

MEDICATION MANAGEMENT

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This information is intended as a general guide only. For specific questions,
it is critical to communicate directly with the resident's doctor.

Prepared by the Department of Human Services
Addictions and Mental Health Division

For Addictions and Mental Health Division Licensed Providers
Adult Foster Homes (AFH)
Residential Treatment Facilities (RTF)
Residential Treatment Homes (RTH)
Secure Residential Treatment Facilities (SRTF)

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If you need this document in an alternate format, please contact
the AMH at 503-945-5763

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SECTION 1:

**THE PROVIDER'S ROLE AND RESPONSIBILITY IN
THE ADMINISTERING OF MEDICATIONS TO
RESIDENTS**

The Provider's Role in Medication Management

- ◆ Understand, follow, and document doctor's orders.
 - Clarify instructions if unsure.
 - Be familiar with intended actions of medications.
 - Where possible obtain information sheets on each medication from the doctor or the pharmacy.

- ◆ Know possible adverse reactions and interactions.
 - Monitor and record medications taken by the resident.
 - Observe and record adverse effects of medications.
 - Report any adverse effects to the ordering prescribing doctor.

- ◆ Be sure that all caregivers understand procedures and are capable of medication management.
 - Work with health professionals to ensure safe and effective medication use by residents.

- ◆ Safely store, dispense, and dispose of medications.

General information and mandatory requirements for all licensed providers.

A written order signed by a physician or other qualified health care professional **is required** for all medications administered in a licensed facility. **A signed** written order is required before any medication and/or delegation is provided to a resident. **This includes:** PRNs, (see p25) over the counter medications, treatments, therapies, vitamins, and special diets.

Medications prescribed for one resident shall not be administered to another resident, or residents that self-administer their own medications cannot administer to other residents.

Medications are to be stored safely in a locked area and each resident's medications shall be stored separate from another resident's and/or the family medication.

Receipt verification of the medication received and the prescribers order/prescription is critical.

- Verify the receipt of the medication by visually matching the MAR (see p22) you prepared or pharmacy MAR record against the actual medication received and then verify the MAR against the most current written order(s).

The provider/manager/administrator or delegated individual(s) has the responsibility to identify any/all problem(s) and have them resolved in a timely manner.

- Immediately contact the pharmacy if there is a discrepancy of any kind or the manner in delivery has changed.

Stock supplies of prescription medications shall not be maintained. You may however, maintain a supply of non-prescription medications to be used based on a written, signed doctors order. *(In an Secure Residential Treatment Facility a variance can be requested.)*

In RTF and/or RTH licensed facilities, there must be a written Policy and Procedure which assures and is verifiable that all orders for prescription drugs are reviewed by a qualified health care professional not less often than every six months.

In AFH licensed facilities the provider shall list for each medical and psychiatric prescriber visit, all of the current prescribed medications. The prescriber is asked to review and make any changes that the caregiver is to be made aware of.

SECTION 2:

**AN OVERVIEW OF COMMONLY PRESCRIBED
MEDICATIONS AND THEIR POSSIBLE SIDE
EFFECTS.**

Overview of Medications and Side Effects

How drugs work in your body.

How drugs work depends upon:

1. Absorption
 e.g. How fast the medication is taken up by the stomach and enters the blood stream.
2. Distribution
 e.g. Some medications enter most body tissue equally, others tend to be stored more readily in the fatty tissues.
3. Metabolism
 e.g. Some medications are changed by the liver into other active or inactive compounds.
4. Elimination
 e.g. Some medications are changed by the liver, others primarily by the kidneys.

All medications can have side effects.

What are side effects?

They are additional unwanted responses to a medication that accompany the intended response. They may be uncomfortable or even dangerous.

- Look for and recognize the side effects

General Categories of Medications

Medications are known by two names, a “brand name” and a “generic name”. In the following, the more commonly used brand or trade name is used.

**Drugs that affect the
NERVOUS SYSTEM****Anti-anxiety**

(Often also referred to as minor tranquilizers)

These medications are most often prescribed for the treatment of anxiousness and anxiety disorders.

Side effects: drowsiness, dizziness, restlessness, nausea, and lethargy.

Examples: Xanax, Buspar, Ativan, Vistaril, Librium, and Valium.

Anti-psychotics

(Often also referred to as “neuroleptics” or “major tranquilizers”)

Medications are generally prescribed for the treatment of psychotic disorders, schizophrenia, some non-psychotic behavioral disorders and Tourette’s syndrome.

Side effects: Muscle spasms or stiffness, restlessness, sedation, dry mouth, dizziness, ocular or vision changes, urinary retention and impotence, abnormal involuntary purposeless movements involving the face, especially the mouth limbs and trunk (tardive dyskinesia).

Examples: Prolixin, Haldol, Zyprexa, Seroquel, Mellarill, Loxitane, Stelazine, Navane Risperdal and Clozaril.

Mood Stabilizers

(Many of these are also anti seizure, or anti convulsant medications)

Generally prescribed for the control of seizures, but many anti-convulsants have a “side-effect” which has shown to improve manic-depressive disorders as well as symptoms of emotional disorders.

Side effects: Headaches, drowsiness, fatigue, lethargy, ataxia (unsteady feet), thirst, nausea and vomiting diarrhea, constipation and anti-convulsants tend to interact with one another, as well as with other medications.

Examples: Lithium, Lithobid and Eskalith Tegretol, Klonopin, Depakote and Lamictil.

Anti-depressants

These are most often prescribed for the treatment of depression and often for post traumatic stress disorder (PTSD).

Side effects: Headaches, dizziness, dry mouth, blurred vision, drowsiness, or agitation, tremors, and weakness. Trazadone, a weak antidepressant, can cause painful erections of the penis that cannot go down and requires immediate care.

Examples: Effexor, Elavil, Desyrel, Celexa, Tofranil, Zoloft, Effexor, Prozac, Wellbutrin, Paxil, Trazadone.

Sedatives

Generally prescribed for their sedating effects or to treat insomnia.

Side effects: drowsiness, lethargy, respiratory depression, skin rash and/or itching, nausea, and vomiting. These medications will react with some heart medications, estrogens, narcotic/opioids, antidepressants as well as other medications.

Examples: Restoril, Dalmane, Ambien

Stimulants

These are most commonly prescribed for attention deficit disorder or sometimes in depression.

Side effects: restlessness, insomnia, a fast heart beat, anorexia, nausea and skin rashes.

Examples: Ritalin, Cylert, Dexedrine

Non-narcotic analgesics and antipyretics

These medications are commonly prescribed for pain control and decrease fever.

Side effects: stomach irritation and pain, tendency to bleed more than usual.

Examples: Tylenol, aspirin, acetaminophen

Non steroidal Anti Inflammatory

Commonly prescribed for the relief of pain, inflammation or swelling, and the reduction of fever.

Side effects: gastrointestinal or stomach irritation (pain and bleeding), dizziness, disturbances with eyesight, tendency to bleed more than usual. (These medications interact with or change the effect of a wide variety of other medications.)

Examples: Advil, Motrin, Aleve, Indocin, Naproysyn, Ketoprofen

Narcotic and opioid analgesics

Commonly prescribed for moderate to severe pain.

Side effects: drowsiness, slowing of the gastrointestinal tract, and respiratory depression. Nausea is common with this drug.

Examples: Codeine, Demerol, Morphine.

ANTICHOLINERGICS:

Kemadrin, Artane, Cogentin, Benadryl, Symmetrel

These medications are used to treat the side effects or unwanted effects of other medications. They act on or work mostly in the brain.

Unfortunately, these medications also have side effects!

They may cause or increase: Dry mouth, blurred vision, constipation, urinary hesitancy or even blockage, fainting or blacking out when standing or sitting up quickly, decreased energy, less acceptance or tolerance of changes in temperature and an upset stomach.

Recognizing adverse Medication Reactions

These include unexpected and undesired drug effects or response, which may be common or rare and mild or severe. Since they can involve almost any body system, they are often hard to tell apart from worsening of the original mental condition, from new medical illness or from unrelated behavior changes.

Changes in mental functioning

e.g. Confusion, disorientation, sleepiness a restlessness and agitation.

Parkinson-like symptoms

e.g. Tremors, shaking, shuffling gait or muscle stiffness.

Breathing difficulty

e.g. Wheezing or shortness of breath.

Visual problems

e.g. Blurry vision or eyes rolling.

Gastrointestinal problems

e.g. Heartburn, nausea, vomiting, diarrhea, constipation.

Urinary tract problems

e.g. Urinary hesitancy or frequent urination, impotence.

When any of these or any other unusual symptoms are observed you are to notify/call the case manager and/or delegated person and arrange for medical attention **As Soon As Possible**.

SECTION 3:

HOW TO ADMINISTER MEDICATIONS SAFELY

How to administer oral medication

How to measure liquid medication

How to administer medication safely

How to administer Oral Medications

Oral medications include tablets, capsules, and liquids.

The following was developed as a guide to help you when giving oral medications to individuals who have no problems swallowing.

PROCEDURE:

1. Have medication chart open to check medication labels against this.
2. Wash your hands.
3. Remove the medications from the locked storage area.
4. Read the label on the medication when you:
 - a. Remove it from the storage area.
 - b. When you place the medication in the medicine cup.
 - c. When you put the medicine away in the right spot.
5. When pouring liquid medications, shake the bottle to be sure the medicine is evenly mixed.
 - Be sure you pick up the right cup and give it to the right person.
6. Place the medication in the person's hand.
7. Stay with the person and observe that the medicine has been swallowed.
8. Document on the medication chart.

REMEMBER:

1. Physician's orders, medication labels, and medication charts should all match.
2. Do not leave the storage area unlocked if you have to leave the area.
3. Do not set up medications for someone else to give.
4. Do not crush or alter a medication without first checking with the prescriber, pharmacist, or registered nurse.
5. Give medications to one person at a time.
6. Inform the prescriber if a medication was refused, vomited up, or there is a question of a reaction.

MEASURING LIQUID MEDICATION:

1. Hold the medication cup at eye level.
2. Use your thumb to mark off the correct level on the cup.
3. Hold the medication bottle so that the medication pours from the side opposite from the label.
4. Pour the medication to the level you marked.
5. Set the cup down and at eye level and assure the level indicator is correct to the dosage poured.
6. Do not pour excess medication back into the bottle discard into a drain and wash away residue with running water.
7. Remove drips from the lip of the bottle first, then the sides, using a clean damp paper towel.
8. For liquids measured in drops, only use the dropper supplied with the medication.

Administering Medications Safely

All of the procedures regarding medication administration are intended to assure the “Six Rights” of medication administration.

- 1. RIGHT MEDICATION**
- 2. RIGHT DOSE**
- 3. RIGHT MANNER**
- 4. RIGHT TIME**
- 5. RIGHT PERSON**
- 6. RIGHT DOCUMENTATION**

FIVE ALWAYS:

1. Always have a physician's order for every medication or treatment.
2. Always wash your hands before giving medication.
3. Always pour the medication from the container into a medicine cup.
4. Always identify and stay with the resident until the medication is swallowed.
5. Always keep the medication storage area locked, clean, orderly, and separate from the provider family medication.

SIX NEVERS:

1. Never leave medication with the resident or on a table.
2. Never give medication prescribed for one resident to another resident.
3. Never administer medication that was prepared by another person.
4. Never give a medication that is outdated or from an illegible or unlabeled container.
5. Never give medication that you have questions about until you have checked with the pharmacist or the physician.
6. Never crush or otherwise alter a medication until you have checked with the pharmacist, physician or the prescriber.

FIVE MUSTS:

1. You must have a Medication Administration Record (MAR) present when giving medications. It must reflect any changes in the physician's orders.
2. You must read the label and compare it with the Medication Administration Record three times before giving the medication.
 - a. Before removing the medication from the storage area.
 - b. Before placing the medication in the medication cup.
 - c. Again, before placing the medication back in the storage area.
3. You must ensure that the resident is in a good position for swallowing the medication.
4. You must record the administration of the medication immediately on the MAR.
5. You must know why you are giving the medication, its actions, and possible side effects or allergic reactions.

SECTION 4:

**HOW TO DOCUMENT ON THE MEDICATION
ADMINISTRATION RECORD (MAR).**

Medication Administration Record Sheets “MARs”

A double check procedure must be initiated for verifying that the MARs prescription information is accurate and reflects the actual prescription. Any discrepancy found must be corrected immediately. The prescription is the legal document. If the pharmacy has made an error, notification must be made immediately. No medication can be dispensed for any reason without a current prescription on file.

Each resident must have a monthly MAR sheet specific to them, and each prescription must be accurately and clearly written on the MARs.

- (1) Each medication dispensed must have an initial in the box.
- (2) No ditto marks are to be used to document the dispensing of any medication.
- (3) Any error must be lined out and initialed and the reason and correction of the error is to be documented on the back of the MARs. (Keeping in mind this is to be an *accurate* record of any/all medications dispensed to a resident.)
- (4) All PRN medication dispensing is to be documented in the same manner, with the reason for the dispensing documented on the back of the MARs as well as in the progress note.
- (5) All discontinued (DC'd) medications must be indicated on the correct date and a line drawn through the remainder of the days on the MARs. The explanation and under whose authority is to be documented on the back of the MARs as well as in the progress note.
- (6) Medications in bottles that have a PRN order and have been dispensed, must be accounted for by initiating a system of counting the content balance and keeping a written record on a monthly basis.
- (7) All medications that have been DC'd or are outdated must be disposed of and a record kept of the action taken. (See sample drug disposal record.)
- (8) The bottom of the MARS must have the name and initial clearly identified for each person assigned to dispense and chart medication dispensing.

For each medication administered there is to be a description of the expected effect, side effects, and when to report them. These descriptions are to be filed in the same binder as the current doctors orders and MAR sheets. All caregivers are to be familiar with this information.

MEDICATION ADMINISTRATION RECORD (MAR)

SAMPLE MEDICATION ADMINISTRATION RECORD, MAR

DOCUMENTING ON A MAR

- DOCUMENTING WHEN A MEDICATION IS GIVEN
- DOCUMENTING WHEN A MEDICATION IS NOT GIVEN
- DOCUMENTING WHEN A MEDICATION IS DISCONTINUED (DC'D)
- DOCUMENTING WHEN A MEDICATION IS ADDED AND
- DOCUMENTING WHEN A MEDICATION IS TIME LIMITED
- DOCUMENTING WHEN A P R N MEDICATION IS GIVEN
(P R N: MEANING given AS NEEDED)

PREPARING A NEW MEDICATION RECORD (MAR)

1. Write the
residents full name,
current month, year,
known allergies or adverse drug reactions
2. In the appropriate identified section of the MAR write the
name of the medication,
dosage (the strength of the medication)
amount to be given and
when it is to be given.
3. Write your initials and your full signature at the bottom if you are the individual dispensing the medication and /or have any other authorized individual provide the same information, initial and name.

DOCUMENTING WHEN A MEDICATION IS GIVEN

Immediately after giving a medication initial the square for the correct date, time, and medication.

DOCUMENTING WHEN A MEDICATION IS NOT GIVEN

First: Initial the square for the correct date, time, and medication.

Second: Then circle your initials, turn the page over.

Third: Write on the back the date, time, name of the medication and the reason why the medication was not given.

DOCUMENTING WHEN A MEDICATION HAS BEEN DISCONTINUED

As soon as you have a change of physician order, draw a line through the remaining blank squares. Write from the date of change of the new order start date, the abbreviation “DC” meaning “DISCONTINUED” along with the date.

DOCUMENTING WHEN A NEW MEDICATION IS ADDED AND IS TIME LIMITED

1. Add the medication, dosage, and time it is to be given.
2. Draw a line through all the times and dates that have already passed, up to the start of the medication.
3. Count out the number of doses or days the medication is to be given.
4. Draw a line through the days when the medication is to end.

DOCUMENTING WHEN A “PRN” MEDICATION IS GIVEN

1. Check to be sure there is an order for the PRN medication.
2. Initial the square for the date given. Turn the page over and write the date, time, medication, and why the PRN medication was given. (Reason given should be what you saw, heard, or was told by the resident.)
4. Document later (approximately 30 minutes to an hour) what the results were of the **PRN** medication, such as what you saw, heard, or was told, and then initial what you wrote.

PRN (Pro Re Nata) means “as needed”

PRN medication is often ordered for minor medical problems that come and go, such as with headaches or menstrual cramps. When they are ordered, they are to be taken when certain symptoms are present, and only then.

You are not to prompt the resident into asking for the prescribed medication, treatment or therapy's. Nor are you to administer the medication or treatment without the required symptoms being present.

E.g. If Tylenol is ordered for “headache” it is to be given only if the resident complains of a headache. You may inquire if a headache is present if you have a suspicion, but you should not suggest the medication if there is no headache.

If, over the course of the month or several months the PRN is found to be needed frequently and the required symptoms have been documented, then the Prescriber is to be notified ASAP.

SAMPLE “MAR” DOCUMENTATION:

When medication is given

When medication is not given

When medication has been discontinued

When medication is added and is time limited

CONTROLLED MEDICATIONS

When a controlled substance is ordered, the following should occur when that medication is obtained from the pharmacy.

1. The pharmacy should provide you with a form that is used for *narcotic* records.

The pharmacy staff should already have the heading completed. The heading should include the following:

- Individuals name
 - Prescribing physicians name
 - Name of home/facility
 - Medication name
 - Amount ordered
 - Amount they prepared and delivered to you (amount received)
 - The prescription number
 - The pharmacist name.
2. The staff person receiving the controlled substance should:
 - Verify the amount of medication the pharmacy indicates should be received.
 - Sign their name then date, time, and amount of medication received on the first line of the “*Resident’s Narcotic Record*”.

3. At the time a controlled substance is given, besides following your policies and procedures for medication administration, the following must occur.

On the Resident's Narcotic Record form, write your name, the date, the time, the amount of medication on hand, the amount of medication you are giving, and the amount of medication remaining in the container.

4. At shift change, all controlled substances must be counted. Following is the procedure to be used:
 - a. Staff coming on duty counts the number of pills in the container.
 - b. Staff going off duty reads the corresponding individual Resident's Narcotic Record to be sure the information matches the count.
 - c. If the pill count and the individual Resident's Narcotic Record are the same, both staff complete the Shift Controlled Substance Count form.
 - d. If the pill count and the Individual Resident's Narcotic Record do not correspond, complete the change of shift Controlled Substance form indicating who in authority was notified.
 - e. The person in authority who was notified shall write a follow-up report that clearly states any/all action taken.

SECTION 5:

THE DISPOSAL OF MEDICATIONS THAT HAVE BEEN:

- Discontinued.
- Have an expired expiration date.
- The resident is no longer at the residence and the medications were not taken at the time of discharge.

MEDICATION DISPOSAL RECORD KEEPING

It is the provider's responsibility to assure that all discontinued and/or unused, expired by date medications are disposed of in a timely, safe, and verifiable manner.

Your residential specialist will provide you with the county preference in drug disposal methods.

The pharmacy that dispensed the medication will most often take it back if it is in bubble packs. You should inquire at the pharmacy if they will take back any medication that you have to dispose of and make agreements for that process. Additionally, most county case managers and Residential Specialists will also assist you.

As the manager/administrator/provider, it is your responsibility to document the manner of the disposal of the medication. This is to be recorded on the back of the MAR and on the medication disposal form.

Please note: The disposal of a controlled substance requires a verifiable witness signature as provided on the drug disposal form.

SECTION 6:

**RESIDENT SELF ADMINISTRATION OF
MEDICATION**

SELF-ADMINISTRATION OF MEDICATIONS:

Medications shall be self-administered by the resident if the resident demonstrates the ability to self-administer medications in a safe and reliable manner.

In the case of self-administration, both the written orders of the prescriber and the personal care plan and/or the residential service plan shall document that medications shall be self-administered.

The Provider and Case Manager shall develop a self-administration-training program plan that describes a step-by-step process with expected outcomes to aid in the evaluation of the self administration of medications.

The self-administration of medications may be supervised by staff who may prompt the resident to administer the medication and observe the fact of administration and dosage taken. When supervision occurs, staff shall enter the information on the MAR as described in these pages.

Any medications self-administered after the training program is completed, shall be stored in a safe environment that the resident has control of and no other resident has access.

SECTION 7:

MISCELLANEOUS:

Medication abbreviations

Medication identification listing

Delegation vs. assignment / order descriptors

Blank Medication Administration Record