT PHOTOGRAPH

Place photograph above

Resident Name: ____________________________

Apt. Number: ____________________________

Approximate Date of Photograph: ________________

(When no longer current, retain this sheet in the resident record)
### COMMUNITY / PHYSICIAN COMMUNICATION

<table>
<thead>
<tr>
<th>Community Name:</th>
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<tr>
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<tr>
<td>City/State/Zip:</td>
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<td>Phone:</td>
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<td>Fax:</td>
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<td>Resident:</td>
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<td>Physician:</td>
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<td>Resident DOB:</td>
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<td>Apartment #:</td>
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<td>Date:</td>
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</table>

#### Community Comments/Concerns

- [ ] Information Only
- [ ] Response Needed

#### Physician’s Response/Orders

(Complete duration of order section below)

These orders are to be in **effect for the next 180 days** unless physician directed otherwise. **Not 180 days** – Orders to be in effect for (physician circle selection): 30 days 60 days 90 days OTHER

---

Community Staff Signature  
Physician Signature

---

For Community Use Only

<table>
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<tr>
<th>Task</th>
<th>Date</th>
<th>Initials</th>
<th>Task (as applicable)</th>
<th>Date</th>
<th>Initials</th>
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<td>Noted on MAR</td>
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<td>Sent for medical records only</td>
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<td>Faxed to Pharmacy</td>
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<td>Notified Responsible Party</td>
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ATTACHMENT C

Revised 12-2016
# MEDICATION RECEIPT LOG

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<tr>
<th>RESIDENT’S NAME</th>
<th>MEDICATION NAME</th>
<th>RX NUMBER</th>
<th>DATE RECEIVED</th>
<th>AMOUNT RECEIVED</th>
<th>MT INITIALS</th>
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**ATTACHMENT D**
# MEDICATION DISPOSAL LOG

Indicate below for Disposal Method, one of the following codes: **P** = returned to **Pharmacy**; **R** = returned to **Resident** or family; **D** = **Destroyed**. If **D**, indicate how:

<table>
<thead>
<tr>
<th>RESIDENT’S NAME</th>
<th>MEDICATION NAME</th>
<th>RX NUMBER</th>
<th>DISPOSAL DATE</th>
<th>DISPOSAL AMOUNT</th>
<th>REASON FOR DISPOSAL</th>
<th>DISPOSAL METHOD P/R/D-HOW</th>
<th>VALIDATING SIGNATURE(S)</th>
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**ATTACHMENT F**
INDIVIDUAL NARCOTIC RECORD

(If extra pharmacy label available, attach for fill-in below.)
Rx No.____________________________________________
Dr._______________________________________________
Resident Name: _____________________________________
Medication: _________________________________________
Amount Received: ___________________________________
Dosage/Frequency: ___________________________________

Date: ______________________________
Disposition: _________________________
Signature: __________________________
Signature: __________________________

Delivery Date: _______________________

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<tr>
<th>DATE</th>
<th>TIME</th>
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(Store forms in MAR binder while current, and in the resident’s record when complete.)

ATTACHMENT G

Revised 12-2016
# PROGRESS NOTES

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Resident: ______________________  MD _____________  Apt.____

ATTACHMENT H

Revised 12-2016
OUTSIDE HEALTH CARE AGENCY
Service Acknowledgment

Resident Name: ________________________________ Service Start Date: ________________

Agency Name ________________________________ Phone Number: ________________

Services Provided:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
**Refer to the policy about use of this form for a hospice agency.**

Frequency of Services (check one):
☐ Daily  ☐ Weekly  ☐ 2X/Week  ☐ 3X/Week  ☐ 4X/Week  ☐ Other (specify): __________________

Duration of Services (approximate total time frame): __________________________________________
_____________________________________________________________________________________

CONTACT INFORMATION:

(check one):  ☐ Resident  ☐ Community
Daytime: __________________ Evening: __________________

Agency Contact Information:
Daytime: __________________ Evening: __________________

I understand that the services described above shall be provided for the duration of this agency’s involvement with the named resident in this Community until the services have been either changed or discontinued by order of the resident, the resident’s family or responsible party, or the resident’s physician.

I further understand that the agency representative will provide documentation after each visit to indicate the resident’s status/condition and the services received.

Community Representative Signature ___________________________ Date ________
(Must be Executive Director, RCC, or Community Nurse)

Agency Representative Signature ___________________________ Date ________
(Retain in the Professional Healthcare Binder until no longer current; then, retain/store in the resident health record.)

ATTACHMENT I
RECORD OF RESIDENT DEATH  (NOTE: To be completed by Community staff – not hospice)

Community Name: ________________________________
Address: ___________________________ Telephone: _________________________
Resident: ___________________________ Apartment: ________________________

Date of Death: ___________ Staff / Hospice (circle one) aware of death at: ________ am/pm

Notifications (contact name / time notified / initials of who made the call)  Time (circle am/pm)  Initials
Hospice: ___________________________ Time: __________ am/pm  ________
Local Authority: _________________________ Time: __________ am/pm  ________
Family: ___________________________ Time: __________ am/pm  ________
Physician: ___________________________ Time: __________ am/pm  ________
Community Nurse: ___________________________ Time: __________ am/pm  ________
DNS: ___________________________ Time: __________ am/pm  ________
Other: ___________________________ Time: __________ am/pm  ________

Did Hospice make any notifications? ☐ Yes ☐ No  Comment: ___________________________

Funeral Home: ___________________________ Time notified: __________ am/pm
Contact name: ___________________________ Telephone: __________________

When body is removed (by ME, Coroner, funeral home, etc.), complete the following:
Contact name: ___________________________ Time notified: __________ am/pm
Telephone: ___________________________ Time body was removed: __________ am/pm

Valuables/Items sent with body: ___________________________

Name of person removing the body (Print): ___________________________
Signature and Title: ___________________________

Staff member present (Print): ___________________________
Signature and Title: ___________________________

This document reviewed by: ☐ Community Nurse  ☐ Executive Director
Name (Print): ___________________________
Signature: ___________________________

1. Send a copy of this completed form to the resident’s physician with copy of current MAR attached.
2. Maintain original form in the resident’s record.
**REFRIGERATOR TEMP CONTROL LOG**

<table>
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<tr>
<th>Day of the Month</th>
<th>Refrigerator Temperature</th>
<th>Medication Room Temperature</th>
<th>Freezer Temp If medications stored in freezer</th>
<th>Notes/Comments</th>
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86°F. Medications requiring refrigeration should be stored at temperatures 36°F to 46°F. Medications that should be frozen should be stored in the freezer at -13°F to 14°F. CDC recommends the above refrigerator temperature range for storage of most vaccine and monitoring twice daily when storing vaccines.
MEDICATION ERROR REPORT

Resident Name: ________________________________________________ Apt: _____________

Date of Incident: ____/____/______ Medication ___________________ Time of Incident: _______ A.M.  P.M.

Describe the incident (please attach any evidence associated with this report):

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Immediate Actions Taken
☐ Resident Monitoring ☐ MD/NP/PA orders followed
☐ Sent to ER ☐ Seen by MD/NP/PA in office
☐ Licensed nurse instructions followed (indicate instructions given):
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Person discovering incident: ______________________ / ______________________
Print Name                                    Sign Name

Error Review
☐ No Error (Potential)

Type of Incident ("No Error" checked, do not indicate type)
☐ Medication Omission ☐ Wrong Technique

☐ Wrong Dose ☐ Wrong Route
☐ Wrong Dosage Form ☐ Wrong Time
☐ Wrong Resident ☐ Monitoring Error
☐ Clinical ☐ Deteriorated Drug Error
☐ Other: _____________________________________________________________________________

Cause/Causes
☐ Communication ☐ Drug Name Confusion
☐ Labeling ☐ Packaging
☐ Knowledge Deficit ☐ Performance Deficit
☐ Recopying MAR ☐ Transcription Error
☐ Other:

Corrective Action/Actions
☐ Policy and procedure reviewed (attach evidence) ☐ Training held (attach evidence of training)
☐ System reviewed & corrected ☐ Discipline action taken (attach evidence)
☐ Issue discussed with pharmacy ☐ Other:

Summary of Findings (including outcome to resident):

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Administrator Signature                                      RN Signature

☐ Notified MD/NP/PA Date: __/__/__ Time: _____ A.M.  P.M. Whom:
☐ Notified Resident/Family Date: __/__/__ Time: _____ A.M.  P.M. Whom:
☐ Notified RSD Date: __/__/__ Time: _____ A.M.  P.M. Whom: ____________________________
POLICY

It is the policy of this facility that the medication room within the Community will be kept stocked with basic supplies that ensure resident safety.

PROCEDURES

The list of supplies, as outlined on the Ageia Med Room Formulary List, should be obtained from approved vendor(s), and items kept in stock in the community med room, per the formulary. Any other purchases and supplies will need prior approval from the VP of Operations and/or the Company President. The community LN, or designee, will conduct a monthly inventory audit, and re-order supplies as needed, to assure adequate inventory is consistently on hand to meet unscheduled resident needs.

FORMS

Med Room Formulary List
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<tr>
<th>ITEM</th>
<th>QUANTITY</th>
<th>TYPE/DESCRIPTION</th>
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<td>Complete First Tech Kit</td>
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<td>Blood Spill Kit</td>
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<td>4x4 gauze</td>
<td>100 ct., or less</td>
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<td>Telfa 3 x 4 pads</td>
<td>100 ct., or less</td>
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<td>Various size bandaids</td>
<td>100 ct.</td>
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<td>Self-adhesive rolled gauze</td>
<td>150 ct. or 300ct.</td>
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<tr>
<td>Steri-Strips (Medi-strips)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Standard Bandage Scissors</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equipment</strong></td>
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</tr>
<tr>
<td>Refrigerator Thermometers</td>
<td>2 per ea. Frig.</td>
<td></td>
</tr>
<tr>
<td>CPR Masks</td>
<td>2 at all times</td>
<td></td>
</tr>
<tr>
<td>Stethoscopes</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure Cuffs</td>
<td>1 sml., 1 large</td>
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</tr>
<tr>
<td>Protective Goggles</td>
<td>2 at all times</td>
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</tr>
<tr>
<td>Disposable Protective Gowns</td>
<td>2 at all times</td>
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</tr>
<tr>
<td>Small Hand Sanitizers</td>
<td></td>
<td>Constant supply</td>
</tr>
<tr>
<td>Pill Counter</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pill Cutter</td>
<td>1</td>
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</tr>
<tr>
<td>House CBG Machine</td>
<td>1</td>
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</tr>
<tr>
<td>Tympanic Thermometer</td>
<td>2</td>
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</tr>
<tr>
<td>Thermometer probe covers</td>
<td></td>
<td>Constant supply</td>
</tr>
<tr>
<td>Nail clippers</td>
<td>2</td>
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</tr>
<tr>
<td>Sharps container (sz. Dep. On community.)</td>
<td>1</td>
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</tr>
<tr>
<td><strong>House Stock Medications</strong></td>
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<tr>
<td>Acetaminophen - 325 mg.</td>
<td></td>
<td>Constant supply</td>
</tr>
<tr>
<td>Acetaminophen - 500 mg.</td>
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<td>Constant supply</td>
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<tr>
<td>MOM (Milk of Magnesia)</td>
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<td>Constant supply</td>
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<tr>
<td>Bisacodyl Suppositories - 10 mg.</td>
<td>10 at all times</td>
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<tr>
<td>Fleets Enemas</td>
<td>5 at all times</td>
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<tr>
<td>Aluminum Hydroxide Magnesium Hydroxide (Antacid)</td>
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<td>Barrier Cream</td>
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<td>Constant supply</td>
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<tr>
<td>Colace Drops</td>
<td>1 bottle</td>
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<tr>
<td>Anti-fungal Cream</td>
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<td>Constant supply</td>
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<tr>
<td>Alcohol Prep Pads</td>
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<td>Supply</td>
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<tr>
<td>Test Date</td>
<td>Control Solution Exp. Date</td>
<td>Test Strip Code #</td>
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Revised 12-2016
## Alert Charting Log

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<tr>
<th>Date</th>
<th>Resident Name/Apt</th>
<th>Reason for Alert</th>
<th>What to Observation and Report</th>
<th>Frequency of Alert</th>
<th>Length of Alert</th>
<th>DC’s</th>
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</thead>
<tbody>
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</table>

*Acceptable abbreviations:*

- **NIF** = Non-injury fall
- **IF** = Injury fall
- **NM** = New Medication
- **S/Sx** = Signs and symptoms
- **SE** = Side Effects
- **O/R** = Observe and report
- **C/O** = Complaints of