FAMILY VISIONS INCORPORATED
POLICY AND PROCEDURE MANUAL

<table>
<tr><td rowspan="3">POLICY:

MEDICATION ADMINISTRATION</td><td></td><td>POLICY NO: HR-024</td></tr>
<tr><td>DATE Issued:
September 28, 2011</td><td>PREVIOUS POLICY NO/NAME:
Medication Administration
HR03-280</td></tr>
<tr><td>DATE Reviewed:
March 16, 2022</td><td>RELATED DOCUMENTS:</td></tr>
<tr><td>APPROVED BY:
Board of Directors</td><td colspan="2">DISTRIBUTION: Human Resources

APPLICATION: Family Visions Employees</td></tr>
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POLICY:
It is recognized that most Supported Individuals require medication for various reasons. Agency staff will adhere to Residential Care Licensing regulations pertaining to medication labelling, administration, record keeping, incident reporting, storage and disposal to ensure quality care and the safe administration of medications in the home.

Objective
To provide simple and easy to understand information about Supported Individuals' and their medications (including the expected outcomes, potential adverse effects and drug interactions, the risks and consequences of non-compliance, and when medications may be discontinued to ensure the safe and proper use of medications.)

Care providers administering medications will:
1. Adhere to current best practice and professional standards.
2. Monitor the effectiveness and interactions of medications including consultant/clinical pharmacy services.
3. Prevent, monitor, promptly respond to and report any adverse events resulting from medication use.
4. Where appropriate, support in the self-administration of medications.

PROCEDURE:
Receiving from Pharmacy
1. Team Leader/designate is to check medications to Medication Administration Record (MAR) for any errors.

Administering Medication
1. Wash your hands.
2. Cross reference the information on the bubble pack/prescription bottle with the medication administration record of each of the following:

a) before removing the medication from the package,
b) before giving the medication to the individual,
c) In addition, after giving the medication to the individual.

3. For the safety of staff and members, do not handle medications. Dispense medications accordingly:
    a) Pills into a medication cup or individual's hand.
    b) Liquid on a medication measuring spoon
    c) Ointments on a Q-tip
    d) Suppository as directed

4. Administer medications in a safe and respectful manner.
5. Pills and liquid
    a) Give the medication directly to the individual and observe the medication being taken.
6. Ointments
    a) Wear gloves. Use swabs, gauze or other as directed.
7. Suppositories
    a) Administer in a private room where the person is comfortable, safe, and their dignity is respected.
8. Safely dispose of any tissue, gauze, swabs or other material used in administering medications.
9. Wash hands, initial the medication administration record and lock the medication cabinet.

When administrating Medication always follow the 5 R's:

1. **RIGHT PERSON -** Only give medication to the person for whom it is prescribed.

2. **RIGHT DRUG -** Often drugs have more than one name. Check the name of the medication.

3. **RIGHT DOSE -** Make sure the dose of the pill is the same as the dose of the prescription. Too much/little of a medication can be just as harmful as taking the wrong medication.

4. **RIGHT ROUTE -** Ensure all medications are administered in the manner in which they are intended. The most common methods of administration are orally, anally, and topically (on the skin).

5. **RIGHT TIME -** Medications are given at specific intervals to maintain the optimum effectiveness in the body. There is a one-hour "window" of time before and after the administration time stated on the drug order. For example, if the drug order states that the medication is to be given at 8:00, the medication may be given as early as 7:00 or as late as 9:00. Any earlier or later is considered a medication error.

6. **RIGHT DOCUMENTATION** – ensure the MARS sheet is initialed next to the medication administered by the staff administering the dose.

Change of Shift Medication Check

Any employee commencing a shift must check the medication administration of the previous employee by documenting their compliance to the following procedure:

1. Cross-reference the information on the bubble pack/prescription bottle with the MAR sheet ensuring that the medication has been administered and documented correctly.
2. Make an entry in the individual's logbook stating that the change of shift medication check was conducted at (state the time) and no errors were found. Sign.
3. **If a documentation error is found**, the employee going off duty may make a correction on the MAR sheet prior to leaving. Entry in logbook in this case would state that documentation error found and corrected by the employee-leaving shift. Sign.
4. **If an administration error is found**, call the pharmacy, health links (1-888-315-9257), or hospital, and explain the nature of the error. Entry in the logbook would state that an administration error had occurred and record the pharmacy or hospital's recommendation in the logbook. Sign.
5. Complete the necessary incident report.
6. If there is no one coming on shift prior to the previous shift leaving, the next employee on shift must complete the medication check, enter his or her findings in the logbook and sign.

General Medication Information

All prescription medications can only be prescribed by a qualified physician or licensed prescriber.

Pro re nata (PRN) and non-prescription medications must be approved in writing by a qualified physician, licensed prescriber or dispensing pharmacist prior to administering the medication. (An over the counter medication form is kept with each person's medication information and must be checked with the physician and/or pharmacist at least annually).

All staff must be familiar with the medications they administer. An information sheet is provided by the pharmacy on all medications. It briefly explains the positive and negative effects of the medication. It is essential that all staff is familiar with this information, as you will be the first to notice any adverse effect.

All medications must be packaged in bubble packs by the pharmacy.

Supervisor/designate must monitor supply of medication to avoid lapses in medication supply.

Discontinued Medications and Dosage Changes

A medication can only be discontinued or changed by a physician.

Discard discontinued medications as the physician recommends. Write, “discontinued” on the medication administration record and draw a line starting at the time the medication is discontinued.

If the dosage is changed, write “dose change” on the medication administration record and draw a line starting at the time the dosage is changed. Start initialing on the date of the new dosage.

Any medication no longer authorized for use by the prescribing physician is to be taken to the pharmacy for disposal.

Medication Questions

A pharmacist must be contacted with any medication questions. **NEVER GUESS**. In the event of a medication administration error, call the pharmacy, health links, or hospital before taking any further action. Include their recommendations on all incident reports involving medication errors.

What is a medication error?
A medication error has occurred when **ANY** of the medication administration steps has not been followed. This can increase the risk of harm to the Supported Individual and/or staff.

If a medication error occurs, an incident report must be written and submitted as outlined in the Incident Report Procedure as referenced in Residential Care Licensing.