DIRECT SUPPORT STAFF TRAINING 1.11.9 B

All Direct Support Staff shall receive Core Curriculum and on-going Healthcare Training in the following areas:

- Universal Precautions/Standard precautions
  - Communicable diseases
  - Infection control
  - Exposure Control Plan (OSHA)
- Wellness and prevention of Illness
  - Nutrition and Food Handling
  - Personal Hygiene
  - Sexual & Reproductive Health
  - Healthy Lifestyle
- Signs and Symptoms of Illness and injury
- Emergency care
  - CPR & Basic First Aid
- Communication
- Medication Administration
- Agency Specific Policies, Procedures and protocols
- Individualized Procedures

All direct support staff are required to demonstrate competency to the licensed nurse on an annual basis or sooner if indicated by the licensed nurse. Documented training will be kept in the employee's personnel file.

DISPOSAL OF MEDICATIONS 1.11.6

All controlled medications including damaged, excess, discontinued, refused and/or expired medications will be disposed of at the WBO. A medication return form will be filled out including the individual's name, medication and reason for disposal and will be signed by a staff trained in medication administration.

The licensed nurse will transport the medication to the WBO for disposal. To dispose of controlled and non-controlled medication, the nurse will:

- Document all fields of the Medication Disposal Log including individual's name, medication name, number/amount of medication, reason for disposal, and date of disposal.
- Two nurses will initial the entry.
- All controlled medication will be mixed with kitty litter and water in a sealed container.
- The sealed container will be kept in a locked cabinet.
- Once full, the sealed container will be placed in a plastic bag secured with duct tape and disposed of in the trash.

If a single pill needs disposal, staff will put the pill in a white med envelope, and write the name, med, dose, time, route on the envelope, and leave for the nurse to discard.

Any identifying information on packaging will be removed prior to disposal of packaging.

For non-controlled medication nursing can use a medication disposal box in the community.

Emergency Medical Care Permit and Vital Statistics Form 1.25.3

The **Emergency Medical Care Permit and Vital Statistics Form** for each individual receiving services from West Bay RI will be maintained in the individual's blue medical book.

Copies of this form will also be kept in the following locations:

- The Coordinator's book at the West Bay RI office
- Each van used to transport the individual
- The individual's medical appointment folder
- Blue medical binder at the home

This ensures that vital medical information is readily accessible when needed.

The following information is included in the Emergency Medical Care Permit and Vital Statistics Form:

1) The individual's name, address, telephone number, and date of birth
2) Social Security number
3) Medicaid number/Medicare number (and/or other insurance information)
4) Guardian and/or next of kin name and telephone number
5) Medical diagnosis
6) The individuals race, gender identity, height, weight range, hair and eye color
7) Any other identifying characteristics that assist in identifying the individual such as marks, scars, tattoos or body piercings
8) Date of last annual physical
9) Immunizations status for Tetanus, hepatitis B, COVID-19 and FLU
10) List of any known allergies
11) Special dietary or nutritional needs, food or fluid restrictions or limitations
12) Physical limitations
13) Advanced directives
14) How the person supported communicates, assistive technology, and the language the person understands
15) The individual's behavior and support needs
16) Any additional information that could assist a person to understand what the person can do for him/herself

FAMILY MEMBER AND/OR LEGAL GUARDIAN MEDICAL COMMUNICATION POLICY 1.11.1 C

West Bay makes every effort to maintain routine, professional communication with family members regarding healthcare concerns. Families may contact the agency directly at the home location of their family member.

While routine communication is emphasized regarding each individual's health care needs, the nurse or a member of the residential team will contact an individual's family member and/or legal guardian regarding significant changes in medication and/or medical status of the person supported.

GUIDELINES FOR WHEN TO CALL THE NURSE

A. THINGS TO REMEMBER:

1. You are responsible to promptly report changes in an individual's condition to the nurse and your manager.
2. You are not responsible for interpreting or explaining changes in an individual's condition.
3. Document in the log the signs and symptoms observed and the direction given by the nurse.
4. Document in the log the results of the treatment, if any, given.
5. Continue to observe for changes in the individual and call the nurse when needed.
6. When an individual has limited communication skills, watch more closely for signs of behavioral, physical or emotional change. Pain or discomfort is often a reason for moody, non-cooperative, or agitated behavior.

B. ROLE OF THE NURSE: To oversee and direct the general health and medical needs of the individuals.

C. DO NOT CALL THE NURSE FOR BEHAVIORAL CONCERNS. Please be aware that behavior episodes should be directed to the house manager. They will access the appropriate supports.

D. SIGNS AND SYMPTOMS TO CALL THE NURSE:

1. Temp 101 or above
2. Vomiting
3. Diarrhea- Lasting three times after prn is given
4. Seizures- If abnormal activity and/or 1st time
5. Passing Blood- Rectal or spitting-up blood or blood-tinged sputum
6. Medications error
7. Bruising, rash or any open area on skin
8. Change in appetite or sleep pattern lasting more than one day
9. Constipation- Only if PRN med or treatment is ineffective
10. Congestion- Only if PRN med or treatment is ineffective
11. Choking
12. Sore Throat with fever
13. C/O of chest pain (Call 911)
14. Difficulty in breathing (Call 911)
15. Severe pain
16. Red, draining, itchy eyes
17. Falls
18. Unconsciousness (Call 911)
19. Any signs or symptoms of illness or change in individual's overall condition
20. Green or red flags in eMAR

GENERAL:

1. Always call when an individual is taken to the Emergency Room.
2. Always call anytime an individual starts a new medication or treatment.
3. Always call anytime an individual has a bruise quarter size or larger or multiple bruises.
4. Always call anytime a medical problem arises or change in medical status.
5. Always call for any medication error.
6. Always call when only 3 days are left of a medication (and document that a nurse was notified in the log).
7. When calling the RN for urgent concerns and they do not pick up leave a detailed message. If the RN does not call back in 30 minutes try again, if they do not pick up again **CALL ANOTHER RN.**

GUIDELINES FOR NOTIFYING THE NURSE VIA EMAIL

1. Email may be used for non-emergent concerns regarding an individual such as a minor cut requiring first aid/band aid.
2. Email the nurse/team for routine doctor's appointments.

***SPECIFIC TRAININGS ON WHEN TO CALL THE NURSE WILL BE ADDRESSED AT STAFF MEETINGS.**

***WHEN IN DOUBT, CALL**

HEALTH CARE RECORD CONTENT 1.11.3

Health Care records for each individual supported by West Bay will include all pertinent health care–related documents, including physician or health care provider assessments and orders. Health Care records will include the following:

Blue Medical Books

• Hospital Procedure

• Emergency Care Permit/Vital Statistics form

• Primary Physician/Annual Physical form, which includes review of all prescribed medications, including over-the-counter medications and herbal/homeopathic supplements, and documentation of completion of accepted primary care screenings. If a routine screening is deferred, documentation as to the reason for the deferral will be included in the individual's health care record. Any documentation of deferred health care screenings or recommendations will be reviewed at least annually, and ongoing efforts will be made to achieve the desired health care goals.

• Dental examinations and cleanings will be performed as recommended by the American Dental Association, unless otherwise determined by the individual/legal guardian of said individual or the individual's licensed health care provider.

• Labs

• Specialty doctors including, but not limited to, vision, audiology, speech consults, orthopedic, physical therapy, occupational therapy examinations, and/or other medical referrals

• Medical History

• Medical Immunizations

• Prescribed diets. A specialized diet will be implemented for every individual who requires one. A copy of the diet will be included on the Emergency Care Permit.

Electronic Documentation

• Medical appointments and immunizations documented in Sandata by the RN

- Annual RN report/assessment with nursing care plans

• Vital signs and weights (eMAR)

• Medication History (eMAR)

• Bowel Health (eMAR)

Data Collection

• If a person supported has a seizure disorder, a seizure record is maintained in which the date, time, length of seizure, incident preceding incident, reactions, observations after seizure, procedure followed, and staff initials are documented.

• A record of menses is kept if determined as needed by the individual's physician or other health care provider.

Health Care Services 1.11.1

A Registered Nurse reviews the Health Care Manual on an annual basis and when any changes are made to it as evidenced by the footer on the Medication Storage policy and Controlled Medication Policy. A Registered Nurse also reviews the Health Care Manual at the Health Care In-service, during the initial Medication Administration Competency and on an annual basis with each employee at the time of the completion of the Medication Administration Competency.

Reviewed by: _____

Date: _____

Health Care Services- Immunization Policy 1.11.1 B

Individuals receiving residential supports from by West Bay will receive vaccinations and immunizations as ordered by the individual's health care providers according to the most current recommendations of the Advisory Council on Immunization Practices (ACP). On an annual basis, the HCP will be asked to document needed immunizations and vaccinations. If an immunization is refused, the RN will document refusal.

INCIDENT REPORTS

Incident reports will be completed for any serious incidents. Examples include but are not limited to:

- Any injury that requires medical care or treatment
- Medication errors
- Unexpected medication reaction
- Neglect
- Unplanned/unexpected visit to an urgent care clinic or to the hospital
- Death
- Missing person

All incident reports must be completed immediately when the incident is discovered.

Reports of serious incidents shall be maintained and reviewed by a licensed nurse and the Incident Review Committee.

INDIVIDUALIZED PROCEDURES 1.11.8

An individualized procedure is one that the individual would be unable to do for themselves but is necessary to maintain or improve their health care status. West Bay, in conjunction with the individual's physician, licensed nurse, the individual and his/her family will develop a plan specific to the particular needs, risks, and individual characteristics of the individual supported.

Appropriate training and documentation of competency shall be specific to the needs, risks, and characteristics of the person supported and shall be completed before a support staff performs said task.

The following standards apply to the delegation of individual procedures:

- RN will assess the individual's condition to determine condition to be stable and predictable.
- Training of support staff is completed by a professional nurse or licensed health care provider.
- Trained staff must demonstrate competency to the RN prior to delegation of the particular task.
- Competency will be re-assessed at least annually or as the individualized procedures change.
- Nurse shall provide on-going monitoring of individuals needs and support staff skills.

If the RN determines that a task or procedure cannot be delegated, the RN must immediately notify the Director of Nursing and the Executive Director. Arrangements must be made for the task or procedure to be performed by a licensed individual while delegation concerns are being resolved, in order to ensure the health and safety of the individual.
.

Medication Ordering Procedure
White Cross Pharmacy
Phone: 401-726-6200 Fax 401-351-5902
Hours of Operation Monday through Friday 9am-7pm Sat 10am-4pm

All individuals must have enough medication for all doses at all times. Each medicator is responsible for being aware of the number of days' supply of medications remaining.

ORDERING MEDICATION

- Medication is to be ordered 7 days prior to running out. Homes are encouraged to assign this task to one person but all are responsible to ensure that medication is ordered on time.
- Refills may be ordered electronically through eMAR.
- If medication is not delivered and there are only 3 days of medication left, White Cross is to be called to ensure that the refill has been processed and is scheduled to be delivered. The RN is to be notified and a note is to be put in the log.
- Low supply of medication and documentation of the phone call is to be put into the log under med notes so all staff are aware.
- There is an on-call pharmacist for emergencies. If there is a problem with the medication, please also notify your RN.

MEDICATION DELIVERY

- Medication on weekends or evenings, such as antibiotics, should be sent to White Cross to be filled unless otherwise directed by the RN to send it elsewhere. When NEW medication is delivered, please call the RN.
- Call RN for any flags seen in eMAR next to a medication order.
- When medication is delivered, staff will compare the medications delivered to the sheet provided by the delivery driver. If any discrepancies, staff will notify the RN and White Cross Pharmacy.
- Staff will log the medication into the medication log entry OR scan into eMAR. They will then put the White Cross sheet into an envelope for delivery to West Bay office.
- Overflow medication will be kept separate from medication being currently used except for controlled substances.
- When medication is delivered, staff are to check the number of refills on the medication.
- If there are no refills, staff are to call White Cross pharmacy to ensure that they obtain a new prescription from the doctor for the following month.

MEDICATION ADMINISTRATION AND TREATMENT 1.11.4 A

Before administering any medications, all unlicensed staff must complete West Bay's Medication Administration and Health Care/Bloodborne Pathogen Training In-Service and successfully demonstrate competency to a licensed nurse. Prior to administering medications using eMAR, staff must also complete eMAR training and demonstrate competency in the use of the software. Documentation of initial and annual health care training and competency evaluations will be maintained in each employee's personnel file.

Medications may only be administered by staff who have received documented medication administration training conducted by a professional nurse, demonstrated competency in performing medication administration procedures, and had their competency validated and documented by a licensed nurse. Appropriate documentation must be placed in the employee's personnel file.

The procedure for Medication Administration by Direct Support Professionals is located in the Medication Administration Training packet and Medication Administration power point.

A professional nurse will train all Support Staff on medication administration. They will be competent in the following areas:

- Administering medications
- Completing treatments
- Documentation
- Reviewing bowel movement, weight, menses, and temperature charts
- Informing the medicator and/or on-coming staff of next shift of any medical concerns, personally or in house log
- Completing med count with another staff person per shift
- Packing medications

Non-medicator support staff will not administer packed medication.

For non-employees administering medication, a Medication Release Form must be completed by the medicator. The Medication Release Form must be placed in the medication book and filed appropriately once it has been signed and returned following the individual's outing.

Medication and Treatment Errors 49.24

We realize that medication and treatment errors will occur. To minimize the impact that these errors have on individuals, open and honest communication is essential. Medication and treatment errors include but are not limited to the following:

Examples of failure to follow proper medicating procedures:

- Not signing medication given in eMAR
- Not administering a scheduled medication (omission)
- Not following bowel protocol
- Not completing prescribed treatments (wound care, creams / ointments, etc.)
- Not performing ADLs (nail care, oral care, etc.)
- Not completing med count
- Not putting dot/initials into box on med sheet when preparing and giving meds
- Not reviewing med sheets after giving meds and prior to the end of shift
- Not reviewing eMAR with two employees at the end of shift for alerts and missed signatures
- Not calling the nurse when medication has three days remaining in the home

Failure to follow the 5 rights of medication administration:

1. Wrong person
2. Wrong medication
3. Wrong dose
4. Wrong route
5. Wrong time

Medication Incident Report

An employee who makes a medication or treatment error or an employee who discovers a medication or treatment error is required to fill out a medication incident report. The completed report must be delivered to the office within 24 hours of the discovery of the error.

Call RN: General guidelines

A West bay Registered Nurse must be immediately notified by employees upon the discovery of a medication or treatment error. The West Bay RN will provide further direction to employees including, but not limited to, medication administration, monitoring, or referral to PCP or emergency medical services.

Intentionally withholding knowledge of a medication error is considered a serious violation of agency policies.

Additional factors for consideration

In situations not clearly defined by the point system, West Bay policies, procedures and practices will be followed.

- **Medication vs. Treatment**
- **Time the medication error was discovered**
- **Procedural error**
- **Extenuating circumstances**

The Incident Review Committee (IRC) will complete further review of the assigned points given for med errors. The IRC will then determine additional recommendations.

Assigning Points

- A Registered Nurse and the Incident Review Committee will review every medication incident report.
- All med errors are reviewed and points are assigned by the Nurse
- Points assigned are based upon the type of medication error and the impact on the individual.
- Employees who accumulate 9 points in a 6-month period will be placed on medication probation.
- Medication error points will be assigned per following list and at the discretion of the nurse
    - 1 POINT
        - Med given but not signed off in eMAR
        - Med given but missing dot/ initials on med sheet
        - Missed medication Count
        - Not reviewing eMAR with two employees at the end of shift for alerts and missed signatures
        - Missed ADL (oral care, nail trim, etc.)
        - Did not call nurse with 3 days remaining of medication in the home
    - 2 POINT
        - Did not follow bowel protocol
        - Prescribed treatment not completed (wound care, prescribed creams / ointments, etc)
    - 3 POINT
        - Omission of medication
        - Wrong Person
        - Wrong Medication
        - Wrong Dose
        - Wrong Route
        - Wrong Time
- Medication errors resulting in medication probation with be reviewed with Director of Nursing prior to submission to Human Resources.

Medication Probation Procedure

When an employee is placed on medication probation, the employee will not be allowed to administer medications.

Employee will be required to complete a probationary period: Level 1 or Level 2 based upon the severity of the error.

- Probation is effective immediately on the date the med error occurred
- A letter of probation will be issued for 60 days, based on the date of the med error
    - The letter of probation will specify corrective action, including attendance of medication administration class based on level
    - Completion of (3) observations and (3) demonstrations of proper medication pour and pass based on West Bay training procedures.
    - Management team will contact the House Nurse to schedule employee re-training at the location

If additional medication errors occur while on probation or if a 2nd medication probation occurs within 6 months of the 1st probationary period, further disciplinary action may be taken depending on the circumstances of the error.

MEDICATION CLOSET POLICY

- The med door will be closed and locked at all times. The medicator will carry the keys with them throughout the shift. The med keys need to include a house key and a van/car key in case of an emergency evacuation. If the medicator is leaving the premises for any reason, the medicator will give the med keys to another medicator on shift and document in the log the time and to whom the keys were handed off to.

- Only staff that are med trained will be given the keys to access the med closet.

    - If any staff need an item from the med closet, they will request that the medicator get it for them.
    - Untrained staff can be in the med closet when they are training but should not be left alone in the med closet.
    - When staff need to sign treatments in the med book or on eMAR on the computer, the medicator will take the med book or computer out of the closet for all staff to sign off all treatments.

- All schedule I and II medications will be kept in a lock box inside the locked med closet, as well as any other medication as determined by the nurse.

- The shift medicator will have the keys to the med closet with them at all times.

    - When new deliveries of counted meds arrive, they are to be logged in per agency protocol, put directly into their appropriate place and added to daily med count if they are a schedule I, II or benzodiazepines (or any other medication identified to be counted in the home).

- In addition to daily counted medications, ALL overflow controlled substance medications will be counted three times a day per agency protocol.

MAKE SURE YOU DO NOT LEAVE THE HOUSE WITH THE KEYS

If keys are lost, contact the manager on call and/or the residential coordinator. DO NOT call the nurse. The managers need to ensure there is an extra set of keys in the combination lock box.

MEDICATION SHEETS 1.114 D E/H

Medication sheets may be used for homes without access to the electronic medication administration record. A medication signature sheet for all staff authorized to administer medications will be kept in the front of the medication/treatment book. All medication sheet will be reviewed and signed monthly by the licensed nurse and include:

* Name of the person to whom the medication is being administered
* Medication(s) Name
* Dosage
* Frequency
* Route of administration
* Date of administration
* Time of administration
* Known allergies or undesirable reaction
* Special considerations in taking the medication
* Signature and initials of staff administering the medication

All prescriptions will be reviewed and renewed at the individual's annual physical exam or as indicated by the physician or other licensed healthcare provider. A new prescription will be obtained for all medication changes.

Separate med sheets will be kept for oral medications, treatments and PRN medication.

PRN medications are administered on an as needed basis and prescribed by the physician or other licensed healthcare provider. PRN medication include specific parameters and rationale for use.

PRN Medication Administration sheets shall include:

* Name of the person the medication is being administered to
* Medication Name, Dosage and Route
* Date, Time and Reason
* Effect of the medication
* Signature and Initials of staff administering the medication

All the above documentation will be included in the medication and treatment orders in eMAR.

MEDICATION STORAGE POLICY 1.11.4C

All medications administered by agency personnel to individuals receiving 24 hr. supports will be:

- Kept in the containers from the pharmacy that meet legal requirements with no changes made to the labeling
- Stored in a locked area.
- Stored separately from non-medical items
- Stored under proper conditions of temperature, light, humidity and ventilation
- Medications requiring refrigeration will be stored in a locked container in the refrigerator or in a locked refrigerator
- Internal and external meds will be stored separately.
- Schedule I and schedule II medications will be double locked.

The dispensing pharmacy shall dispense medications in containers that meet legal requirements. An exemption from storage in original containers is carried out using a pre-poured packing distribution system packaged by a pharmacist. No changes will be made to the pharmacy label. Any change to the medication will be noted on the medication administration sheet or in eMAR and a pink label will be affixed to the pharmacy label to indicate the change.

Potentially harmful substances should be clearly labeled and stored in an area separate and apart from medications.

Schedule I and II medications will be stored in a locked box in the locked medication closet (RN will let staff know which medications are Schedule I and II). One key for the lock box will be kept with the medication closet key and one key for the lock box in the house safe.

WEST BAY RI
INNOVATION ● INCLUSION ● ADVOCACY

MEDICATION ADMINISTRATION TRAINING PACKET

INTRODUCTION TO MEDICATIONS

Medicines are used to treat disease, injury, or pain. Medications are strong enough to cure, but if given improperly, can cause harm. Medications used to treat chronic conditions *(long term)* such as high blood pressure or diabetes are given on a daily basis.

- It is important that these medications be given according to their correct schedule as they maintain proper body function.
- Medications used to treat injury or pain may be given on either a short- term or long-term basis.
- All medications have side effects but not all people taking the medication experience them.
- Side effects may or may not be life threatening.
- It is important to know the people whom you are administering medications to so that it can be determined if they are experiencing a side effect.

GENERIC MEDICATION

It is the chemical name of a drug that is generally less expensive than brand-name drugs, even though they are chemically identical to brand-name drugs and meet the same standards of the FDA (US Food and Drug Administration) for safety, purity and effectiveness.

RESOURCES FOR INFORMATION ABOUT MEDICATIONS

Employees should be aware of the resources that are available to learn about the medications they are administering to the person. The following resources are available:

- Drug Handbook
- The Pharmacist
- Information tab on eMAR tile
- House nurse

LEGAL AND ETHICAL ISSUES

Employees are legally responsible to follow all Medication Administration policies and procedures when administering medications.

- Proper medication administration is an important part of health care. The people we support have a right to expect that properly trained Employee will administer the medications, which have been prescribed for them, in a safe manner.
- A properly trained employee will know and adhere to the “5 Rights” of proper medication administration and follow proper medication administration procedure.

- It is important to take care when administering medications. Acting according to habit or in haste can lead to medication errors.

- When errors occur proper communication and documentation need to be followed, such procedures will be discussed in this packet.

INITIAL TRAINING

1) **Employee receives a medication training packet at the Orientation In-Service.**
   Review packet **BEFORE** attending the Medication Administration In-Service.

2) **Employee must attend the Medication Administration In-service at the office, prior to beginning medication training at the home, provided they meet the objectives below.**

   Employees who take the Medication Administration In-Service MUST:

   - Meet all in-service objectives
   - Pass the on-line (Relias) test with a score of 80 or better
   - Test score of 80 or better: move on to In-home Medication Training
   - Test score less than 80: instructing nurse will review medication administration content at time of class

TRAINING AT THE HOME:

All of these objectives are to be met before a new employee can administer medications

1) Observe a manager administering medications 3 times on 3 different shifts
2) While being observed by management 3 times, the employee administers medications on 3 different shifts
3) Learn to fill out and submit a "Medication Incident" report correctly.
4) Training on when to call the nurse
5) Once approved by management, the employee contacts the nurse via email, sending their schedule in order for a date & time that works for both of the can be scheduled.
6) Nurse will then observe employee demonstrating proper administration of medications.
7) The Nurse signs the employee's "Pour and Pass" competency after proper completion.
8) Employee must take a written "Medication Quiz"
9) The Nurse will correct and review the test with the Employee.

MEDICATION ADMINISTRATION
GENERAL RULES: DO'S

1) **Always be alert and focused when handling medications**. Communicate to the person and explain what it is you are going to do.

2) **Start early.** There is an hour leeway as to when the medications are given. This means the medication may be given one hour before up to one hour after the designated administration time.

3) **Hands should be thoroughly washed before handling medications** as it is considered the single most effective way to reduce the spread of infection. (i.e. Wash hands in between administering medications to another person).

4) **Always use eMAR for administering medications** (unless home still uses medication sheets). Be alert to medication orders that may change.

5) **Ensure you understand the information on the blister pack and in eMAR.** If not, call the nurse prior to administrating the medication.

6) **Always MEDICATE ONE PERSON at a time.**

7) **If you become distracted, then start again.**

8) **Read the medication tile in eMAR carefully for special instructions regarding the medication.** (i.e. give on an empty stomach, crushing, use of dairy products, food, etc.)

9) **Medications may be crushed unless contraindicated on the medication tile in eMAR or label.**

10) **Administer medication at the scheduled time – this helps to maintain proper body function.**

11) **Always perform the 5 RIGHTS three times when you are pouring the medication to give to a person.**

12) **The 5 RIGHTS are:**
RIGHT PERSON, RIGHT MEDICATION, RIGHT DOSE, RIGHT ROUTE, RIGHT TIME

13) **The 3 checks when using eMAR -**

Check #1:

Compare label on Medpack or blister pack to the eMAR tile to check the 5 Rights. For Medpacks, read the description of the pill on the medpack, and turn medpack over to confirm pill is in the package. Put check mark next to medication name on medpack.

Check #2

Compare label on Medpack or blister pack to the eMAR tile to check the 5 Rights. For Medpacks, put a check mark on the medication tile on eMAR. For Blister packs, scan the barcode to generate a check mark on the eMAR tile. For Blister packs, turn over the blister pack & write your initials, date, time on the cardboard above the foil of the blister you are taking the medication from. Push med through foil and into med cup.

- **Tabs from a bottle**

place the required number of pills in the bottle cap and then empty pills into a med cup.

- **Liquid medicine**

hold the med cup at eye level on a level surface and pour the liquid to the correct line on the med cup

Check #3:

Compare label on Medpack or blister pack to the eMAR tile to check the 5 Rights. For medpacks, open the package and pour into med cup. COUNT PILLS in med cup and compare to number of pills checked on eMAR- amount should match.

The 3 checks when using med sheets -

1st check the prescription label on the blister pack/medication bottle to med on med sheet
Pour the medication using the above instructions

2nd recheck the prescription label on the blister pack/medication bottle to med on med sheet
Place a dot in the box of the med you have just poured

3rd recheck the prescription label to blister pack/medication bottle to med on med sheet.
Place blister pack back into bin.

14) **Always check how many items you should have, to the number of items you do have, prior to administering the medications.**

15) **Always click on the record all tab, in Emar, once you have administered the medication.** This is your signature that you have passed the medication.

For med sheets – place your initials in the box/boxes that you have placed a dot in.

16) **Ensure you record the results of a PRN medication.**
In eMAR, a tile will appear to chart effectiveness. For med sheets, record the results on the back of the yellow med sheet, putting date, time, and your initials

17) **Know the medications you are administering-** therapeutic effect and major side effects

18) **For a person that can self-medicate**, observe to be sure that medications are taken.

19) **Always call the nurse for the following-**

-person chooses not to take their medication

-you find that a medication was not given.

-there is a green or red flag is present for a person's medication.

-a medication from White Cross does not scan

MEDICATION ADMINISTRATION
GENERAL RULES: DON'TS

NEVER do any of the following**:**

1) **Give a medication from a container** that has a label you can not read.
2) **Change a medication label** – place a stick on blister pack/bottle to indicate direction change.
3) **Marry medication –this means you do not pour a near empty bottle of pills or liquid into another bottle.** All bottles have lot #'s for identification purposes and expiration dates.
4) **Substitute a dose of medication** i.e., order is to give one 800 mg tab of Ibuprofen. There are no more of the 800 mg left, so you administer four tabs of 200 mg Ibuprofen. Call the nurse and ask to have the order changed to the 200 mg of Ibuprofen.
5) **Give a medication that has fallen to the floor**. Place the dropped med into a white envelope, label the envelope with the 5 rights, place in designated container in med closet for the nurse. The person should be given another pill. (nurse does not need to be called)
6) **Pour a medication for that you are not going to administer** unless you are packing it.
7) **Give a medication you have not poured unless** it is a packed medication.
8) **Have a person we support administer medication to another person**.
9) **Leave medication unattended.**
10) **Sign a medication off for someone else.**
11) **Touch medication with your bare hands –** use gloves if needed.
12) **Pass medication to a person you cannot identify.**
13) **Pre-pour a medication**
14) **Give a medication that has expired.**
15) **POUR LIQUID MEDICATIONS OVER THE EMAR COMPUTER.**

REMEMBER: AVOID CONVERSATIONS & INTERUPTIONS WHILE administering medications**:** this is a frequent **CAUSES OF ERRORS.**

EFFECTS OF MEDICATION

THERAPEUTIC - It's the primary action of the medication. Some medications are monitored by blood work. Ex. Seizure medication levels, Calcium. Some medications are monitored in the home. Ex. Blood pressure and blood sugar medications.

SIDE EFFECTS
The medication does what its primary action is but performs another action at the same time. Ex- a blood pressure medication is keeping your blood pressure in control but you get a headache when you take it.

INTERACTIONS

Medications can interact with each other. This may affect the intended action of the medication causing it to increase or decrease its effect. Ex. Birth control medication and antibiotics. The antibiotic decreases the effectiveness of the birth control medication and a person can become pregnant.

REACTIONS

Photosensitivity – some medications can cause individuals to be sensitive to sunlight and they will get a sunburn quicker than if they were not taking the medication. This occurs with anti-depressants, blood pressure meds, seizure meds, diabetic meds, to name a few.

Behavior changes: can cause agitation, hyperactivity, tiredness.

Allergic response: rash, hives, generalized swelling, or difficulty breathing

Minor reaction – rash or hives. Call nurse for instructions, fill out a blue injury/incident report, document a note in log, using a red pen, the directions the nurse gave.

Major reaction can be life threatening- Call 911- stay with the person and be prepared to perform CPR, call nurse once person is safe, fill out a blue injury/incident report, write in log using a red pen

RESPONSIBILITIES OF THE MEDICATOR

The **Medicator** is legally responsible for the administration of medications. The employee who has been assigned as **Medicator** for a particular shift is responsible for the following:

1. **Safely administer medications to all people.**
2. **Administer medications to ONE person at a time.**
3. **Oversee that all treatments have been done and signed off.**
    a. If another employee forgets to sign off on a treatment the medicator will need to notify the employee, if they are still on shift, if not then the medicator will fill out a medication incident report.
    b. If the employee has left for the day the medicator will leave a sealed note for that person to fill out & sign their portion of the medication incident report.
4. **Reviews** bowel movement, weight, menses and temperature charts.
5. **Ensures that documentation** in eMAR has been completed.
   For medication sheets ensure that all meds on med sheets have been initialed for that shift
6. **Verbally inform the on-coming Medicator and employees of any changes** in medications and or any other important medical concerns.
7. Ensures **that Medication Count is performed with an incoming staff or a staff already on shift.**

8. **MED COUNT IS ALWAYS PERFORMED WITH 2 STAFF AT THE SAME TIME**
   There are a few exceptions. It can be performed by one person only if that person is working alone for 2 shifts in a row. Ex-staff is working alone for1st and 2nd shift.
9. **Fills out any incident reports for any medication errors found.**
10. **At the end of all log entries for every shift the medicator will write the following-**
    All medications and treatments were completed and signed for.

Medicator will then sign their name.

OR

All medications and treatments were completed and signed for except – Sally needs her temp retaken at 3:30 and results need to be recorded in Emar (or written on back of med sheet)

Medicator will then sign their name.

All entries written in the log must be in blue or black ink. Medical entries must be written in **Red Ink.**

NON-MEDICATOR RESPONSIBILITIES

Non-Medicator can:

Perform med count

Assist with tooth brushing, apply lotions, showering, treatments, weights, nail care, etc.

Non-Medicator CAN NOT ADMINISTER

-EYE DROPS **-NASAL SPRAYS,**

-EAR DROPS **-FLEET ENEMAS/SUPPOSITORIES**

-MEDICATION

-PERFORM ANY SPECIALIZED PROCEDURES -CHECK BLOOD SUGAR, NEBULIZER TREATMENTS, G/J-TUBE FEEDINGS. ETC.

GENERAL GUIDELINES FOR HOMES THAT USE MEDICATION SHEETS

Staff must sign the bottom of all medication/treatment sheets initial with their signature & initials
All medication and treatment sheets are legal documents.

DO NOT alter in anyway,
DO NOT use white out,
DO NOT sign-off a medication/treatment for someone else.
Use only blue or black ink to sign.

Any discrepancies noted on the medication sheet should be addressed to the nurse immediately.

If a medication is refused or not given, circle your initials in the appropriate box on the medication sheet. On the back of the sheet, write the medication, dose, time and reason why the medication was not given. Be sure to call the nurse for any direction.

The nurse will replace and review all medication/PRN/treatment sheets monthly.

TYPES & PURPOSES OF MEDICATION SHEETS

MEDICATION COUNT SHEET-

These sheets are also used by some homes that have eMAR. They are used to count all controlled medications.

These sheets are the first sheets inside the medication book.

Medication count needs to be done by two people at the same time either with on-coming staff or staff on shift once the medications for that shift have all been passed. (there are a few exceptions)

When counting medication put the number in the box, below that both staff are to record their initials

If there is **a discrepancy** in the medication count it should be noted on the back of the medication count sheet and the **nurse is to be notified.** If you are unable to reach your house nurse, you are to call another West Bay nurse.

MEDICATIONS THAT ARE COUNTED –

Medications in the Benzodiazepine class – Lorazepam, Diazepam, Xanax, etc. need to be added into med count as soon as the blister pack enters in the home.

Staff need to continue to count these blister packs even if the medication **has expired.**

Scheduled II medications - CDB, THC, Vicodin, Morphine, etc, need to be double locked (in a locked box in a locked med closet) as well as counted as soon as they enter the home. Nursing will supply a lock box if it is needed.

It is the discretion of the nurse if he/she wants other medication beside the above to be counted.

WHITE SHEETS

White medication sheets are used for oral medications, supplements, drinks, meals that are given on a regular basis. These sheets also pertain to people with a feeding tube for their feeding, medications & water flushes.

BLUE SHEETS

Blue medication sheet are used for treatments. Some treatments may be done on a daily, weekly, monthly basis, including inhalers and nebulizers. Ex. skin cream, tooth brushing, eardrops, foot spray etc.

YELLOW SHEETS

Yellow medication sheets are used for PRN orders: A medication ordered for a person to be given only if needed for a specific reason.

The PRN medication is given if the person displays signs/symptoms specific for the medication order. Ex.- Acetaminophen for pain or fever.

The effectiveness of the PRN medication or treatment should be documented in eMAR one hour after the PRN medication is administered. If using medication sheets, employee should document on the back of the yellow PRN sheet the date, time, and effectiveness of PRN medication or treatment and employee initials.

Before administering the PRN medication, ALWAYS:

-Check PRN order for correct dose

-Check the person's medication sheet for the specific parameters for administering the

PRN medication.
-Check the person's medication sheet for restrictions or allergies.
-Check the medication sheet for the last time the PRN medication was given to be sure it fits the prescribed time frame.
-Many over the counter and PRN'S are not used on a consistent basis. Be careful to check the expiration date on the medication container
-If it is a **behavior** medication, follow PRN "**Behavior Protocol Sheet below.**

PRN BEHAVIOR MEDICATION PROTOCOL GUIDELINES

Yellow PRN sheet needs to be specific to match the Medication order.

Behavior medication protocol specific to the persom to be placed in front of the person's yellow PRN sheets.

Before giving the PRN behavior medication, follow protocol written by Behavior Consultant.

If the behavior still continues administer the PRN behavior medication. If the behavior PRN medication states to call nurse first, you need to call the nurse before you can administer that medication.

If you cannot reach the house Nurse, call another nurse in the agency.

Be sure to tell the covering Nurse of all Psychotropic medications that have been and will be given for that day.

Be ready to read the behavior protocol sheet to the covering Nurse.

COPYING A MEDICATION ORDER FOR MEDICATION SHEETS

FOR EMAR - MEDICATION ORDERS ARE PLACED THROUGH PHARMACY. & NURSE HAS TO APPROVE THE ORDER

TRANSFERRING A PRESCRIPTION UNTO A MEDICATION SHEET

Routine transcription of medications onto a medication sheet is completed by the nurse.

EXCEPTIONAL CIRCUMSTANCE: Direct Support employee will only be allowed to write a new medication order on a medication sheet with verbal direction from the nurse when exceptional circumstances occur and/or when deemed necessary.

RN'S DISCRETION: It is at the nurse's discretion to decide who will be allowed to carry out this procedure.

ANNUALLY: On an annual basis, for homes that use med sheets, the nurse will train the employee with pour and pass competency on how to copy a new med order from the pharmacy prescription label onto the appropriate documentation form.

The nurse will initial the written order within 48 hours of the order being written.

Example: A person goes to the emergency room in the middle of the night and the Doctor orders an antibiotic and a nasal spray. The employee will call the nurse and the nurse will verbally talk the employee through writing the medication order onto the medication sheet.

- An order cannot be written on the medication sheet without verbal direction from the nurse.
- The nurse will initial the order on the medication sheet within 48 hours.
- If the employee cannot reach their house nurse, he/she will need to contact another West Bay nurse for direction.

LOGGING DELIVERED MEDICATIONS

When medications are picked-up or delivered, they need to be logged-in to the home's inventory of medications.

EMAR DIRECTIONS TO LOG IN MEDICATION

Medication from **White Cross** –

1. go to home page
2. click on receive meds
3. choose drop down menu to choose pharmacy where med is from
4. click on okay tab
5. scan the bar code on blister pack. You can scan all the blister packs that were delivered
6. click on done tab once all medication has been logged in

Medication from **another pharmacy** ex CVS, Walgreens.

1. follow steps 1-4 above
2. using the scanner, scan any bar code that is not from White Cross. (It can be any item that has a bar code– shampoo, acetaminophen, etc)
3. click on the add manually tab
4. fill out the information requested –med & dosage, person, Rx #, amount of tabs/capsules/liquid
5. click on add tab
6. click on close tab
7. click on done tab

FOR HOMES THAT USE MEDICATION SHEETS

The following information that needs to be logged in either on an index card or in a notebook depending on the house system.

1) Name of individual
2) Date RX #
3) Medication
4) Quantity
5) Dosage schedule
6) # of refills

Once the medications are logged in they are to be placed into the overflow bin.

ROUTES OF MEDICATION

Ears, Eyes, Nose
Oral by mouth or under tongue
G-tube, J-tube
Topical – on skin in small amounts
Injection
Vaginal
Rectal

HOW TO ADMINISTER THE FOLLOWING

Ear drops - Have person either tilt their head to the side or have them lay down with ear facing the ceiling. Gently pull the outer top of the ear up towards the back of the head. Insert tip of dropper into the ear canal and squeeze the amount of drops ordered. Wipe off excess solution

Eye drops – wipe eye gently, using a gauze, starting from the inner eye corner to the outer eye. With one hand pull down the lower eye lid. Hold dropper about 1 inch above eye. Squeeze dropper to administer the number of required drops into the inside of lower lid. Wipe off any excess solution.

Nasal spray – Clear mucus from nose if possible by having the person blow their nose. Have them sit upright. Place tip of sprayer at base of nostril. Squeeze the ordered amount of spray into nostril. Wipe excess solution from person. Use clean tissue to wipe tip of spray bottle.

Rectal - when administering a suppository/fleet enema **to facilitate a bowel movement**, ensure person is laying on their **left** side. For other rectal medications person may lay on either side.

THE FIVE RIGHTS OF MEDICATION ADMINISTRATION

If you remember the five rights every time you administer medications and follow West Bay RI's policies and procedures, there should be no medication errors

<u>The FIVE RIGHTS of medication administration</u>

1. RIGHT PERSON
2. RIGHT MEDICATION
3. RIGHT DOSE
4. RIGHT ROUTE
5. RIGHT TIME

MEDICATION ADMINISTRATION PROCEDURE FOR EMAR

Passing medication or performing treatments -

Determine where the person is.
Explain to them what you are going to do
Wash your hands
Obtain the necessary supplies to prepare the med
Click on Emar icon to open Emar
Enter your user name –first name, period, last name, wb –all lower case
Enter password – first time your password is 123456. It will direct you to change your Password and pick a security question (for if you ever need to reset your password).
On home screen you will choose to pass meds & the time frame you are passing meds
person's picture will show on screen. Ones in color need a med or treatment at that time.
If person is are grayed out, that means there is nothing due at that time.
Click on the person and you will see the meds & treatments to be performed.

For meds –

First check -You will take out the blister pack, medication bottle, liquid medication bottle for the medication you are going to administer & perform the 5 rights –right person, right medication, right dose, right time, right route, comparing it to the blue medication tile in Emar

Second check -You will use the scanner to scan the bar code on the blister pack. This will place a green check mark on the Emar blue medication tile. If the med will not scan then place the cursor on the blue medication tile and click it. A green check mark will be displayed on the label.

-to pour a **pill** from a **blister pack**, you will write your initials, date, & time on the card-board of the back of the blister pack for that medication & remove it from blister pack

-to pour a **pill** from a **bottle,** pour the correct amount of pills in the cap of the bottle & then place pills in a med cup

- to pour a **liquid med** – hold the prescription label to your hand, place the med cup at eye level on a level surface. Pour correct amount of liquid into med cup. Wipe bottle top.

Third check -You will **recheck** the 5 rights using the medication blister pack, medication bottle, liquid medication to the blue medication tile in Emar.

You will perform this process for all meds to be given at that time.
Once you have all the meds poured for that time, you will count how many will items you have poured to how many items you should have. If they are correct, select the **next** button in the lower right corner.
Screen will display medications & treatments that have not been selected at that time.
You will hit the continue button.
You will lock the med closet and administer the medication.
Return to the med closet & click the record all button.
The screen will display your name as the person it will record that passed the med & you will click OK.

You will follow this procedure to pass medication to everyone who is to receive meds at that time.

Performing treatments –

You will log in the same way as above.
You will click on each treatment label for the green check mark.
Click on the next button. Screen may show meds or treatments that remain to be done.
Click continue & then record all.

Charting for Vitals Signs, Bowel Movements, Intake, Output

Go to home screen. There are 2 ways to chart for an individual.
You may choose charting on the home screen or choose the person you are going to chart on and choose charting there.
Vital signs – BP, Pulse, Temp, O2, BS, weight, pain, respirations
Bowel movement
Intake, output

Exceptions –

Used when a medication is being held
Person has chosen not to take their medication
Person is not at home to take the medication (may be at the ER)
Medication is not available at the home
Medication is being packed for the person

Both the Emar or Medication Sheet and Medication Label should match exactly. If there is any discrepancy in the order, contact the nurse for direction.

Medication Administration Procedure for medication sheets

1. Locate all the person that you will be administering medications to.
2. Wash hands. Hands should be thoroughly washed with soap & water before administering medications.
3. Gather all equipment needed and bring to the medication closet or pour medication and prepare it in the kitchen. Follow the procedure that your house does.
4. Locate the person's medication tray and medication book in the medication closet. Put tray on the side of the medication book. Medications are to be given to 1 person at a time.
5. **Read the first order on the person's medication sheet -** specific to that day & hour.

First Check - compare medication blister pack, medication bottle, liquid medication bottle to medication sheet checking for the "5 rights – right person, right medication, right dosage, right time, right route

-to pour a **pill** from a **blister pack**, you will write your initials, date, & time on the card-board of the back of the blister pack for that medication & remove it from blister pack

-to pour a **pill** from a **bottle**, pour the correct amount of pills in the cap of the bottle & then place the **pills** in a med cup

-to pour a **liquid med** – hold the prescription label to your hand, place the med cup at eye level on a level surface. Pour correct amount of liquid into med cup. Wipe off bottle.

Second check – recheck for the 5 rights comparing the medication blister pack, medication bottle, liquid medication bottle to the medication sheet.

Place a <u>dot</u> (i.e. ●) **in the appropriate box**, associated with the medication for the date & time. (Dot indicates that the medication has been poured)

Third check – recheck for the 5 rights comparing the medication blister pack, medication bottle, liquid medication bottle to the medication sheet.

6. You will perform this process for all medications to be given to that person for that time.
7. Count the number of items you should have to compare to the number of items you have. If they match, then you can proceed to pass the medication
8. You will lock the med closet and administer the medication

9. Return to the med closet & record your initials in every box that you have place a dot in. Your initials indicate you have given the medication.

10. You will follow this procedure to pass medication to everyone who is to receive meds at that time.

PACKING MEDICATION

An employee who is not med trained can not pour, pack or give an individual a medication.

1. A medicator will pack the med (pills) in a white med envelope and list the following on the envelope –
   -Date the med is to be given
   -Person's name
   -Medication
   -Dosage
   -Time
   -Route

For liquids: Employee will either send the bottle or will contact the pharmacy to obtain an empty bottle with a label to put the med in.

2. A. medicator puts a **"p"** for packed in the appropriate box on the Medication Sheet or in Emar staff will put an exception that medication will be given later by family, etc.
3. Shift medicator fills out a **Medication Release Form** and gives it to the family member, friend Or WB staff and will explain the directions of how the person takes their medication.
4. Family member, friend, or WB staff will administers the medication and signs and dates the **Medication Release Form**. The form is returned to the house staff when the person comes home.
5. **The Medication Release Form** is to be placed in the front of the medication book until the end of the month and then filed in person's overflow.

If a medication trained employee, is accompanying a person who lives in the home they are working in, requires a medication while out in the community, they are to pack the medication themselves. A medication release form is not required.

For Emar - the employee will pack the medication, putting it in a white envelope labeled with the 5 rights. When the employee and person return to the home, the employee will sign into Emar and sign for the medication. It may ask why medication is being signed for late. Employee is put a note that it was given on time while out in the community.

For medication sheets -employee will pack the medication in a white medication envelope labeled with the 5 rights. On the medication sheet for that medication employee will place a dot in the box. When employee returns to the home they will sign for the medication.

MEDICATION ERRORS

Medication & treatment errors include but not are not limited to the following –

Wrong-

- Person
- Time
- Medication
- Dosage
- Time

Failing to

- Properly documentation medication & treatments
- Following proper medication procedures
- Not signing a medication or treatment. For Emar not signing is if you don't click on the record all button.

When a medication or treatment error is discovered –

- Stay calm
- Ensure safety of person
- Follow agency policy for notification- Call nurse, fill out medication incident report
- Follow instructions given by nurse & document them in the log using red ink

Knowingly withholding knowledge of a medication error will be considered the most serious violation of agency policy

The seriousness of the incident will be based upon the impact or potential impact upon the person.

Med errors are based on a point system of 1-3 points as determined by the house nurse

Med probation is determined by a total of 9 points (Dawn Dr is 10 pts) in a 6 month period. Probation last for 60 days.

MEDICATION PROBATION

There are 2 med probations –

Probation 1 –

Employee is placed on probation immediately & may not pass meds
Will receive a probation letter listing dates of errors & copies of med incident reports
Employee will retrain with manager, watching manger pour & pass meds on 3 different days
Manager will observe employee pour & pass meds 3 different days
Employee will **email** the house nurse to set up med retraining.

Probation 2 –

Is the same as probation 1 except that employee needs to complete Medication Administration prior to retraining with manager.
Once the employee has completed training with the manager, they will **email** the house nurse to set up med retraining.

If further med errors occur while on med probation additional disciplinary action may be taken depending on the circumstances of the error.

MEDICATION DISPOSAL

Pill form – place in white med envelope with the 5 rights. Place envelope in bin in med closet for nurse to dispose of.

Liquid meds – pour into absorbent material & throw in trash.

Expired or discontinued blister packs are to be given to house nurse for proper disposal at WB office

REORDERING MEDICATION

White Cross – In Emar, click the reorder button on medication label
Other pharmacies – call in script number

Do not order **Over The Counter** (OTC) medication through Emar. This is medication that the office supplies such as Acetaminophen, Ibuprofen, Vitamin D, Multi-vitamin, etc.

COMPUTER MAINTENANCE

Ensure that the computer is fully charge at all times.
Update Emar when an update message appears.
Fully shut down the computer and restart the computer to ensure updates are maintained (once a week if possible).

PROPER STORAGE OF MEDICATIONS

Medications must be properly stored to maintain their effectiveness and remain free from contaminants. Where and how medications are stored include:

- A locked closet
- A locked boxed if a medication needs to be refrigerated

Separating Internal & External Medications

- Internal and external medications are stored in separate bins or trays
- Stored in the original bottle/pack that it came in
- Stored protected from extreme heat or humidity in a well-lit, clutter free closet.
- Medications are kept separate from non-medical items

MEDICAL ABBREVIATIONS & SYMBOLS

A.M. - morning

BM – bowel movement

CC – cubic centimeter

D/C – discontinued

HS – hour of sleep

Mg – milligram

Ml – milliliter

NKA – no known allergies

NPO – nothing by mouth

P.M. – evening

Tsp - Teaspoon

Tbsp - Tablespoon

Ongoing Job Requirements for Medication Administration

Employee will participate in an annual Pour and Pass & Specialized Procedure Competency Fair held at the West Bay office

Verbal question and answer session will occur during the Competency Fair.

Employees will review a person's plans of care every year.

MONITORING OF CONTROLLED MEDICATIONS 1.11.5

A controlled accountability record will be completed when receiving a controlled medication - Schedule I, II, III, IV, or V medication. The following information will be included:

- Name of the person for whom the medication is prescribed
- Medication name
- Dosage of medication
- Route of medication
- Dispensing pharmacy label
- Date received from pharmacy
- Quantity received
- Name of person receiving delivery of the medication
- Signature of the person administering the medication

Schedule I and II medications will be stored separately from other medications, double locked in a locked box or compartment and kept in the locked medication closet. If indicated Schedule I and II medications may be stored in a separate storage location that has been designated solely for that purpose which is locked and has additional security restrictions such as a combination lock.

Controlled Medication Accountability Record:

Any and all controlled medications (Schedule II, III, IV, V medications) will be counted 3 times daily at the beginning and end of every shift (1st, 2nd & 3rd). This count will be conducted by 2 employees, and properly documented. Shift counts will be signed by the person(s) conducting counts and the accountability record will be maintained.

Individuals living in independent living arrangements who take controlled medications and controlled medications being self-administered will be counted. Frequency will be determined on an individual basis.

Sharps Injury Log

Record all work-related needlestick injuries and cuts from sharp objects that are contaminated v
material (defined by *Bloodborne Pathogens Standard* 29 CFR 1910.1030).

Date of Injury	Type & Brand of Device	Location	Where did incident occur?

vith another person' blood other potentially infectious

Explanation of how incident occurred

NURSING DOCUMENTATION POLICY 1.11.3A

Documentation and corrections in health care information will be completed in accordance with standard nursing practice. All health care information will be placed in the individual's medical record in reverse chronological order. Required nursing tasks and documentation for individuals receiving services from West Bay include:

- Nursing Assessment Review and plans of care (acute and/or chronic) on an annual basis or whenever there is a significant change in the individual's health status
- Interagency for any physician appointments, doctor's orders, emergency room/urgent care visits and hospitalizations
- Nursing documentation for results of physician appointments, doctor's orders, emergency room/urgent care visits and hospitalizations
- Log documentation when needed and as indicated
- Medication sheets monthly, when needed, and as indicated
- Review of medication in eMAR when needed and as indicated

Health care records will be kept for a minimum of ten (10) years following the cessation of services.

Oxygen Therapy Guidelines

The delivery of oxygen (O2) shall be administered according to the orders of the individual's healthcare provider.

All orders will include O2 parameters, including backup source of O2. All storage and transportation of O2 will meet the requirements of the National Fire Protection Association.

Physical Therapy Policy 1.11.2E

West Bay provides physical therapy consultation on an as needed basis. If the need for PT is questioned, an assessment will be completed by a Physical Therapist. If indicated, the assessment will include needs for adaptive equipment, and the proper fit and usage of the adaptive equipment.

If indicated, an annual PT plan will be completed outlining any PT needs and changes.

Equipment is replaced or repaired if broken and/or need has changed.

Home visits or community visits for Physical Therapy are made as needed, as indicated and/or as ordered by a provider based on the needs of the individual. The Physical Therapist also attends staff meetings as needed and as indicated based on the needs of the individual.

Administration of Hospice Schedule II Medications

When a Hospice Schedule II medication is ordered for an individual the medication will be double locked. When the medication is administered, the staff person administering the medication will verify the following information on the medication sheet and medication count sheet:

a.) Name of the person to whom the medication is being administered
b.) Name of controlled Schedule II medication, dosage, and route of administration
c.) Staff will sign their initials in appropriate box for the date and time on the medication sheet for the controlled Schedule II medication after it is administered to the person
d.) Staff signature and initials must be signed on the bottom of the medication sheet
e.) Staff will complete medication count with two staff when a controlled Schedule II medication is administered. The medication count will reflect amount of medication administered and the amount of medication remaining.

The medication count sheet will correlate with the medication sheet.

MEDICAL CARE 1.11.2

All individuals supported by West Bay will receive an annual physical exam. This annual physical will include a review of medications including all prescriptions, treatments, supplements, over the counter medications. Completion of accepted primary care screenings will be kept in the individual's health care record. If routine screenings are deferred by the individual or by individual's physician or other licensed health care provider, documentation as to the reason for the deferral will be included in the individual's health care record.

Dental Examinations and cleanings, vision, audiological, speech consults, orthopedic, PT, OT evaluations and services, and other medical consults, shall be provided as recommended and when indicated by the health care provider.

Any refusal of tests, exams, procedures, screenings, and/or doctor appointments will be documented in the health care record. The necessity of said tests/procedures will be reviewed periodically. A plan will be developed to achieve the desired health care goal (s).

The provision for substituted consent is available through BHDDH. Documentation and corrections in health care information shall be made in accordance with standard nursing practice.

POLICY AND PROCEDURE FOR ADMINISTRATION OF PRN MEDICATIONS FOR BEHAVIORAL INTERVENTIONS 1.11.4 J

1. Medication checks for anyone taking psychotropic medications is performed on a regular basis between the person for whom the medication is prescribed and the physician, psychiatrist, or other licensed health care prescriber. The effectiveness and use of the medication is assessed on a regular basis by the multidisciplinary clinical team.

2. Certain individuals at West Bay RI receive PRN psychotropic medication when experiencing severe or prolonged anxiety or agitation. A PRN behavior protocol is written by behavioral consult team and put in front of the PRN medication sheet for administration of such mediations.

3. PRN medications are always prescribed by a consulting physician or other licensed health care provider who includes specific parameters and rationale for use. Use and effectiveness of PRN medications are reviewed by the physician or licensed health care provider and the multidisciplinary clinical team on a regular basis.

4. The West Bay nurse review the PRN medications on the medication administration sheet or in eMAR on a monthly basis and when indicated if there is a change in the PRN medication order from a prescribing physician. The electronic medication administration program (eMAR) or the medication administration sheet includes:
    a). the name of the person to whom the medication is being administered,
    b). the name, dosage and route of the medication,
    c). the date, times and reason for administration,
    d). the effect of the medication; and,
    e). the initials of the person (s) administering the medications

5. Before giving the PRN medication, staff will follow the written protocol outlining behavioral interventions and behavioral criteria for use of medication.

6. If the behavior continues and appropriate criteria have been met, staff will call the house nurse for approval to give the medication if indicated on the medication sheet or in eMAR. If the house nurse cannot be reached, staff will call another nurse in the agency to get nursing approval. Staff will be sure to tell the nurse of all other medications that have been given that day and will be ready to read the written protocol to the nurse.

Policy and Procedure for Bloodborne Pathogens

Sharps injuries, Splashes, and Bites

A **needle stick injury** is a percutaneous piercing wound typically set by a needle point, but possibly also by other sharp instruments or objects.Employees can be exposed by:

a) Contaminated needle or lancet with a puncture of skin surface,
b) Any wound secondary from a contaminated object,
c) Contamination of an open wound or mucous membrane by saliva, blood or any body fluid,
d) Exposure of unbroken skin by blood, saliva or other body fluid.

If an employee experiences a needle stick or sharps injury or were exposed to the blood or other body fluid of a patient during the course of your work, **immediately follow these steps**:

1**) Cleanse the Wound:** thoroughly with soap and water. Flush splashes to the nose, mouth or skin with water for a minimum of 15 minutes, irrigate eyes with water or normal saline for a minimum of 15 minutes.

2) **Immediately Report the Incident**: to your supervisor and the Human Resource Department.

3) **Immediately Seek Medical Attention**: The employee should immediately seek medical attention to have their blood tested for HIV, Hepatitis B and Hepatitis C.

4) **Lab Testing and Prophylactic Therapy:** The primary purpose of seeking medical treatment as soon as possible is to establish a baseline for studies and so prophylactic therapy for HIV or other blood borne pathogens can be offered, ideally, within 2 hours of initial exposure.

5) **Infectious Status of the Source:** Needs to be determined by establishing a baseline for studies from a medical laboratory. Unless the source is known to be negative for HBV, HCV, and HIV post-exposure prophylaxis (PEP) should be initiated, ideally within two hours of the injury.

6) **Document the Incident:** Using a *Work-Related Incident Report* describe the details of the exposure and the follow-up medical care. Bring the incident report and medical care follow-up notes to the Human Resource Department within 24 hours of the incident so it can be reported to the Worker's Compensation Insurance Company.

7) **Follow-up Medical Care:** will be determined by the treating physician.

Incident Review

1) All incidents will be confidentially maintained in the Human Resource Department

2) Sharps Injuries, Splash Incidents and bites will be reviewed monthly by the Incident Review Committee to determine best practices for decreasing exposure incidents.

WEST BAY RI
INNOVATION • INCLUSION • ADVOCACY

POLICY FOR MEDICAL APPOINTMENTS

1. West Bay nursing personnel will monitor all appointments made. This is to ensure that all appointments are current and the doctor's recommendations are implemented in a timely fashion. The appointments will be made in coordination with parent's schedules, whenever requested and when possible.

2. Transportation to and from a doctor's appointment will be provided by appropriate West Bay staff and special equipment e.g. mouth guard, braces, etc. will be brought along on the doctor's appointment. The individual's medical folder, including an interagency, copies of the EMCP and medical cards will be brought on each appointment.

3. A manager or designated staff along with support from the house nurse will make or change doctor's appointment. This person will be responsible to contact those who would be attending the appointment.

4. All medical concerns that a parent has should be addressed with the West Bay nurse, management staff, or Residential Coordinator. The nurse will then determine the urgency of contacting the physician and will arrange an appointment as deemed necessary by the physician's recommendations.

5. Changes in medical procedure, medication, or medical equipment will not take place without the formal approval of the attending doctor in coordination with the West Bay nurse. If a change is necessary in ancillary services, then the appropriate person (Physical Therapist, Speech Therapist or Behavioral Consultant) will be involved. Changes will not take place until staffing levels are appropriate, proper staff training has been conducted and documented, proper equipment is on site and working, as well as parental notification has been obtained.

6. The West Bay nurse will be the central contact during hospital admissions to optimize continuity of care to individuals we support. The nurse will obtain the most accurate and current doctor's recommendations in order to prepare and properly train staff, if necessary. This will ease the individual's transition home after a hospital stay. The nurse will work closely with family members.

7. An interagency will be completed for each appointment. The RN will complete the interagency if specific concerns need to be addressed. For routine appointments, the interagency can be completed by DSS, Mgt. or RN. The appointment will be recorded in the individuals file in Sandata. The nurse should be contacted in cases where changes in medication or immediate treatment are prescribed. The nurse will co-sign all interagencies and will review all interagencies upon completion by the provider.

POLICY FOR SELF MEDICTION 1.11.4 – 1

West Bay will teach each individual who can safely self-administer medications proper technique to minimize risk and increase the probability that correct medication and treatments are administered.

Implementation:

The individual must be able to wash his/her hands prior to going to med closet

The individual must be able to get a glass of water

` The individual must be able to:

- Take correct med out of bin at the correct time
- Pour medication into the med cup
- The individual must be able to take medication

This same procedure applies to treatments.

Staff will assist with documentation on the med sheet or in eMAR if applicable.

PROCEDURE FOR MEDICAL APPOINTMENTS

Before you leave

1. Give pre-med if prescribed and as directed prior to appointment.
2. Ensure you have direction to the office you are taking the person supported to.
3. Make sure all medications and treatments are complete before you leave (Pack medications if needed).
4. Bring medical folder.
    a. Interagency in the front pocket of the medical folder with the date, doctor's name and top section completed. If an interagency has not been completed by RN, staff can fill out the interagency. If you have any questions call RN.
    b. Ensure the physicians order form is in the medical folder.
5. Leave 20 minutes early to avoid being late due to traffic, parking...ect.

At the appointment:

1. Make sure all the questions on the interagency are answered by the provider. Take your own notes.
2. Questions to ask- Are labs/tests ordered? Is the blood work fasting/non-fasting? When does MD want them done? *Make sure you have the slip before leaving.
3. If medications are ordered or need to be refilled, have the MD send an escript to White Cross.
    a. If the MD is ordering antibiotics, steroid or pain medicine ask to have them sent to White Cross unless otherwise specified by the house RN.
4. Schedule follow up appointment as directed before leaving. If you are unable to schedule the next appointment, make sure it is clearly written on the interagency when the MD wants them to go back.

After the appointment:

1. Write the follow-up on the medical appointment calendar/book and on the right upper corner of the interagency. If an appointment card was given, REPLACE it with the old card in their blue medical book.
2. Write pertinent information about the appointment in the LOG.
    a. New medications or med changes
    b. Labs/ Tests that were ordered with the details
    c. Any recommendations from the doctor
3. Are the appropriate people notified?
    a. Notify managers and RC's according to house policy. (ie: log, email, voicemail)
    b. Notify house RN of appointment details.
    c. Notify family or guardian if needed.
4. If new medication orders or refills need to be followed up on with White Cross, leave a detailed note in the log for staff to follow up the next day.
5. Leave completed interagency and lab slips in the front pocket of their folder for RN to review and file.

Professional Nursing 1.11.10 A/B

24 Hour Nursing Support

West Bay nurses will maintain compliance with the RI Department of Health's "Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs" regarding delegation to unlicensed assistive personnel, including the criteria for appropriate delegation to support staff.

West Bay provides on-call nursing support 24 hours a day, 365 days a year for all urgent issues and emergencies. In addition, each home has a Residential Coordinator available 24 hours a day, 365 days a year.

Each location has access to a nurse for both routine and urgent issues. This arrangement supplements each community's 24-hour emergency response system. Nurses covering West Bay's locations have a cell phone to facilitate communication. If the designated nurse is not available or does not answer the phone, staff are trained to contact another nurse in the agency.

Support Staff Training 1.11.9 A

West Bay ‘s policy for annual healthcare training and medication administration is designed to ensure direct support staff have completed the required trainings within a required timeline. All healthcare training is conducted and supervised by a licensed nurse. The professional nurse will delegate tasks only to support staff that have received training in West Bay’s protocols and have demonstrated competencies in each area of training.

All direct support staff must complete annual nursing training, individualized procedure training, demonstrate competency in all individualized procedures and pass a medication “Pour and Pass” test. A competency training form verifies that the direct support staff has read, reviewed, and will follow as trained, the Medication Administration Training packet. The support staff will demonstrate the proper procedure for pouring and passing medications. Training will be documented after completion and will be placed in the employees’ personnel files. Professional nursing staff will delegate tasks only to direct support staff that have demonstrated competency in each training area. Retraining will occur annually and as determined by the Registered Nurse.

Transportation and Admittance to the Emergency Room/Hospital

If an individual needs to be transported to the emergency room/hospital the following steps are to be taken:

- Call the house nurse. If the house nurse cannot be reached, please call another nurse in the agency.
- If there is no employee on shift that can accompany the individual to the hospital, the individual will go alone in the rescue. Call the manager on call to arrange staffing to meet the individual at the emergency room.
- **The staff person will take the medical folder with them.**
- The Residential Coordinator should be notified if an individual is brought to the hospital.
- If the Residential Coordinator cannot be reached, follow the chain of command.
- The legal guardian should also be notified if an individual is being seen in the emergency room/hospital.

What to do when the rescue arrives at the house:

- Keep the individual safe and calm.
- Give the rescue personnel a copy of the interagency.
- Call the manager on call to coordinate staffing to meet the individual at the hospital.
- The Residential Coordinator needs to be notified.

What to do at the Emergency Room:

- Give a completed interagency stating the reason why the individual was brought to the emergency room to the hospital personnel
- **The Interagency should be filled out as follows**:
  1. **By staff** – top section; describing the problem in detail.
  2. **By doctor** – bottom section; stating diagnosis, medication orders (dosage, frequency, duration), treatment orders (frequency, duration).
  3. **Do not leave unless** the doctor has completed and signed the bottom of the interagency (A nurse's signature is not sufficient) or the hospital personnel gives you a print out explaining the visit, medication orders and instructions for treatment for the individual etc.
- **Report any allergies** to the doctor.
- **Report medications** using the med list provided in the medical folder.
- The emergency care permit/vital statistics form which is kept in the clear sheet protectors in the first section of the medical folder is the hospitals permission to treat the individual. The hospital personnel may copy this form.
  .
- **The insurance cards** (Medicare/Medicaid or private insurance if applicable) are in the plastic page protector or plastic pouch.

- **Notify the nurse** during the hospital stay and before leaving the hospital with the individual to maintain continuity of care.
- **Fill out a Incident Injury Report**. (Detailed information including follow up on the report).

Hospital Admission:

- Same as above.
- The West Bay Nurse is usually the primary contact person unless otherwise determined.
- Be sure to give the House nurse the individual's pin number if applicable.

TRANSCRIPTION OF A MEDICATION ORDER ONTO A MEDICATION SHEET

Routine transcription of medication orders onto a medication sheet (when applicable, if the electronic medication administration is not in use at the home) is completed by the nurse. Direct Support Staff will only be allowed to copy a medication order from the pharmacy prescription label onto a medication sheet with verbal direction from the nurse when exceptional circumstances occur and/or when deemed necessary. It is at the nurse's discretion to decide who will be allowed to carry out this procedure. The nurse will initial the written order within 48 hours of the order being written.

On an annual basis the nurse will train staff on how to copy a new med order from the pharmacy prescription label onto the appropriate form.

Example: An individual goes to the emergency room in the middle of the night and the Doctor orders an antibiotic and a nasal spray. The staff person will call the nurse and the nurse will verbally talk the staff person through writing the medication order onto the medication sheet. An order cannot be written on the medication sheet without verbal direction from the nurse. The nurse will initial the order on the medication sheet within 48 hours. If the staff person cannot reach their house nurse, he/she will contact another West Bay nurse for direction.

New medication orders may only be entered into eMAR by the pharmacy or by the nurse. The staff person will contact the nurse for all new medications when using eMAR for medication administration documentation.