

COMMUNITY LIVING-CENTRAL HURON

MEDICATION POLICY and PROCEDURES  
MANUAL

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## MEDICATION POLICY and PROCEDURES

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**COMMUNITY LIVING-CENTRAL HURON****MEDICATION POLICY**

The health, safety and well-being of the people the Agency supports is of primary concern to the Board of Directors. Therefore, to assist in ensuring the welfare of all individuals, Community Living-Central Huron has developed policies and procedures which address the area of “medications.”

A “medication” includes medicines prescribed by a doctor or health professional and over the counter medicines. Medications may come as or be contained in the following: capsules, eardrops, nose drops, inhalants, liquids, lotions, creams, patches, powders, tablets, sprays and injectibles.

Employees and the Agency both share responsibilities associated with administering medications. The Agency must establish guidelines, policies, procedures and protocols, including orientating and training employees.

Employees are responsible for adhering to the established policies and procedures and to seek clarification or training when needed from their immediate Supervisor.

Non-compliance with medication procedures is subject to discipline; up to and including dismissal from Community Living-Central Huron’s employment.

In an effort to ensure medications are administered safely and responsibly, the following procedures/guidelines will be adhered to:

1. Community Living-Central Huron utilizes a variety of dispensing methods, such as: pharmaceutical containers, dosettes, syringes, blister packs and vials. A Support Worker is not to administer prescribed or over the counter medication prior to receiving approved training in the proper procedures relating to dispensing and recording medication as outlined in this procedural document.

Community Living-Central Huron utilizes a variety of dispensing methods: pharmaceutical containers for liquids and tablets; blister packs; dosettes and syringes; however, this does not preclude the use of other dispensing methods.

2. A Supervisor or designated person will provide on-site training in administering and recording of medication prior to newly hired employees administering medications independently. Employees may also require re-orientation of medication training, as determined by the relevant Coordinator and/or Supervisor.
3. In an effort to ensure employees are familiar with the Agency’s Medication Policy and Procedures, all new employees will be asked to complete a written Medication Questionnaire and achieve a proficiency of 100% prior to assuming full medication responsibilities. In addition, new employees will be observed administering medication by their relevant Supervisor and/ or Coordinator prior to administering medications independently. An Observation Testing Checklist - Medication Administration form will also be completed by the observer.

4. It is the responsibility of the new employee to obtain valid Emergency First Aid, C.P.R. and any other required certificates within the first 3 months of employment. Community Living-Central Huron will compensate employees for subsequent training. Refer to Policy E-006.

Refer to the attached "Medication Policy and Procedures Manual."

## **ORIENTATION:**

### **Purpose:**

All Staff hired by this Agency who will be responsible for medication preparation, dispensing and administration, will undergo an initial Orientation procedure intended to promote consistency and competency, understanding that the main goal of medication procedures are to prevent medication incidents from occurring. Subsequently, training will be ongoing and based on participant needs/supports and staff needs/requirements.

### **Staff Responsibilities:**

The following procedure must occur prior to newly hired staff or staff who did not previously have medication administration responsibility as per the Medication Policy and Procedures document, independently preparing, dispensing and administering medication unsupervised. Further, the relevant Coordinator and/or Supervisor will determine if Staff require re-orientation of some or all of the following:

1. Complete orientation as identified by Agency Policy, 'Staff Orientation,' Policy No.E-005 and sign all acknowledgements. Seek clarification from Supervisor/designate as required.
2. Read Community Living-Central Huron's Medication Policy and Procedures Manual and individual Medication Information Folders/Files and seek clarification from Supervisor/designate.
3. Demonstrate knowledge and applications of the Agency's Medication Policy and Procedures Manual by:
  - a) completing the Medication Questionnaire with 100% proficiency;
  - b) preparing, dispensing and administering medication in accordance with Agency Procedures while observed by a Supervisor or designate. (Observation Testing Checklist - Medication Administration)
4. Recognize that as an "Unregulated Care Provider," a support worker has legal responsibilities which must be observed regarding medication as defined by Canadian Federal and Provincial Drug Legislation including the Regulated Health Professions Act and Unregulated Care Providers. This includes but is not limited to:
  - a) ensuring a consent is signed by the individual/caregiver
  - b) medication may be administered only on the written order of a physician
  - c) know all pertinent information about the individual (ie. medication, allergies,

health concerns, etc.)

- d) know names and numbers to seek clarification as required from appropriate source(s) (ie. Doctor, hospital, pharmacist, supervisor regarding recommended treatment and health concerns)
- e) consult with a variety of resources (ie. CPS , Pharmacy Fact Sheet, etc) each time a medication change occurs
- f) store all medication safely, including refrigerated medication, in a locked location
- g) keep accurate counts and records as defined by the Canadian Food and Drugs Act and Regulations and The Narcotic Control Act and Regulations as established within this document.
- h) follow the six rights of administration

**Note:** The Regulated Health Professions Act defines the scope of “who can do what” within and among the professions regulated by the Act. It includes a practice statement and thirteen controlled Acts.

- the Controlled Acts are allocated to specific professions. Only members of those professions are authorized to perform them unless permitted by an exception.

Resources: College of Nurses of Ontario Publications  
Utilization of Unregulated Care Providers (UCPs) May 2008  
Working With Unregulated Care Providers May 2008  
Legislation and Regulation RHPA: Scope of Practice, controlled Acts Model May 2008.

### **Agency Obligations:**

1. To provide the Agency Medication Policy and Procedures Manual and Medication Information Folder/ Files and afford time to read said documents and seek clarification.
2. Not to ask new Staff to prepare, dispense and administer medication until:
  - a) they first observe such duties being performed by other Staff for each individual requiring medication;
  - b) they perform under the observation of the Supervisor or designate (Observation Testing Checklist - Medication Administration); and
  - c) they complete the written Medication Questionnaire with 100% proficiency.
3. Upon completion of the Medication Questionnaire, if less than 100% proficiency, the Supervisor will review and retest Staff in an effort to achieve the desired competency.
4. The right to extend this portion of the Orientation process if a performance concern is identified by the Staff themselves or the Supervisor or designate.

## **OBSERVATIONS:**

### **Purpose:**

Observation is essential to assist in making a diagnosis or in keeping track of an individual's progress. It gives purpose and direction to an individual's care. It aids others (doctors, therapists, social workers) in their work with an individual or family.

### **Observation Skills:**

Skill and judgment in observing develop with practice, patience and the will to improve, the same as with any other skill. There are five personal resources which are used when observing people:

1. **Looking** - take note of any changes in the following: facial expressions, skin, body posture, person's immediate surroundings (ie. ventilation, temperature) and their condition (ie. lack of appetite, dehydration, lack of energy, etc.).
2. **Listening** - is the most important half of a conversation. Purposeful listening during conversation is a means for gaining such information as coherence, disorientation, worries, fears, needs and interests of the person.
3. **Smelling** - Unusual odours are an index to circumstances and they capture the attention of the alert care giver. For example, the observation of a sweet odour on a person's breath might be a valuable aid to the physician.
4. **Talking** - It is important to show acceptance towards the person. Keep in mind that how something is said or asked (tone of voice, language used, facial expressions, attention, etc.) makes a difference in the way a person responds.
5. **Touching or Feeling** - Taking the pulse is a good example of observing through touch. Placing the hand on the brow detects fever or perspiration. During both, the sense of touch may locate abnormalities of the skin or scalp.

The Support Worker's role is one of supplying accurate, specific information to the physician and other professionals. **This is a vital role at all times and particularly for new medication.**

### **Signs and Symptoms:**

A **SIGN** is an indicator or a fact that points out evidence of something. These indicators are things that can be seen, heard, felt, smelled, etc. (ie. taking temperature). A **SYMPTOM** is evidence the individual shares or tells, such as nausea, headache, chills, fever, fatigue, dizziness, fear.



### **Guidelines for Recording Observations:**

The following are not necessarily numbered in order of importance, nor would all nine of the following particulars apply to each recording. However, the time something was observed must accompany the remarks. The nature of what is recorded is determined by what is important for the physician or other professionals to know. Observations:

1. Time/when observed.
2. Location of abnormal sensation (exactness in so far as possible).
3. Duration (how long it lasted, ie. chill).
4. Frequency/intensity (pain was constant, intermittent, severe, mild throbbing, etc).
5. Relief obtained from nursing measures (whether or not they seemed to help).
6. General appearance of the person (if this has changed).
7. Amount, colour, character of discharge (urine, feces, vomit, sputum, drainage).
8. Exact words of the individual, when indicated.
9. Complaints (as to eating, sleeping, pain, etc).

All recordings should be made away from the individual's sight if possible. This helps prevent anxiety and worry which might arise if the individual watched a care giver make notations about themselves.

**Note:** Should an individual show signs of an allergic reaction to a medication, contact a medical professional and refer to Medication Incident Response, page 23.

### **MEDICATION RESPONSIBILITIES:**

The Activity Centre has Staff designated with the responsibility of pouring and administering medication and on occasion the completion of Medication Administration and Treatment Records (M-7). See Transfer of Medication, #2.

Within each residential setting, a "Medication Responsibility List" is posted noting Residential Support Workers responsibilities towards ensuring the medication requirements are adhered to. \*Note: It is standard practise for the Designated Support Worker/Full-Time Support Worker to update Medication Information Folder/File, complete MAR Sheets, fill repeats, prepare medication and all proper forms in advance for vacation etc. as per Medication Policy.

**The Medication Responsibility List Includes:**

1. Administration of medication.
2. Ordering of medication.
3. Visually inspecting medication upon receipt to verify the accuracy of information (ie. individual's name, name of medication, dosage and times for administration). In the case of blister packs, visual inspection will also verify, as per the label (s), the physical description of medication, contents and quantity is accurate. Note: In some work locations, it may be deemed necessary to count all or some of the medication to confirm accuracy and monitor on a pre-determined basis (ie. each shift; 3 month time frame; ongoing).
4. Writing up Medication Administration and Treatment Record (M-7) for residential locations.
5. Writing up Medication Administration and Treatment Record (M-7) and Medication Transfer Form (M-8) for the Activity Centre, other locations/programs. ie. Employment Support, Camp.
6. Counting out medication for the Activity Centre, Employment Support or other locations/programs and placing in appropriate pharmacy labelled bottles for transportation.
7. Changing Medication Administration and Treatment Record (M-7) on an as-needed basis.
8. Ensuring new medication and changes are noted in red ink in the Communication Book.
9. Informing the relevant Residential Support Worker when medication repeats are required, including the notification of expired medication.
10. Ensure there is sufficient medication daily, for weekends, vacations and any period of time away.
11. Ensure that the Medication Information Folder/File is up to date and contains all appropriate forms, as per section 'F', "Medication Information Folders/Files".

**Ordering New Prescriptions:**

When new prescriptions are ordered, the designated Residential Support Worker, as per the Medication Responsibility List, will be responsible for following proper Medication Policy procedures as noted below.

1. Ensure Medication Information Sheet is updated if necessary.
2. Take new prescription to Pharmacy or have attending Physician fax to Pharmacy.
3. Ensure arrangements are made to pick up or have new medication delivered.
4. Ensure a Pharmacy Fact sheet and any other information regarding the new medication is received and placed in the individual's Medication Information Folder/File.
5. Ensure Medication Administration and Treatment Record is set up as per Policy. Refer to Section D.
6. Ensure new medication information is noted in the Communication Book in red ink, also noting pharmacy fact sheet is in the Medication Information Folder/File.

**Refilling Prescribed Medication:**

The designated Residential Support Worker will:

1. Contact the pharmacy as noted on the pharmaceutical container.
2. Identify themselves to the Pharmacist.
3. Speaking clearly and slowly, give the Rx number and individual's name as written on the pharmaceutical container and any additional information required by the pharmacy.
4. Ensure prescriptions are picked up/delivered on time and properly stored.
5. When the refilled prescription is obtained, do not mix same medication refills with current medication.

**Changes to Prescribed Medication:**

When changes are made to an existing prescription (ie. change of dosage, administration times, etc.), the designated Residential Support Worker, as per the Medication Responsibility List, will:

1. Ensure Medication Information Sheet (M-10) is updated as necessary.
2. Take the updated prescription to the Pharmacy for re-labelling or filling, as necessary, or ask the attending Physician to fax the prescription changes to the relevant Pharmacy.
3. Ensure Medication Administration and Treatment Record is updated as necessary (Refer to section E, How to Record Medications: Noting New Medications and Changes to Existing Prescriptions).
4. Ensure changes to prescription are noted in the Communication Book in red ink and advise incoming Staff verbally of changes whenever possible.

**Preparing Medication Administration and Treatment Records (M-7) MAR Sheets** (refer to Section D)

**Preparing Medication Transfer Form (M-8)** (Refer to Section H)

**Preparing Medication While on a Leave of Absence:**

If applicable, the designated Support Worker will prepare or have available, medication in a pharmaceutical labelled container/package (ie. pharmacy vials, dosettes, blister packs) indicating:

- Individual's Name
- Name of medication
- Times for administration
- Dosage
- Cautionary Labels

Staff will then complete a Medication Transfer Form (M-8.) See pages 27-28.

**Setting up a Standing Order Form (M-1 or M-2):**

A Standing Order Form is completed by a Medical Professional ie. Pharmacist, Doctor etc. for all non-prescription medication that will be administered by Staff. It is the physician's or the Pharmacist's role to determine what non-prescription medication is appropriate for the individual with consideration given to the individual's prescribed medication. The designated

Residential Support Worker (or S.I.L. Worker if applicable) is responsible for ensuring the form is updated annually or any time there is a new prescription or a prescription change.

**Setting up a Medication Information Sheet (M-10):**

A Medication Information Sheet is completed by a Medical Professional, ie. Pharmacist, Doctor etc., to provide Support Workers with the time ranges and/or instructions for the administration of medication. The expectation is for the medication to be administered at the time recommended/prescribed by the medical professional. In the event the medication is unable to be administered at the specific time or has not been administered at the specific time, Support Workers are to refer to the time range noted on the M-10 (Medication Information Sheet). A medical professional must be contacted for direction, should the M-10 not specify the action to occur when the time range has lapsed. If written direction can't be obtained, ensure the name and title of the medical professional is obtained and the information is reported in the Communication Book. The designated Residential Support Worker (or S.I.L. Worker if applicable) is responsible for updating the form annually or any time there is a new prescription or a prescription change.

**Destruction of Medication (M-9)/Destruction of Medication to Pharmacy (M-9A):**

All medication that is discontinued, contaminated or expired, must be placed in the designated locked container within the Activity Centre or residential setting. Ensure that medication placed in the box is appropriately labelled, either in a pharmaceutically labelled container or in a bag with a label attached. Do not mix medications. The Support Worker involved is responsible for entering the medication information onto a Destruction of Medication Form (M-9) and signing off on all medication being placed in the box. The relevant Supervisor will be responsible for emptying the medication disposal box and to confirm the medications in the disposal box are as reported on the Destruction of Medication Form (M-9). The relevant Supervisor will complete the Destruction of Medication to Pharmacy Form (M-9A) and ensure proper disposal of the medication (ie. delivery to Pharmacy) upon notification by Staff that the box is full or a minimum of once per calendar year.

**Contaminated Medication:**

Medication may become contaminated as a result of various circumstances, such as: medication coming in contact with an object not included in the medication's administration protocol, such as: dropped on floor; removal for reason other than administration, from a dosette or blister pack which has been in contact with other medication, expelled due to individual's actions (i.e spitting out), deviation from the Agency's Medication Policies and Procedures (ie. touching medication with hands; unsafe storage).

**MEDICATION ADMINISTRATION AND TREATMENT RECORD**

**Purpose:** To keep an accurate record of an individual’s medication, as well as to accurately reflect relevant information regarding the administration of each medication as per the prescription label(s) and Medication Information Sheet. It is used in conjunction with medication and treatment notes. MAR provides for:

1. Recording administration of medication and treatments;
2. Providing comprehensive information regarding restrictions or conditions of use pertaining to medication;
3. An indication of any medication or treatments not given, refused "R", omitted "O", discontinued, the introduction of new medication and treatments, medication sent to the Activity Centre, out into the community, etc. as a "L.O.A.," etc.

**Setting up a Medication Administration and Treatment Record - 'MAR Sheet' (M-7):**

1. Enter legal name of individual, location, month and year, in appropriate spaces.
2. Staff are required to record personal signatures and initials on the "Staff Signature/Initial Sheet (M-7A)" which will be kept with the current MAR sheets.
3. For each medication, as per the prescription label, record the name of the medication, time to be administered and the prescribed dosage. Administration times are to be noted as per the 24 hour clock system (see page 38). Should the prescription not provide for a specific time, refer to the Medication Information Sheet (M-10) for the specific time or time range (i.e 0800 or 6 hours apart). Ensure MAR sheet entries include all relevant information from the prescription container/package/label and the Medication Information Sheet, including restrictions specific to the medication (ie. Take medication with plenty of water). Also record on the MAR sheet the total dosage to be administered. When more than one pill or a portion of a pill is to be administered, record the number of pills times the individual medication dosage in brackets. See example below.

e.g. Dilantin 100 mg. 0800  
 (2 X 50 mg.)  
 Take with plenty of water  
 Take minimum 1 hour before calcium

Dilantin 25 mg 1600  
 (½ of 50 mg.)  
 Take with plenty of water

Note:

Medication abbreviations can be found on page 36.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
0800 Dilantin 100 mg (2 x 50 mg) Take with plenty of water Take minimum 1 hour before Calcium														
1600 Dilantin 25 mg (½ of 50 mg.) Take with plenty of water														

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**  
 Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

4. Record all food and medication allergies or any restrictions/procedures that affect all medications in red ink on the MAR Sheet, preferably in the left top corner (ie. "No Grapefruit" or "Crush all tablets"). For other uses of red ink note: "Overview of Use of Red Ink." (Page 33).
5. Number each MAR Sheet (e.g. Page 1 of 1, Page 1 of 2, or Page 2 of 2, etc.).
6. No notes or messages to other Staff will be recorded on the MAR Sheet.
7. Do not erase or use 'white-out' on MAR Sheets, see section "G - Medication Incidents."
8. All signatures, recordings and any other information in the body of the sheet will be recorded in ink (blue, black or red), **never pencil**. \*Note: Overview of Use of Red Ink. (page 33)
9. At the end of each month, the MAR Sheet (M-7) will be placed in a folder/file marked "Completed MAR Sheets". **(See example below)**

**Example: Setting up a Medication Administration and Treatment Record (M-7)**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100mg (2 x 50mg tabs)																															
0800 Paxil 30mg take 1 tablet																															
1200 Dilantin 50mg take 1 tablet																															
1200 Paxil 30 mg Take 1 tablet																															

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**  
 Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**E. HOW TO RECORD MEDICATIONS:**

**i) Recording Medication - Staff Administered**

After each administration, all medication given must be followed by recording the hour given in the upper box and the Staff's initials in the lower box under the appropriate date. Staff must ensure they take note of the number of MAR sheets each individual has.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100mg (2 x 50 mg tablets)OD																															
0800 Paxil 30 mg take 1 tablet																															
1200 Dilantin 50 mg take 1 tablet																															
1200 Paxil 30 mg take 1 tablet																															

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**ii) Recording Medications-Self-Administered**

Staff must ensure they take note of the number of MAR sheets each individual has when there is Staff involvement/support with respect to medications. Refer to Pages 31 and 32 for details on Self-Administration options.

Following are recording requiring requirements for Staff who assist persons supported in Residential and Day Programs with self-administration of medications:

- a) Staff pouring medication - will initial the upper box for the relevant medication (s) on the appropriate day.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100mg (2 x 50mg tabs)OD																															
0800 Paxil 30mg take 1 tablet																															
1200 Dilantin 50mg take 1 tablet																															
1200 Paxil 30mg Take 1 tablet																															

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1



- b) Staff observing the person supported taking medication - will record the time of the observation and SA (representing Self Administered) in the lower box.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100 mg (2 x 50 mg tabs)OD																															
0800 Paxil 30 mg take 1 tablet																															
1200 Dilantin 50 mg take 1 tablet																															
1200 Paxil 30 mg Take 1 tablet																															

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

- c) Person supported self-administers medication (no Staff observation). Staff will record SA (representing Self Administered) in the lower box for the relevant medication (s) on the appropriate day after confirming with the person they self-administered. Note: Confirmation may be obtained by speaking directly with the person and/or checking the medication dispensing method (ie Medication cup, dossette, blister pack).

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100mg (2 x 50mg tabs)OD																															
0800 Paxil 30mg take 1 tablet																															
1200 Dilantin 50mg take 1 tablet																															
1200 Paxil 30 mg Take 1 tablet																															

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

- d) Person supported pours own medication and Staff witness the pouring. Staff will record the time they witnessed the person pouring their medication in the upper box on the appropriate day and a W (representing witnessed person supported pouring medication). An arrow will be drawn in blue or black ink starting on the day the Staff witnessed the pouring and ending on the last day for the time period the medications were poured (ie. Poured 2 days of medications; poured 1 week of medications). See example.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
0800 Dilantin 100mg (2 x 50 mg tablets)OD																																
0800 Paxil 30 mg take 1 tablet																																
1200 Dilantin 50 mg take 1 tablet																																
1200 Paxil 30 mg take 1 tablet																																

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**Medication Refused - "R":**

If an individual refuses a medication, refer to the Medication Incident Response (pg. 28). If the administration time range has lapsed, record an "R" and initials in the appropriate boxes in blue/black ink; circle "R" in red ink.

A Medication Incident Report (M-6) must be completed by the end of the shift and submitted to the relevant Supervisor or designate within 24 hours or the next business day.

Administering Staff must also advise incoming Staff of Medication Refusal via written report in the Communication Book and reported verbally, when possible.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100mg (2 x 50mg tablets)OD																															
0800 Paxil 30mg take 1 tablet																															
1200 Dilantin 50mg take 1 tablet																															
1200 Paxil 30 mg Take 1 tablet																															

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Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**Omissions - "O"**

If a medication is not administered within the allocated time range, refer to the Medication Incident Response (pg. 28). If the administration time range has lapsed, record "O" and initials in the appropriate boxes in blue/black ink; circle "O" in red ink.

A Medication Incident Report (M-6) must be completed by the end of the shift and submitted to the relevant Supervisor or designate within 24 hours or the next business day.

Administering Staff must also advise incoming Staff of Medication Omission via written report in the Communication Book and reported verbally, when possible.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
0800 Dilantin 100mg (2 x 50mg tablets)OD																																
0800 Paxil 30mg take 1 tablet																																
1200 Dilantin 50mg take 1 tablet																																
1200 Paxil 30 mg Take 1 tablet																																

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**Medication on Leave of Absence - "L.O.A.":**

If a medication is not administered because the individual is absent or does not receive support on that particular day, record the initials "L.O.A." for Leave of Absence within the allocated time range, in the appropriate box and initial.

If a medication is to be administered at another location, refer to Preparing Medications While on a Leave of Absence (pg. 7) and Transfer of Medication While On Leave of Absence (pg. 32-34).

Staff pouring the medication must also advise incoming staff, if applicable, of the Leave of Absence via written report in the Communication Book and verbally, when possible.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
0800 Dilantin 100mg (2 x 50mg tablets)OD																																
0800 Paxil 30mg take 1 tablet																																
1200 Dilantin 50mg take 1 tablet																																
1200 Paxil 30 mg Take 1 tablet																																

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**Discontinuing a Medication - “ \_\_\_\_\_ ”**

**Medication can only be discontinued after receiving written confirmation from the medical professional.** Draw a red line from the last medication given, straight through until the end of the month and on every line of each given time slot and each given initial slot. "Discontinued" is written across the top of the first line in red ink.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
0800 Dilantin 100mg (2 x 50mg tablets)OD																																
0800 Paxil 30mg take 1 tablet																																
1200 Dilantin 50mg take 1 tablet																																
1200 Paxil 30 mg Take 1 tablet																																

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**Noting New Medication and Changes to Existing Prescriptions:**

**Medication changes can only be made after receiving written confirmation from the medical professional.**

Discontinue previous medication and dosage if applicable (refer to “Discontinuing a Medication”).

Re-enter new dosage and medication change as if it was a new medication added to the MAR (M-7) Sheet. Refer to “How to Record a Medication”.

Draw a blue or black line on Medication Chart (M-7) to the appropriate date and time of when the medication change is to begin.

In the event of a name change for a given medication (ie dilantin brand name changes to generic name phenytoin), discontinue the original entry by drawing a blue or black line from the last date given to the end of the month. Enter the new name of the medication, as though it were a new medication. Draw a blue or black line up to the date the new medication is to begin. Monitor the individual for side effects, as per the Pharmacy Fact Sheet, as there may be changes to the composition of the new medication.

Within residential settings, all changes to medication orders are to be recorded in the Communication Book in red ink. **Incoming Staff must read and initial the Communication Book at the commencement of their shift.** When possible, incoming Staff are to be advised verbally of changes.

The designated Activity Centre Staff will be advised of all medication changes in writing, when applicable.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
0800 Dilantin 100mg (2 x 50mg tablets)OD																																
0800 Paxil 30mg take 1 tablet																																
1200 Dilantin 50mg take 1 tablet																																
1200 Paxil 30 mg Take 1 tablet																																

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1



**Periodic Medication - "X"** - ie. Ear Drops

If a medication is used only on certain days, **do not** draw a line through the omitted days as it may be confused with a discontinued medication. Place an "X" using **red ink** on the day it is not to be given and leave a space on the day it is to be given.

Periodic Medication includes medications that do not have specified days, but are administered on a regular basis (ie. eye drops to be administered on swimming days only).

**EXAMPLE:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
2100 Sofracort Ear drops (3 drops in each ear every other day)																																	

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

## Medication Used Only As Necessary - "P.R.N."

Write the medication name, dosage and route in BLUE/BLACK pen but write 'P.R.N.' in RED ink, in the medication column. Include in the entry all information regarding administration of the medication (ie. Tylenol 325 mg, take two tabs po every 4 hours for fever.) Note: In all cases a P.R.N. protocol is required for prescribed medications prior to administration of said P.R.N. A P.R.N protocol is typically developed with Team/work location input and must be signed off by the prescribing medical professional. The written protocol must include the following:

- Name of the person the P.R.N is prescribed for
- Name and dosage of the medication
- What the P.R.N. medication is for
- Details as to what factors are to be present/observed prior to administration of the P.R.N
- Minimum length of time between dosages
- Maximum dosage
- Signature of prescribing medical professional, title and date of signature
- See Appendix D for PRN Protocol example.

To calculate the number of squares needed to potentially sign-off the medication, you determine the maximum allowable doses in a 24 hr. period as ordered by the doctor. Ie if the medication is ordered q4h P.R.N. then the maximum doses in a 24 hr. period would be 6 doses and you would leave 6 spaces. If the medication was ordered q6h P.R.N. then the maximum doses in a 24 hr. period would be 4 doses and you would leave 4 spaces. Draw the lines for each square up to the actual day the order was written or administered.

Following administration of the P.R.N., write the TIME and your initials in the square, starting with the top square for each date. Any squares not used for a day, leave blank, until the next dosage time. Then go back and draw a straight line from the last dosage date and time to the new dosage date and time. For prescriptions which allow for dosage options (ie. 1-2 tabs), record the dosage administered above the time entry and circle in blue or black ink. (See examples below).

Administering Staff must also advise incoming Staff of P.R.N. Medication Administration and dosage via written report in red ink in the Communication Book and verbally, when possible.

**Example:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
Lorazepam 5 mg PRN take 1 tablet for agitation minimum 8 hours apart.																																	

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

**Re-Administering Medications:**

In the event a medication is expelled (ie. spitting, vomiting), seek advice from a medical professional to determine whether the medication should be re-administered and if subsequent medication times would need to be changed. If the directive is to re-administer the medication (s), do so, and record time and initials above the original entries on the MAR. Complete a medication incident report for the “contaminated medication” with regard to the medication originally administered. If a written directive is unable to be provided, ensure the name and title of the medical professional providing the directive is recorded in red ink in the Communication Book. Update the MAR if the directive includes changes to administration times.

**EXAMPLE:**

Allergic to Erythromycin

Prescribed Medication, Dosage & Time (as per container label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0800 Dilantin 100mg (2 x 50mg tablets)OD																															
0800 Paxil 30mg take 1 tablet																															
1200 Dilantin 50mg take 1 tablet																															
1200 Paxil 30 mg Take 1 tablet																															

**LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed**

Chart for: Jane Doe Location: 123 Main St., Goderich Month: November, 2008 Page 1 of 1

## F. MEDICATION INFORMATION FOLDERS/FILES:

### **Purpose:**

The purpose of the Medication Information Folder/File is to provide comprehensive information regarding the individual's medical needs (ie. reason for medication). The Medication Information Folder/File will accompany the individual each time he/she is seeking medical attention.

The designated Residential Support Worker (or S.I.L. Support Worker, if applicable) will be responsible for ensuring the Medication Information Folder/File is kept up-to-date. Any changes will be made as outlined under, "How to Record Medications.", Section E

Residential and Day Programs will have a separate Medication Information Folder/File for each individual, if applicable, containing the following:

### **Contents:**

1. **Standing Order Form (M-1):**  
Used for non-prescription medication as determined by a physician or Pharmacist.
2. **Personal Data Sheet (M-4):**  
Form containing such information as Health Card number, name of doctor, dentist, emergency contacts and significant medical conditions (ie. medical alerts and diagnosis).
3. **Medical Appointments Form (M-5):**  
A form used to document each individual's medical appointments.
4. **Medication Administration and Treatment Record - (MAR Sheet) (M-7):**  
A form used when administering/recording each individual's current medications.
5. **Staff Signature/Initial Sheet (M-7A):**  
A form used to identify Staff signatures and corresponding initials.
6. **Medication Transfer Form (M-8):**  
An Agency form to be completed by Staff Member when transferring and receiving medication from any other person (ie. Activity Centre, family members, other facilities).
7. **Destruction of Medication Form (M-9):**  
To be completed when medication can no longer be administered (ie. discontinued, contaminated, expired).
8. **Destruction of Medication to Pharmacy Form (M-9A):**  
To be completed by the Supervisor when taking medication to the Pharmacy for disposal.
9. **Medication Information Sheet (M-10):**  
Information on administration time, administering time range, administering method, special considerations/instructions and protocol for medication refusal can be acquired from this form. Time range for administration will **only** be determined by a medical professional and confirmed by the medical professional's signature on the Medication Information Sheet (M-10).

10. **Pharmacy Fact Sheet: (See Appendix C)**  
A Pharmacy Fact Sheet should be provided by the Pharmacy with each prescription and will list information on medication uses, side effects, precautions, etc.  
Should an individual show signs of an allergic reaction to a (current or new) medication, contact a medical professional and the Supervisor immediately. Also, please refer to “Guidelines For Recording Observations” to ensure all observations are identified and recorded.
11. **Annual Physical:** A form completed by the physician or medical professional performing an individual’s Annual Physical.
12. **P.R.N. Protocol:** A written protocol which provides comprehensive guidelines for the use of P.R.N. Medications. Sample on page 57.
13. **Biographical Time Line:** A written chronological overview of significant events in an individual’s life.
14. **Medication Time Line:** A chronological overview of significant events in an individual’s medication history.
15. **Psychiatric Consultation/Intake and Psychiatric Appointment Update Form:**  
Forms to provide information to the individual’s psychiatrist from initial intake to follow-ups.
16. **Individual Baseline:** This document is to be completed annually. A current copy is to be kept on file in the individual’s Medication Information Folder/file. The document provides an overview of the individual’s medical and personal history and current status; as well as information on the functioning abilities concerning various areas. The intent of this document is to establish a baseline of an individual’s skill set; behaviour; abilities and activities of daily living, to be able to identify any **future** changes in such skill set, behaviour and abilities.
17. **Health Related Protocols:** (ie. Diabetes/Insulin/Blood sugar recordings, bowel movements etc.) A written protocol which provides comprehensive guidelines for managing complex medical conditions.

## **G. MEDICATION INCIDENTS**

**Purpose:** In an attempt to ensure the health, safety and well-being of all individuals, Staff responsible for administering medication will be required to do a visual check of all medication and MAR (M-7) when reporting for duty and prior to leaving their shift, to confirm no medication incidents have taken place. Should a medication incident be identified, notify the appropriate Supervisor or Designate. A Medication Incident Report (M-6) must be completed prior to the end of shift and submitted to the relevant Supervisor within 24 hours or the next business day. Also please refer to Medication Incident Response (pages 28 and 29).

### **Definitions of Medication Incidents and How To Record:**

**Note: While every attempt has been made to ensure all possible incidents are listed, the listing below is not to be considered all-inclusive. All Medication Incidents are to be recorded in red ink in the Communication Book.**

1. **Unordered Medication Given** - any medication given to an individual not prescribed for that person.
2. **Wrong Dosage** - any dose above or below the correct prescribed dosage, as per licensed medical professional.
3. **Unaccounted Medication** - missing and/or found medication.
4. **Wrong Day and/or Time** - any medication given on the wrong day and/or either prior to or beyond the time range found in the Medical Information Sheet (M-10). If a medication is recorded in the wrong time slot, do not erase or use liquid paper. Circle the error in red and initial in the correct spot. Example: Person administering for 0800 signed for 1200 by mistake. Person administering 1200 meds would initial above the error.
5. **“Refusal”** - individual refuses a medication and the administration time range has lapsed. Record an “R” and initials in blue/black ink; circle “R” in red ink. Refer to the Medication Information Sheet (M-10)
6. **“Omission”** - any dose not given within the allocated time range. If medication is not given within the allocated time range, record an “O” and initials in the appropriate boxes in blue/black ink; circle “O” in red ink. Refer to the Medication Information Sheet (M-10).
7. **Inaccurate Administration of Medication** - example - eye drops administered in ears.
8. **Failure to Record** - failure to record administration time and/or initials on MAR Sheet (M-7) or Medication Transfer Form (M-8). Circle and initial the appropriate box in red ink.
9. **Failure to Record Correctly** - incorrectly recording a medication on MAR Sheet (M-7) or Medication Transfer Form (M-8). Circle error in red ink and initial.

10. **Unauthorized Discontinuation of Medication** - medication discontinued without written approval of a licensed medical professional. Circle error in red ink and initial.
11. **Contaminated** - medication that has become contaminated due to various circumstances, such as dropped on floor, removal for reason other than administration, expelled (ie. spit out).
12. **Transportation** - Failure to ensure transportation of medications as per individual protocol.
13. **Failure to Comply with the Medication Policy and/or Procedures** - any circumstance where Medication Policy and Procedure is not followed.

**Medication Incident Response:**

1. Immediately review the Individual's Medication Information Sheet (M-10) for information regarding administration time ranges, special instructions, and protocols pertaining to the particular medication incident.
2. Should the M-10 not address the specific medication incident and the health and safety of the individual may be at risk.

**All Staff will:**

Follow **one OR more** of the following options immediately, as deemed appropriate:

- **Contact 911**
  - Contact Tele-Health at 1-866-797-0000 for instructions/information.
  - Contact the Family Physician or local hospital for instructions.
  - Contact the dispensing Pharmacist for instructions/information.
  - Contact the Ontario Poison Information Centre at 1-800-268-9017 for instructions/information.
  - Special Services at Home Contract Workers will contact the Parent/Guardian directly, or if unavailable, the nearest hospital for instructions.
3. For any and all medication incidents, the Staff or Contract Worker will complete a Medication Incident Report (M-6) prior to the end of shift and submit such to their immediate Supervisor or designate within 24 hours or the first business day. If the medication incident is serious in nature (ie. medical intervention/treatment required), the relevant Supervisor or designate must be contacted directly during office hours. After office hours the pager should be accessed and voice mail left with the relevant Supervisor. For non-medical emergencies, Staff will contact the relevant Supervisor or designate via voice mail.



4. After the Support Worker and the Supervisor have completed a Medication Incident Report, the Coordinator will make comments and return the original to the Supervisor. The Supervisor will review the said Report with the Support Worker and then place in the Staff member's file\binder. The Coordinator will provide a copy to Central Administration Staff to be placed into the Master Medication Incident Report Binder in order that a monthly summary may be completed.

**Disciplinary Action:**

A medication incident is defined as any deviation from the Agency's Medication Policies and Procedures.

All Staff who have received medication administration orientation and have successfully completed the Medication Questionnaire will be expected, as part of their duties, to administer medication as prescribed by a medical practitioner. Although each work location may have distinct individual requirements such as: someone who self-administers, insulin treatment, the expectation is that no errors in procedure will take place.

Should a medication incident occur, the appropriate medication incident procedure (ie. contacting the hospital, pharmacy) would be followed as outlined on the previous page, "Medication Incident Response."

When a Staff member has a medication incident, the medication incident will be reviewed as soon as possible by the relevant Supervisor or designate. Recommendations will be made at the discretion of the Coordinator in consultation with the relevant Supervisor or designate. Recommendations will be based on the nature and the severity of the incident; if Staff acted negligently at any time after the incident (ie. Staff trying to cover up errors or falsifying records), as well as the frequency of such medication incidents made by the particular Staff member. It is the Agency's expectation that the following disciplinary protocol will occur, notwithstanding consideration for exceptions:

1. The first medication incident for a Staff member will result in a verbal reminder of their responsibilities and the relevant Medication Policy and Procedure will be reviewed with said Staff. After review, the Medication Incident Report will be filed in the Staff member's file/binder. A copy will also be filed at Central Administration in the Master Medication Incident Binder.
2. Should a second medication incident occur within twelve months of the first, the Staff member will be required to review the Medication Policy & Procedure Manual and may be given a written letter of warning and may be required to retake the Medication Questionnaire prior to being allowed to administer medications.
3. Should a third medication incident recur within a twelve month period, the Staff member will be subject to any of the aforementioned disciplinary action as referenced in point #2 above and/or be required to participate in medication training and may be suspended from independently fulfilling any medication responsibilities and may be subject to suspension without pay and/or termination.

Note:

All Medication Incident Reports completed at each stage of the disciplinary process will be filed in the Staff member's file/binder after review. A copy will also be located in the Coordinator, Adult Services Master Medication Incident Binder.

**H. GENERAL PROCEDURES:**  
**How to Administer Medication:**

**Procedure:**

The following procedure **must be** adhered to when dispensing both prescription and non-prescription medication. Only non-prescription medication that has been approved by the individual's physician or Pharmacist, and is listed on the Standing Order Form (M-1/M-2) may be administered.

Medication must be administered to the six rights of medication administration:

- right person
- right medication
- right dosage
- right day and/or time
- right route, form and technique as ordered
- right documentation

**Pouring and Administering all Medication:**

1. Wash hands prior to giving medication. Never touch medication with your hands.
2. Support Workers pouring and administering medication will concentrate their complete attention on what they are doing, which may include isolating themselves.
3. Prior to pouring medication(s), check the individual's Medication Administration and Treatment Record (MAR Sheet; M-7), then read the pharmaceutical label(s) looking for the individual's name, the medication name, dosage and expiration date, as well as any other information regarding administration (ie. Take with plenty of water). The MAR entry is to match the information on the label(s). If it does not, seek clarification from a medical professional (ie. Prescribing doctor, dispensing pharmacist, etc).
4. Tablets will typically be split by the pharmacy. Should a Support Worker need to split a tablet, use a pill splitter. Place remaining portion of medication back into the appropriately labelled pharmaceutical container. Do not touch medication with your hands. Wash pill splitter after each use.
5. Place medication directly into an unused medication cup from dispensing source. As an option to aid in the prevention of over pouring and over dispensing into the medication cup, the medication may be dispensed into the cap of the medication container prior to dispensing into an unused medication cup. Do not touch medication with your hands. All medication for each individual may be placed into one cup unless instructions specify otherwise. In some instances, capsules may be pulled apart, but never without the written consent and direction from a medical professional. Direction must be sought with respect to handling the capsule (ie. gloves), the appropriateness of placing medication in food or liquid and disposal of the empty capsule.
6. When pouring liquid medication, remove bottle cap, place cap upside down on counter top to maintain asepsis (freedom from bacteria). Holding medication cup at eye-level, pour required dose. Pour away from the labelled side, keeping label clean and legible. Wipe rim clean with an unused, wet paper towel. Do not pre-pour liquid medication.

7. After pouring and before returning container to the shelf, perform a visual check to verify the prescribed dosage has been dispensed, in addition check Medication Administration and Treatment Record (M-7) and pharmaceutical label(s) ensuring they are identical.
8. Identify the individual for whom the medication is intended.
9. Staff or Contract Worker must always remain with the individual until the medication has been swallowed.
10. Medication will be charted immediately after it is given on Medication Administration and Treatment Record, (MAR Sheet) (M-7). Only Staff or Contract Workers administering medications are to record their signature with coordinating initials.
11. Discard medication cup(s) after each use. Medication cups are not to be reused.
12. In order that Special Services At Home Contract Workers can administer medication, it is required that a Medication Training Form and a Parental/Guardian Consent - Administration of Medication form (M-3) be completed.

### **Self-Administration of Medication:**

Self-administration of medication is an option for individuals. The Agency recognizes each individual's right to independently administer their own medication. Refer to pages 12, 13, 14 and 15 for details on how to record self-administered medication. With respect to storage of medication and dispensation, assistance by Community Living-Central Huron Staff or Contract Workers may include, but is not limited to, the following options:

### **Options for Storage of Medication:**

- a) Support Worker stores individual's medication in a locked medication cupboard.
- b) Individual stores own medication in locked storage in own room.
- c) Individual stores own medication on person or in unlocked location in own room.

### **Options for Dispensation of Medication:**

Medication may be dispensed to dosette or other dispensing options (ie medication cup) by Support Worker or Individual.

### **Options for Documentation of Medication Administration:**

- a) Support Worker initials Medication Administration and Treatment Record as per “How to Record Medications” (page 11).
- b) Individual initials Medication Administration and Treatment Record as per “How to Record Medications” (page 11). Support Worker may periodically perform documented spot checks and initial Medication Administration and Treatment Record.
- c) No recording on Medication Administration and Treatment Record. Support Worker will monitor and document any concerns.

When MAR Sheets (M-7) are used for documentation on any of these options, a copy must be kept in the individual’s Medication Information Folder/File.

Note: In Residential locations, the relevant Supervisor is required to approve all of the preceding self-administration options. Typically Option C under “Storage of Medication” would not be approved for people residing in residential locations.

### **Transfer of Medication:**

Each time a transfer of medication occurs, upon delivery and upon return, both parties involved are responsible to sign a Medication Transfer Form (M-8) to confirm the medication(s) and quantity noted on the M-8 has been delivered and/or returned. In the event an individual is to transfer their own medication, a Medication Transfer Form (M-8) is to be signed by both the individual and Agency Staff.

#### **1. Leave of Absence:**

The designated Residential Support Worker, as per the Medication Responsibility List, will:

- a) Complete a duplicate MAR Sheet (M-7) and a Medication Transfer Form (M-8) located on the back of the duplicate MAR Sheet (M-7).
- b) Prepare medication for the total number of days plus one or two days more (in case of emergency - ie. winter weather) in approved pharmaceutical labelled container/package. For creams or liquid medications, the vial or container will be transferred. For blister packs, transfer sufficient packs to satisfy the total number of days away, plus extra medications for emergencies, unable to return home as scheduled, etc. Refer to example on M-8 (page 50).
- c) Provide the Family member/Caregiver/Support Worker with the prepared medication, duplicate MAR Sheet (M-7) and Medication Transfer Form (M-8). Also, provide a copy of the individual’s Personal Data Sheet, Pharmacy Fact individual’s Personal Data Sheet, Pharmacy Fact Sheet(s), and other pertinent medication information/supplies. Ensure the delivering and receiving parties both sign the Medication Transfer Form (M-8).

- d) Ensure the return of the duplicate M-7 and M-8, as well as any unused medications, as per individual protocol. Upon receipt of unused medication, verify amounts returned. Both parties are to sign for medications received on the Medication Transfer Form (M-8). Note: if "0" pills are returned, sign to verify that this was the "amount" returned. Do not mix returned unused medications with current medication. It is expected that the returned medications be used immediately upon return as per Policy. Duplicated MAR Sheet (M-7)/ Medication Transfer Form (M-8) will be placed in the "Completed MAR File/Folder".

2. **To the Activity Centre:**

- a) The designated Residential Support Worker will complete a duplicate MAR Sheet (M-7) and a Medication Transfer Form (M-8) located on the back of the duplicate MAR Sheet (M-7).
- b) The medication (maximum one month's supply), will be provided to the Activity Centre in an approved pharmaceutical labelled container/package. For liquid medications, the vial or container will be packed. The designated Residential Support Worker will ensure that Activity Centre Staff have updated Personal Data Sheets, copy of Pharmacy Fact Sheets and other pertinent medical information. It is also the responsibility of the designated Residential Support Worker to notify the Activity Centre Staff of any changes to medications listed on the MAR Sheet (M-7).
- c) Upon receipt of the medication, the designated Activity Centre Staff will count the medication and verify all information listed on the Medication Transfer Form (M-8). The designated Residential Support Worker will ensure that both parties sign the Medication Transfer Form (M-8).
- d) The designated Residential Support Worker will chart the medication administered in the Day Program, if applicable, as "L.O.A." medication on the original MAR (M-7) as per "Medications on Leave of Absence" page 18.
- e) When an individual attends the Activity Centre and does not receive support through CL-CH Residential Services, the designated Activity Centre Support Staff will complete a MAR Sheet (M-7) and a Medication Transfer Form (M-8). Ensure that both parties involved in the transfer sign the Medication Transfer Form (M-8) as per Policy.
- f) The designated Activity Centre Staff will return any unused medications, as per individual protocol, to the designated Residential Support Worker, S.I.L. Support Worker, individual/Family member/Caregiver, or other facility, as well as the completed monthly MAR (M-7), and Medication Transfer Forms (M-8). Ensure the Medication Transfer Form (M-8) is signed both for delivery and receiving of medications, as per Policy. Note: If "0" pills are returned, sign to verify that this was the "amount" returned.

- g) The designated Residential Support Worker or S.I.L. Support Worker, will file the returned Activity Centre MAR (M-7) and Medication Transfer Form (M-8) in the “Completed MAR File/Folder”.
  
- 3. **To the Community** (Employment Support/Job Sites/Community Activity):  
When requested, Support Workers will provide assistance to individuals in administering medications when in community employment and activities.
  - a) In the event that CL-CH Agency Staff are preparing the medications for transfer, it will be their responsibility to have a duplicate MAR Sheet (M-7) and Medication Transfer Form (M-8) prepared. Should medications be prepared by Non-Agency Staff it would be the responsibility of the Agency Staff receiving the medication to prepare the aforementioned forms.
  - b) Support Workers providing support in the community will ensure they have the prepared medication for the outing/activity, duplicate MAR Sheet (M-7) , Medication Transfer Form (M-8), Personal Data Sheet, and other pertinent medication information/supplies). Ensure the Medication Transfer Form (M-8) has been verified and signed by both parties prior to the outing/activity.
  - c) Ensure the return of any unused medications, as per individual protocol. Upon receipt, verify amounts returned and ensure that both parties involved in the transfer sign for medications received on the Medication Transfer Form (M-8). Note: If “0” pills are returned, sign to verify that this was the “amount” returned. Do not mix returned unused medications with current medication. It is expected that the returned medications be used immediately upon return as per Policy. Duplicated MAR Sheets (M-7)/Medication Transfer Forms (M-8) will be placed in the “Completed MAR File/Folder”, if applicable.

Example

**M-8**  
**COMMUNITY LIVING CENTRAL HURON**  
**MEDICATION TRANSFER FORM**

<b>DATE</b>	<b>QUANTITY</b>	<b>MEDICATION</b>	<b>DOSAGE</b>	<b>DELIVERED BY:</b>	<b>RECEIVED BY:</b>
Dec. 5. 2008	13 tablets	Dilantin	100 mg (2 x 50 mg) 0800 25 mg (1/2 x 50 mg tablet) 1200	Mary Doe	John Doe
Dec. 5. 2008	10 tablets	Paxil	30 mg (1 x 30 mg tablet) 0800 30 mg (1 x 30 mg tablet) 1200	Mary Doe	John Doe

This example is based on John Doe going away for 3 days and an extra 2 days of medication was packed.

Most Frequently Used Abbreviations  
in Medication Prescriptions & Labels

cap	capsule
cc	cubic centimeter
dr or z	drachm or dram
ELIX	ELIXIR
g	gram
gr	grain
I.M.	intramuscular
I.V.	intravenous
L	litre
mcg	microgram
mg	milligram
m	minim
mL	milliliter
oz	ounce
s.c.	subcutaneous
a.c.	before meals or food
B.I.D. or b.i.d.	twice daily
c	with
gtt.	drop
h.s.	at bedtime
o.d.	in the right eye
o.u.	in each eye
o.s.	in the left eye
p.c.	after meals
per os or p.o.	orally, by mouth
p.r.n. or PRN	as required
qd	every day, daily
q.i.d.	four times a day
q.h.	every hour
q.2h.	every 2 hours
q.s.	sufficient quantity
stat	at once
s	without
supp.	suppository
susp.	suspension
tab	tablet
tbsp.	tablespoon
tsp	teaspoon
ung	ointment



COMMUNITY LIVING-CENTRAL HURON'SGuidelines for Times of Medication Administration

OD or qd	daily
b.i.d. or BID	twice daily
t.i.d. or TID	three times daily
q.i.d. or QID	four times daily
qh	every hour
q2h	every 2 hours
q3h	every 3 hours
q4h	every 4 hours
q6h	every 6 hours
hs	at bedtime - one night only
qhs	at every bedtime
qd x 2	one dose for two days
a.c.	before meals - 30 minutes
p.c.	after meals - 30 minutes
q4h x 4	4 doses <u>only</u> given at 4 hour intervals
t.i.d. & hs	3 times a day and at bedtime

## 24-Hour Clock System



Examples:

One minute past midnight	= 0001 hrs.
8:00 a.m.	= 0800 hrs.
8:00 p.m.	= 2000 hrs.
One minute before midnight	= 2359 hrs.

## APPENDIX A

## OVERVIEW of USE of RED INK

The health, safety and well-being of the people the Agency supports is of primary concern. In an effort to alert staff to pertinent medical issues the Agency mandates the use of red ink as follows:

### Page /Item

1. As per the Medication Responsibility List:  
New medications and changes to medications are **to be** noted in red ink in the Communication Book.
2. Record all food and medication allergies, as well as any restrictions/procedures affecting all medications, in red ink on the MAR Sheet, preferably in the top left hand corner.
3. Medication refusal- record an "R" and initials in blue\black ink on the MAR under the relevant date/time; circle "R" in red ink.
4. Omission - record an "O" and initials in blue\black ink on the MAR under the relevant date/time; circle "O" in red ink.
5. When discontinuing a medication, as per written medical directive, on the MAR draw a red line from last date given, until the end of the month and on every line of each given time slot and each given initial slot. Write "Discontinued" across the top of the first line in red ink.
6. When recording Periodic Medication on the MAR, mark red "X" on days not to be given.
7. "PRN" is to be recorded in red ink on the MAR beside each PRN medication.
8. Record all medication incidents in red ink in the Communication Book.
9. Wrong day or time - circle and initial error in red ink.
10. Failure to Record - circle and initial the appropriate box in red ink.
11. Failure to Record Correctly - circle and initial error in red ink.
12. Unauthorized Discontinuation of Medication - circle and initial error in red ink

### References of Red Ink:

In Communication Book: Refer to #1 and #8

On MAR: Refer to #2, #3, #4, #5, #6, #7, #9, #10, #11 and #12

## **APPENDIX B FORMS**

COMMUNITY LIVING-CENTRAL HURON

ADULT SERVICES

STANDING ORDER FORM

\_\_\_\_\_  
PATIENT'S NAME

\_\_\_\_\_  
DATE

The following medication may be used as a standing order from:

\_\_\_\_\_ 20\_\_ to \_\_\_\_\_ 20\_\_

MEDICATION	YES	NO
Acetaminophen _____ Dosage & Times		
A.S.A. (Aspirin) _____ Dosage & Times		
Cough Preparation _____ (Brand name) Dosage & Times		
Cold Preparation _____ (Brand Name) Dosage & Times		
Antacid _____ (Brand Name) Dosage & Times		
Laxative _____ (Brand Name) Dosage & Times		
<b>OTHER</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____		

Medical Professional's Signature \_\_\_\_\_

M-1

COMMUNITY LIVING-CENTRAL HURON  
CHILDREN'S SERVICES

STANDING ORDER FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

The following medication may be used as a standing order from:

\_\_\_\_\_ 20 \_\_\_\_\_ to \_\_\_\_\_ 20 \_\_\_\_\_

MEDICATION	YES	NO
Acetaminophen _____ <b>Dosage &amp; Times</b>		
A.S.A. (Aspirin) _____ <b>Dosage &amp; Times</b>		
Cough Preparation _____ <b>(Brand name)    Dosage &amp; Times</b>		
Cold Preparation _____ <b>(Brand name)    Dosage &amp; Times</b>		
Antacid _____ <b>(Brand Name)    Dosage &amp; Times</b>		
Laxative _____ <b>(Brand Name)    Dosage &amp; Times</b>		
<b><u>OTHER</u></b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		

**Parental/Guardian/Caregiver consent:**

I hereby give permission to \_\_\_\_\_ to administer the above medications when needed.

\_\_\_\_\_  
Signature Parent/Guardian/Caregiver

\_\_\_\_\_  
Date

# COMMUNITY LIVING-CENTRAL HURON

## PARENTAL/GUARDIAN/CAREGIVER CONSENT - ADMINISTRATION OF MEDICATION

Name of Individual: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian/Caregiver name: \_\_\_\_\_ (H) Phone: \_\_\_\_\_

Business address: \_\_\_\_\_ (B) Phone: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage or amount to be given at each time: \_\_\_\_\_

Additional instructions re: Administration of medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical conditions needing medication (With parental/guardian/Caregiver consent): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Duration of medication to be given: \_\_\_\_\_

Anticipated reaction (if any): \_\_\_\_\_

Prescribing physician's name, address and phone number:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

### Parental/Guardian/Caregiver approval:

I, \_\_\_\_\_ hereby request and give permission to  
\_\_\_\_\_ to administer medication to  
\_\_\_\_\_ according to procedures adopted by  
Community Living-Central Huron and the detailed instructions noted above.

\_\_\_\_\_  
Signature of Parent/Guardian/Caregiver

\_\_\_\_\_  
Date

**COMMUNITY LIVING-CENTRAL HURON  
PERSONAL DATA SHEET**

**Name:**

**Address:**

**Postal Code:**

**Phone:**

**Date of Birth:**

**S.I.N. #:**

**Health Card #:**

**ODSP #:**

**Doctor:**

**Phone:**

**Dentist:**

**Phone:**

**Other Professionals:**

**Phone:**

**Program Initiation Date(s) :** \_\_\_\_\_  
**Activity Centre      Residential      SIL      Emp. Support**

**Medical Alerts/Notable Points:**

**Prescribed Medications:**                      **See back of page.**

**In Emergency Contact:**

**Contact 1:**

**Contact 2:**

**Relationship:**

**Relationship:**

**Address:**

**Address:**

**Phone:**

**Phone:**

**Agency Contact:**

**Phone:**

**Orientation:**

**Initial orientation conducted by:**

**Date:**

**Annual orientation conducted by:**

**Date:**

**Individual Support Plan/Person Directed Planning**

**Date of current Plan**

**Date:**

**Review Date**

**Date**

**Annual Review:**

**Abuse - education and awareness building on  
abuse prevention and reporting**

**Date:**

**How was the review conducted (ie. Abuse dvd)?**

\_\_\_\_\_



**MEDICATIONS TAKEN REGULARLY (Prescribed and over the counter medications)**

Medication	Dosage	Admin Time as per MAR	Purpose	Other Information
<b>PRN Medication:</b>				

**RECORD OF IMMUNIZATIONS**

Immunization	Year	Year	Year	Year
Last tetanus booster				

**OTHER INFORMATION**

Power of Attorney for Personal Care: \_\_\_\_\_

Power of Attorney for Finances: \_\_\_\_\_

Does person sign own consents? No \_\_\_ Yes \_\_\_ Printing/Writing \_\_\_ Stamp \_\_\_

Does person have a Will and if so, where? \* No \_\_\_ Yes \_\_\_ at \_\_\_\_\_

Does person have Prepaid Funeral Arrangements? If so, where? \* No \_\_\_ Yes \_\_\_

Arrangements with \_\_\_\_\_

(\*Only needs to be completed for people who receive residential or SIL support)

Written protocols in file? No \_\_\_ Yes \_\_\_

# COMMUNITY LIVING-CENTRAL HURON

## MEDICAL APPOINTMENTS FORM

**INDIVIDUAL'S NAME:** \_\_\_\_\_

DATE	STAFF'S INITIALS	PRACTITIONER	REASONS FOR VISIT	DIAGNOSIS	TREATMENT	FOLLOW-UP OR CONDITION CLEARED

M-5

# COMMUNITY LIVING-CENTRAL HURON

## MEDICATION INCIDENT REPORT

INDIVIDUAL'S NAME: \_\_\_\_\_

SUPPORT WORKER INVOLVED: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

DISPENSATION TIME: \_\_\_\_\_

LOCATION: \_\_\_\_\_

Indicate by checkmark

(✓)

1) Unordered Medication Given	
2) Wrong Dosage	
3) Unaccounted Medication	
4) Wrong Day and/or Time	
5) Refusal	
6) Omission	
7) Inaccurate Administration of Medication	
8) Failure to Record	
9) Failure to Record Correctly	
10) Unauthorized Discontinuation of Medication	
11) Contaminated	
12) Transportation	
13) Failure to comply with the Medication Policy and/or Procedures	

SUPPORT WORKER'S COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

SUPERVISOR NOTIFIED: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PERSON NOTIFIED: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

M-6 (continued)

**Dates of Incidents in the last 12 months:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE** **DATE**

**COORDINATOR'S COMMENTS:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE** **DATE**

**RECOMMENDATIONS/FOLLOW-UP:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE** **DATE**

**ORIGINAL TO:** Support Worker File/Binder after review.  
**COPIED TO:** Coordinator Adult Services:  
Master Medication Incident Binder:

\_\_\_\_\_  
\_\_\_\_\_

**Revised: January 19, 2010.**

**COMMUNITY LIVING-CENTRAL HURON  
MEDICATION ADMINISTRATION AND TREATMENT RECORD (MAR)**

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

**NOTE:** After administering medication, Staff are to record time given in the upper box and their initials in the lower box under the appropriate day. If self-administered, Staff pouring, initial upper box.

**LEGEND:** O = Omission / R = Refused / X = Periodic / LOA = Leave Of Absence / SA = Self-Administered / W = Witnessed

**CHART FOR:** \_\_\_\_\_ **LOCATION:** \_\_\_\_\_ **MONTH:** \_\_\_\_\_, \_\_\_\_\_ **Page** \_\_\_\_\_ **of** \_\_\_\_\_

**M-7**

**Revised: January 2016**

# COMMUNITY LIVING-CENTRAL HURON

## MEDICATION TRANSFER FORM

DATE	QUANTITY	MEDICATION	DOSAGE	DELIVERED BY:	RECEIVED BY:

M-8

# COMMUNITY LIVING-CENTRAL HURON

## Staff Signature/Initial Sheet for Medication Administration and Treatment Record (MAR)

Individual's Name: \_\_\_\_\_

Staff Signature	Staff Initials	Date

Implemented: September 1<sup>st</sup>, 2005.

M - 7A

**COMMUNITY LIVING-CENTRAL HURON  
DESTRUCTION OF MEDICATION**

DATE	MEDICATION	DOSAGE	AMOUNT	INDIVIDUAL'S NAME	STAFF SIGNATURE

\_\_\_\_\_  
Supervisor's Name (Please Print)

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date Received Meds

\_\_\_\_\_  
Date Supervisor reviewed meds

Information reported is correct:     Yes     No

If no, provide details: \_\_\_\_\_

Any further action to occur:     Yes     No

If yes, provide details: \_\_\_\_\_

Copy to:    Coordinator, Adult Services.



**COMMUNITY LIVING-CENTRAL HURON  
DESTRUCTION OF MEDICATION TO PHARMACY**

\* Ensure identifiers are removed.

MEDICATION - List Narcotics	DOSAGE	AMOUNT	NON-NARCOTIC MEDICATION
			Returning to Pharmacy for destruction Yes <input type="checkbox"/> No <input type="checkbox"/>

\_\_\_\_\_  
Supervisor's Name (Please print)

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_

Pharmacist's Name (Please print)

Name of Pharmacy

Pharmacist's Signature

Copy to: Coordinator, Adult Services.

Date Received

M-9A

Revised: December, 2015.

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### COMMUNITY LIVING-CENTRAL HURON

#### MEDICATION INFORMATION SHEET

Individual's Name: \_\_\_\_\_

The following time range(s) and/or instructions are appropriate for the administration of the medications listed below :

Medication	Administration Time	Time Range	Administration Method	Special Consideration(s)/ Instructions	Protocol for Med. Refusal

\_\_\_\_\_  
Signature of Medical Professional

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

COMMUNITY LIVING-CENTRAL HURON  
ANNUAL PHYSICAL

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eyes \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Ears \_\_\_\_\_

COMMENTS: \_\_\_\_\_

HEART RATE: \_\_\_\_\_ Rhythm: \_\_\_\_\_ Pulse: \_\_\_\_\_

LUNGS: \_\_\_\_\_

BLOOD PRESSURE Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_

IMMUNIZATION: Current: \_\_\_\_\_

IMMUNIZATION: Given: \_\_\_\_\_

Result: \_\_\_\_\_

AUSTRALIAN ANTIGEN Negative \_\_\_\_\_ Positive \_\_\_\_\_

BLOOD (testing if individual is on medication) \_\_\_\_\_ Date: \_\_\_\_\_

Female: Breast Exam \_\_\_\_\_ Male: Genitals \_\_\_\_\_  
Menstruation \_\_\_\_\_  
Pap Smear \_\_\_\_\_  
Urine \_\_\_\_\_

Are there any specific conditions limiting the activities of this individual? Please specify any physical activities, working conditions that are to be avoided.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Examining Physician

**APPENDIX C: EXAMPLE PHARMACY FACT SHEET**

RIECK PHARMA PLUS  
144 THE SQUARE  
GODERICH, ONT.  
N7A 1M9

OPEN 8 AM WEEKDAYS!

For:

Allergies: NO ALLERGIES REPORTED BY PATIENT

Med. Cond: NO MEDICAL CONDITIONS REPORTED BY PATIENT

---

MEDICATION: Betamethasone Valerate

OTHER NAMES: Betaderm, Betacort, Betagel, Betnovate,  
Celestoderm-V, Celestoderm -V/2,  
PrevexB Rholosone, Valisone

USUALLY PRESCRIBED FOR:

- \* Treatment of psoriasis and dermatitis
- \* Relief of pain, itching and redness of skin conditions

NOTE: Your prescription could be used for reasons other than those listed above.

SPECIAL INSTRUCTIONS:

- \* This is for external use only.
- \* Use exactly as prescribed for the length of time advised.
- \* Lotion: Apply to entire affected areas of skin or scalp.  
Your health is my concern.
- \* Avoid contact with the eyes.
- \* Do not use this medication for long periods of time unless advised by your doctor.

Alcohol containing preparations can cause stinging & burning  
\* Do not apply to infected areas or cover the treated area unless advised by your doctor.  
\* Use exactly as prescribed and for the length of time advised. Overuse or extended use can cause skin thinning.

\*If the affected area becomes more red and inflamed, contact your doctor.  
\*Do not use other creams/lotions, cosmetics or other medication along with this one.  
\*Check with your doctor about taking this if you become pregnant or are breast-feeding.  
\*If you forget an application, apply it as soon as you remember. Do not double-up.  
\*Do not share your medication with anyone.

POSSIBLE SIDE EFFECTS:

Most people have few or no side effects when using this medication. Check with your doctor if any of the listed side effects, or other unusual problems occur.  
\* Burning or itching that was not present before use.  
\* The affected area becomes infected, red, sore or swollen.  
\* The affected area becomes worse or does not improve.

MEDICATION STORAGE:

\* Store away from direct light, heat and moist places such as bathrooms or below the kitchen sink.  
\* Store this medication away from children.

Please call me if you have any questions about this medication.

Phone: 519-524-7241

Prepared by: \_\_\_\_\_, Pharmacist

Date: August 7, 2001.

BETAMETHASONE VALERATE - 1

### PRN Protocol Example

Name of Individual: John Smith

Name and dosage of PRN medication: Risperdal, 1 mg

What is the PRN for: To alleviate anxiety and to help calm John to prevent escalation of behaviour.

Details as to what factors are to be present/observed prior to administering the PRN:

1. Should John display signs of anxiety, specifically: pacing, biting his finger nails, rocking or asking a series of questions, ask John if there is anything bothering him and if there's something you can assist him with.
2. Attempt to deal with John's concerns, if possible, in a supportive, non-confrontational manner.
3. If possible, try to provide John with a quiet environment, whether he is willing to go to another room or his roommates move to another room.
4. Should John's anxiety, as per #1, continue for 10 minutes or begin to escalate (i.e raising his voice, crying, arguing), offer John a PRN of Risperdal, 1mg.
5. The PRN of Risperdal 1 mg., may be given every 4 hours, as per the foregoing protocol, up to a maximum of 4 times in a 24 hour period.

Staff are to record in the Communication Book all PRN administrations, noting the specific behaviours and Staff response which occurred prior to the administration of the PRN, as well as the period of time it took John to appear to calm down.

Lastly, leave the Supervisor or designate a voice mail message outlining the details of the circumstances giving rise to the administration of the PRN.

I have reviewed and approve of the foregoing PRN Protocol.

\_\_\_\_\_  
Prescribing medical professional, title

\_\_\_\_\_  
Date

**APPENDIX E**

**Community Living-Central Huron  
Observation Testing Checklist - Medication Administration**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Position: \_\_\_\_\_ Location/Team: \_\_\_\_\_

<u>Task</u>	<u>Successful Completion</u>	<u>Assistance Required</u>
1. Washes hands prior to administering medication.	_____	_____
2. Gather necessary equipment/supplies.	_____	_____
3. Prior to pouring medication(s), the MAR sheet was checked, the pharmaceutical label(s) read to ensure the MAR sheet corresponded (correct medication, name, dosage & Time) and the correct individual's name was on the container/package, and the expiration date was checked (if applicable).	_____	_____
4. After pouring, check MAR sheet and pharmaceutical label(s) ensuring they are identical.	_____	_____
5. Administered properly prepared medication to correct person, never touching tablets with hands.	_____	_____
6. Ensured medication was swallowed.	_____	_____
7. Completed documentation correctly and promptly after meds swallowed.	_____	_____
8. Discarded medication cup(s).	_____	_____
9. Returned equipment/supplies to med cupboard.	_____	_____
10. Locked medication cupboard.	_____	_____
11. Concentrated their complete attention on med administration; appropriately handled interruptions.	_____	_____
12. Adhered to the six rights of med administration throughout administration - right person, right medication, right dosage, right day and/or time, right route, form and technique as ordered, right documentation.	_____	_____
13. Displayed regard for personal safety, as well as safety, care and comfort of others.	_____	_____
14. Checked all MAR sheets.	_____	_____
15. Adhered to CL-CH's Med Policies and Procedures.	_____	_____

Date of completion of written test with 100% accuracy \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Supervisor's Signature                      Date                      Employee's Signature                      Date

## MEDICATION QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Observation is an essential skill when keeping track of an individual's progress, and/or in preparation to report plausible signs and symptoms to an attending physician. List the five personal resources you may use when observing:

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_

2. What are the nine guidelines you would use for recording observations?

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_
- vi) \_\_\_\_\_
- vii) \_\_\_\_\_
- viii) \_\_\_\_\_
- ix) \_\_\_\_\_

3. Please complete the following sentences:

A sign is an indicator \_\_\_\_\_

A symptom is evidence \_\_\_\_\_

4. Convert the following times into the opposite method of calculating hours:  
(ie. 0700 hrs = 7:00 a.m.)

0800 hours = \_\_\_\_\_

1200 hours = \_\_\_\_\_

1600 hours = \_\_\_\_\_

2000 hours = \_\_\_\_\_

7:00 a.m. = \_\_\_\_\_

9:00 p.m. = \_\_\_\_\_

4:00 p.m. = \_\_\_\_\_

2300 hours = \_\_\_\_\_

5. Within each residential setting, a "Medication Responsibility List" is posted itemizing and designating Residential Support Workers' responsibilities toward ensuring the medication requirements are adhered to. List the **11** items included in the "Medication Responsibility List."

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_
- vi) \_\_\_\_\_
- vii) \_\_\_\_\_
- viii) \_\_\_\_\_
- ix) \_\_\_\_\_
- x) \_\_\_\_\_
- xi)** \_\_\_\_\_

6. Describe the procedure for pouring and administering medications.

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7. Describe the procedure involved when ordering new medications.

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8. Explain the procedure involved in refilling prescribed medication.

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9. Explain the "Destruction of Medication" procedure.

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10. Fill in the blanks with reference to the Medication Administration and Treatment Record.

Enter the legal name of the individual, \_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_ in the appropriate space. Record all prescription medications to be administered with corresponding \_\_\_\_\_ and \_\_\_\_\_ as prescribed. If more than one tablet must be given, record the \_\_\_\_\_ dosage, then in brackets, the \_\_\_\_\_ of \_\_\_\_\_ x the individual tablet dosage. \_\_\_\_\_ each Medication Administration and Treatment Record monthly. No \_\_\_\_\_ or \_\_\_\_\_ to other Staff will be recorded on the Medication Administration and Treatment Record. Do not \_\_\_\_\_ or use \_\_\_\_\_ on Medication Administration and Treatment Records. All signatures, recording and other information in the body of the sheet will be recorded in either \_\_\_\_\_ or \_\_\_\_\_ ink, never \_\_\_\_\_. \_\_\_\_\_ ink is used to discontinue a medication, record a \_\_\_\_\_ or \_\_\_\_\_ allergy, record a medication refusal, and record an \_\_\_\_\_. Red ink is also used to record \_\_\_\_\_ or \_\_\_\_\_ prescriptions in the \_\_\_\_\_ book. For periodic medication, mark a red \_\_\_\_\_ on day not given. Wrong day or time, circle and initial error in \_\_\_\_\_ Ink. All medication incidents are to be recorded in the \_\_\_\_\_ \_\_\_\_\_ in red ink.

At the end of each month, the Medication Administration and Treatment Records will be placed in the \_\_\_\_\_ .

11. How do you indicate a medication refusal on a Medication Administration and Treatment Record?

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12. What form has to be completed when there is a medication refusal?  
\_\_\_\_\_
13. How do you set up a Medication Administration and Treatment Record for a periodic medication?  
\_\_\_\_\_  
\_\_\_\_\_
14. Explain how to record administration of a P.R.N. medication on a Medication Administration and Treatment Record.  
\_\_\_\_\_  
\_\_\_\_\_
15. List the procedure for recording medications while on a leave of absence:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. To discontinue a medication, draw a \_\_\_\_\_ from the last medication given, straight through until the \_\_\_\_\_ on \_\_\_\_\_ line of each given time slot. "Discontinued" is written across the \_\_\_\_\_ of the first line in \_\_\_\_\_ ink.
17. Explain the procedure involved when noting new medications and changes to existing prescriptions on a Medication Administration and Treatment Record.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
18. What is the purpose of the Medication Information Folder/File?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. In an attempt to ensure the health, safety and well-being of all individuals, Staff responsible for administering medication will be required to do a visual check of all medication and MAR (M-7) when \_\_\_\_\_ and \_\_\_\_\_ their shift, to confirm no medication incidents have taken place.

20. Name the 16 items in a Medication Information Folder.

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_
- vi) \_\_\_\_\_
- vii) \_\_\_\_\_
- viii) \_\_\_\_\_
- ix) \_\_\_\_\_
- x) \_\_\_\_\_
- xi) \_\_\_\_\_
- xii) \_\_\_\_\_
- xiii) \_\_\_\_\_
- xiv) \_\_\_\_\_
- xv) \_\_\_\_\_
- xvi) \_\_\_\_\_

21. List four examples of medication incidents:

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_

22. Medication Incident Response:

a) Describe the first step in responding to a Medication Incident.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b) List 3 options that should be considered following step one.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Fill in the blanks:  
If the medication incident is serious, the \_\_\_\_\_ or \_\_\_\_\_ must be contacted directly during office hours. After office hours the \_\_\_\_\_ should be accessed and a \_\_\_\_\_ left with the relevant Supervisor. For non-emergency, Staff will contact the \_\_\_\_\_ or \_\_\_\_\_ via \_\_\_\_\_.

24. Describe the disciplinary action taken when a staff member performs an administration error:

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25. Self administration of medication is an option for individuals.  
a) List 3 options for storage of medications.

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b) List 3 options for documenting self-administered medications.

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26. If an individual requires medication to be administered at the Activity Centre, then:  
a) The designated Residential Support Worker, if applicable, will complete a \_\_\_\_\_ and a \_\_\_\_\_.  
b) A \_\_\_\_\_ month's supply of medication will be provided to \_\_\_\_\_ in a \_\_\_\_\_ labelled container.  
c) Upon receipt of the medication, the designated Activity Centre Staff will \_\_\_\_\_ the medication and \_\_\_\_\_ all information listed on the \_\_\_\_\_.

- d) The designated Residential Support Worker, if applicable, will chart for residential purposes the medication administered at the Activity Centre as \_\_\_\_\_ medication on the Medication Administration and Treatment Record as per “Medications on Leave of Absence.”
- e) In the event an individual who attends the Activity Centre does not receive support through CL-CH Residential Services, the \_\_\_\_\_ will complete a MAR Sheet (M-7) and a \_\_\_\_\_.

27. Answer the following with True or False:

- a) At month’s end, the Day Program Staff will destroy any unused medications. \_\_\_\_\_
- b) The Residential Support Worker or SIL Support Worker will file the Day Program’s MAR Sheet (M-7) and Medication Transfer Form (M-8) in the “Completed MAR File/Folder.” \_\_\_\_\_
- c) When requested, Support Workers will provide assistance to individuals in administering medications when in community employment and activities. \_\_\_\_\_
- d) When transferring medication to the community, Support Workers should ensure they have the prepared medication for the outing/activity, duplicate Medication Administration and Treatment Record (M-7), Medication Transfer Form (M-8), Personal Data Sheet and all other pertinent medication information/supplies. \_\_\_\_\_

28. Draw a connecting line between the recording methods (left) and the appropriate corresponding abbreviations (right):

Recording Leave of Absence	W
Medication forgotten	L.O.A.
Self-administration	PRN
Medication refused	SA
Periodic medication	-----
Medication used only as necessary	R
Discontinuing a medication	X
Witnessed pouring	O

29. Circle items normally included on a container label being prepared for L.O.A. medications:

- |                                 |                            |
|---------------------------------|----------------------------|
| - individual’s name             | - times for administration |
| - individual’s age              | - allergies                |
| - drug                          | - dosage                   |
| - list of possible side effects |                            |

30. Write the abbreviated forms for the following terms:

At bedtime \_\_\_\_\_  
Before meals \_\_\_\_\_  
Twice a day \_\_\_\_\_  
Without \_\_\_\_\_  
Every 2 hours \_\_\_\_\_  
Every 4 hours \_\_\_\_\_  
Tablet \_\_\_\_\_  
In the left eye \_\_\_\_\_

Four times a day \_\_\_\_\_  
After meals \_\_\_\_\_  
Once daily \_\_\_\_\_  
Milligram \_\_\_\_\_  
Three times daily \_\_\_\_\_  
Tablespoon \_\_\_\_\_  
By mouth \_\_\_\_\_

31. On the (mock) MAR sheet below, show the proper recording of the following medication information pertaining to John Smith:

**COMMUNITY LIVING-CENTRAL HURON**  
**MEDICATION ADMINISTRATION AND TREATMENT RECORD (MAR)**

Prescribed Medication, Dosage & Time (as per container/package label)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

LEGEND: O = Omission / R = Refused / X = Periodic / LOA = Leave of Absence / SA = Self-Administered / W = Witnessed

CHART FOR: \_\_\_\_\_ LOCATION: \_\_\_\_\_ MONTH: \_\_\_\_\_, \_\_\_\_\_ Page \_\_\_ of \_\_\_

- i) Seroquel, 25 mg. Take 1 tab once daily @ 0800 hrs.
- ii) Prepulsid, 10 mg. Take 2 x 5 mg. tablets twice daily @ 0800 hrs & 2000 hrs. Discontinue on the 15<sup>th</sup> & start Prepulsid, 5 mg. Take 1 tab twice daily.
- iii) Sofracort ear drops. Instill 2 drops in each ear every other day @ 2000 hrs.
- iv) John has an allergy to Penicillin.

Revised: Dec. 2015