Ingersoll Support Services Inc.

Policy: Medications: Administration and Self-Administration	**Policy # QAM 8** Section: Quality Assurance
Reviewed and Effective: April 17 2019 **Revised:** Sept 22/11; Sept 26/16; April 17/19 **Date of Origin:** March 19 2009	**Ministry Requirement** – QAM II.7(1)3.ii

Essential best practices will be employed by ISSI staff persons to effectively suppo people with medication administration. Self-administration of medications by perso supported will be facilitated by ongoing assessment, documentation, and training of th person supported and of the employees assisting.

Ingersoll Support Services Inc. must support employees in meeting their obligations through orientation, monitoring and ongoing training of resource access.

Procedure:

Administration of Medications

Ingersoll Support Services Inc. and employees are liable to ensure medication and treatment procedures are followed. Administration of Medication procedures are followed when it is understood that the agency and its agents bear responsibility for the medication, its care, and administration, fully or partially. These procedures are to ensure that the correct person is given the correct medication and dose at the correct time, using the correct route and documenting accordingly.

1. The person administering medication must be eighteen years of age or older. Employees are responsible for the manner in which medications and treatments are administered and are accountable to the person involved and their family member(s) or friends, the person's physician and the organization.

2. The person administering must be first oriented to medication procedures by the Supervisor or trained designate prior to administering medications. They must complete a Medication Orientation Check List and an Administration of Oral Medication Performance Checklist BEFORE they can independently administer any medications or treatments as per Policy # QAM 9b, Medication Orientation.

3. Medication must be in an original container with original pharmacy label. Where dosettes are used, the pharmacy shall pour it. Staff may sign to indicate the person

has taken meds poured in dosette, based on the medication Administration Record or an individual plan.

4. Follow any special instructions on the label or Drug Information, such as “keep refrigerated”. Administer according to medication type recommendations, as per attached document Doc.QAM8, Medication Administration Methods: Recommendations.

5. Always understand how best to approach the person receiving the medications. Do you need to talk softly, do you need to use applesauce, do you hand it to the person or do you assist them to take it.

6. Medication must always be locked, out of reach, where it will not be exposed to extreme conditions of heat, cold or moisture etc. Medications will be locked in order to ensure everyone’s safety as per Policy # QAM 12, Medication Storage, Access and Transfer.

7. Never give a medication by mouth to a person who is vomiting, who cannot swallow or is semi-conscious.

8. Concentrate when pouring and giving medications. Fully complete medication procedures for 1 (one) person at a time.

9. All recording must be in ink. For written errors, simply draw a line through the words you wish to omit and sign your name. All medical information noted in log notes will be written in RED ink.

10. Prior to administrating any new medications or treatments, each staff person must read the information in the Drug Reference Book or detailed pharmacy sheets.

11. Routine / PRN orders for MEDICATION must be filled out by the doctor. No medication or treatment can be given without Doctor’s signature.

12. The person administering a medication is responsible for filling out the Medication Administration Record (MAR). This information must be identical to information listed on orders for MEDICATION.

13. Medication administered is recorded by putting a dot in the appropriate space after pouring and then initialing the appropriate box for date and time given on the MAR after medication is given.

14. Medication and/or treatment that are self-administered should be noted in the special instructions/directions on the MAR.

15. Medication Administration Record (MAR) is to be changed monthly. Outdated MAR sheets are to become a part of the Medication History in the Medical Journal.

16. Complete the entire procedure for one person at a time.

17. NEVER administer a medication that you have not personally poured.

18. Handle medication in such a way that fingers do not come in contact with the medications.

19. NEVER leave poured medications unattended and/or in reach of other people.

20. In giving medication, be sure to give:

    - THE RIGHT PERSON
    - THE RIGHT DOSE
    - THE RIGHT MEDICINE
    - THE RIGHT TIME
    - THE RIGHT METHOD
    - THE RIGHT DOCUMENTATION

Failure to do any of these is a Medication Error. Remember people have the RIGHT TO REFUSE. Document this if it occurs. This is not a medication error. Note when a medication is Withheld using the proper code.

21. If the person being given the medication is not with staff at the time medications are to be given use the appropriate code on the MAR sheet.

22. When giving medication, compare the label on the medication, to the MAR 3 times! Each comparison needs to include checking the individual pills/capsules to ensure the right pills/capsules are in the container.

23. Carefully check that the name on the medication label is exactly the same as the name written on the MAR. Check the dose on the MAR with the dose on the bottle/blister card. It may be necessary to give ½ or multiple tablets/capsules.

24. P.R.N. medications may only be given when accompanied by a P.R.N. Order signed by a physician. Non- Prescription Medications and Treatments are to be given only with a Doctor's Standing Order as per attached form F.QAM8a, Non-Prescription Medications and Treatment Orders. When administered, P.R.N.

orders and Non-Prescription Medications and Treatments must be entered on the MAR.

25. When a medication / treatment is discontinued as per Doctor's orders, the prescription line on the MAR sheet needs a ruled line with DISCONTINUED written on that line. The date discontinued will be noted in the log/progress notes (in red) and in the Medication/treatment History (see attached form F.QAM8, Medication History).

26. Any changes to a person's medications / treatments will be documented in their Medical Journal.

27. Under the Regulated Health Care Professionals Act, employees of ISSI as unregulated care professionals, may assist or perform aspects of care traditionally provided by Registered Health Care Providers, only if it is a daily routine and they are properly trained.

28. Non-compliance with medication procedures are subject to discipline up to and including dismissal from Ingersoll Support Services Inc.

Self-Administration of Medications

1. Ingersoll Support Services Inc. recognizes each person's right to independently administer their own medications. A Medication Self-Administration Plan will be developed with the person, family members or friends and support workers to assist them in achieving their goal.

2. **Medication Self Administration Plan**

   A plan may include but are not limited to the following steps:

   - The person's medicine is stored with other medications. The person self-administers and a support worker records. Or,
   - The person's medicine is stored with other medications. The person self-administers and signs the medication sheet. A support worker performs documented spot checks and initials medication sheet. Or,
   - The person stores medicine in their room and signs medication sheet. A support worker performs documented spot checks and initials medication sheet. Or,
   - A Pharmacy dispenses medication to a dosette (or other dispensing option) and the person self-administers or stores medication and self-administers. The Support Worker will monitor and document any concerns.
   - When new medications are prescribed, the self-administration procedure will be reviewed and amended as necessary.

- If for the safety of others, medications need to be kept locked, the person self-administering may keep the key to their medication storage area.
- Amendments to self-administration may be made based on individual needs, areas of concern, support options, etc.
- Any medication sheets used for self-administration under any of these options MUST be kept as a matter of record.

3. **Guidelines to assessing a person's ability to Self-Administer Medications and Treatments**

- Ability to swallow medication.
- Ability to voluntarily & purposefully move hands and arms.
- Ability to identify the correct route, drug, time and dose.
- Ability to follow proper medication procedures.
- Ability to physically access the medications.
- Ability to store medications appropriately.
- Ability to order and check prescribed medication.
- Ability to seek assistance if needed.
- Recognize the 5 rights of medication.
- Must have policy/procedure knowledge, monitoring and regular evaluation.

Non Prescription Medication and Treatment Orders

**** NO medication or treatment may be administered without a doctor's orders ****

Name: _____ Date: _____

The following may be used as P.R.N. orders from _____20____

to _____20_____

	Dosage & Times (Frequency)	Directions: (to be used for)
Pain medication Name:		
Antacid Name:		
Laxative Name:		
Cold Preparation Name:		
Other		
1.		
2.		
4.		
5.		
6.		
7.		
8.		
9.		

_____
Signature of Physician

To be kept in Medical Section of Personal File

Medication Administration Methods: Recommendations

Administration Procedures of Medications are to be fully completed for ONE person at a time.

Pill / Capsules

Pills: Given as they are, unless directed that they should be crushed and dissolved in water or other substance. Pill may be crushed by pressure between two spoons. Use a pill crusher if one is available.

Capsules: To be given as they are. Capsules can only be opened if directed by the Doctor or Pharmacist to open.

From a Bottle or Blister Card:

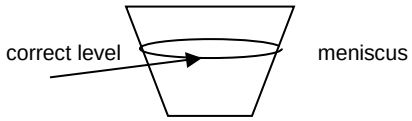
1. Wash hands before and after procedure.
2. Unlock med location.
3. Read medication sheet and give **only** medication listed.
4. Select **correct** medication **(1st check)**.
5. Before pouring, check **MAR** with label on the med container **(2nd check)**.
6. Use cap of container or med cup to drop the tablet into or from the blister card to the med cup.
7. For PRN medications, initial blister pack under tab taken.
8. Before returning bottle, check label with **MAR (3rd check)**.
9. Dot on MAR sheet after you pour.
10. Lock medication back in locked location
11. Take medication to the right person at the right time and give as directed (i.e. given with water, juice or food).
12. Observe that the medication has been swallowed.
13. Immediately initial **MAR** in appropriate box (don't forget to sign the bottom).
14. Tidy up. Clean any spoons and dispose of used tissues and med cups.
15. Wash hands before and after procedure.

Liquids: Given as measured, or diluted with water after measuring, as directed.

1. Wash hands before and after procedure.
2. Unlock medication location.
3. Read medication sheet and give **only** medications listed.
4. Select **correct** medication **(1st check)**.
5. Before pouring, hold the bottle with the label in palm of your hand to avoid spilling on the label.
6. Check correct way of measuring liquids:

i. <u>For pouring amounts labeled on med cup, i.e.) 5c.c.</u>

a) put measuring cup on flat surface,
b) measure at eye level and mark with thumb the desired volume on the med cup,
c) slowly pour liquid to **correct** dosage,
d) read the volume at the low level of meniscus



ii. <u>For pouring amounts not on med cup, i.e.) 6 c.c.</u>

a) pour approximate level into a med cup,
b) use a syringe to draw up the exact amount,
c) pour into a second med cup or other method of administering, or give directly from syringe **after completing the rest of the method – must do third check!**
d) pour excess medication back in bottle,
e) syringe should never contact the med bottle

7. Dot on MAR sheet after you pour.
8. After pouring, wipe the neck of the bottle with a damp cloth or paper towel.
9. Before returning med to cupboard, check label with the **MAR (3rd check)**.
10. Lock medication back in locked location.
11. Take medication to the right person at the right time and give as directed (i.e. given with water, juice or food).
12. Check that medication has been swallowed.
13. Immediately initial MAR in appropriate box (don't forget to sign the bottom).
14. Tidy up. Clean any spoons/ syringes and dispose of used tissues and med cups.
15. Wash hands before and after procedure.

<u>Ear Drops:</u>

1. Wash hands before and after procedure.
2. Unlock medication location.
3. Read medication sheet and give **only** medications listed. Select **<u>correct</u>** medication **(1st check)**.
4. Before administering, check MAR with label on the med container **(2nd check)**.
5. Pour if appropriate and complete **3rd check.**

6. Rub/hold the drops in your hand to warm them to a comfortable temperature.
7. Have the person lie on their side with affected ear up.
8. If an adult, gently pull their ear upward and back. If a child, gently pull their ear downward and back.
9. Instill drop, being careful not to touch ear with dropper. **Do not let the drop fall directly on the ear drum - allow it to slide into ear.**
10. Have the person remain lying on their side for a few minutes.
11. Immediately initial **MAR** in appropriate box (don't forget to sign the bottom).
12. Tidy up.
13. Wash hands before and after procedure.

Eye Drops and Eye Ointments:

1. Wash hands before and after procedure.
2. Unlock medication location.
3. Read medication sheet and give **only** medications listed. Select **correct** medication (**1st check)**.
4. Before administering, check MAR with label on the med container **(2nd check)**.
5. Have the person lie down with their head tilted backwards or sitting in a chair with head tilted backwards.
6. Cleanse eyelid and lashes from inner corner to outer corner with moistened cotton swab, using a clean swab for each eye.
7. Draw medication into dropper, complete the **3rd check** (if using a dropper).
8. Draw down lower lid, carefully steady hands on the person's face, have the person look up, allow drop(s) to go into eye pocket between lower lid and eyeball, release eyelid. Have them keep their eye closed for a minute, use a cotton swab to wipe eye.
9. Immediately initial **MAR** in appropriate box (don't forget to sign the bottom).
10. Lock medication in locked location.
11. Tidy up.
12. Wash hands before and after procedure.

Nose Drops:

1. Wash hands before and after procedure.
2. Unlock medication location.
3. Have the person lie on back, head turned to side and slightly back.
4. Draw med into dropper, completing all checks.
5. Instill prescribed number of drops into each nostril.
6. Have the person remain in that position for a few minutes.
7. Immediately initial **MAR** in appropriate box (don't forget to sign the bottom).
8. Lock medication in locked location.

9. Tidy up.
10. Wash hands before and after procedure.

Rectal Medications:

1. Wash hands before and after procedure.
2. Unlock medication location.
3. Read medication sheet and give **only** medications listed. Select **correct** medication **(1st check)**.
4. Before administering, check **MAR** with label on the med container **(2nd check)**.
5. Pour med, complete **(3rd check)**.
6. Lock up unused medications.
7. Have the person lie on their **left** side with their right knee at right angle keeping the person covered as much as possible and their buttocks slightly elevated.
8. Put on glove or finger cot, lubricate index finger. You do not need to lubricate index finger for enema, pre-packaged fleet enemas are already lubricated.
9. Displace all air from the enema. Enema should be between room temperature and body temperature.
10. Insert solid medication so that it is between the stool and rectal wall.
11. The enema is inserted into the rectum 2 – 3 inches. The fluid is allowed to flow. **Once you have started to squeeze the fleet enema bottle do NOT release until it has been removed from the rectum.**
12. Hold buttocks together for a few minutes to prevent expulsion.
13. Provide for discomfort – place on back and ask to retain suppository/ enema 15 – 20 minutes if possible.
14. Immediately initial **MAR** in appropriate box (don't forget to sign on bottom).
15. Tidy up.
16. Wash hands before and after procedure.
17. Record results.

Inhalers:

1. Review and follow the protocol for each individual person.
2. Wash hands before and after procedure.
3. Unlock medication location.
4. Read medication sheet and give only medications listed.
5. Select correct medication **(1st check)**.
6. Before administering, check MAR with label on the inhaler **(2nd check)**.
7. Dot on MAR sheet when you take the inhaler to the person.

8. Before leaving to give the medication ensure that you have all equipment that is needed (indicated on MAR and/or protocol) to administer the inhaler and check label and directions with MAR **(3rd check)**.
9. Take medication to the right person and at the right time and give as directed.
10. As indicated in each person's protocol, observe and/or administer the medications prescribed, giving the necessary assistance as indicated.
11. Immediately initial MAR in appropriate box (don't forget to sign the bottom).
12. Tidy up. Clean all equipment and inhaler, as directed and return medication to storage area.
13. Lock med back up in locked cupboard.
14. Wash hands before and after each procedure.

Approved Standard Abbreviations

ABREVIATIONS	MEANING	ABREVIATIONS	MEANING
@	at	p.c.	after meals
a.c.	before meals	per	by
ad lib.	As desired	p.m.	afternoon
a.m.	morning	p.o.	by mouth
b.i.d.	twice a day	p.r.n.	when required/needed
c	with	pt., or O	pint
cc.	cubic centimeter	q.	every
dc (disc)	discontinue	q.d.	every day
Gm.	gram	q.h.	every hour
gt., or gtts.	Drop, or drops	q. (2,3 etc.) h.	every (two, three etc.)
h (hr.)	hour	q.i.d.	4 times a day
h.s.	at bedtime (hour of sleep)	q.o.d.	every other day
		Rx	take, treatment
L	liter	s.	without
mg.	milligram	ss	one half
ml.	milliliter	soln	solution
NPO	nothing by mouth	tab.	tablet
od	right eye	t.i.d.	3 times a day
os	left eye	tsp.	teaspoon
ou	both eyes	T (tbsp.)	tablespoon
oz.	ounce	ungt., ung.	Ointment

Conversions

24 HOUR CLOCK SYSTEM
*eliminates use of a.m. & p.m.

12:01 a.m.	= 0001 hrs. (1 min after midnight)
8:00 a.m.	= 0800 hrs.
8:00 p.m.	= 2000 hrs.
11:59 p.m.	= 2359 hrs.
12:00 midnight	= 2400 hrs.

VOLUME CONVERSIONS

1 c.c.(cubic cm)	= 1ml = 1 mm
1 tsp.	= 5 ml
1 T.	= 20 ml