POLICY, PROCEDURES, & GUIDELINES FOR MEDICATION ADMINISTRATION

II. PROCEDURES FOR MEDICATION ADMINISTRATION

Procedures used for medication administration are in compliance with Rule 65G-7, FAC. Procedures are recommendations for staff to follow to help ensure that staff share responsibility for client medication administration whenever possible. If staff from different companies work with a client, ensure you are familiar with the policies and procedures the other company is following. Contact your supervisor immediately if there is any conflict between the Rule 65G-7, FAC, and the policies and procedures for medication administration for the provider for whom you work and any other company providing services to a client for whom you work. Every effort will be made to ensure that all companies as well as all staff from the same company providing services to a client will co-operate in all areas of medication administration to ensure the health, safety, and well-being of the client.

If there are more than one staff working for a client, the following procedures will be followed:
- Staff will work together in the best interest of the client.
- Staff will work together to prevent confusion, blaming, and errors.
- Staff will work together to ensure the policies and procedures for medication administration are implemented and followed.
- Staff will work with the client to ensure the health, safety, and well-being of the client.

Training and Validation
1. Staff will become familiar with Rule 65G-7, FAC.
2. Staff will attend APD authorized training for medication administration and ensure a copy of the Training Certificate is provided to the office and a copy is filed in each **Medication Administration Record (MAR) Book** for each client for whom the staff works.
3. Staff will complete an initial assessment and ensure a copy of the Validation Certificate is provided to the office and a copy is filed in each MAR book for each client for whom the staff works. To be validated on a route, staff must know:
- the name of the medication being administered
- the purpose of the medication being administered
- general side effects to watch for
- how to administer the medication

4. Staff will ensure they become re-validated within 60 days preceding the expiration of the current validation or must retake the training and complete the validation process again.
5. Staff will ensure they are validated on any route for medication administration for which they help a client.
   For example, if staff is initially validated on only by mouth, eye drops, and topical, but at some point needs to assist with ear drops, staff must ensure they are validated on this route and that a copy of the Validation Certificate is updated (or the **Provider Route Authorization** form is used) and one copy is provided to the office and a copy is filed in each MAR book for each client for whom the staff works

Authorization and Consent
1. Staff will accompany the client to his primary care physician or ensure the client goes to his primary care physician to complete the **Authorization for Medication Administration** form. This will be repeated annually and if the client's condition changes. Staff will ensure a copy of the Authorization for Medication Administration will be provided to the office and a copy is filed in the client's MAR book.
2. Staff will assist client, or guardian when applicable, in completing the **Informed Consent** form authorizing specific staff to assist with medication administration. If the client has a guardian, staff will add the client's printed name and birthdate to the form. This will be repeated annually or if the client and/or guardian change their minds. Staff will ensure a copy of the Informed Consent form is provided to the office and a copy is filed in each MAR book for each client for whom the staff works.
3. Staff will assist client with completing the **Medication Administration Agreement** form indicating that
- agrees to have staff administer medications to him and document and store medications properly
- agrees to have staff assistance with medication administration, documentation, and storage
- agrees to do his own self-administration, documentation, and storage
- agrees to keep a folder (Grab and Go) with his **Client Demographics**, current MAR, and **Health History**

Staff will ensure a copy of the Medication Administration Agreement is completed and provided to the office and a copy is filed in the client's MAR book.

Medication Administration

Staff will ensure they understand the different kinds of medications:
- Regular *routine* prescribed medications - Medications that are used on a regular basis, every day, every other day, once a month, etc. to prevent or reduce health problems (multivitamin, calcium, seizure medication, anti-depressants, cholesterol medication, etc).
  - obtained from the pharmacy using a prescription from the doctor
  - obtained over the counter (OTC) when used routinely - must have a prescription
  - obtained from the physician in the office (Sample) - must have a label with directions
- *PRN* medications - Medications that are used only on an "as needed" basis (pepto bismol, tylenol, narcotics, robitussin, etc)
  - obtained from the pharmacy using a prescription from the doctor
  - obtained over the counter (OTC)
  - obtained from the physician in the office (Sample) - must have a label with directions
- *Controlled* Medications - Medications that are considered addictive.
  - obtained from the pharmacy using a prescription from the doctor
  - obtained from the physician in the office (Sample) - must have a label with directions

Staff will:
- Know the **client**
- Know the **names** of the medications the client takes
- Know the **purpose** of each medication the client takes
- Know the **possible side effects** of the medications the client takes
- Know **what to do** if there is a problem
- Know when to document

Staff must: (*65G-7.005*)
- perform appropriate hand sanitation measures
- assist only 1 client at a time
- check directions and expiration dates
- observe the complete ingestion of oral medications before doing anything else
- document on the MAR and other forms, as appropriate
- store medications properly at all times
- only administer or assist with medications that are that are properly labeled and dispensed and prescribed or approved in writing by the prescribing practitioner
- report any torn, damaged, illegible, or mislabeled prescription labels to the pharmacy or prescribing practitioner
- observe the client for a minimum of 20 minutes following the first 3 doses of a new or PRN medication and follow the procedures for 3-Dose Tracking.
- observe the 9 rights for medication administration

There are **9 Rights** for medication administration. Each time staff assists with medication administration, staff will ensure these are completed. Staff will ensure he has the right:
- Client — name on the label and MAR match
- Medication — name on the label and MAR match
- Time — label states times per day or exact time; MAR states exact time
  Administer from 1 hour before to 1 hour after the stated times.
- Strength/ Dose — strength and dose on the label and MAR match
- Route — the how, way, and where on the label and MAR match
- Reason — the medication is administered for the correct reason
- Position — know the special needs for the client and the medication
- Texture — know the special instructions for the medication (crushed, liquid, in food, etc)
- Documentation — always document immediately after a medication is administered and document anytime there is a problem, when refills are needed, when there is an error, etc.

Items and Supplies to have on hand
Always have on hand the following items in the medication cabinet:
- Gloves (preferably latex and powder free)
- Box of Kleenex
- Applicators (sterile)
- Q-tips
- Cotton pads
- Yellow Marker
- Black ink pen
- Red ink pen (to mark controlled substances on the MAR)
- Alcohol swabs or liquid
- A small funnel or pharmacy counting device
- Controlled medications lockable container for each client, if necessary
- Expired and D/C Medications container
- Stock Medications container
- Containers for each client's medications as necessary (make sure liquid medications have room to stand upright)

Documentation and Record-Keeping
A **Medication Reference** should be kept in each client's home containing:
- Policy, Procedures, MAR Guidelines, Medication Administration Steps
- Rule 65G-7, FAC
- Training materials from the Medication Administration Course
- Blank forms
- Supplementary Materials
- Updates

There are two items which APD calls Medication Administration Record (MAR):
1- the MAR Book — which contains APD required forms, adapted forms, client and medication information
2- the MAR Log — which is a client specific document/log on which medication administration or self-administration is recorded

The Client's MAR book must be kept where medication is stored, in a readily accessible location, and contains:
Table of Contents
- Client Information
  - Client Demographics
  - Guardianship documents
  - Living Will documents
  - Healthcare Surrogate documents
  - Power of Attorney documents
  - Other information specific to the client
- Consent Forms
  - Authorization for Medication Administration Form (APD)
  - Informed Consent Form (APD) - one copy for each staff working with the client
  - Medication Administration Agreement
- Medication Administration Record Form - Logs may be used from the provider or the pharmacy
  - Regular MAR log - for routine medications
  - PRN MAR log - for as needed medications
  - Medication Notes form

- Prescriptions
  - Regular prescriptions
  - PRN prescriptions
  - Doctor Approval for OTC PRN Medications
  - Pharmacy Notes for each medication
  - Temporary prescriptions
  - Discontinued prescriptions
- Copies of Forms - should be kept in the Medication Reference Book
  - Client Demographics
  - Health History
  - Medication Administration Record (MAR) – regular and PRN
  - Medication Notes Form
  - Authorization for Medication Administration
  - Informed Consent
  - Medication Administration Agreement form
  - New and Refill Medication Form
  - Medication PRN OTC List
  - 3 Dose Tracking Form
  - APD Medication Destruction Record
  - APD Controlled Medication Count
  - APD Off site Custody of Medications
  - APD Medication Error Report
  - Incident Form
  - Medical Treatment Log
  - Medical Exam Form
  - Seizure Log
  - Provider Route Validation
- Certificates
  - Staff Certificate of Training
  - Staff Certificate of Validation - one copy for each staff assisting with medication administration for the client
- Archive
  - Any documentation that is not current is maintained at the back of the client's MAR book

Staff will be responsible for starting the MAR log for each client each month following the directions provided on the MAR log. The MAR log can be initially filled out on the computer and then updated each month thereafter. New, changes in, or discontinued medications must be marked correctly as they occur.

Staff is responsible for:
- documenting all medication administration in the client's MAR book
- using the appropriate forms as necessary
- ensuring there are enough forms in the MAR book
- maintaining the MAR book in a readily accessible location
- updating the MAR log as necessary
- ensuring required documentation is provided to the office each month (*65G-7.008 (2)*)
  - MAR log
  - Controlled Medication Count
  - a list of potential side effects, adverse reactions, and drug interactions for each medication
    This may include:
    - Updated Pharmacy Notes
    - A list of medications, side effects, adverse reactions, and drug interactions
    - A complete MAR with the side effects, adverse reactions, and drug interactions listed in the Special Instructions section
  - Any medical exam forms and medical treatment logs
- ensuring all required documentation is maintained in the client's MAR Book and available and readily accessible for routine auditing
  - client information sheet
  - all consent and agreement forms
  - training and validation certificates for each staff working with the client
  - medication notes
  - 3-dose tracking forms
  - new and refill medication forms
  - medication destruction records
  - off-site custody of medication forms
  - medication error reports
  - prescriptions
  - over-the-counter medication orders, directions, or prescriptions
  - pharmacy notes
  - discontinued prescriptions, pharmacy notes
  - any other client-specific documentation

Each month's documentation will be maintained in the back of the MAR book for the client in a section labeled "Archive" in order to make room for the current month's documentation. This documentation will be collected at a minimum of once each year to be maintained in the office.

Whenever possible, the SLC will double-check the MAR log when changes are made in the MAR log. A supervisor will review the client's MAR book at a minimum of every 3 months to ensure that all documentation is accurate and being maintained in the MAR book.

The Grab and Go Folder
A client who is self-medicating is not required to have a MAR book. The SLC supervising the self-medicating client is required to maintain a MAR book. The client should be encouraged to have a Grab and Go Folder which will contain, at a minimum:
- the **Client Demographics**
- a current **MAR**
- health history (**Health History**)

Medical, Dental, Mental Health Appointments
Documentation should be made whenever a client goes to a medical, dental, or mental health appointment on either the **Medical Treatment Log** or the **Medical Exam Form**. Staff who accompany a client to an appointment will also take the MAR book in order to have the most current medical information. A client who is self-medicating should be encouraged to take, at a minimum, his Grab and Go folder. Documentation must also be made in staff casenotes.

3-Dose Tracking
Whenever a new medication is started or a change is made to the medication (strength, dose, times), including when PRN medications are used, staff will observe the client for any adverse reactions (*65G-7.005(2)(k)*), check the MAR for any special instructions, and complete the **3-Dose Tracking Form**. Observation is made to detect and respond to any adverse reactions.

Obtaining a New Medication
A copy of the prescription or order will be made and placed into the client's MAR book. The new medication will be written in on the MAR with all required information in black ink on the correct MAR (regular or PRN). The medication will be counted and then placed in the appropriate storage location in the client's home. Documentation will be made on the **New and Refill Medication** Form (NARM). Whenever possible, the SLC will complete this task, and at minimum, will doublecheck that this procedure has been completed correctly.

Determining Need for Medication Refills
Once a week, the SLC (or IHSS) and client will determine which medications need to be refilled by counting the medications to ensure there are 7 days worth. The date, medication name, and script number will be documented on the NARM form.

Ordering Medication Refills
Staff will ensure that medications are promptly refilled to ensure the client does not miss a prescribed dose of medication. (*65G-7.005(5)*)
Medication refills will be done by:
- Staff and client call in the medications requiring refills to the pharmacy once a week

OR
- The pharmacy's automatic refill system

Staff will ensure that refills required are marked on the NARM form

Picking up Medications
The IHSS and client or SLC and client will pick up the medications at the pharmacy on the day the SLC (or IHSS) and client count medications
OR
The pharmacy will deliver the medications
Staff will ensure that all medications that have been refilled or that are new are counted and marked off on the NARM form once they are received.

Counting Medications
There are four times when medications will be counted:
- when the medication is brought home from or delivered by the pharmacy
- when the medication is a controlled substance
- when determining whether refills are needed
- when the client leaves and returns if medications are taken for administration while the client is away

What you need:
- gloves
- shallow bowl
- paper towel
- small funnel if available

OR
- a pharmacy medication counting device

To count medications, including controlled medications, that have been brought home from or delivered by the pharmacy:
1- wash your hands
2- use gloves
3- use a pharmacy counting device for steps 3-6, then go to step 6
OR
3- place a shallow bowl over a clean paper towel on a table
4- pour the medication into the bowl
5- count the medication and place each one onto the paper towel, in groups of 10, as you count
6- place the medication back into the original container by:
- making a funnel of the paper towel
- using a funnel
- using the pharmacy counting device

7- if the count is not correct, re-count the medication to ensure you did not make an error. If the count is still incorrect, call the pharmacy, return the bottle to the pharmacy for correction, and start at step 1 again when the correction is made
8- If the count is correct, store the medication in the appropriate location, and mark the NARM Form

To count medications, including controlled medications, to determine whether refills are needed:
1- wash your hands
2- use gloves
3- use a pharmacy counting device for steps 3-6, then go to step 6
OR
3- place a shallow bowl over a clean paper towel on a table
4- pour the medication into the bowl
5- count the medication and place each one onto the paper towel, in groups of 10, as you count
6- place the medication back into the original container by:
- making a funnel of the paper towel
- using a funnel
- using the pharmacy counting device

7- if there are less than 7 days worth of medication doses, then mark the NARM form so that refills can be ordered. If refills are automatically done by the pharmacy, then this can be used to doublecheck that the correct medication is obtained.

To count medications, including controlled medications, when a client will be away during times for medication administration:
1- wash your hands
2- use gloves
3- use a pharmacy counting device for steps 3-6, then go to step 6
OR
3- place a shallow bowl over a clean paper towel on a table
4- pour the medication into the bowl
5- count the medication and place each one onto the paper towel, in groups of 10, as you count
6- place the medication back into the original container by:
- making a funnel of the paper towel
- using a funnel
- using the pharmacy counting device

7- Complete the **Off-Site Custody of Medications** form and follow the procedures as stated under the section *Off-Site Medication Administration*.

To count medications that are controlled substances (controlled medication count):
1- wash your hands
2- use gloves
3- use a pharmacy medication counting device for steps 3-6, then go to step 6
OR
3- place a shallow bowl over a clean paper towel on a table
4- pour the medication into the bowl
5- count the medication and place each one onto the paper towel, in groups of 10, as you count
6- place the medication back into the original container by:
- making a funnel of the paper towel
- using a funnel
- using the pharmacy counting device

7- if the count is not correct, re-count the medication to ensure you did not make an error. If the count is still incorrect, call your supervisor immediately, document the error on the **Controlled Medication Count** (CMC) form and the **Medication Error Report** (MER).
8- If the count is correct, store the medication in the appropriate location and mark the Controlled Medication Count form.

When to count controlled medications (*65G-7.007*)
If staff is a full time IHSS, then count each morning before administering the first dose for that day and document on the Controlled Medication Count form. Count again after the last dose for that day has been administered and document this on the CMC form. If the IHSS is gone during a time when a controlled medication is to be administered, then the staff person who assists the client (such as an SLC) will count the controlled medication before and after administering the medication and document this on the Controlled Medication Count form.

For shifts:
Each staff must ensure a count is done and documented before leaving and before giving the first dose of the controlled medication
- when the shifts overlap (where a second staff comes on while the first staff is at the client's home, such as when a client cannot be left alone and is at home)
- when one shift has left before the second shift comes on (where the second staff comes on after the first staff has already left, such as when a client is at a day program)

Destroying Medications (*65G-7.007*)
Any prescription medication that has expired or is no longer prescribed must be destroyed appropriately and documented on the **Medication Destruction Record**. Medications that have expired or are discontinued will be placed in the Expired and D/C Medications container, separate from all other medications. Staff will dispose of the medications at the end of the month by removing labels from containers, emptying all pills, ointments, and liquids into a bag with either some dirt, kitty litter, or coffee grounds and placing the bag into the trash for garbage pickup.

Medication Errors (*65G-7.006*)
Staff will be familiar with what constitutes a medication error and what to do if a medication error occurs.

Reporting Errors (*65G-7.006*)
If an error occurs in the client's home and staff made the error, then staff must:
- notify the supervisor
- submit a **Medication Error Report** (MER) to APD after discovering the error
  - within 24 hours
  - by 5:00pm, next business day if the error is medication count error
- ensure a copy of the MER is provided to the office and a copy is filed in the client's MAR book
- document the error on the client's MAR and on the Medication Notes form

In addition, if the error is the administration of the wrong medication or the wrong dose, staff must also:
- observe the client for a minimum of 20 minutes
- report any observed changes in the client's condition to the prescribing doctor
- call 911 if the client exhibits any potentially life-threatening symptom

If staff makes an error that is determined to justify corrective action, staff will comply with a *corrective action plan* from APD within a specific and reasonable timeframe.

Storing Medications (*65G-7.007*)
Staff will ensure a client who is *self-medicating* stores his medications properly
- stored in a secure, locked place within his room

OR
- centrally stored in a locked container in a secured enclosure if:
  - the client's physician documents that leaving the medications in the client's personal possession would constitute a threat to the health, safety, or welfare of the client or others
  - the client fails to securely maintain the medication in a locked place
  - based on the home's physical arrangements or the habits of others in the home, the client's personal possession poses a threat to the safety of others as determined by APD or staff
  - the client's authorized representative requests that the client's medication be centrally stored

Staff will ensure medications are stored at the correct temperature.
Staff will ensure liquid medications are stored upright.
Staff will ensure medications are centrally stored in a locked container in a secured enclosure
Staff will ensure that controlled medication is stored separately in a locked container in a secured enclosure
Staff will ensure medications requiring refrigeration are stored in a refrigerator
- in the original containers
- within a locked, clearly labeled storage container

Staff will ensure medications are stored, organized, and maintained in a way that ensures their safe retrieval and minimizes medication errors.
Staff will return medications to storage immediately after medication administration
Staff will ensure medications that have expired or that are no longer prescribed are destroyed and documented on the **Medication Destruction Record** following the procedures as stated under the section, *Expired and Discontinued Medications*.
Staff will ensure a master set of keys to all locked containers and secured enclosures is readily accessible in case of an emergency. The location and how keys can be accessed will be provided to the Program Administrator and to all other staff who provide medication administration assistance to the client.

Sample Medications
Staff will ensure there is a written order or prescription from the prescribing practitioner (65G-7.003(3))
Staff will maintain sample medications in the original containers labeled by the prescribing health care practitioner with:
- the client's name
- the practitioner's name
- directions for administration

Staff will document on the label and the Medication Notes the date when the medication is opened (*65G-7.007(1)(c)*)

Over-the-Counter Medications (vitamins, supplements, herbs, etc that can be bought without a prescription)
Staff will ensure there are written directions or a prescription from the prescribing practitioner (65G-7.003(6))
Over-the-counter medications that are used on a regular basis (multivitamin, calcium, etc) must have a prescription for their use.
Over-the-counter medications that are used occasionally or as needed must be listed on the **OTC PRN Medication List** showing the primary care physician has approved them and provided direction for their use.
Staff will maintain over-the-counter medications in the original containers

As-Needed (PRN) Medications (may be either obtained from the pharmacy with a prescription or over-the-counter)
Staff will ensure there are written directions or a prescription from the prescribing practitioner (65G-7.003(6))
Staff will ensure that prescribed PRN medications (such as a pain medication, anti-anxiety medication, etc) are stored the same as all regularly prescribed medications, but separately from other routine medications. PRN medications that are also controlled will be stored in compliance with storage requirements for controlled medications.
Staff will ensure that PRN medications that are also over-the-counter medications (such as tylenol, pepto bismol, etc) are listed on the **OTC PRN Medication List** and the primary care physician has approved them and provided direction for their use.
Staff will ensure that administration of any PRN medication will be documented on the Medication Notes form and on the PRN MAR.

Controlled Medications
Staff will ensure that controlled medications are stored separately from other medications in a locked container within a locked enclosure.
Staff will count controlled medications following the procedure as stated under the section, *Counting Controlled Medications*.
Staff will ensure a controlled medication count is performed:
- for each incoming and outgoing shift, if applicable
- when any staff assists with controlled medication administration
- twice a day, at a minimum if there is no shift
  - once before administering the first dose of the controlled medication for the day
  - once after administering the last dose of the controlled medication for the day

Staff will document the count on the **Controlled Medication Count** form.

Stock Medications
Staff will ensure that stock medications that are used for multiple clients (such as neosporin, hydrogen peroxide, etc) are stored in a container separate from all other medications and labeled Stock Medications. Eyedrops, eardrops, lip ointments, and nose ointments are personal medications and are NEVER considered stock medications. Personal medications are stored in compliance with the type of medication they are.

Expired and Discontinued Medications
Staff will ensure that expired and discontinued medications are placed in a container labeled Expired and D/C Medications and stored separately from other medications.
Staff will ensure that expired and discontinued medications are destroyed as stated under the section, *Destroying Medications*.
For discontinued medications, staff will:

- remove all prescriptions, pharmacy notes, etc and place them in the section for Expired and D/C Medications in the MAR book
- file the D/C order in the section for Expired and D/C Medications in the MAR book
- place the medication in the Expired and D/C Medications container for later disposal
- document the D/C order on the client's MAR log:
  - immediately to the right of the last dose given, make a vertical line (|) in that space
  - write D/C, the date, and your initials to the right of the vertical line – | D/C 01/01/01 RL (*training, page 5*)
  - use a yellow marker to mark out the entire section that has been discontinued
    For example, a medication that is given 3 times a day may be discontinued only for one of the doses. Use the yellow marker to mark out only the time that has been discontinued. A medication that is discontinued completely will be marked from the name of the medication through all of the times to the end of the space for the last day of the month.

NOTE: Section III, MAR Book and MAR Log Guidelines provides direction for how to document medication administration on the MAR log.

- document the D/C on the Medication Notes
- provide a copy to any programs where medication is administered
- file the D/C order in the MAR book
- observe the client for any reactions, notify supervisor if necessary

Off-Site Medication Administration (*65G-7.009*)
If the client will be away from home and requires medication during that time while away:

- staff will ensure there is an adequate amount of medication for all dosages the client requires while away
- staff will count the medications before the client leaves and after the client returns
- document off-site information on the **Off-Site Custody of Medications** form and provide a copy of the form to the person responsible for assisting the client while he is away
- file the original form in the client's MAR to use when the client returns with the medications
- provide the person responsible for assisting the client with medication administration while he is away with:
  - the name and phone number of contact staff
  - the name and phone number of prescribing practitioner

If the client is self-administering, then medications may be transferred from the original container to a pill organizer or otherwise co-mingled only by:

- the client
- the client's guardian
- the client's family member

Procedures for documenting medication administration in the MAR Book and on the MAR log are provided in **Section III, MAR Guidelines**.

I have read and fully understand the Medication Administration Procedures Policy and agree to follow its dictates.

Staff Signature _____ Date _____