Acknowledgements

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The Elizabeth M. Boggs Center on Developmental Disabilities, Rutgers Robert Wood Johnson Medical School, wishes to thank all who contributed to the production and revision of this module.

Original Production – 1989


The Boggs Center would like to acknowledge the help and leadership of all the members of the New Jersey Training Network in updating and revisions of this curriculum.

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Introduction

The health and safety of the individuals you support is your priority. Some individuals with developmental disabilities are capable of taking their medication independently. Others need staff assistance and support. This module will provide you with the help you need to give assistance and support.

Agencies cannot use typical, everyday procedures. For example, most of us take medication without using formal rules. When a medical professional prescribes a medication “twice a day” we take it in the morning and evening, often not at exact times. We can decide to take that risk because we are taking our own medication. However, programs involve many different staff, individuals with developmental disabilities, and sometimes families. The more people involved in this process the more risk for errors. This is why there are a consistent set of rules and procedures to follow. You need to know these rules and procedures to lower the risk of errors.
In addition to protecting the physical and mental health of the individuals you support, following these procedures will protect you and your agency from errors that could have serious health and legal consequences.

**Important Concepts to Keep in Mind:**

**Safety:** Many of the individuals that you support will need medications that you may not be familiar with and may be potentially dangerous.

Any medication can be extremely dangerous if taken incorrectly. There are rules in place that you must follow to make sure that the individuals receive the medication exactly how it has been prescribed.

**Health:** Medications may be taken for many different reasons and for different lengths of time. Regardless of the reason or how long a person takes medication the purpose remains the same - to support the individual physically and emotionally.

**Advocacy:** It is important that staff advocate for the individuals. Advocacy includes observing and immediately reporting any change in the person’s physical or mental health.

Advocacy also includes speaking to health care professionals about ways in achieving the individual’s health goals while also being respectful of the person’s choice and normal routine.

**Independence:** It is extremely important that the individuals you support are involved in all areas of their medication process. Their knowledge (e.g. in going to the doctor, getting their medication, understanding what the medication is for, etc.) will lead to greater independence and participation.

**Personal Values:** It is important that your personal values regarding medication do not interfere with what the individuals you support need for their physical and mental well-being.
What is Medication?

Medication or medicine is any chemical substance intended for use with medical prevention, diagnosis, cure, or treatment.

Medication Must Be:

• Approved by an individual’s licensed medical practitioner (with the appropriate signed documentation)
• Kept locked
• Documented by staff when given

Defining Medication:

Medication or medicine is any chemical substance intended for the use with medical prevention, diagnosis, cure, or treatment.

Medication must be:

• Approved by an individual’s doctor (licensed medical practitioner, physician, advanced practice nurse (with the appropriate signed documentation).

• Kept locked for those who do not self-administer. If sharing a home, room, etc... with someone who does not self-administer the individual should have their own locked box.

• Documented by staff when given
Categories of Medications

- **Prescription Medications**: prescribed by a licensed medical practitioner
  - Controlled Medications
  - Non-controlled Medications

- **Over-the-counter (OTC) Medications**: medications available to the public without a signed order
  - In our system, these require written prescriber’s approval before being given.

*Either may be prescribed on an as needed basis*

Categories of Medications

Medications are divided into two (2) categories:

1. **Prescription Medications**
   This category includes all medications that must be prescribed by a physician or advanced practice nurse and dispensed by a pharmacist.

   Prescription medications can be broken down into two sub-categories:

   a. **Controlled Medications**
      Controlled medications are medications which have been legally designated “controlled substances.” The medications in this category are considered (by medication control agencies) to have high potential for abuse. Examples might include narcotics such as Percocet, certain medications prescribed for sleep, certain anticonvulsants, and/or certain psychotropic medications.

      Your agency may have special reporting and storage procedures for all controlled medications. Some agencies double lock controlled medications. Check with your agency for specific policies.

   b. **Non-controlled Medications**
      Non-controlled medications include all prescription medications that do not appear on the list of controlled substances, e.g. antibiotics such as Penicillin.
2. Over-the-Counter (OTC) Medications

OTC medications include any medication that can be purchased without a prescription. Common OTC medications include pain relievers such as aspirin and certain cold remedies.

According to Licensing Standards, “a statement from the physician regarding the usage and contraindications of over-the-counter medications shall be available for staff reference and use and shall be updated annually.”

A common way to meet this requirement is to have an “Over-the-Counter Medication Orders for Use as Needed” form in place. This form lists various symptoms and then what medication can be taken and how it should be taken. This form is signed by a prescriber and is good for one year. This form may also be called a “Standing Order” form. You may also have an individual prescription for an OTC medication that needs to be taken routinely.

The procedure for administering as needed medications will be covered in another part of this training. It is important to know that in our service system we cannot administer any medication, prescription or OTC, without a prescriber’s written approval.
The Medication Cycle

1. Observe for changes in physical and behavioral signs.
2. Report changes verbally & in writing.
3. Assist with visit to the doctor.
5. Document all medication/medical information.

The Medication Cycle
Staff Role

1. Observe for changes in physical and behavioral signs
2. Report changes – verbally and in writing
3. Assist with visit to the doctor
4. Get and store medication
5. Document all medication/medical information
6. Administer medications and document
7. Continue to observe…

Safe Administration

The following areas will be covered throughout this medication module. Your agency will have many additional policies you need to follow.

1. **Observe for changes in physical and behavioral signs**: Look for both physical (cough, limp, bruise, etc.) and behavioral (tired, upset, quiet, etc.) changes.

2. **Report changes - verbally and in writing**: Tell the right people about the changes you saw. Tell them as quickly as possible depending on how serious the problem is. Document the changes you observed.

3. **Assist with visit to the doctor**: Support the individual at the doctor’s office and/or pharmacy. Make sure all information is documented.

4. **Get and store medication**: Medication may be delivered or picked up and must be stored according to procedures.

5. **Document all medication/medical information**: Be sure to write down all new or changed medical/medication information in all the right places such as a medication sheet and log or communication books.

6. **Administer medication(s) and document**: Administer the medication that the individual is prescribed and document what you gave.
7. **Continue to observe** for changes in physical and behavioral signs to see if the medication is working correctly or if there are any problems (allergies, unwanted effects etc...).
Observation – Your Responsibility

1. Know the people you support so you will notice anything unusual.
2. Be observant.
3. Ask questions.
4. Report what you have seen according to your agency policy.
5. Offer whatever assistance you can as per agency policy, prescription, and/or medical advice.

Observation

Since we cannot feel another person’s pain and because people with developmental disabilities may not express pain in traditional ways, it is extremely important that we pay attention to even the slightest change so we can offer help (e.g. rest, medication, heating pad, etc.). Through observing body language and asking questions, we will have a better understanding of what the individual is experiencing.

Think of the people that you support and their communication. Sometimes, people may communicate pain or discomfort through behavior (holding head, rubbing stomach, banging head, pulling ear). Especially in cases where the person does not use traditional communication methods (such as someone who has limited verbal communication), it is important to cue into body language and behavior to rule out and/or address physical issues.

Your responsibility:
1. Know the individuals that you support so you will notice anything unusual.
2. Be observant.
3. Ask questions.
4. Report what you have seen according to your agency policy.
5. Offer whatever assistance you can as per agency policy, prescription, and/or medical advice.
Types of Symptoms

There are three types of symptoms that we must look for.

**Objective Symptoms** are physical symptoms which are clearly seen.

These symptoms are easy to observe and document. Some examples include:
- Cough
- Rash
- Limping
Subjective Symptoms are physical symptoms which are only experienced by the individual.

These symptoms are harder to observe because we each experience and express pain differently. Some examples include:

• Pain
• Dizziness
• Spots before the eyes

We have to look closely at the actions of the person and ask questions. Some examples of actions include:

• Holding onto a chair to get up because the person has arthritis in the knees
• Squinting at bright lights because the person has a headache
Types of Symptoms
Behavioral Changes

Changes in an individual’s typical behavior which are observable. Examples include:

- Excessive Talking
- Irritability
- Outbursts
- Changes in Eating Habits
- Unusually Quiet

**Behavior Changes** are changes in an individual’s typical behavior which are observable. Some examples include:

- Excessive talking
- Irritability
- Outbursts
- Changes in eating habits
- Unusually quiet
Reporting Symptoms

- Report Changes to Agency (verbally)
- Document (in writing)
- Report Changes to Medical Professional

Reporting

Reporting Changes to Agency
We must always report any changes in physical or behavioral signs both verbally and in writing. Who we report it to and how we document it will depend on the situation and your agency.

Document
Regardless of the way that your agency collects information (case notes, critical logs, etc.) the information you will document remains the same. Write only what you see or what someone says to you. It is important to be as specific and as objective as possible. If you believe that you know the reason for the symptoms based on your interpretation of body language or history with the person, be sure to write that it is your opinion. We should not write any information as a fact that is actually our opinion or feelings about the situation.

Report Changes to Medical Professional
Physical and behavioral changes are often hard to interpret because there can be many reasons for the same symptom. Diagnosis, interpretation, and treatment are the responsibility of a medical professional. Your responsibility is to consistently observe, report, and document any changes according to your agency’s policies and procedures including calling 911 for life threatening emergencies per Danielle’s Law.
Case Study - Jen

Jen lives with her parents and has just started attending a new day program, where she works on social and recreational skills. The table was adapted to fit both Jen and her wheelchair so she could interact easily with her peers, where they engage in competitive games, such as playing cards, as well as paint and create other artwork. The first couple of weeks Jen had been doing well and was participating in all activities.

Recently, she has become irritable. She gets upset if she is criticized in any way and if she makes a mistake, she yells and throws things. The staff have no idea why she has shown such a dramatic change in behavior so they have decided to meet and discuss what to do.

Case Study

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Recently, she has become irritable. She gets upset if she is criticized in any way and if she makes a mistake, she yells and throws things. The staff have no idea why she has shown such a dramatic change in behavior so they have decided to meet and discuss what to do.
Medication Considerations

Before looking for medication to solve the problem, we should consider the following:

- **Environmental Issues:** There may be an issue with the person’s surroundings; a change in the person’s home or personal life, or something in the work environment that is causing the issue. Something may be able to be changed environmentally (rearrange seating, check noise, temperature, activity levels, etc.) which would reduce the behavior.

- **Coping Skills:** Medications are not complete solutions. Even with a medication, the person still needs to learn how to cope with the stresses of life, either physical or emotional, and how to express feelings. Teaching the person effective ways of coping such as: effective communication, sharing feelings, anger-management, breathing techniques, advocating for self, etc... may eliminate any need for medication.

- **Medication Issues:** Medications have the potential for unwanted effects, some of them very serious. There are some medications that have risks that are worse than the issue they were designed to treat. Medications are not permanent solutions, sometimes medications only work for a short period of time. There is also the potential for a person to become resistant to medication over a period of time.
Medication Considerations

Whether the person has medication prescribed or not, you need to:

- Find out what is bothering the person
- Make whatever changes are possible in the environment to help the person
- Teach the person how to communicate what is bothering him/her
- Support the person to cope with the situation

Ultimately whether the person has medication prescribed or not, you still need to:

- Find out what is bothering the person
- Make whatever changes are possible in the environment to help the person
- Teach the person how to communicate what is bothering him/her
- Support the person to cope with the situation

It is your responsibility to advocate for the person so that the misuse and overuse of medications does not occur. If the person is still having difficulty after we have done that work, then we can advocate for a medication to address the problem. We will know that we are now advocating for this because we are looking for the best quality of life possible for the person, not because we wanted an “easy” answer for ourselves.
**Medication Considerations – Your Role**

- **Be objective:** Provide accurate information to the doctor. Don’t over or under dramatize what you have seen. Even if you have been the target of some of the problems, do not say things like “he is abusive to everyone.” You also should not say that everything has been perfect just because you don’t want to seem like a complainer. If the person has had some difficult moments then you must communicate that to the doctor.

- **Be specific:** Let the doctor know about any specific changes. For example, if the person has become physically aggressive 3 times in the past month, say that. Do not say that the person has been “beating people up all month.”

- **Advocate:** If you think the person is on too much medication, that their current dose is not working, or the person’s quality of life could be improved in some way, talk to your supervisor and the doctor. Make sure that any medication prescribed is in the best interest of the person, not for the staff or because the doctor thinks we are looking for an “easy fix.” Always look to see if there are any alternatives.
Encourage Independence

- Have the person do as much as possible
- Review with the person what s/he is taking and why
- Prepare medication for one person at a time
- No yelling of names or “medication time”
- No bells or intercom systems
- Draw as little attention to the process as possible
- Keep it confidential and private

Teaching/Encouraging Independence
Everyone should be provided the opportunity to learn how to administer his or her own medication. Staff should make the administration process a learning experience. This may also increase skills in other areas of life (e.g. learning time, colors, counting, etc…).

Involvement and participation are important, no matter how much support is required. Obviously, individuals will differ greatly in their ability to participate, however everyone should be involved in some way. This is your responsibility.

1. Have the person do as much as possible (e.g. get cups, water, etc…)
2. Review with the person what he/she is taking and why
3. Prepare medication for one person at a time
4. No yelling of names or that it’s medication time
5. No bells or intercom systems
6. Draw as little attention to the process as possible
7. Keep it confidential and private
6 Rights of Medication Administration

*Each time* you administer a medication, you need to be sure to have the:

- Right individual
- Right medication
- Right dosage
- Right time
- Right route
- Right documentation

Compare the medication sheet the pharmacy label, and copy of the prescription very carefully. Make sure that they match exactly. Double check them. If they do not match, contact your supervisor immediately. Do not give a medication to an individual when the documentation does not match.

**Right Individual**

This process should be a learning experience. To be able to teach, you have to know the individuals and their medication. You should not give medication to individuals that you do not know. Giving medication to the wrong person is dangerous! Medication should be given one-on-one and not as part of a group.
Right Medication
Be sure to check both the name and the strength of the medication. Sometimes a person is prescribed the medication, but with different strengths throughout the day (i.e. Depakote 250mg, 500mg). Both name and strength must match what has been prescribed.

If an individual tells you that “those aren’t my meds,” step back and look at the medication. See if you can figure out why the person is saying this. Is it a change in the size, shape or color of one of their routine medications? Is this medication new (so unfamiliar) to this individual? Could this be a violation of one of the rights of medication administration?

Notice if the medication looks different (color, size, shape, etc…) from the last time you gave the medication. If it does, stop. Do not administer the medication until you have checked with designated agency staff for guidance.

Never give a medication from another person’s container, even if it is the same medication.

Right Dosage
Carefully measure or count the correct dosage and compare this amount with the pharmacy label and medication sheet.

Right Time
Some medications are administered at specific times of the day (e.g. a clock time such as 8am or an event time such as after meals, at bedtime, etc…). Start administering medications at the time prescribed and continue until the process is done. Medications must be given at the prescribed time unless otherwise authorized by the prescriber.

Medications can be given in the standard window, one hour before or one hour after the designated medication time, unless otherwise specified by the physician. For example, a medication that is supposed to be given at 8am can be given between 7-8am or 8-9am. If it falls outside of this window, contact your designated agency personnel for approval on administering the medication. Usually, the pharmacy or doctor will need to be consulted to ensure it is still safe to give the medication.

Right Route
When a physician/advanced practice nurse prescribes a medication, he or she will specify the way it will be taken. This is known as the route (ear drops in ear, eye drops in eye, etc…). Capsules and tablets are usually swallowed (oral route). Ointments are usually applied externally (topical route). The route and body location needs to be included on the prescription (e.g. apply cream on top of right foot). It cannot be a general statement (e.g. apply to infected area).
Right Documentation

Once the medication has been successfully administered, you must initial the appropriate box on the medication sheet. Look for the time you administered the medication and compare it to the date of the month in order to find the correct box. Then initial the box. Be sure to write your full signature and initials in the signature box if it is the first time you’ve administered medication on that medication sheet. Do not initial or sign your name in advance on any medication sheet.

Check Each of the Rights

This procedure is essential each time you administer any medication. Even if an individual is on a medication for a long period of time there is always a possibility that some change has been ordered that you are unaware of. You must check for all six rights each and every time you administer any medication.

If any of the 6 Rights of Medication Administration are in doubt, STOP! You must check with the appropriate person (e.g. supervisor, prescribing person, pharmacist) to resolve any issues before administering the medication.
Information for the Doctor

For the best treatment the doctor must have several pieces of information. With the aid of the following information, the doctor will have a better opportunity to offer maximum help and minimize potential dangers. You are responsible for knowing where this information is kept.
The five types of information which should be provided to the prescriber are:

1. **Reason for the visit**
   Written observations of recent changes in objective, subjective or behavioral signs. This information may be gathered from daily logs, seizure records, incident reports, etc... All information should be brought with you to healthcare appointments.

2. **The individual's medical records**
   It is impossible to know the types of information the healthcare professionals may want to know. Communicating all medical information between all healthcare professionals is essential.

   Some pre-existing conditions may greatly influence the doctor's choice of treatment.

3. **Allergies**
   Allergic reactions can be fatal. It's important that any allergy is brought to the attention of the person's healthcare provider. This includes allergies related to foods, medication, insects, and the environment.

4. **Current medications being administered and for what purpose [prescription, prescription PRN, and Over the Counter (OTC)]**
   The prescribing person needs to be made aware of all medications a person is taking and the administration times. Mixing medications can result in a variety of unwanted effects.
5. Updates
Provide updates on medical or dental conditions currently not being treated by medication (i.e. hypertension, arthritis, heart disease, etc...) as well as information on recent hospitalizations (sprained ankle, influenza, etc.) and surgeries (gall bladder, appendix, etc.).
Encourage Participation

- Support the person to communicate what is wrong.
- Remind the health care professional to speak to the individual
- Model respectful behavior

Encouraging Participation
Support the person to communicate what is wrong. Individuals differ greatly in their ability to represent themselves. Some individuals need minimal support from staff (e.g. transportation, assistance with documents, etc...). Others may require more support from staff.

Encourage the health care professional to speak to the individual. Some of the health care professionals you meet may not have experience working with individuals with developmental disabilities. All efforts should be made to include the person in any conversations. Before the appointment, staff should discuss what will occur, questions that may be asked, and what the person wants to let the medical professional know. If what the person is saying differs from known observations you will need to respectfully discuss this with the person and the health care professional.

Model respectful behavior. When you show respect and have a positive attitude toward the people you support, you are being a good role model to others.
<table>
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<tr>
<th>Wrong Way</th>
<th>Right Way</th>
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<tr>
<td>1. You describe all the individual’s symptoms and behavior changes.</td>
<td>1. Encourage the individual to provide his or her own description first and you fill in later.</td>
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<tr>
<td>2. You interrupt, disagree, or argue with the individual over answers to questions.</td>
<td>2. Respectfully communicate factual information to the medical professional.</td>
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<td>3. You answer the doctor’s question without waiting to give the individual a chance.</td>
<td>3. Always allow the individual to answer first. If necessary, redirect the doctor’s question to the person.</td>
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<td>4. You ask the doctor all the questions about any effects, how long it should take to see results, etc…</td>
<td>4. Encourage the individual to ask all the questions he or she can remember. Then you ask the rest with permission from the individual.</td>
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<td>5. You go to the pharmacist and have the prescription filled without the individual.</td>
<td>5. Have the doctor give the person the prescription and provide the assistance, if necessary, to have it filled.</td>
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Discussion with Doctor

- What are the treatment options?
- Can this medication be prescribed in a way that fits with the person’s home and work schedule?
- Remind doctor of the person’s insurance:
  - Is the medication going to be covered?
  - If it’s not covered, is there another medication that would work as well that is covered?
- Advocate.

Important Discussions to have with the Doctor When a Medication is Prescribed

1. What are the treatment options?
   Not all symptoms need to be treated with medication. For example, the best treatment for cold symptoms may be rest and plenty of liquids. Medication may not be needed and could even prolong the symptoms. Be sure to discuss all treatment options, including those that may not involve medication.

2. Can this medication be prescribed in a way that fits with the individual’s home and work schedule (including sleeping late on weekends, working in the community, etc…)?

3. Remind the doctor of the insurance plan the person has. Ask these questions:
   a. Is this medication going to be covered by the individual’s prescription plan?
   b. If the medication is not covered by the individual’s prescription plan, is there another medication that would work as well that would be covered by the individual’s prescription plan?

4. Advocate
   a. You may need to contact your supervisor to handle a situation.
   b. Inform the doctor if the person needs a liquid, chewable, or another form of medication.
Ask the Doctor:
Six Important Questions

1. What is the purpose of the medication?
2. What is the desired effect of the medication?
3. What is the response time?
4. Are there any unwanted effects that this medication is likely to have?
5. Are there any special instructions?
6. Are there any interactions with other medications, food, or the environment to be aware of?

Information to get from the Doctor About the Chosen Medication

If a medication is prescribed, ask 6 important questions about the medication. Get the answers in writing and do not rely on your memory. Review the answers with the pharmacist. Your agency may have a form that includes this information. Check with your agency for specifics. A sample form is in the resource section.

Six Important Questions

1. **What is the purpose of the medication?**
   What is the medication being prescribed for?

2. **What is the desired effect of the medication?**
   How will we know if it’s working? Are we looking to lessen symptoms someone is feeling, or to prevent something?

3. **What is the response time?**
   How long will it take this medicine to start working? Some medications may take weeks to reach a level where improvement will be seen, others may only take a few days or even hours.

4. **Are there any unwanted effects that this medication is likely to have?**
   All medications have the possibility of causing effects other than the reason we are taking it. We want to know what we should specifically look for when taking this medication. Even if the unwanted effect is common or predictable, such as
getting sleepy with an allergy medicine, we want to know so that we can tell if the person’s response is worse than expected.

5. **Are there any special instructions?**
   **Storage:** Should this medication be stored in a special way, such as in a refrigerator or never in an area that is too hot? Is it a controlled substance? Not all pharmacies note on the bottle if a prescription is a controlled substance. We want to be sure to know if it is, so we can follow extra safety precautions.

   **Administration:** We also want to know if the medication needs to be taken on an empty stomach, with food, with milk, etc...

6. **Are there any interactions with other medications, food, or the environment to be aware of?**
   How will this medication react with other medications the person is already taking or that is being prescribed at the same time? Interactions can be very serious so knowing all of the medications that a person takes will help the doctor avoid them.
Don’t leave without documentation

Examples include:

• Original and Copy of the prescription
• Doctor’s Visit/Medical Consultation form
• Signed discharge papers from a hospital
• Print out of the electronic prescription

Documentation to get from the Prescriber

It is required that agencies have a signed order on file for each medication being administered. The most common forms of a signed order are:

• Original and Copy of the prescription
• Doctor’s Visit/Medical Consultation form
• Signed discharge papers from a hospital
• Print out of the electronic prescription (e-script)

Regardless of the type of documentation remember that it must be signed by the prescriber. Staff must write or stamp the word “copy” on the copy of the prescription or print out of the e-script. This copy should be kept in the person’s section of the medication book.

Some agencies may require more than one form of documentation. For example an agency may use a Doctor’s Visit or Medical Consult form that needs to be completed by the individual or the staff supporting the person with information about why the person is seeing the health care professional. The health care professional would then be asked to make notes about anything done during the visit including any medication changes, additions, or discontinuations. However the agency may still require a copy of the written or electronic prescription for filing in the medication book. Check with your agency for specifics.
If a medication is discontinued and that is the only information on the signed order, you can file the original and provide a copy to the day program if medications are also administered there. Typically it will be stapled to the medication sheet and filed at the end of the month.

**Electronic Prescriptions**

Electronic prescriptions (e-script) are when the prescriber sends the prescription information directly to the pharmacy electronically. Electronic prescriptions can also be referred to as e-prescribing or eRx.

When electronic prescriptions are used, the staff must ask for a print out of what was sent to the pharmacist. The printout typically includes all the medication changes, additions, and discontinuations on one page. Staff should be sure that they:

- Ask the prescriber to sign the paper if there is not already a signature
- Write or stamp the word “copy” on the print out
- Keep the copy in the medication book

If the printout cannot be obtained at the time of the medical appointment, the person who receives the printout must review it for accuracy and contact the prescriber if there are any questions.

**Understanding the medication**

Having the documentation and understanding it can help us safely administer the medication.

- Read and fully understand all the information on the prescription
- If there is anything that seems confusing or is unclear, ask questions before leaving the prescriber’s office
SAMPLE E-SCRIPT

Copy of Renewal Authorizations
Sidney Spina, Male, DOB Nov. 28, 1970

Authorizing Provider: Dr. Sandra Hankuc MD
Name of Practice: Feeling Better Family Practice

Address: 123 Sesame Street
Oz, NJ 00000
Telephone # 555-555-1234
DEA # - 314314314

Patient: Sidney Spina
1601 Pennsylvania Ave
Hack, NJ 00000
1-555-555-4567

Pharmacy: * Yellow Oak Pharmacy
100 Yellow Oak Road
Hack, NJ 00000
1-555-555-3143 Phone
1-555-555-2132 Fax

Health Plan: Happy Health Plan USA
Member ID: 11235813213455

Metformin OR TABS 500 MG (Renewal)
Quantity: 90 (ninety) Tablets
SIG: Take one tablet at 7:00am and one tablet at 9:00pm
Refills: 3
Substitution Permissible
Note to Pharmacist:

Celebrex OR CAPS 100 MG (Renewal)
Quantity: 60 (sixty) Capsules
SIG: Take 2 capsule with breakfast
Refills: 0
Dispense As Written
Note to Pharmacist: Brand medically necessary

Date: Tuesday, August 31, 2014 3:30 PM EST
Authorized:

* This copy lists the pharmacy specified and date prepared, but it is not a confirmation of successful transmission. Please refer to the Activity Report.
Verbal Orders/Telephone Orders

Verbal orders occur when you speak to a doctor over the phone and s/he changes an individual's medication or treatment.

Verbal Orders/Telephone Orders

Verbal orders occur when you speak to a doctor over the phone and s/he changes an individual’s medication or treatment (i.e., fasting for blood work, continued use of crutches etc.).
Be prepared for a verbal order:

- Have the person’s medical information available including allergies, weight, current medication and administration times, etc…
- Write down the date, name of person, medication, dosage, time, and route.
- Read back the verbal order to make sure it’s right.
- Immediately write the information on the MAR
- A signed and dated confirmation of the verbal order must be received from the prescriber within 24 hours/next business day.
- Follow your agency’s policies and procedures.

Confirmation of Verbal Orders

When speaking to the prescribing person on behalf of someone with a disability, make sure to have their medical information available (e.g. allergies, weight, current medication and administration times, etc…).

Your responsibility as the person accepting the verbal order is to write down the date, name of the individual, medication, dosage, time, and route. It is important to read back the verbal orders to the prescribing person to make sure that you have the right directions.

The instructions given in the verbal order must be followed immediately.

The information must be written on the medication sheet immediately (e.g. discontinue, skip a dose, continue as prescribed, new medication is added, etc…).

A signed and dated confirmation of the verbal order must be received from the prescribing person within 24 hours or the next business day. Follow your agency’s policy regarding how verbal orders are documented and where they are kept (e.g. critical log, individual log, etc…). You also need to tell other staff members about the verbal order.

If there is a medication change the label will not match the new order. Do not change the original pharmacy label. You will need to get a new pharmacy label from the pharmacist within 24 hours or the next business day. The prescription and pharmacy label must match.
Your agency shall establish procedures to ensure that medications are picked up, delivered, and administered within 24 hours unless otherwise documented by the prescribing person.
Medication at Multiple Locations

Residential Programs:
• Get a 2nd copy of the signed order for the day program.
• Calculate how much medication is needed at each location.
• Tell the pharmacist you need a separate container for each location and how much is needed in each.
• Check your agency’s policy to see how the medication is transported to the other location.

When Medication Will Be Administered at More than One Location

Residential Programs
If the person has medication that needs to be administered both at home and at day program, you must:
• Get or make a second copy of the signed order from the prescribing person for the day program.
• Calculate how much medication is needed in each location.
• Tell the pharmacist that you need a separately labeled container for each location and explain how much needs to be in each container.
• Check with your agency on how the medication must be transported to and from the day program.

If the person has medication that will be needed while away from home (e.g. visiting friends and family, movies, shopping, work, etc...), the Standards for Community Residences for Individuals with Developmental Disabilities (N.J.A.C. 10:44A) states that “all medications shall be kept in their original containers from the pharmacy and shall be properly identified with the pharmacist’s label.”
Medication at Multiple Locations

Day Program:
- Keep a copy of the signed order.
- Keep the medication in the original, properly labeled container.
- Record the receipt of the medication including the date and amount.

When Medication Will Be Administered at More than One Location

Day Programs
If medication must be administered while someone is at your program, you must have:

a. A copy of the signed order from the prescriber with the word “copy” written or stamped on it.
b. The medication in the original container issued by the pharmacy and it must be properly labeled.
c. A record of the receipt of the medication including the date received and the number of pills indicated on the bottle. If medication comes in another form (e.g. creams, liquids, etc…) the amount received must be documented.
d. Your agency might have a policy to count the pills. Check with your agency for specifics.

According to the Standards for Adult Day Programs, if you are going to be away from the program when a medication is due then the medication must be in a sealed container labeled with the following:

a. Individual’s name
b. Name of medication
c. Dosage
d. Frequency
e. Time of administration, and
f. Method of administration
Pharmacist Gets Prescription

Once a medication is prescribed, you will need to make sure the written prescription gets to the pharmacy. A prescription functions as a signed order from the physician to the pharmacist. A sample prescription is shown below.

---

**State of New Jersey**

**PRESCRIPTION BLANK**

T. Berry, M.D  
4965 Center Street  
City, NJ  
(908) 555-9237

Batch #: ZYX987654321CBA  
LIC#: 123456  
DEA#: 987654

**PATIENT** Timothy Potter  
**ADDRESS** 40 Cedar Lane, Mana, NJ 07686

**Rx**

Lipitor 10 mg

**Sig:** tab QD at 8am

#30

**STATIONERY PERMISSIBLE**

**DO NOT REFILL**

**REFILL** 3 TIMES

**SIGNATURE OF PRESCRIBER**  
T. Berry, M.D.

---

DDD Community Services Curriculum  
**Prescription Explanation**

1. The phone number, name of prescribing person, and address. The information must appear on the prescription.

2. The batch, license, and DEA numbers (#’s) are numbers verifying that the person has the authorization to prescribe.

3. Name of the person for whom the medication is prescribed. This must match with other medications and the existing medication sheet. Date of birth and address are typically not written by the doctor, but are used as verification by the pharmacist. The date must also be included on every prescription.

4. RX is a formulation from a Latin word meaning “take thou.” It is followed by the name and strength of the prescribed medication. In this case, the name of the drug is Lipitor and the strength is 10mg (milligrams).

5. Sig is an abbreviation of the Latin Word meaning “write on label.” Tab is tablet. The daily dosage is sometimes written in Latin numerals and abbreviations. † means “1” and QD means “once daily.” Your agency may require that specific administration times be indicated on the original prescription. The pharmacy will translate and staff are not required to memorize these abbreviations. However, direct care staff have caught pharmacy errors by referring to the abbreviation list and comparing the pharmacy label to the original prescription.

6. Dispense: Specifies the number of units (count) of medication the pharmacist is to provide.

7. The prescriber must indicate whether or not substitutions are permissible. If the prescriber indicates no substitution for a brand name medication, he/she must indicate "brand name medically necessary" so that Medicaid will pay for the medication.

   If the prescriber permits substitution, the pharmacist may give you a generic brand (e.g. phenytoin) instead of a brand name (e.g. Dilantin). The generic medication will be the same thing chemically as the brand-name medication and is very likely to be less expensive. Ask the pharmacist to verify that a particular generic drug is exactly the same thing as the brand-name prescribed by the physician. Ask the pharmacist to include both the brand name and generic name on the pharmacy label. If the medication is generic the pharmacy may type “generic for” or “s/f” which can mean substituted for or same formula as.

8. Refill: Tells how many times a medication may be reordered without obtaining another prescription.

9. The prescriber’s signature: The doctor or advanced practice nurse must sign each prescription.
Medication Packaging

1. Medication can be packaged in many other ways besides in a bottle. Some of the other packaging includes:
   a. Bubble packs: one month on each “card” or can be weekly cards
   b. Cassettes: often 2 weeks in each cassette labeled M, T, W, etc.
   c. Rolls/spools: each tablet/capsule is fully labeled and can be removed one at a time
   d. Bags: Tablets/capsules due at a particular time in one sealed clear bag that is labeled

2. The pharmacy label on the package may be arranged differently, but the information required remains the same as a pharmacy label on a pharmacy bottle.

3. Check your agency’s policy regarding documenting the amount of medication received.
Pharmacy Label

The pharmacist will give the medication in a “container” which has a pharmacy label. The pharmacy label must match the prescription exactly. The pharmacist cannot add instructions to the typed label. No one can write on the pharmacy label or medication container or medication packaging.

The pharmacist might add additional information on “stickers” on the pharmacy container, such as “drink with milk,” “may cause drowsiness,” etc… If the new information is in conflict with the person’s schedule contact the prescriber immediately.

The label shown below is an example of a pharmacy label made from the prescription looked at previously.

---

**My Pharmacy**

908-555-2868 • 3821 Cummings • City, New Jersey

1 Timothy Potter

2 40 Cedar Lane

3 Mana, NJ 07686

Date prescription was filled

4 Lipitor 10mg

5 #30

6 Take 1 tablet at 8am

7 Rx 2284112376

8 Refills Remaining 3

9 Expiration Date

Dr. T. Berry

One year later or less
**Label Explanation**

1. Pharmacy’s name, phone number, and address

2. The individual’s name and address

3. Date the prescription was filled

4. Name and strength of the medication. The name and strength may not match the prescription if substitutions (e.g. generic for brand) are permissible. It is a good idea to have both the brand and generic names on the label; in fact some agencies require it.

5. Dispense Number

6. Directions for taking the medication

7. Prescription number (given by the pharmacy) and the physician’s name

8. Number of times a medication may be re-ordered without a new prescription

9. Medication’s expiration date should appear on the pharmacy label. It is unsafe to take some medications after a certain period of time. The expiration date for prescribed medication must be one year or less from the date on the pharmacy label.
Check for Mistakes

Check and Double Check

• Compare the pharmacy label with the copy of the signed order.
• If there is a mistake talk to the pharmacist in order to correct it.
• Do not document on a medication sheet or administer the medication until the mistake is corrected.

Complete the following practice activities.

Checking for Mistakes

Although pharmacy labels may look different, all of the information must be on the label.

Check and Double Check

When you are at the pharmacy, immediately compare the pharmacy label with the copy of the signed order (e.g. prescription copy, e-script, etc…). If there is any mistake, show it to the pharmacist and ask for the pharmacist’s help in making these two pieces of information match.

If you do not pick up the prescription at the pharmacy, make this comparison at the time it is delivered to you. If you find a mistake, contact your supervisor immediately.

You cannot document on a medication sheet or administer the medication until the mistake is corrected.

Check your agency’s policy regarding counting medications. If your agency’s policy requires checking the amount of medication received, you must let the pharmacist know if the amount is incorrect.

Sometimes medication is prescribed over the telephone. When you get the medication, look for mistakes by comparing it with the verbal order and then with the signed order once it is received.
Advocacy

- Consider Kathy’s preferences, work/home schedule.
- Look for other options for Kathy
- Contact Kathy’s prescriber to advocate for changes as needed.

Advocacy:

1. If all the additional instructions for Kathy were correct (3rd label from prior activity), then this medication would be very difficult for staff to administer and Kathy to take:
   a. Were her preferences and work/home schedule considered?
   b. Will she be able to avoid food/milk in the timeframes described or will this be too difficult for Kathy?
   c. Will this completely disrupt Kathy’s normal routine and cause her stress?

2. As an advocate for Kathy we should be looking for other options for her. There may be another medication that would work for her but would not have so many restrictions.

3. If this medication is the only one that will work for Kathy, at least she will see that we worked together with her to try for another option. This may be helpful in the difficult days ahead as she tries to manage this medication within her schedule of work, mealtimes, snack times, etc.
Effects of Medication

- **Desired Effect** – The beneficial effect of the medication
- **No Effect** – An absence of any effect
- **Unwanted Effect** – Effects that are produced by the medication other than the desired ones

Effects of Medication

Whenever a prescriber prescribes a medication he or she must weigh the potential benefits of the desired effect and the potential dangers.

Only physicians and/or advanced practice nurses may prescribe medications; only registered pharmacists may dispense medications; only trained staff may administer medications.

1. **Desired Effect**
   - The desired effect is the beneficial effect of the medication. The medication is doing what it was prescribed to do.
   - Examples of desired effect include seizure activity being reduced by an anticonvulsant (Dilantin), a headache stopped by a pain reliever (aspirin) or preventing an illness (rubella, H1N1, chicken pox) with a vaccine.
2. **No Effect**
   No effect means an absence of any effect; the medication is producing no change. If the response time has been reached and no benefit has been seen, there is no effect.
   For example, an infection does not improve or may get worse, even though an antibiotic was taken; or seizure activity is not reduced or controlled by an anticonvulsant.

3. **Unwanted Effects**
   Unwanted effects are the effects that are produced by the medication other than the desired ones.
   They can be relatively harmless (e.g. drowsiness, urine discoloration, etc...), harmful (e.g. rash, vomiting, etc...) or life threatening (e.g. difficulty breathing, etc...).

**The Staff are Responsible for Reporting Any Changes**
Even if the unwanted effects are expected, it is necessary to observe and report these effects. This could be to the prescribing person, agency personnel (administrative staff, agency nurses etc.), and/or others as directed by your agency.

The most important thing to remember is that any change (physical or behavioral), especially during the first few days when a new medication is introduced, may have been caused by that medication. As a staff person, you are best able to observe for any behavioral or physical changes. In fact, it is up to you to observe and report any and all suspected effects of the medication immediately.
Medication Interactions

Whenever one person is taking two or more medications, an interaction is possible. Every medication has the potential to interact with another medication. Medication interactions are the result of taking two or more medications at the same time.

The resulting interaction may:

a. **Increase** the effects of one or more medications. For example, if someone is taking Fluvoxamine (brand name Luvox) and then is prescribed Diazepam (brand name Valium), the effects of the Diazepam will last much longer.

b. **Decrease** the effects of one or more medications. For example, if someone is taking Esomeprazole (brand name Nexium) and then is prescribed Iron Chews, the iron will not be absorbed into the body properly.

c. Create **New and Unique** unwanted effects. For example if someone is taking Phenytoin (brand name Dilantin) and then is prescribed Omeprazole (brand name Prilosec) it can cause toxicity resulting in symptoms such as drowsiness, seizure, and nausea.
Medication Interactions:  
Points to Remember

• The chance of interactions increases with the number of medications being taken.

• Each prescribing person must be made aware of all medications a person is taking in effort to avoid unwanted interactions.

• Consider food, beverage, and environmental interactions.

There are important points to remember concerning interactions:

1. The greater the number of medications taken at one time, the greater the possibility that a medication interaction will occur.

2. It is important that each prescribing person is made aware of all medications a person is taking to avoid unwanted medication interactions.

3. There may also be food/beverage interactions. Some medications require that certain foods/beverages be avoided while others require that specific food/beverages be consumed with the medication. One example would be to avoid foods high in acid when taking antibiotics because antibiotics are destroyed by stomach acid. Another would be to increase foods high in acid (e.g. orange juice) when taking urinary antiseptics, as these medications work best when the body has a high acid content. In addition, many medications specify that you shouldn't drink alcohol while taking them.

4. Sometimes there are environmental interactions. Some medications (antibiotics, cardiac, diabetic, and psychiatric) can cause an individual to be very sensitive to sunlight which can cause a quick and serious sunburn. Other medications (blood pressure, arthritis, and skin) will increase the likelihood that individuals will be cold. You must be aware of the potential interactions of the medication the person is taking and take precautions to prevent harm.
Medication Effect Terminology

• Medication Allergy
• Cumulation
• Tolerance
• Addictive Effect
• Toxicity
• Medication Elimination
• Medication Allergy
• Medication Sensitivity

In addition to medication effects previously described there are additional terms to be familiar with when discussing medication effects.

• **Medication Allergy** – An adverse reaction to a medication (e.g. antibiotic, etc...) that is mediated by the body’s immune system. The response may be immediate or slow to appear, and can become life threatening.

  The following are serious signs of allergic reactions that can be life-threatening and require calling 9-1-1:
  
  ➢ Trouble breathing, including wheezing, shortness of breath, tightening of throat
  ➢ Swelling of face or tongue
  ➢ Rash/hives covering face or large portions of body
  ➢ Dizziness, lightheadedness or loss of consciousness

• **Cumulation** – The body does not eliminate one dose of a medication before another dose is given.

• **Tolerance** – Resistance to the effect of a medication

• **Addictive Effect** – The physical or emotional dependence on certain medications

• **Toxicity** – When medication levels are dangerous and/or poisonous to the body
• **Medication Elimination** – The effects of a medication cease when the medicine has been eliminated from the body. Medications are eliminated by the lungs, kidneys, intestines, skin, liver, or salivary glands. However, bear in mind that many medications build up in the body and when the medication is stopped the effects may continue for several days until it is completely eliminated from the body.

• **Medication Sensitivity** - an unusual reaction to a medication that does not involve the immune system and is typically less severe, such as drowsiness from a medication that typically does not cause that reaction.
Medication References

Your agency must provide access to a medical reference book. Some useful resources include:

- The Pill Book
- WebMD
- Yahoo Drug Guide

Medication Information

Your agency is required to provide you access to a medication reference written for the lay person. The reference must be current within three years and include information on the effects and interactions of medications.

The Pill Book is one of several medication information manuals that will help you get this information. This manual will list the medication by both the generic name and brand name as well as describe important information about each medication.

If a prescribed medication is not listed, you should call the prescriber or a pharmacist to get the information. You can also get a lot of information on the internet (e.g. WebMD, Yahoo Drug Guide, etc…).

The following is an example of the information you would find in The Pill Book and a description of items of information.
Ativan  
(Lorazepam) - Biovail

THERAPEUTIC CLASS  
Benzodiazepine

INDICATIONS  
Management of anxiety disorders or for short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms.

ADULT DOSAGE  

PEDIATRIC DOSAGE  
Pediatrics: >12 yrs: Initial: 2-3mg/day given bid-tid. Usual: 2-6mg/day in divided doses. Insomnia: 2-4mg qhs.

HOW SUPPLIED  
Tab: 0.5mg, 1mg*, 2mg* *scored

CONTRAINDICATIONS  
Acute narrow-angle glaucoma.

WARNINGS/PRECAUTIONS  
Avoid with primary depression or psychosis. Withdrawal symptoms with abrupt discontinuation. Careful supervision if addition-prone. Caution in patients with compromised respiratory function. Caution with elderly, and renal or hepatic dysfunction. Monitor for GI disease with prolonged therapy. Periodic blood counts and LFTs with long-term therapy.

ADVERSE REACTIONS  
Sedation, dizziness, weakness, unsteadiness, transient amnesia, memory impairment, visual disturbance, depression, respiratory depression, constipation, vertigo, change in appetite, headache.

DRUG INTERACTIONS  
CNS-depressant effects with barbiturates, alcohol. Diminished tolerance to alcohol and other CNS depressants. Increased plasma levels with valproate and probenecid, decrease dose by 50%.

PREGNANCY  
Not for use in pregnancy or nursing.

MECHANISM OF ACTION  
Benzodiazepine; antianxiety agent, interacts with GABA-benzodiazepine receptor complex.

PHARMACOKINETICS  
Absorption: Absolute bioavailability (90%); C_max=20ng/mL (2mg PO); T_max=2 hrs. Distribution: Plasma protein binding (85%). Metabolism: Glucuronidation. Elimination: Urine; T_1/2=12 hrs.

ASSESSMENT  
Assess for acute narrow-angle glaucoma, pre-existing depression and/or psychosis, compromised respiratory function (e.g., COPD, sleep apnea syndrome), impaired renal/hepatic function, and possible drug interactions. Assess addiction-prone individuals (e.g., drug addicts, alcoholics).

MONITORING  
Monitor worsening of depression and/or suicidal thinking, physical/psychological dependence, paradoxical reactions, CNS depression, lab tests (CBC, LFTs, and LDH). 

PATIENT COUNSELING  
Inform that psychological/physical dependence may result; consult physician before increasing dose or abruptly d/c drug. Caution with hazardous tasks (e.g., operating machinery/driving); do not drink alcohol or take other CNS depressants concomitantly.

ADMINISTRATION/STORAGE  
**Documentation**

**Preparing a Medication Administration Sheet/Record**

*(General Information)*

- Print.
- Use black ink.
- The Medication Administration Sheet/Record is a legal document. No erasures or correction fluid/tape are permitted.
- If a mistake is made on a new Medication Sheet, destroy it and start over.
- If a mistake is made on an existing Medication Sheet, draw one straight line through the mistake, initial, and make the correction.
- Yellow highlighter may be used on a Medication Sheet. Check with your agency’s policies.

---

**Medication Sheet**

All medications that are administered must be documented. The form used for this purpose is called a medication sheet. Your agency may call this form something else, such as the Medication Administration Record (MAR). The important thing is that the document allows you to keep a record of each medication administered.

The form used in this training may differ slightly from the one in your agency, but the basic information must be included. Some agencies use pharmacy generated medication records. These forms can be changed upon agency request to meet the criteria mentioned in the following pages.

**General Information for preparing a Medication Sheet**

1. Print.
2. Use black ink.
3. The medication sheet is a legal document. No erasures or correction fluid/tape are permitted.
4. If a mistake is made on a new medication sheet, destroy it and start over.

5. If a mistake is made on an existing medication sheet such as in spelling, draw a straight line through the mistake, initial it, and make the correction. You must sign and initial the medication sheet for that month. If the mistake is on a pharmacy supplied medication sheet, make the correction the same way, and call the pharmacy to notify them of the mistake.

6. Yellow highlighter may be used on a medication sheet. Check with your agency regarding the policies and procedures.
<table>
<thead>
<tr>
<th>Name</th>
<th>Code</th>
<th>Staff Signature</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D</td>
<td>1.</td>
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<tr>
<td></td>
<td>X</td>
<td>2.</td>
<td></td>
</tr>
<tr>
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<td>C</td>
<td>3.</td>
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<td>NPO</td>
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<td></td>
<td>A</td>
<td>9.</td>
<td></td>
</tr>
</tbody>
</table>

| Month and Year | 10.         |         |

| Allergies | 1.          |         |

<table>
<thead>
<tr>
<th>Medication</th>
<th>Day</th>
<th>Code</th>
<th>Staff Signature</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give, how many? e.g. tablets</td>
<td>HRS</td>
<td>D</td>
<td>1.</td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>X</td>
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<td>NPO</td>
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<td>A</td>
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</tr>
</tbody>
</table>

| | 10. |         |

| | Code | Staff Signature | Initials |
| | D | 1. |         |
| | X | 2. |         |
| | C | 3. |         |
| | R | 4. |         |
| | V | 5. |         |
| | P | 6. |         |
| | H | 7. |         |
| | NPO | 8. |         |
| | A | 9. |         |

| | 10. |         |
Description by Item Number

1. Enter the **name of the person** receiving medication. If a person has a nickname, the nickname can be included in parenthesis.

2. Enter the **current month and year**. No abbreviations. Spell out the month and write the full year (e.g. January 2014).

3. **Allergies** – This box must be filled in with the name of any allergies (e.g. pollen, food dye, wheat, cats, antibiotics, etc...).
   
   If there are no known allergies at this time put “None Known” in the allergy box. Do not use “NKA,” “N/A,” etc… Your agency might indicate allergies by using red ink. Check with your agency for specifics.

4. **Medication** - In this box, copy the name of the medication, strength (e.g. mg., grams, etc…), dosage, and frequency directions exactly as they appear on the pharmacy label (e.g. Erythromycin 250mg 1 tablet, 4 times a day for 10 days). All of this information must be included in the medication column. Do not abbreviate unless the abbreviation is already on the pharmacy label. If a medication is being applied to a particular area of the body remember to copy exactly from the pharmacy label (e.g. apply cream to right hand, etc…).

   After all directions are complete, draw a line underneath to separate other medication entries.

5. Give **how many** (e.g. tablets)? – Write down how many or how much is to be given at each administration time (e.g. 2 capsules, 1 tablespoon, etc…). You must not abbreviate.

6. **Hours** – The time should reflect what is written on the prescription and pharmacy label. This is where the time of day that the medication is to be administered is written. If not specified by the physician or pharmacist, it is up to the discretion of the individual’s staff member to decide upon appropriate times to administer the medication. The administration times should be based on the person’s schedule (e.g. work, home routine).

   **Clock Time**: This is the exact time that a doctor prescribes the medication to be given or the time determined by the person and his/her supports based on schedule (e.g.. 7am, 11am, 6pm).

   **Event Time**: The prescriber may use an event (e.g. breakfast, bedtime) as a time to take medication, therefore that event is written in the hours box. Do not write a clock time (e.g. 8am) in place of the event (e.g. breakfast). Use more than one box if more space is needed.

**Common Time Abbreviations**:
- AM – A
- PM – P
- Before – Bef
- After – Aft
- Breakfast - Bkft
7. **Day** – This section is only used when medications are administered on specific
days of the week (e.g. M, W, Th). Staff should write the initial for the day of the
week that the medication is to be given in the boxes above the numbers, (e.g. M=
Monday).

8. **1 – 31** – These are the days of the month. This is where you would initial after you
have given a medication. You would find the correct box by locating the day of the
month and the time of the day that the medication was given. The staff then initials
in the box which intersects these two points. If a medication is started on any day
other than the first of the month, draw a straight line through the unused boxes prior
to the start date and time.

   By the end of the month, if completed correctly, each box for each medication will
be filled with either staff initials, codes, or a straight line. The medication sheet
must not be initialed in advance.

9. **Staff Signature** – Any staff who initials on the medication sheet must sign their first
and last name and initial in this section. These initials will be used in the boxes
when signing for medications which are administered to the individual. The initials
that are recorded in this section need to match what is recorded in each
administration box (area #8). Your signature needs to be clear, legible, and
understood by everyone.

   If any staff members have the same initials, then staff members need to decide how
they will make their initials differ from each other (e.g. Mary A. Jones will use MAJ;
Mark Jensen will use MJ to sign or J as long as the initial is not a code).

10. **Code** - If a medication is not given for any reason, then one of these codes (from
area #10) must be written in the box (area #8) instead of initials to explain why. The
code should be written in the box at the time the dose is due. If any code is used
other than those listed it must be explained in this area.

   If there are any changes in the medication during the month (e.g. dosage, time,
frequency), discontinue it on the medication sheet. This is done by writing the code
“D” in the correct box of that date for the medication and drawing a straight
horizontal line from that box through the rest of the month. If there is more than one
dose per day for the medication then repeat the code “D” in the lines for each dose.
If there is a new order immediately document it on the
medication sheet.

   a. If a medication is discontinued prior to the end of the month, write “D” in
the box and draw the lines as described above.

   b. Documentation of the change/discontinuation must be received from the
prescriber within 24 hours or the next business day.

Only codes “D”, “X”, and “C”, those above the line, can be written in advance. An
example of this would be a prescription shampoo to be used every other day. For all
the days that the shampoo will not be used a staff person could write “X” in the boxes in advance to be sure it is not administered on those days in error.

Medication Sheet Practice

The prescription, pharmacy label, and medication sheet shown on the next page demonstrate how you should check information and record it on the appropriate documentation. After going over this example as a group, you will practice making Medication Sheets and then be given an opportunity to receive instructor feedback.
My Pharmacy
908-555-2868 • 3821 Cummings • City, New Jersey

Nina Wyatt
3 Morey Rd.
Hack, NJ

Dilantin 100 mg. Take 1 capsule 3 times a day. 8am, 12pm, 4pm.

# 90

Rx NF99999

Refills Remaining 3

Expiration Date One year later or less

T. Berry, M.D.

Date prescription was filled

DDD Community Services Curriculum
Learner’s Manual - Medications 6th Edition
Pharmacy Supplied MAR

- Some agencies use pharmacy supply companies that prepare monthly computer-generated Medication Sheets. Follow your agency’s policies and procedures related to this.

- Note that you still must check the Medication Sheet for mistakes. You must check the Medication Sheet and the label against the written order.

Pharmacy Supplied Medication Administration Sheet/Record (MAR)

Some agencies will use pharmacy supply companies that prepare monthly computer-generated Medication Sheets. Your agency will instruct you on its policies concerning administration and documentation.

Additional information may appear on the Medication Sheets, such as unwanted effects, diagnosis, allergies, blood pressure, etc....

You must check pharmacy-supplied MAR’s to be sure changes have been made and all medications match the current prescriptions.

Please note for agencies that use pharmacy-supplied MARs, if there is an mistake on the medication sheet, it is likely to be on the label as well. You must check the medication sheet and label against the written order.
Storing Medication

• There are specific things you need to know when it comes to storing medications.

• Follow the information found in this NJ Medication Learner’s Manual along with your agency’s policies and procedures.

Storage of Medication

1. All medication must be kept locked.

2. Staff shall have a key to permit access to all medication at all times and to permit accountability checks and emergency access to medication.

3. Specific controls regarding the maintenance and use of the key to stored medication shall be established by your agency procedure (e.g. key on you, combination lock, locked key storage box).

4. Your agency may have a policy to double lock controlled substances. Check with your agency for specifics.

5. A storage area of adequate size and lighting for both prescription and nonprescription (OTC) medications shall be provided and kept locked in a box or cabinet for those individuals who are not self-administering their own medication.

6. All medications must be stored in a central location.

7. Medications should not be stored in a location where there are severe temperature or moisture changes (e.g. bathroom).

8. If refrigeration is required, medication must be stored in a locked box in a refrigerator or a separate locked refrigerator.
9. Oral medication and other medication may be kept in the same locked cabinet.

10. All medications must be stored in the original containers in which they were dispensed by a licensed pharmacist, with labels kept intact.

11. Each person’s prescription medications must be kept in separate containers within the storage area (e.g. Ziploc containers, cosmetic bags, Baggies).

12. Prescription PRN medication can be stored with other prescription medication.

13. OTC medications are stored in a separate container from prescription medications. They also must be stored in a locked container. They may be stored in the same storage cabinet or box.

14. Oral medications (e.g. tablets, capsules) must be kept separate from other medications (e.g. eye drops, foot creams). Your agency may request that you store other medications such as eye drops and foot cream separately.

15. There should typically be no more than a one month supply of any prescription or PRN prescription medication available.
Administering Medications

General Rules:

1. Staff must successfully complete Pre-Service Medication training as well as an on-site competency assessment prior to administering medications. Classroom training alone does not allow you to administer medications independently.

2. You must only prepare medication for one person at a time.

3. You cannot pre-pour medication.

4. Only the staff person who gave the medication can be the staff person that initials and signs.

5. If a staff person is going to administer a medication to an individual while away from the program, that same staff person has to be the one to prepare the medications prior to the trip and sign the medication sheet when you return back to program.
6. No medication can be signed for prior to administration.
7. Following universal precautions, staff members and individuals should wash their hands before medications are administered. However, medications should still not be touched.
8. Medications should be placed into a small cup to be given to the individual to avoid dropping the medication.
9. Medication should be given with water, unless otherwise prescribed.
10. If an individual coughs or spits out medication, contact the prescriber before re-administering. Follow the instructions you receive, document on the back of the medication sheet, and follow your agencies policies.
11. Tablets cannot be crushed or capsules opened without written authorization from the prescribers.
   a. Written authorization should say what it can be put into (e.g. applesauce, ice cream, etc...)
   b. The individual should be told that the medication is in the food unless otherwise documented.
   c. Staff must remain with the individual until the food with medication is finished.
12. Try your best to minimize distractions for both yourself and the individual receiving medication (e.g. taking turns, etc...).
13. Try to make this process as private as possible (e.g. one to one, speaking quietly, etc...) with the preference of the individual’s needs and dignity as priority.
14. Follow any special instructions included with medication (e.g. keeping eyes closed for 10 minutes, sitting upright for a specified period of time, etc...) and provide support as needed.
15. Never leave medication unattended.
16. Check prescriber instructions or other documentation (e.g. Service Plan, agency policy, etc...) to determine if more than one type of medication can be administered in a cup at the same time for the individual.
17. As per the Standards for Community Residences for Individuals with Developmental Disabilities (N.J.A.C. 10:44A) and Standards for Adult Day Programs, “a supply of medication adequate to ensure no interruptions in the medication schedule shall be available to individuals at all times.” As a general guideline, refill the prescription when a five-day supply remains. Finish the previous prescription before starting the new one.
Avoiding Errors & Maintaining Safety

- Don’t take shortcuts.
- Be Patient. Don’t rush.
- Give your FULL attention. Avoid distractions.
- Stay with the person until the medication has been taken.
- Prepare medication for only one person at a time.
- Never hide your error.
- Never cover for another staff person’s error.

Avoiding Errors & Maintaining Safety

1. Don’t take shortcuts.
2. Be patient. This process should not be rushed.
3. Avoid distractions while administering medications.
4. Give your full attention to the task.
5. Stay with the individual until the medication has been taken.
6. Watch the person swallow.
7. Make sure that the food that contains the medication is finished (e.g. apple sauce, ice cream, etc…).
8. Allow time for special instructions to be completed (e.g. eye closed for prescribed time frame after eye drops, laying down after a suppository, etc…).
9. Prepare medication for only one individual at a time.
10. Never hide your error.
11. Never cover for another staff person’s error.
Administering Pills/Capsules

- Pills and capsules are the most common forms of medication you will need to administer.
- With all medications there are specific instructions with regard to administration.
- Follow the information found in the Medication Learner Manual along with information provided by the pharmacy in the administration of these medications.
- Instructions on how to administer other types of medication can be found in the Medication Learner Manual Resource Section.

How to Properly Administer Tablets/Capsules

1. Wash hands and gather all necessary supplies (e.g. cup, water, etc).

2. Obtain key and open box.

3. Using the medication sheet, find the correct medication to be administered.

4. Compare pharmacy label to the copy of prescription and to the medication administration record/sheet to assure correct medication to be administered.

5. Count the correct dosage of medication and pour into cup without touching the medication.

6. Compare the pharmacy label to the copy of prescription and to the medication administration record/sheet to check again that the correct medication was to be administered.

7. Hand the cup to the individual receiving medication. Encourage the individual to put medication directly in mouth from cup.

8. Offer water to the individual (unless otherwise prescribed).

9. Watch for the person to swallow the medication and follow any special administration instructions (food, sit upright, etc).
10. Initial the medication sheet for the correct medication, day, and time.

11. Sign and initial the medication administration record/sheet if administering medications for the first time that month on that sheet.

12. Ensure the packaging is secure and put everything back in the medication box.

13. Lock box and secure the key.

Instructions on how to administer other types of medication (e.g. creams, drops, suppositories, etc…) can be found in the Resource Section.
Self-Medication

Many people want to and are capable of self-medicating.
- An IDT meeting can be held to discuss and evaluate this possibility.
- The person’s service plan must state that the person can self-medicate.

If someone you support shows interest in or you recognize that they have the capability to be self-medicating this should be discussed with the person’s Interdisciplinary Team (IDT). A self-medication assessment must be completed for each individual and presented at an IDT meeting. This assessment can include factors such as the person’s willingness to self-medicate and their ability to manage the medication physically, behaviorally, and medically. The IDT will evaluate the results and determine if the individual is ready to start the process. This first must be identified in the person’s Service Plan.

If the individual has been determined through their Service Plan process to self-medicate, medication will not be stored with everyone else’s. Their medication must be locked for the safety of others. No medication sheet is required.

If a person lives alone and self-medicates, the person’s medications don’t need to be locked. This information needs to be documented in the Service Plan (e.g. IHP, ELP, ISP).

If people living together self-medicate and all understand which medication is theirs and that they should not take others’ medication they don’t need to be locked. If a person has been determined through the person’s support plan to self-administer, their medications are stored separately. This information needs to be documented in the person’s Service Plan (e.g. IHP, ELP, NJ ISP).
Periodic review of the person’s ability to self-medicate should be done. Agencies usually have their own policy and procedures which must be followed for individuals who are self-medicating or learning to be self-medicating. The review should be done respectfully and should not interfere with the person’s independence.
PRN (pro re nata)

- PRN medications are those prescribed by a physician to be given on an as needed basis.
  - Can be prescription or OTC
  - Some agencies have specific policies and procedures for administering PRNs.

PRN

Some medications will be prescribed by the physician to be given only on an as needed basis. These medications are called PRN (pro re nata). PRN medications can be over-the-counter (OTC), such as Tylenol, Imodium, allergy medications, or Blistex; or prescription medication (e.g. lorazepam, piroxicam, oxycodone etc. etc.).

OTC medications that are prescribed to be taken at specific times, such as a multi-vitamin, are not PRN medications.

Some PRN prescriptions medications can only be administered with authorization from physicians, nurses, behavior specialists, or supervisors. If your agency requires authorization to administer certain PRN prescriptions, you should know how to reach the authorizer or designee immediately.
PRN – Three Issues to Consider

1. Does the person need the medication?

   Is the person telling you about (“My right ear hurts”) or showing symptoms (e.g. crying, rubbing forehead, squinting, tugging ear, etc…) that could require medication? Do you think the person is asking for the wrong medication such as Imodium for constipation?

2. What medication is the person able to have for the symptoms?

   Check the person’s Standing Order Form or OTC prescription to see what is prescribed for that person. Some people are allergic to certain medications, some medications interact with other medications the person may be taking, and some medications don’t work they way they are meant to. Do not assume that everyone can have medications such as aspirin or Tylenol.

3. When did the person have the medication last?

   Sometimes the symptoms return before the next dose can be given. Remember that medications have limits on how often they can be taken. Always make sure that the full time has passed before administering the next dose. Also make sure that the same medication was not given for a different symptom within the same time frame. In the meantime, try to make the person comfortable while waiting.

Once you have the right answers to all 3 questions you are now ready to give the medication and follow the procedure for administering it.
PRN: Documentation

• Use the same MAR to document PRN medication – follow instructions in your Medication Learner Manual to complete
• Remember you must:
  – write on the back of the MAR what you gave and why.
  – write in your programs communication log what you gave and why
  – verbally communicate to the next shift what you gave and why.
• Review the PRN MAR for Linda Miller found in your Learner Manual.

PRN Medication Sheet

Use the same medication sheet form to document a PRN medication.

OTC PRN medications cannot be on the same medication sheet as prescriptions.

OTC PRN medications do not require a medication sheet until the first dose is needed. Prescription PRN medication should be recorded immediately.

You must:
• Write on the back of the medication sheet what you gave and why
• Write in your programs communication log what you gave and why
• Verbally communicate to the next shift what you gave and why

The main differences in setting up the PRN medication sheet are:

• Write “PRN” in the “HRS” box when using the type of medication sheet in this manual since we will not know when the person will need the medication.
• Write the maximum amount in 24 hours (e.g. not to exceed 6 doses in a 24 hour period) in the “Medication” box.
• If a stop date is indicated be sure to write that in the “Medication” box.
PRN Follow-up

- Check in 1 – 2 hours to see if PRN is working, making calls as needed.
- If not working, contact doctor/advanced practice nurse for options.
- Document results.

PRN Follow Up - Including Additional Documentation

Once a PRN medication is administered it is important to check the person 1-2 hours later to see if it is working. This may mean calling home or work for a follow-up. If the medication isn’t helping enough, contact a doctor/advanced practice nurse to look for other options.

As a staff person it is our responsibility to document the results on the back of the medication sheet and in your agency’s critical log.
## Over-the-Counter Medication Orders for Use as Needed

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date (good for one year):</th>
<th>Doctor’s Signature:</th>
</tr>
</thead>
</table>

### Allergies

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Maximum Amount in 24 Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
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<tr>
<td>Menstrual Cramps</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Constipation</td>
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<tr>
<td>Cold Symptoms –</td>
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<tr>
<td>Indicating coughs</td>
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<tr>
<td>Allergy Symptoms</td>
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<tr>
<td>Fever under 101°F</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Nausea/Vomiting</td>
<td></td>
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<tr>
<td>Indigestion</td>
<td></td>
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</tr>
<tr>
<td>Any medications that should never be given.</td>
<td></td>
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</tr>
</tbody>
</table>
# Over-the-Counter Medication Orders for Use as Needed

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Maximum Amount in 24 Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Headache</strong></td>
<td>Acetaminophen 500mg, (e.g. Tylenol Extra Strength)</td>
<td>2 tablet</td>
<td>Every 4 hours as needed</td>
<td>Not to exceed 6 doses in 24 hours</td>
</tr>
<tr>
<td><strong>Menstrual Cramps</strong></td>
<td>Ibuprofen 200mg, (e.g. Advil)</td>
<td>2 tablet</td>
<td>Every 4 hours as needed</td>
<td>Not to exceed 6 doses in 24 hours</td>
</tr>
<tr>
<td><strong>Diarrhea</strong></td>
<td>Loperamide 1mg, (e.g. Imodium A-D)</td>
<td>1 tablet</td>
<td>1 tablet 1/2 hour stool, repeat for every loose stool</td>
<td>Not to exceed 4 tablets in 24 hours</td>
</tr>
<tr>
<td><strong>Constipation</strong></td>
<td>Milk of Magnesia (Sp.)</td>
<td>30cc or 2 tablespoons</td>
<td>Followed by 8 oz. of water once a day</td>
<td>Not to exceed 3 consecutive doses then call doctor</td>
</tr>
<tr>
<td><strong>Cold Symptoms –</strong></td>
<td>Dextromethorphan 15mg, (e.g. Robitussin Cough Suppressant DM)</td>
<td>2 tsp.</td>
<td>Every 6 hours as needed</td>
<td>Not to exceed 4 doses in 24 hours</td>
</tr>
<tr>
<td><strong>Allergy Symptoms</strong></td>
<td>Chlorine 10mg.</td>
<td>1 tablet</td>
<td>Once daily as needed</td>
<td>Not to exceed 5 doses</td>
</tr>
<tr>
<td><strong>Fever under 101°F</strong></td>
<td>Acetaminophen 325mg, (e.g. Tylenol Regular Strength)</td>
<td>2 tablets</td>
<td>Every 4 hours as needed</td>
<td>Not to exceed 6 doses in 24 hours</td>
</tr>
<tr>
<td><strong>Other:</strong></td>
<td>Pepto Bismol</td>
<td>30cc or 2 tablespoons</td>
<td>Every 30 min. as needed</td>
<td>Not to exceed 4 doses in 24 hours</td>
</tr>
</tbody>
</table>

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**Allergies**

None Known
**Medication Administration Sheet/Record**

<table>
<thead>
<tr>
<th>Medication Details</th>
<th>Code</th>
<th>Staff Signature</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td>Linda Miller</td>
<td>1. Jane Smith</td>
<td>BS</td>
</tr>
<tr>
<td><strong>Month and Year</strong></td>
<td></td>
<td>2. Dave Davis</td>
<td>DB</td>
</tr>
<tr>
<td><strong>Current Date &amp; Year</strong></td>
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</tr>
<tr>
<td><strong>Allergies</strong></td>
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</tr>
<tr>
<td><strong>Medication</strong></td>
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<td></td>
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</tr>
<tr>
<td>Robitussin Cough</td>
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<tr>
<td>Suppressant D.M.</td>
<td>B - Discontinued</td>
<td>3. Alex Lee</td>
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</tr>
<tr>
<td>Take 2 teaspoons every 6 hours as needed for cold symptoms including cough. Not to exceed 8 teaspoons in 24 hours.</td>
<td>X - Not needed</td>
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<td></td>
<td>C - Closed</td>
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<td>R - Refused by individual</td>
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<td>V - Vacation, Visit</td>
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<td>P - Program</td>
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<td></td>
<td>H - Hospitalized</td>
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<td></td>
<td>NPO - Nothing by mouth</td>
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<td>A - Absent from program</td>
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<tr>
<th>Day</th>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
<th>Code 5</th>
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<tr>
<td>HRS</td>
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<td>8/15</td>
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**Note:** The table continues with more entries, but not all are visible in the image. The entries are marked with 'X' indicating the administration or non-administration of the medication.
The following information would have been written on the back of the medication sheet for Linda Miller. This information can be written in “portrait” view or “landscape” view.

October 9, 2013 - at 8:00 am 2 teaspoons of Robitussin Cough Suppressant DM was given to Linda Miller because she was coughing frequently. Ilene Selba

October 9, 2013 - at 10:00am I called her Day Program and they said Linda was not coughing very often. Ilene Selba

October 9, 2013 - at 4:00pm Linda Miller was coughing a lot again so I gave her 2 teaspoons of Robitussin Cough Suppressant DM. Dave Bade

October 9, 2013 - at 5:30pm I noticed Linda was not coughing as much. Sandy Howell

October 11, 2013 - at 5:00am Linda Miller woke up coughing. 2 teaspoons of Robitussin Cough Suppressant DM were given to her. Dave Bade

October 11, 2013 - at 7:00am Linda was sleeping soundly and not coughing. Dave Bade

October 13, 2013 - at 10:30am, Linda Miller was coughing frequently. 2 teaspoons of Robitussin Cough Suppressant DM were given. Ilene Selba

October 13, 2013 - at 12:30pm Linda was still coughing frequently. I contacted Dr. Berry who said to continue with the medication for now and to call him tomorrow if the cough has not improved. Dave Bade

October 13, 2013 - at 4:30pm Linda Miller was given Robitussin Cough Suppressant DM because she was still coughing. Dave Bade

October 13, 2013 - at 6:30pm Linda Miller was not coughing as much. We will contact the doctor tomorrow. Dave Bade
Special Situations

There may be situations that result in the medication administration process being changed.

1. **Documentation**: You cannot give a medication if you do not have the medication sheet, it is hard to read, the prescription copy is missing, information is incorrect, or if anything does not match. Follow your agency’s procedure on what to do next or who to contact.

2. **Label Issues**: If you can’t read the pharmacy label or it is not intact, you need to get a new pharmacy label from the pharmacist before you can administer the medication.

3. **Mishandled Medication**: Any medication which has been mishandled must not be administered and must be disposed of by following your agency’s policy. Mishandled medication includes medications being touched by staff, dropped on
floor or counter, spilled, etc… Follow your agency’s policy on medication disposal and make sure that a new medication is administered.

4. **Change in Health:** If the person has a sudden change in health (e.g. seizure, vomiting, etc...), handle the health situation first.
   - If the sudden change in health is possibly life threatening, you must call 911 immediately.
   - If the change is not life threatening, contact the prescribing person to ask what to do next. The prescribing person may ask you to give the medication later or skip the dose entirely. Follow verbal order information according to this training module.

5. **Medication Looking Different:** If the medication looks different than it usually does (different color, shape, marking, etc.), then you must contact the pharmacist before administering it. Sometimes the medication may be from a different generic company so the different look may be okay. Other times the different look may be because a mistake was made at the pharmacy so we need to get the correct medication.

6. **Refusal:** If the individual refuses to take medication, do not bribe, nag, lecture, force, lie, or threaten. This should not become a power-struggle with the person. People have the right to refuse their medication. However, we have a responsibility to encourage the person to take it. Here are some suggestions:
   - Ask the individual why they are refusing and discuss their concerns. Document the concerns and follow-up with the doctor as needed.
   - Explain to the individual why the medication was prescribed and what could happen if it’s not taken.
   - Give the person a couple of minutes and then try again.
   - Ask a co-worker to try.

If the individual still refuses, this may not be a reflection on your effort. Follow your agency’s procedures for documentation. Write “R” in the box on the medication sheet and follow any other procedures your agency requires.
Types of Errors

- **Documentation Error** – occurs when the medication has been given, but some type of documentation is wrong
- **Medication Error** – occurs when a medication has been administered incorrectly or not given at all.
  - You must contact the prescriber
  - Follow your agency’s policies and procedures

**Documentation Error**

A documentation error is when the medication has been given but some type of documentation is wrong (e.g. forgot to sign, signed the wrong place, put a code “X” in the wrong place, etc...).

The first step for the person who discovers the error is to circle the box on the medication sheet in red. This informs other staff that there is a problem, therefore, stopping that error from causing further potential damage.

**Circling in red is the responsibility of the staff discovering the error and should NEVER be passed on to another staff person (e.g. manager, nurse, etc...).** Staff should never be told not to circle in red.

Next you must find out what happened. Check the packaging (e.g. bubble packs, cassettes, spools, etc...) to see if the medication was given. If packaged in a bottle, check with the staff that was responsible for administering medication during that time to see if it was given or not. If the medication was given but not documented correctly, a documentation error has occurred.

You must explain what happened on the back of the medication sheet and sign your full name. In the case of a documentation error, staff should never go back and initial inside an empty red circle. Thus, to avoid this, put one line through the empty circle in red.

**Sample:**

(\text{dd/mm/yyyy}) Betty’s 10am 100mg Dilantin given but not signed for by staff Tim Reed - Jasmine Woods
Medication Error

A medication error is when the medication has been administered incorrectly or not given at all.

The first step for the person who discovers the error is to circle the box on the medication sheet in red. This informs other staff that there is a problem, therefore stopping that error from causing further potential damage.

Circling in red is the responsibility of the staff discovering the error and should NEVER be passed on to another staff person (e.g. manager, nurse, etc...). Staff should never be told not to circle in red.

Next, you must find out what happened. If when checking with the staff you find out that the medication was given incorrectly or not given at all, a medication error has occurred. If the staff person is no longer present on shift, it is handled as a medication error.

Call your supervisor or designated agency personnel, then call the physician unless otherwise directed by your supervisor. When giving details include whether or not you know the medication was given. Follow his/her instructions. On the back of the medication sheet, write the instructions you were given or write that you documented the information in the critical log. There are times that the prescriber may not return your calls but you still want an answer about what to do next. In those cases, you should check with your supervisor or designated agency personnel about what to do. It may involve contacting the pharmacist and then documenting his/her instructions. If your agency’s policy allows you to contact a pharmacist, then you must document your attempts to reach the prescriber on the back of the medication sheet along with the pharmacist’s instructions.

Agencies have different policies for when they want staff to notify supervisors. You should check your agency’s policy for specifics.

Not all medication errors can be circled on the front of the medication sheet (e.g. pharmacy packaging error as this should be handled before putting on the medication sheet); but documentation must be done on the back of the medication sheet. An unusual incident report may be required. Follow your agency’s policies on how to handle these situations.

Types of Errors

There are two types of errors – documentation and medication. The following shows steps to take in the event an error has occurred.
Error

1. Circle in Red

Find out what happened

- Documentation Error
  2. Write what happened on the back of the medication sheet

- Medication Error
  2. Contact prescriber, provide details, and follow orders
  3. Write his/her instructions on the back of the medication sheet
  4. Complete an in-house and/or Unusual Incident Report (UIR)
Disposing Medication

- Medications that are outdated, mishandled, or no longer in use must be disposed of.
- Medication disposal must be witnessed and documented.
- Follow your agencies procedures for disposing medication.
- State and Federal guidelines can be found in the resource section of your manual.

Disposing of Medication

1. Medications that are outdated, mishandled, or no longer in use must be disposed (e.g. returned to pharmacy or destroyed according to your agency’s policy).

2. The disposal of medication is to be witnessed and documented on the back of the medication sheet. The documentation must include the date, the time, name and dosage of medication, the reason for disposal, and two (2) full signatures - the person discarding the medication and the witness.

3. When a medication is left after an individual’s death, certain procedures must be followed in disposing of the unused medication. Contact your supervisor for more information.

4. State and Federal guidelines for disposal of medication can be found in the resource section of this manual.
Agency Follow-up

• Agencies differ in their internal procedures regarding medication.
• Each agency must review its own requirements with staff and review/ observe medication procedures following completion of this training before you may administer medications independently.

Agency Follow-Up

The information you have learned in today’s Pre-Service Medication Training is based on rules developed by the state of New Jersey and The Division of Developmental Disabilities.

Your agency must follow these rules.

Your agency may have additional policies and procedures (e.g. where key for medication is located, what forms to use in regards to medication administration) and should train you in the specifics before you administer medications independently.
Medications

Resource Appendix
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<td>• Blank medication sheet</td>
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Medication Abbreviations

a................. before
a.c. ............. before meals
b.i.d. ........... twice a day
c................ with
c.c. ............. cubic centimeter
cap ............ capsule
elix ............ elixir (drugs dissolved in syrup containing alcohol)
Gm.............. gram
gr. ............ grain
gtt .............. drop
h.s. .......... hour of sleep (bedtime)
i................. one
IM .............. intramuscular
IV ............. intravenous
mg ............. milligram
o.d. ........... right eye
o.s. ........... left eye
p.c. ........... after meals
p.o. .......... by mouth
per ........... by or through
p.r.n .......... when necessary, as needed
q ............. every
q.d. .......... every day
q.h. .......... every hour
q4h .......... every four hours
q.i.d. ........ four times a day
q.o.d. ........ every other day
s............. without
Sig........... write on label
Sol............. solution
stat ............. immediately
i................. one
ii............. two
iii........... three
tab ............ tablet
t.i.d. ........ three times a day
ung .......... ointment
\\ outsourcing dram — one teaspoon
\\ outsourcing ounce

Measurements

1000 ml = 1 quart
30 ml = 1 fluid ounce
4 ml = 1 fluid dram
1 ml = 15 minums
30 Gm = 1 ounce
15 Gm = 4 drams
1 Gm = 15 grains
60 mg = 1 grain
10 mg = 1/6 grain
1 mg = 1/60 grain
2 tbsp = 1 fluid ounce
1 tbsp = 1/2 fluid ounce
1 tsp = 5 cc.
30 ml = 1 fluid ounce
1 cc. = 15 drops
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<td>Date/Time</td>
<td>Medication/Dosage</td>
<td>Reason</td>
<td>Results/Response</td>
<td>Date</td>
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**NURSE'S MEDICATION NOTES**

**INSTRUCTIONS:**
- Record date/time when medication given.
- Record time when medication refused.
- Record reason for refusal in Nurse's Medication Notes.
- Include MRN Medication given and results should be noted in Nurse's Medication Notes.

**CHARTING CODES:**
- A - Chanted in error
- B - Patient refused
- C - Product out of stock
- D - Drug not given. Indicate reason in Nurse's Medication Notes.
- E - Missed RNM's Medication Notes
- F - Patient did not retain medication
- G - Effective
- H - Indelicate
- I - Hospital
- J - Leave of absence

**DATE**

- Temperature
- Pulse
- Blood Pressure

**DIAGNOSIS**

- Pain
- Fever
- Other

**MEDICATIONS**

- Medication 1
- Medication 2

**MORBIDITY**

- Allergies
- hypertensive
- Diabetic

**NURSE'S MEDICATION NOTES**

- Date/Time
- Medication/Dosage
- Reason
- Results/Response

**DATE**

- 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
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**DDD Community Services Curriculum**

**Learner's Manual - Medications 6th Edition**

A - 4
1. All documentation should be in black ink. Do not erase, write over, or use correctional fluid. Draw a straight line through errors.

2. Document an administration of a PRN medication in the date boxes, as follows: Time/staff initials. In addition, summarize the administrations on the back of the MAR (include date/time/reason and condition for administration and full signature).

3. Document a Daily Log for Critical Information entry for every administration of a PRN medication.

4. When pharmacy direction is used in substitution of that obtained from the prescribing doctor (and only after a 1/2 hour wait for the doctor’s response, following your request), detail the effort made to initially reach the doctor on the back of the MAR and on Case notes.

5. Process new or changed Medications and Treatments, at local pharmacies. (Unless it is more convenient for fill initially, at Adler's Pharmacy). Fax prescriptions for new, changed, or discontinued Medications and Treatments to Adler's Pharmacy for future refills, and to update their records for next month’s pre-printed MARS. (Specify clear details regarding the fax, on your transmission ("Filled locally, first. Hold script for future refills", remove from next month's pre-printed MARS", etc).

Staff Administering the Medication(s)/Treatment(s) must have their signature and initials listed below:

<table>
<thead>
<tr>
<th>STAFF SIGNATURE</th>
<th>INITIALS</th>
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**Code** (Use to document time/date boxes, as applicable):
- **R:** Refused by Individual. Prompt individual at least 1 hour before documenting refusal
- **V:** Vacation
- **P:** Program
- **H:** Hospitalized
- **D:** Discontinued (Place only in the first applicable block. Draw a line through the remaining blocks)
- **NPO:** Nothing by mouth
- **A:** Absent
- **O:** Other (i.e., med not initialed, med received late or taken on outing—explain on reverse with full signature)
- **X:** Medication not needed
- **C:** Closed ——: Draw a line through extraneous boxes for new, changed or discontinued medications

*One hour leeway before or after the designated administration time is acceptable under certain circumstances, (e.g., early pick-up for day placement, late return from activity, temporary refusal)*
How to Properly Administer Tablets/Capsules

1. Wash hands and gather all necessary supplies (e.g. cup, water, etc).

2. Obtain key and open box.

3. Using the medication sheet, find the correct medication to be administered.

4. Compare pharmacy label to the copy of prescription and to the medication administration record/sheet to assure correct medication to be administered.

5. Count the correct dosage of medication and pour into cup without touching the medication.

6. Compare the pharmacy label to the copy of prescription and to the medication administration record/sheet to check again that the correct medication was to be administered.

7. Hand the cup to the individual receiving medication. Encourage the individual to put medication directly in mouth from cup.

8. Offer water to the individual (unless otherwise prescribed).

9. Watch for the person to swallow the medication and follow any special administration instructions (food, sit upright, etc).

10. Initial the medication sheet for the correct medication, day, and time.

11. Sign and initial the medication administration record/sheet if administering medications for the first time that month on that sheet.

12. Ensure the packaging is secure and put everything back in the medication box.

13. Lock box and secure the key.
How to Properly Administer Liquid Medication

1. Check label of bottle against medication sheet and the copy of the prescription and/or physician’s orders to assure the right medicine is being given to the right individual.

2. Shake bottle, unless directions state otherwise.

3. Carefully pour medication from the bottle so the label remains legible and intact. Measure the exact dosage prescribed into a measuring spoon obtained from the pharmacy, measuring spoons used for baking or a medication cup made for this purpose. Do not use a kitchen teaspoon.

4. Wipe the bottle with a moist paper towel and replace the cap.

5. Again compare the medication record with the label on the bottle before administering.

6. Liquid medication may be diluted or followed by liquid with physician’s authorization only.

Note: If the individual coughs, spits, or vomits the medication, DO NOT repeat. Follow your agency’s procedure for handling this situation.

Remember
When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
How to Properly Administer Ear Drops

1. Wash hands thoroughly with soap and water.
2. Wear latex/vinyl gloves.
3. Check the dropper to make sure it is not chipped or cracked.
4. The eardropper must be kept clean. Avoid touching the dropper against the ear or anything else.
5. Warm the bottle to near body temperature by holding it in your hands for a few minutes.
6. If the drops are a cloudy suspension, shake well for ten seconds.
7. Draw the medicine into the dropper.
8. Have the individual tilt the affected ear up or lie on their side.
9. To allow the drops to run in:
   1. Adult — Hold the earlobe up and back.
   2. Child — Hold the earlobe down and back.
10. Place the prescribed amount of drops in the ear.
11. To avoid injury, do not insert the dropper into the ear.
12. Keep the ear tilted up for a few minutes, or insert a soft cotton ball, whichever has been recommended.
13. Take off gloves and wash hands.

Remember —
• Follow instructions carefully.
• Do not miss doses.
   — Adapted from the Michigan Pharmacists Association’s Patient Education Program

Remember
When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
How to Properly Administer Eye Drops

1. Wash hands thoroughly with soap and water.
2. Wear latex/vinyl gloves.
3. If a dropper is supplied, make sure there are no chips or cracks at the end of the dropper.
4. If a dropper is supplied, hold the dropper tip down all the time. This prevents the drops from flowing back into the bulb where they may become contaminated.
5. The dropper must be kept clean. Avoid touching the dropper against the eye or anything else.
6. If the eye drops are a cloudy suspension, shake them for ten seconds.
7. Individual should be lying down or have his/her head tilted back.
8. With your index finger, pull the lower lid of the eye down to form a pocket (see drawing A).
9. Hold the dispenser with the opposite hand and place as close to the eye as possible, without touching it.
10. Brace the remaining fingers of this hand against the nose or cheek.
11. Drop the prescribed amount into the pocket made by the lower lid. Placing the drops on the surface of the eyeball (cornea) may cause stinging.
12. Replace the cap or dropper right away. Do not wipe or rinse it off.
13. Press your finger against the inner corner of the eye for one minute. This prevents medication from entering the tearduct (see drawing B).
14. Close eye gently and wipe off any excess liquid with a tissue.
15. Remove gloves and wash hands.

Remember —

• Follow instructions carefully
• Use the exact number of drops prescribed.
• Do not miss doses.

— Adapted from the Michigan Pharmacists Association’s Patient Education Program

Remember

When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
How to Properly Administer Eye Ointments

1. Wash hands thoroughly with soap and water.
2. Wear latex/vinyl gloves.
3. This ointment must be kept clean. Avoid touching the tip of the tube against the eye or anything else.
4. Hold the tube between the thumb and forefinger. Place the tube as near to the eyelid as possible, without touching it.
5. Brace the remaining fingers of this hand against the cheek or nose.
6. Tilt the head back and up.
7. With your index finger, pull the lower lid of the eye down to form a pocket.
8. Place the ointment into the pocket made by the lower lid.
9. Ask the individual to blink their eye gently.
10. With a tissue, wipe any excess ointment from the eyelids and lashes.
11. Replace and tighten cap right away.
12. Remove gloves and wash hands.

Remember —
• Follow instructions carefully.
• Eyesight may be cloudy after using the ointment.
• Do not miss doses.

— Adapted from the Michigan Pharmacists Association’s Patient Education Program
How to Properly Administer Nose Drops

1. Ask individual to blow their nose gently.
2. Wash hands thoroughly with soap and water.
3. Wear latex/vinyl gloves.
4. Check the dropper tip for chips or cracks.
5. The nose drops must be kept clean. Avoid touching the dropper against the nose or anything else.
6. Draw the medicine into the dropper.
7. Individual should be lying down or have their head tilted back.
8. Place the prescribed number of drops into the nose.
9. To allow the medication to spread in the nose, ask the individual to remain in this position for a few minutes.
10. Replace dropper in bottle right away.
11. Remove gloves and wash hands.

Remember —  
• Follow instructions carefully.  
• Use only as long as prescribed.  
— Adapted from the Michigan Pharmacists Association’s Patient Education Program

Remember  
When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
How to Properly Administer Nasal Spray

1. Ask individual to blow their nose gently.
2. Wash hands thoroughly with soap and water.
3. Wear latex/vinyl gloves.
4. Remove the cap and gently insert the nasal tip into one side of the nose. Close off the opposite nostril by pressing against it with one finger.
5. Squeeze the bottle and deliver the puff of medication.
6. Ask the individual to gently sniff in as you deliver the spray.
7. Repeat into the remaining nostril or as ordered.
8. Provide the individual with a tissue to wipe any excess medication from the nose. Do not blow the nose.
9. Wipe the tip of applicator with a clean tissue.
10. Replace the top.
11. Remove gloves and wash hands.

Remember —
• Follow instructions carefully.
• Use only as long as prescribed.
• Do not share nasal sprays among residents.

Remember
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How to Properly Administer Topicals

1. Wash hands thoroughly with soap and water.
2. Wear latex/vinyl gloves.
3. Before applying more medication, clean the area thoroughly by washing the area gently with soap and water, or soaking an involved site.
4. Spread evenly, cover well, without applying an overly thick layer.
5. Lotions and creams — smear lightly. Do not rub.
7. Powder — light dusting to cover affected area.

Remember —
- Often there is a gauze dressing to cover and protect.
- Check the directions for specific amounts of application (e.g. size of a dime, etc.).
- Liniment — Preparation usually containing alcohol, oil, or soapy emollient that is applied to skin.
- Lotion— Drug in liquid suspension applied externally to protect skin.
- Ointment (salve) — Semisolid, externally applied preparation usually containing one or more drugs.
- Paste — Semisolid preparation, thicker and stiffer than ointment; absorbed through skin more slowly than ointment.

Remember
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How to Properly Administer a Metered-Dose Nebulizer

Don’t

- Don’t teach the individual how to use the nebulizer when they are short of breath — they’ll be too distracted to give you their full attention.

- Ask them not to exhale immediately after inhalation or the aerosol spray won’t reach their airway’s deeper branches. Instead, they should hold their breath approximately ten seconds after inhalation.

- Don’t let them repeat inhalations before the next scheduled dose.

- Don’t let residue accumulate around the mouthpiece since residue can prevent the medication from being properly distributed when the individual operates the nebulizer. Show them how to clean the mouthpiece with warm water.

Do

- Assess their ability to hold and manipulate a metered-dose nebulizer.

- Ask them to remove the mouthpiece cover and shake the nebulizer well. If they don’t shake it, fine particles won’t be aerosolized. Tell them to spray a new nebulizer once into the air before using it.

- Show them how to place the mouthpiece into their mouth with the opening toward the back of their throat. (With some models, the mouthpiece should be held one to two inches (2.5 cm to 5 cm) from the open mouth.)

- Tell them to fully exhale through their nose, then grasp the mouthpiece with teeth and lips to prevent medication from escaping through their mouth. They should inhale slowly and deeply through their mouth as they press down on the medication canister to release the dose. If they inhale or spray incorrectly, droplets of medication may land on their pharynx or tongue and cause them to gag.

- Teach them to exhale slowly using pursed-lip breathing to keep the small airways open. Tell them to wait five minutes (or as prescribed) between medication inhalations.

Remember

When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
How to Properly Administer Rectal Suppositories

1. Wash hands thoroughly with soap and water.
2. Wear disposable gloves.
3. Store suppositories in a cool place to avoid melting. Refrigerate them if so labeled.
4. If necessary, suppositories may be held under cool water to harden them prior to insertion.
5. Remove wrapper if present.
6. Lubricate tip of suppository with a water soluble lubricant such as K-Y Jelly, not petroleum jelly (Vaseline). If not available, moisten the rectal area with tap water.
7. Have individual lie on side with lower leg straightened out and upper leg bent forward toward the stomach.
8. Lift upper buttocks to expose rectal area.
9. Insert suppository with finger until it passes the muscular sphincter of the rectum, about one-half to one inch in infants and one inch in adults. If not inserted past this sphincter, the suppository may pop back out.
10. Hold buttocks together for a few seconds.
11. Have individual remain lying down for about 15 minutes to avoid having the suppository come back out.
12. Discard used materials and wash hands thoroughly.

Remember —
• Follow instructions carefully.
• Use suppositories only as often as directed.
• The person should be assessed for their ability to administer rectal suppositories.
• Maintain privacy.
  — Adapted from the Michigan Pharmacists Association’s Patient Education Program

Remember
When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
How to Properly Administer Vaginal Suppositories/Creams

1. Wash hands with soap and water.
2. Wear latex/vinyl gloves.
3. Remove wrapper from suppository and insert in applicator. If using a cream, fill applicator with cream as directed.
4. Provide privacy. Ask the individual to lie flat on her back with legs apart.
5. Spread the lips of the vagina with one hand and gently insert the applicator a few inches into the vagina with the other hand. Lubricating jelly or simple tap water may ease insertion if necessary. The consumer may prefer to do this herself with assistance as necessary.
6. Do not use a tampon afterward. A panty liner will protect underwear from medication that may leak out.
7. Wash reusable applicators with warm, soapy water and dry them well.
8. Dispose of gloves and wash hands.

Remember
When administering any type or route of medication you must always check the medication sheet and prescription copy, compare them to the pharmacy label to be sure they match, and initial for the dose and day. If it is the first time you are administering on that sheet for that month, include your initials and full signature.
Guidelines for Proper Disposal of Household Medication
New Jersey Department of Environmental Protection

Over the counter and prescription medications should not be disposed down the drain because wastewater treatment facilities are not designed to remove pharmaceutical compounds and they may end up in your local waterways, and may eventually be found in drinking water. Properly disposing of unwanted and expired prescriptions and over-the-counter medications in the trash promotes a healthy aquatic environment and prevents accidental poisoning and intentional abuse.

4 STEPS FOR PROPER DISPOSAL

1. Keep medicine in original container. Mark out personal information on prescription bottles.

2. Mix liquid medicine with undesirable substances like coffee grinds, cat litter, or dirt. Dilute pills with water, then add coffee grinds, cat litter, or dirt.

3. Place bottles in an opaque container, like a yogurt container, and secure lid; or wrap in a dark colored plastic bag.

4. Hide the container in the trash. Do NOT recycle.

Improper disposal in your trash allows others to divert the substance and consume medication that was not prescribed to them.

Do NOT dispose of medication down the drain or toilet.

Prevent water pollution, Promote a healthy environment, Properly dispose of your unneeded and expired medication.

Do NOT keep excess or expired medication around the home.

For More Information Contact:
DEP Solid & Hazardous Waste Program
(609) 633-1418

For proper disposal of household sharps visit:
http://www.state.nj.us/health/ehoh/phss/syringe.pdf
Or call 609-984-6620
Federal Guidelines:

- Do not flush prescription drugs down the toilet or drain unless the label or accompanying patient information specifically instructs you to do so. For information on drugs that should be flushed visit the FDA’s website.

- To dispose of prescription drugs not labeled to be flushed, you may be able to take advantage of community drug take-back programs or other programs, such as household hazardous waste collection events, that collect drugs at a central location for proper disposal. Call your city or county government’s household trash and recycling service and ask if a drug take-back program is available in your community.

- If a drug take-back or collection program is not available:

  1. Take your prescription drugs out of their original containers.
  2. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds.
  3. Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a sealable bag.
  4. Conceal or remove any personal information, including Rx number, on the empty containers by covering it with black permanent marker or duct tape, or by scratching it off.
  5. Place the sealed container with the mixture, and the empty drug containers, in the trash.
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DDD Community Services Curriculum