Medication Policies
Nebraska Assisted Living

Use of Medication Aides

Policy

It is the policy of this facility to utilize Medication Aides to provide medication to residents in accordance with the Medication Aide Act, the Nurse Practice Act, and the Assisted Living Licensure Act. Medication Aides may also perform additional activities by following the established protocols, policies and procedures.

Procedure

1. Verification of the presence of the individual on the Medication Aide Registry with 40 hours of appropriate training and appropriate background checks shall be documented in the employee's file.
2. Competency testing shall be accomplished for each medication aide upon hire and at least annually thereafter, following the approved protocols.
3. Medication Aide Orientation Checklist:
    a. Facility Medication Administration System Policies and Procedures Facility Policies for Use of Medication Aides
    b. PRN protocol system and other additional activity protocols Obtaining and transcribing physician orders
    c. System for acquiring medications Medication Administration Record Storage and handling of medication Controlled substances
    d. Self-medication policies Drug disposal
    e. Medication error procedure
    f. Responsibility for Direction and Monitoring Resident specific training
4. Competency testing shall be accomplished and documented by a licensed nurse or Medication Aide. All medication aides shall also pass a written competency test by answering at least 70% of the questions correctly. Additional activities must be competency tested by a licensed nurse.
5. Documentation of medication aide competency testing shall be provided by the facility and submitted to the Department by the facility as required every two years in order to maintain the individual on the Medication Aide Registry.
6. Continuing education specific for medication provision may be provided and documented.
7. Medication Aides may provide additional activities including PRN medications, assistance with direction and monitoring, and additional routes, if all the following are present:
    a. A written statement verifying the individual medication aide's competency to perform the specific additional activity.
    b. Written direction for each additional activity specific for each resident.
    c. A written statement by the Physician for each recipient that it is safe for a medication aide to perform each additional activity for each resident.
8. Special conditions for medication aides to provide Additional Activities must include:

a. Written direction as to when the specific medication may be provided
b. Written observations to be made including time, signs and symptoms, and directions for reporting and recording.
c. Directions are reviewed periodically with the medication aides and are available to them.

9. A Medication Aide that is terminated for violation of competency standards shall be reported to the Medication Aide Registry in writing.

Medication Administration System

Policy

It is the policy of this facility that each medication be administered as prescribed and as directed by the prescribing physician, in compliance with state law, and only by persons lawfully authorized to do so.

Procedure

1. Physician orders
    a. A physician order must be present for every prescription medication, non-prescription medication, and herbal medication that this facility provides or administers. Orders may be faxed from the physician, handwritten as a prescription, written on a physician's order form, or included on a transfer form from another entity. The physician's signature must be included for the order to be complete.
    b. Verbal orders are discouraged and may only be taken by licensed nurses in this facility. If orders are sent directly from the physician to the pharmacy, a copy must be obtained. All orders are stored on the resident record.
    c. A complete list of medications is sent with each resident the facility provides medication for to every physician's appointment. The physician should review and sign the list, making any changes necessary.
2. Direction and Monitoring
    a. Upon admission, the person responsible for the direction and monitoring of medication administration is determined and documented. If medications are provided by the staff of this facility, the responsibility for direction and monitoring is assigned to the licensed nurse(s).
        i. If the licensed health care professional is a LPN, direction for this activity is provided by a RN or physician using these protocols and procedures.
    b. The Wellness Director determines those personnel authorized to provide medications to residents of the community.
        i. Authorized personnel provide medications in a manner that meets the prevailing licensing standards for medication administration and the statutes governing medication administration of unlicensed personnel.
        ii. A Registered Nurse shall be available to provide supervision to Licensed Practice Nurse and unlicensed personnel.
        iii. All Medication Aides must show proof of training upon approval for hire to

the Wellness Director.

iv. The Wellness Director or designated staff will verify that each Medication Aide has an active status on the Nurse Aide/Medication Aide Registry.
v. The Wellness Director or designated staff will have each Medication Aide complete a competency evaluation prior to providing medication and annually.
vi. The DON verifies that competency assessment and/or courses for the Medication Aides are completed in accordance with the Nebraska regulations at Title 172 Chapter 95: Regulations Governing the Provision of Medications by Medication Aides, and Title 172 Chapter 96: Medication Aide Registry.

c. At least annually, the RN Consultant shall review the Medication Administration System Policies and Procedures. The review shall include current regulations, standards of practice, use of medication aides, and facility practice. The training of medication aides provided by the facility (medication aide training course, facility orientation, and continuing education) shall be reviewed and approved by the RN. The RN shall be available to the medication aide trainers for consultation and guidance. The results of the review including any recommendations shall be documented, dated, and signed by the RN

3. Provision
   a. Medications must be administered in accordance with the written orders of the attending physician.
   b. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR).
   c. Medications authorized for one resident must not be used for another resident. Identification of the resident must be made prior to providing medication to the resident.
   d. Medications must be administered within one hour before or after their prescribed time or within the person-centered timeframe as indicated on the MAR.
   e. Authorized personnel providing medications use the Six Rights to safely provide medications. Those Six Rights are:
      i. Right drug
      ii. Right dose
      iii. Right time
      iv. Right route
      v. Right person
      vi. Right documentation
   f. Prior to providing the resident's medication, the staff person should compare the drug and dosage schedule on the resident's MAR with the drug label 3 times.
   g. Medications are provided as soon as possible after preparation and by the same person who prepared the dose. Presetting of medications is not permitted.
   h. All medications that are administered by community staff must be securely stored and locked.
   i. Topical medications must be kept separate from all other medications.
   j. Unit dose packaging is required for all solid oral medications unless the resident uses the VA pharmacy for obtaining their medications. Upon admission of the resident, nursing discretion is appropriate for initial medication packaging, for no

more than 90 days.

k. Additional activities are provided **in** this facility by a licensed nurse or by a medication aide that has been trained and competency tested on the skill.
l. Step by step procedures will be available on-site

4. Self-Administration
    a. Upon admission, each resident or responsible party will be asked about their wishes regarding self-administration of medications
    b. If self-administration is desired, the self-administration competency evaluation will be completed and be the basis for determining the resident's cognitive, physical and visual capabilities and safety of others. A licensed nurse will complete this competency evaluation.
    c. A physician's order must be obtained for a resident to keep any type of medication (prescription, nonprescription, and herbal) is his or her room for self-administration.
    d. If the resident requests self-administration of all medications, an evaluation is completed and documented. The following requirements must be met:
        i. The resident is competent and physically capable of taking or applying the medication according to prescription as proven by a self-medication assessment.
        ii. The resident monitors and directs his or her medication administration.
        iii. Medications are stored in the resident's room in a locked area or the resident locks the apartment door when leaving the room.
    e. The resident's medication regime shall be reviewed at least annually by the resident's physician.
    f. If potential health hazards exist because of self-administration of medications, the resident and/or designee shall be counseled, and the results documented.
    g. A current list of medications, biologicals and devices used shall be provided to the facility at least annually.
    h. If the competency evaluation determines the resident cannot self-administer medications, it will be based on the determination the practice would be unsafe to the resident.
5. Adverse Medication Reactions
    a. Adverse reactions must be reported to the resident's physician
    b. Adverse medication reactions and medication errors with adverse clinical consequences must be reported to the Wellness Director or designee.
    c. The Wellness Director or designee will contact the resident's physician.
    d. Nursing service must immediately implement and follow the physician orders. The resident's condition must be monitored as needed per licensed nurse's discretion.
    e. A detailed note must be documented in the clinical record, including but not limited to: date, time, reaction, persons notified, and follow up indicated.
    f. The resident's physician, the resident and/or the resident's responsible party, Wellness Director and/or the Executive Director must be informed of all adverse reactions.
6. Controlled Substances

a. Controlled substances (Schedule II-IV) will be counted at each change of shift by both the departing and oncoming personnel responsible for medication administration and documented on the company provided form or electronic record. The form or electronic record must be signed by both counting persons, noting the date and time in the correct column.
b. Controlled substances (Schedule II-IV) are to be counted whenever a change of personnel responsible for medication administration occurs in the middle of a shift by both the departing and oncoming personnel responsible for medication administration and documented on the form or electronic record. The form or electronic record must be signed by both counting persons, noting the date and time in the appropriate column.
c. Controlled substances (Schedule II-IV) are to be counted at time of administration by person providing the medication and documented on the form or electronic record noting amount dispensed; amount remaining; date and time in the appropriate column.
d. Discrepancies in the controlled substance count must be reported to the Wellness Director or designee immediately upon discovery.

7. Crushing Medications
    a. Prior to crushing any medications an order must be obtained from the physician and reviewed by the licensed nurse for safety on what can be crushed.
    b. Medication tablets may be crushed, or capsules emptied.
    c. The following guidelines must be used when crushing a medication is necessary:
        i. The resident's MAR must indicate which medications can be crushed.
        ii. Medications should be crushed to prevent contact between the drug and the crushing device.
        iii. Crushed medications can be given with soft foods or liquids to ensure that the resident receives the entire dose ordered.
8. Destroying Medications
    a. When a physician orders to discontinue a drug is received, notify the pharmacy and remove the drug from storage. The drug is placed in the disposal storage area. Countable drugs are left in the double locked narcotic box and counted at the end of each shift until the time of disposal.
    b. Discontinued or expired medications will be destroyed as listed below and destroyed by a licensed nurse.
        i. Ointments, creams, and other like substances may be discarded into the trash receptacle in the drug room after the resident's information on the label is removed and destroyed.
        ii. All effervescent (e.g. antacids, potassium supplements) will be disposed or destroyed in kitty litter or coffee grounds and disposed in a trash receptacle.
        iii. All other medications (including controlled substances) will be placed in the Drug Buster™ or its equivalent, kitty litter or coffee grounds according to manufacturer's guidelines.

c. Used controlled substance transdermal patches (i.e. Fentanyl) will be removed from the resident's skin according to the order and the staff member and a witness must roll it up and flush the patch down the toilet. This will be documented on the Disposition form or electronic record.
d. Controlled substances will be destroyed by a licensed nurse and a witness using the Disposition form or electronic record.
e. Controlled Disposition forms or electronic records must contain, at a minimum, the following information:
    i. The resident's name
    ii. Date destroyed
    iii. The name of the drug
    iv. The strength of the drug
    v. The quantity destroyed
    vi. Signature of witness and licensed nurse
f. Completed form will be forwarded to closed records.

9. Insulin
    a. The facility allows medication aides to assist with provision of insulin via a pen system
    b. Insulin will only be administered using an insulin pen syringe per physician's orders. Assistance with the use of vials is not permitted.
    c. A licensed nurse will evaluate each resident who is insulin dependent for appropriateness of trained staff to assist with administration per state guidelines.
    d. Each resident who has insulin must have a sharps container and all other necessary supplies in their apartment or access to them in the community's med room/med cart.
    e. Pens until opened will be kept in medication refrigerator. After the pen is opened, it can then be placed in the locked medication drawer or cabinet of the resident's apartment or community's med room or med cart.
    f. Once the insulin pen is opened, the date and time will be written on the pen. This pen is to be discarded per manufacturer's instruction.
    g. Insulin administration assistance will be evaluated as needed to ensure the resident continues to meet retention criteria.
10. Medication Administration Record (MAR)
    a. Each facility will maintain a current Medication Administration Record (MAR) for each resident who is given medication assistance by community staff.
    b. All prescriptions including over-the-counter medications as prescribed by a physician are entered on the resident's MAR.
    c. The information on the MAR includes:
        - Resident name
        - Apartment/room number
        - Allergies
        - Physician
        - Medication name, strength, dose, and route of administration
        - Frequency of administration and administration times

- Administration parameters (e.g., pulse, blood pressure, blood sugar) if applicable
- Stop date if applicable (antibiotics, treatments, etc.)
- Date ordered, date changed, date discontinued
- Indication for use for as-needed (PRN) medications
- Date and time that medication was taken by resident
- Name and initials of person assisting with medication administration

d. When a medication is discontinued or a prescription changes, the medication is edited in the electronic charting system (ECS) with documentation explaining the "DC'd" entry. In the event the ECS is non-operable, write "DC'd" on the printed MAR along with date and First Initial, Last Name, Credential.
e. Medication administration is documented on the resident's MAR at the time the resident takes the medication by the person providing the medication.
f. Initials on the MAR are verified with a full signature in the space provided on the MAR or MAR signature sheet. Electronic signatures in the ECS are password protected for security. The resident's printed MAR is initialed by the person providing medication in the space provided in the event that the ECS is non-operable under the date and on the line for that specific medication.
g. If a dose of a medication is refused by the resident or held, document appropriately in the ECS. In the event the ECS is non-operable, place initials in the appropriate box and circle. On the back of the MAR, indicate date, time, reason for missed medication followed by signature. If a resident consistently refuses medications, report this to the Wellness Director for follow-up with the physician/prescriber and/or responsible party
h. When medications are taken "as needed" or PRN, the following documentation is provided in the ECS or on the back of MAR when the ECS is non-operable:
   - Date, time, dose, and route of administration
   - Reason for administration
   - Effect of the medication and the time it was noted
   - Signature and initials of person recording provision
i. Completed Medication Administration Records are retained in the resident's file.

11. Medication Errors
    a. A medication error may result from noncompliance with the five rights, by omitting a dose of the drug, or by failure to document the provision. The individual who discovered the error is responsible for generating a Medication Error Report and reporting the incident to the supervisor, person responsible for direction and monitoring, and the physician as applicable. The incident is also documented in the Narrative Notes including a description of the incident, observations, reactions, and notifications. The MER is sent to the supervisor for review and then stored in the administrative office as part of the Quality Assurance program.
    b. Medication errors may also occur when:
        i. Medications are given/held without a valid physician order/prescription or direction from a licensed nurse
        ii. Medication is not administered due to unavailability from pharmacy

iii. Failure to complete medication inventory and notify appropriate person for re- ordering so there is no interruption of medication administration. Pharmacy is to have a 5-7-day notice of all medication refills needed

c. Treatment Errors: The failure to perform prescribed treatments including but not limited to: vital signs, wound cares, weights, blood glucose monitoring, oxygen saturation levels, application of or removal of therapeutic stockings or other treatments as prescribed by the physician or directed by the nurse.

12. Medication Labeling
    a. All medications provided to residents by the facility must be properly labeled by a pharmacist. The label should contain the name of the pharmacy, resident's name, prescription number, physician, date, drug name and strength, dosage, route, and time. Facility staff do not alter labels.
    b. No person other than the dispensing pharmacist shall alter a prescription label. If the physician changes the directions for use, the nurse may place a change of order-check chart label on the container ensuring not to cover important label information. Any changes should be documented in the resident's MAR.
    c. All medications received from the pharmacy should be checked immediately upon receipt for proper labeling. If medications are not labeled appropriately by the pharmacy, the resident and/or community may refuse to take delivery until corrected.
    d. Prescription labels should be permanently affixed to the outside of prescription containers.
    e. Over-the-counter medications are kept in the manufacturer's original container and identified with the resident's name.
    f. The pharmacy must be notified of any prescription changes, so the new container will show a corrected label.
    g. Medication containers having soiled, damaged, incomplete, or illegible labels are disposed of in accordance with company policy.
    h. Medications in multiple dose vials (e.g., B-12 injections) or containers (e.g., bulk liquids) must have a label indicating the date when the container or vial was first opened.
13. Medication Refusals
    a. This facility is to honor a resident's request not to receive medications and/or medical treatment as prescribed by his/her physician.
    b. It is a resident right to refuse specific medication and/or treatment even though a physician prescribes it.
    c. Should a resident refuse his/her medications, and/or treatment, documentation must be recorded concerning the situation.
    d. Documentation pertaining to a resident's refusal of medication/treatment should include:
        i. The date and time the medication/treatment was attempted
        ii. The resident's reason for refusal
        iii. Signature of the person attempting to provide the medication/treatment
        iv. Document each time the resident refused his/her medication/treatment, including any adverse effects. Any adverse effect must be reported to the

physician.

e. If the resident consistently refuses medication/treatment, the licensed nurse must complete a review of the record and identify potential cause, need for physician notification and add interventions to the service plan as applicable.

14. Provision of Medications for Resident's Leave
    a. When a resident plans to be gone from the facility during a medication provision time, each dose of each medication is packaged in a separate envelope and labeled with the resident's name, name and dose of the medication, and the time and date to be taken. The resident or designee is instructed about the medication provision. The procedure is documented in the electronic charting system recording that the medication was sent with the resident, with who it was sent, and any instructions given.
    b. Absences of more than two days are handled on an individual basis.
    c. Medications requiring special storage, such as refrigeration, must be labeled as such and the resident or responsible party should be made aware of this.
    d. Controlled substances (Schedule II-IV) are documented and signed by preparing staff noting the number dispensed on The Controlled Substances Count Sheet or electronic record. The quantity dispensed will be subtracted from the balance on hand.
15. PRN Medication
    a. The facility allows medication aides to assist with provision of insulin via a pen system
    b. The facility may administer PRN medications to residents with appropriate PRN orders, documentation, and evaluation of effectiveness.
    c. A licensed nurse will obtain the PRN order. An appropriate order includes specific medication; route; dosage; frequency; and indication for administration. If a dosage range order is received, the licensed nurse will seek clarification from the physician.
    d. Staff will document on the medication administration record, what medication was given and the indication for administration.
    e. Staff will document on the medication administration record within 1 hour of administration or as indicated by the PRN used (i.e. laxative), the effectiveness of the PRN medication by asking or observing the resident. If the medication is ineffective, the staff must notify the licensed nurse who is responsible for direction and monitoring for further recommendations.
    f. Any PRN given "routinely" will be evaluated for appropriateness and possible need to seek a routine order.