Medication Policy and Procedures

Contents

Nurses are responsible for ensuring that medications and treatments are provided in the safest and most effective means possible. All medication and treatments administered by COC staff must be ordered by a physician. Nurses must review each medication for the following:

- Possible adverse reactions
- Drug interactions
- Side effects
- Contraindications

Client allergies should also be reviewed with each new medication order; all client medication allergies are listed on the medication record and plan of care. The prescribing physician must be notified when problems are noted with a medication. If there is a question regarding safety of a new medication, the nurse must speak to the physician before administering the medication.

Medication Storage

Client medications must be stored in a location separate from the rest of the family. The exact location of Medication storage is found on the client's Medication Record.

Medication Administration

- Only COC licensed nurses may administer medications.
- PCAs can pass medications but not draw them.
- Family members can give medications. If a family member gives a scheduled or PRN medication during your shift use the following abbreviations:
    A. F1: nurse observed family administering Medication or Treatment
    B. F2: family reports the Medication or Treatment administered, nurse did not observe
    C. F3: family was responsible for client at time of administration.
        - Example: family only has nursing from 0800-2000. Medications are due at 2100.
    D. H: Client hospitalized. Draw a line through the affected days.

The 5 R's for 5 rights of Medication Administration:

1. Right Patient
2. Right Medication
3. Right Dose
4. Right Time
5. Right Route

- The medication, dosage, time, expiration, and route must be checked for each medication prior to administration.
- Medications administered via G-tube or G/J-tube must be administered separately with a flush between medications.
- The nurse drawing-up or preparing medications must also administer the medications.
- Charting must be completed immediately after medication administration following COC documentation procedures.
- If you administer a PRN such as a Saline neb, you must document it on the Medication Sheet under the PRN section and on the PRN Rationale form. The time the neb was administered should also be included with your initials. Follow up documentation must be provided on the Rationale for PRN Medication and Treatment.

Which day should I document my medications and treatments on if I work a night shift?

If you are scheduled for nights you will document on the date your shift starts up until 2400. At 2400, you will begin to document on the following day.

What if a family asks me give administer a treatment or therapy that we do not have physician orders for?

If the family wants to provide medications, treatments, or care that is not ordered by a physician, they can do so. **A nurse cannot.**

- Nurses can **only** provide medications, treatments, and other cares that are included on a signed Care Plan/ Medication Record until a new order is received from the physician.
- Provide education to the family regarding possible complications of not checking with the physician prior to administration.

How to Manage Changes to the Care Plan or Medication Record

Changes to the Care Plan (POC) or Medication Record (MAR) must be given by a physician before nurses can perform the changes. We use a PCO to get the physician's approval for the change. The PCO must be filled out by a nurse.

A. PCO can be brought to a physician's office, filled out, and signed all at the same time.
B. If change orders come via phone, the nurse can talk to the physician's office to receive the order and then send the order in for signature.
C. If no nurse is on duty and the family is on the phone with the physician's office, the nurse can take the verbal change order from the family member, complete the PCO, and fax it into the physician for signature. Also fax the order into the office.
D. Once a verbal order has been given from the physician (methods B or C) the nurses can perform the new orders.
E. Change orders should be hand-written onto the Care Plan/Medication Sheet in the blank spaces provided.
F. Signature for change must be received within 7 days (Director of Nursing will follow up to ensure this is received within the time frame).

After receiving a discontinuation or change order from the doctor:

1. Take a yellow highlighter and highlight the entire box and write "discontinued or changed," the date, and nurse's initials on the MAR.
    a. White out is not acceptable. This is true for any medication change, (different dose or frequency of the same medication or a new medication).
2. Write the new order on the MAR on a separate line with the start date.

Physician Change Orders (PCO)

Changes to medication orders, treatments, or the care plan can be given by a physician in person, via a phone call, or communicated through the responsible party (parent). When a physician makes a change to the Care Plan or Med Sheet:

1. Completely fill out a Physician Change Order (filed in the black box).
2. Fax the Change Order (with a fax cover sheet) to the physician's office and COC. The physician will fax the signed copy to the COC office. We will keep it on file in the office.
3. Hand-write the change directly on the Care Plan or Med Sheet. Be sure to hand-write the change on all subsequent Med Sheets until a new one is updated, printed, and signed by the physician.
4. Put the Change Order in the nursing notebook in front of the Med Sheet.
5. Write a note to all staff about the change in the communication log.
6. Keep the change order in the nursing notebook until a new Care Plan/Med Sheet has been updated by Communities of Care and signed by the physician. At that time, send the Change Order to Communities of Care along with the other documentation due.
7. If needed, use the Change Order Log sheet to help organize PCOs. Keep the Logs on file in the chart. Do not send them to COC with regular charting.

- If you will be attending a doctor's appointment with a client, bring the chart and blank physician change orders with you. Fill it out while you are there and get the physician's signature before you leave the appointment. Then you can skip step 2 above.
- The PCO must be completed by the nurse who received the order the day it was received. Never leave the PCO or PCO Log to be completed by someone else.
- Please see example below of how to properly fill out PCO.

Client Name: *Tom Thumb* **DOB:** *7/25/1987*	**Physician** *Dr. Hyde*
Source _____Telephone order _X_ Office visit _____As per family report _____Other (describe)	**Nurse receiving order** *Sally Sunshine, RN* *SS* **Read back to MD for verification (initial)**

Medication(s)	Strength	Dose	Route	Frequency	Order Status	Duration
Prevacid	*15mg*	*15mg*	*G-tube*	*Once Daily*	□ New □ Discontinue	□ Ongoing □ _____days/ weeks
Prilosec	*20mg*	*20mg*	*G-tube*	*Once Daily*	□ New □ Discontinue	□ Ongoing □ _____days/ weeks

Treatments: *NA*

Special Equipment: *NA*

Restrictions: *NA*

Reason for order: *Insurance will not cover Prevacid. Physician recommends switching to Prilosec.*

Physician's Signature	

***Please review, sign, and fax to Communities of Care 651-482-0280

Medications in the Community

Staff may bring medications outside of the client home in the original pharmacy packaging.
The client should be provided privacy for medication administration in the community
All steps in basic medication administration must be followed while administering medications in the community setting.
Bring the chart with you; record medication immediately after administration.

How do I Document PRN Medications or Treatments?

1. Document on the MAR:
    a. Number (#): Number of mg, mL, or pills administered. This only applies to medications with a dose range.
    b. Time (T): Time you administer the PRN
    c. Initials (I): initials of nurse who provided the intervention
2. Document on the PRN Rationale for Medications and Treatments Document:
    a. See example below
3. You will not need to document in your comments if you fully explain on the PRN Document
4. If you perform an intervention but will not provide follow up (end of your shift), inform next shift to follow up. They will fill in the Outcome section and co-sign the Nurse Initials box.

Date	Time	Medication or Treatment	Reason for Intervention	Outcome of Intervention	Nurse Initials
8/25/13	*0800*	*Tylenol, removed excess blankets*	*Elevated temperature 100.3*	*Temperature decreased 97.9.*	*SS*
8/28/13	*1235*	*Tilt Wheelchair*	*Left Leg discomfort, pain level 5*	*Pain now 3*	*JJ*
8/28/13	*1700*	*Oxycodone*	*BLE pain (7)*	*Pain now 4*	*SC*
8/29/13	*1030*	*Ativan*	*Client request due to anxiety*	*Resting comfortably*	*MS*
Incomplete Outcomes					
Date	Time	Medication or Treatment	Reason for Intervention	Outcome of Intervention	Nurse Initials
8/25/13	*0800*	*Tylenol*	*Elevated temperature 100.3*	*Helpful-**How do you know?***	*SS*
8/28/13	*1235*	*Tilt Wheelchair*	*Left Leg discomfort, pain level 5*	*Effective- **What indicates it was effective?*** *Resting, client rates pain less than 7*	*JJ*

Initials	Nurse Signature	Initials	Nurse Signature
SS	*Sally Sunshine, RN*	*JJ*	*John Jones, RN*
SC	*Stan Carlson, LPN*	*MS*	*Marcia Shoap, LPN*

What if the family or the client refuses an ordered medication, treatment or care?

The client and/or their family legally have the right to refuse any medication, treatment, or care. If the client or their family refuses:

1. Set medication or therapy equipment aside but do not dispose of it.
2. Ask WHY they don't want to take it! If you can determine WHY they won't take the medication, alternatives may become clear. Refusal may be their way of letting you know:
    a. The medication has negative side effects
    b. You were interrupting a favorite activity.
3. Find out if they understand what the medication is for.
    a. If they do not understand, remind them of the purpose and ask them again to take it.
    b. Find out if they understand the implications of not taking their medication. If they do not understand, remind them of the implications and ask them again to take it.
    c. If refusing the medication or treatment can have immediate adverse effect on the client's condition (example: a neb when client has a respiratory infection), contact the primary physician with the information about refusal. Additionally, write an incident report and send it to COC office.
    d. If refusing the medication or treatment will not have immediate negative effect on the client's condition (example: antacid), record the incident in the communication book as well. If repeated incidents happen, contact the primary physician with the information about refusal. Additionally, write an incident report and send it to COC office.
4. Wait a short time, and then encourage them again before the acceptable time frame expires. Generally the time frame is one hour unless the physician gave more specific instructions.
5. If client/family still refuses, write **R** on the medication or treatment record. Additionally, write a narrative description of the client's reason for refusal (i.e. they indicated nausea), any education provided and whether the physician was notified in the comments section of the flow sheet.
6. Dispose of the medication in the appropriate manner. Document form of disposal in your narrative note on the flow sheet.

How do I properly dispose of Controlled Substances or other medications?

Disposal of Controlled Substances must be witnessed by 2 people and recorded on the Controlled Substance Log. This could mean 2 nurses or the nurse on duty and the client or family member.
Non-narcotic medications must be recorded in the comments section of your flow sheet.

1. Do not flush medications down the toilet unless the manufacturer instructs you to do so.
2. Whenever possible take advantage of community take back programs. Call your city or county offices to find out if this is an option.
3. If there are no instructions on the drug label and your community does not offer a take back program please take the following precautions before throwing medications in the trash:
    a. Take the medication out of the original container and mix it with an undesirable substance such as coffee grounds or cat litter. COC will provide cat litter for the disposal process.
    b. Put the mixture in a sealable storage bag, empty can or other container to prevent the medication from leaking or breaking out of a garbage bag.
    c. Scratch out client information on the bottle before throwing it into the trash to protect client identity.
4. When in doubt about proper disposal, talk with your pharmacist.
5. The disposal of controlled substances **must be recorded** on the Controlled Substance Log and in the comments of your flow sheet.
    a. Controlled Substance Tablets that have been removed from their original wrapper and not used must be wasted and placed in the in the undesired substance.
    b. Controlled Substance pre-filled syringes that have been removed from their original tamper-evident container and not administered to the patient must be wasted in the undesired substance.
    c. Narcotic patch removed from a patient requires a witness. The nurse folds the patch in half so that the adhesive or sticky ends are folded together. The patch should then be disposed of in the approved undesired substance. The wastage must be witnessed and documented at the time of removal. Documentation of waste must be recorded in your flow sheet.

1. Both parties that witness the destruction will sign off on the destruction of the medication on the Controlled Substance Log.

CSL rules when parents keep main stock

If you have a client whos parents only send or give the nurses a set amount of controlled substances, you will always have a continuous running count. It may never zero out. Add in the number of medication given to you by the family PRN.

What should I do if a medication error occurs?

Assess/ monitor the client for adverse reactions.

1. Research side effects/ adverse reactions to the medication in the drug handbook found in the home.
2. Contact the following parties:
    a. Responsible party and/or the client
    b. Communities of Care office
    c. Primary physician as needed depending on the medication
3. Fill out an incident report found in the black box. After completing the incident report fax a copy to the office within 24 hours of the event. Take a prepaid envelope out of the black box and mail the original Incident Report to the office.

How do I properly document late doses of scheduled medications?

Medications are not considered late until you are outside your 1 hour window (½ hour before, ½ hour after). Once your window expires you will need to research the medication in the drug handbook to make sure it is compatible with other medications that you will administer soon. Also check if the medication is to be given at set intervals that require subsequent doses to be administered later than scheduled.
If the medication is given late for any reason, write the time you administered it in the appropriate box on the MAR. In your comments on your flow sheet document the reason the dose was late.

How do I document withheld medications?

If medications are withheld for any reason, document "held" in the appropriate box on the MAR. In your comments on your flow sheet document the reason the dose was withheld and if the physician was contacted as a result of the hold.

What happens if medication is spilled?

A spilled medication needs to be written up on an Incident Report and sent to the office within 24 hours of the event. Notify the client of the spill as well. Correct the CSL if it was a Narcotic. Contact the pharmacy as needed.

Sharps Use Protocol

At no time and under no circumstances is an employee of Communities of Care allowed to reuse a sharp of any sort. This includes lancets, syringes, and needle tips on reusable, pen-style insulin carriers.

Proper Disposal of Sharps in the home setting

Syringes can be disposed of in the following ways:

1. Sharps container
2. Empty laundry bottle with screw on lid.
3. Incinerator: high heat melts needle reducing them to size of a BB ball. The BB can then be thrown away in the garbage.
4. Needle cutter: automatically stores cut needles while away from home. Dispose of clipped needles in sharps container

Once a container is full of Sharps:

1. **Do not** throw them in the trash.
2. They can be mailed to a licensed disposal facility. There is a fee for this service.
3. Counties have a drop site available free of charge to residents. Check your counties website for details on locations and drop off times.
    a. *How to Use the Collection Site*
        - Bring proof of residency, such as a driver's license.
        - Ramsey County locations are open to residents of Ramsey, Washington, Hennepin, Anoka, Dakota and Carver Counties.
        - Remain in your vehicle while a technician unloads your hazardous waste.
        - You may be asked to answer a short survey; your answers will help improve the household hazardous waste program.

Controlled Substance Logs (CSL)

1. All use of Controlled Substance shall be documented in the medication record and on the Rationale for PRN Medication and Treatment.
2. Do not sign the CSL every time a narcotic is administered.
3. Controlled Substances must be counted at every shift change. Record your count on the Controlled Substance Log with two nurses present if possible. In homes where the nurse reports off to the family instead of a nurse, an end of shift count will be done as well. Please record in your count the amount of medication set up for the family to administer (if a nurse will not be present) prior to leaving your shift.
    a. At shift change, document beginning and end count of the Controlled Substance.
    b. Counts will be verified against the previous count.
    c. Discrepancies or evidence of tampering must be reported to COC immediately.
4. After receiving new inventory of Controlled Substances, verify with another nurse or family member the following:
    a. Correct Medication
    b. Correct Amount and Dose
    c. Date received
    d. Current count
    e. Inspection for tampering and expiration date

    Start a new Controlled Substance Log for new inventory. Finish the entire current Narcotic (in use) on the Controlled Substance Log. Once the first inventory is gone, document as such and yellow out any remaining boxes on the appropriate Controlled Substance Log. Please see example below.
5. Liquid narcotics are allowed 10% wastage in oral syringes. The count will be corrected upon completion of each bottle
    a. Mark the bottle at the fill line, date and initial by the nurse.
6. Inspect for expiration date during count as well.
7. See example on next page.

RX Name	*Ativan*	Dose	*1 tab*	Expiration	*05/2014*	Quantity	*2 tabs*

Date *(One line per shift)*	Time Count Conducted	Starting Count	Amt administered during your shift	Amt set up for family admin.	Amt remaining at end of your shift	Nurse signature(s) 1. Outgoing nurse 2. Incoming nurse **Nurses counting alone, use line 1 only. Line out #2**
8/31/13	*0800*	*2 tabs*	*1 tab*	*0*	*1 tab*	1. *Sally Johnson, LPN* 2. *John Jones, RN*
8/31/13	*2000*	*1 tab*	*1 tab*	*0*	*0*	1. *John Jones, RN* 2. *Jill Anderson, RN*
8/31/13	*See new inventory*					

New Inventory Check In

RX Name	*Ativan*	Dose	*1 tab*	Expiration	*08/2014*	Quantity	*30 tabs*

Date *(One line per shift)*	Time Count Conducted	Starting Count	Amt administered during your shift	Amt set up for family admin.	Amt remaining at end of your shift	Nurse signature(s) 1. Outgoing nurse 2. Incoming nurse **Nurses counting alone, use line 1 only. Line out #2**
8/25/13	*2000*	*30 tabs*	*New Inventory*	*0*	*30 tabs*	1. *Sally Johnson, LPN* 2. *John Jones, RN*
9/1/13	*0800*	*30 tabs*	*1 tab*	*0*	*29 tabs*	1. *John Jones, RN* 2. *Jill Anderson, RN*

References

http://nursing.ucsfmedicalcenter.org/NursingDept/AdminPolicies/PoliciesPdf/_PDFs2004/NarcoticsandControlledSubstances.pdf

http://pediatrics.unm.edu/divisions/coc/common/docs/guidelines.pdf

http://www.viha.ca/NR/rdonlyres/AAB9434F-EB58-4F75-AAE1-51380C9AAB5A/0/narcotic_count.pdf

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