MEDICATION POLICY & PROCEDURES

PURPOSE
To establish policies and procedures for the administration (giving to the person), storage (put away properly) and dispensing (handling while giving) of medications.

SCOPE
These policies and procedures cover medication administration and treatments, as well as storage and dispensing for all people receiving supports and employees/staff. LADD does not prescribe medications.

POLICY
Medications must be properly secured, stored and dispensed at all times at all program locations. All employees must follow the procedures below and only trained staff can administer medication. Medication can have significant impact on the person's overall state of health, behavior, and the ability to prevent, combat, or control disease. There are two main categories of medication: prescription and non-prescription (over the counter).

1. Prescription medications (prescription drugs) include all drugs which must be prescribed by a person licensed to do so by the State of Michigan (e.g., physician, dentist) and dispensed by a pharmacist.
2. Non-prescription or "over the counter" medications (or drugs) include all drugs which do not need to be prescribed by licensed Health Care Professional and dispensed by a pharmacist. A person can buy the drug over the counter in a store and medicate themselves.

All drugs given in community residential settings (ex: group homes, vocational programs, adult foster care, and contracted supported independent living) are considered to be prescription medication. All medications administered must be prescribed by a person licensed to do so (i.e. doctor, dentist). Over the counter medications are approved by the licensed Health Care Professional by signing the Protocol Orders. If Hospice services are approved for a person supported; then Hospice is the authorized/licensed health care professional.

Prescription medications are further divided into sub-categories: controlled and non-controlled.

1. Controlled Medications (controlled drugs): these are prescription medications which have been legally designated "controlled substances." Drug control agencies have considered drugs in this category to have a high potential for abuse. Codeine, Dexedrine, Valium, and Librium are some controlled substances. As drugs are identified as having a high potential for abuse, they are placed on the Controlled Substance list. There are special procedures for handling controlled substances listed below in this document.
2. Non-controlled medications or drugs include all other prescription drugs that do not appear on the list. This does not mean that all drugs not on the controlled list have been tested and found to have no potential for abuse. A drug can be placed on the list or moved from one list to another as findings about the drug are documented.

<u>CONSEQUENCES OF DRUG MISUSE OR ABUSE</u>:
Drug Misuse is when a staff does not follow medication procedures and/or medications are not accounted for at any time. Improper medication administration can be life threatening; and therefore, staff are held accountable for their actions or mistakes. Police may also be contacted any time medications are missing. Taking a person's supported medication is a criminal offense.
Drug Abuse refers to using a medication in a manner other than that for which it was intended.

1. *Physical dependence* (addiction): Without the drug, the person experiences withdrawal symptoms. When the drug is re-administered, the withdrawal symptoms disappear. For example, a person who is use to having three cups of coffee each day may have a headache and a tired feeling when caffeine is withheld.
2. *Psychological dependence* (habituation) is an emotional dependence upon a drug. The dependence may range from a mild desire for a drug to compulsive use. The person prefers the drug-induced feeling. For example, a person could have an emotional dependence on the need for pain relievers. The person could begin to believe that s/he cannot function without it.
3. Drugs which have beneficial medical effects also have the potential for abuse. These drugs are often abused because they alter one's state of mind. The major categories of drugs that have the potential of drug abuse are:
   • Narcotics (heroin, morphine, Demerol)
   • General central nervous system depressants (barbiturates, alcohol)
   • Central nervous system stimulants (cocaine, amphetamines)
   • Mind-altering drugs (LSD and marijuana)

Functional impairment is when the body can no longer function normally without the drug. For example, overuse of laxatives will prevent normal movement of the bowels. *Overdose (accidental or intentional)* is when a person receives too great of a dose (as of a Therapeutic agent), or a lethal or toxic amount (as a drug); an excessive quantity or amount as prescribed or intended. Overdose (OD) happens when a toxic amount of a drug, or combination of drugs overwhelms the body. People can overdose on lots of things, including alcohol, Tylenol, opioids or a mixture of drugs.

LAWS

There are laws governing every aspect of drug therapy. The Department of Community Health (DCH) has issued specific guidelines regarding medications used to decrease some thoughts, feelings and behaviors (psychotropics) and medications used to decrease seizures (anticonvulsants). See Psychotropic Procedure in this document.

1. All medication must be prescribed by a person licensed to do so by a State Regulatory Agency. (i.e., doctor, dentist, neurologist)
2. In order to administer medication, there must be a **consent** signed by the parent or guardian stating that LADD employees/staff may administer medications once trained. Employees must have taken and successfully completed medication **training** with LADD or Contract Agency approved courses.
3. Any person has the right to refuse medication. The refusal must be reported and documented appropriately. Rarely, a decision to force medication is made by the physician, and provisions for this are included in Michigan Mental Health Code. **Never force a person to take medication; he or she has the right to refuse medication.** Safety is the prime concern when administering medications.

PROCEDURES

LADD is responsible for the receipt and dispensing of medication in programs. The following procedures address the administration, dispensing, maintenance and all other aspects of medication used in the programs. The following is offered for clarification and understanding with the procedures outlined more thoroughly in this document:

- The safety of the individual served is the prime concern when administering medications. LADD follows the pharmaceutical recommended training **6 Rights of Administering Medications**. Other courses may include the old format of "5 Rights"; however, the 6th Right of insuring the 'Right Documentation' is best practice; and therefore, needs to be followed. When administering any medication or treatment, you must follow the "**6 Rights**": **DO IT RIGHT - THE 6 RIGHTS:**
    1. Right Person,
    2. Right Drug,
    3. Right Dose,
    4. Right Time,
    5. Right Technique/route and
    6. Right Documentation.

    If any of the "6 Rights" are violated, this constitutes a medication error.
- Medications may be classified as Non-PRN, PRN and/or Treatments. Administering and documenting these medications are outlined in this document:
    - **PRN** – is an abbreviation that stands for the Latin phrase '**p**ro **r**e **n**ata' meaning 'in the circumstances or as circumstances arise' (Wikipedia). It is abbreviated PRN in reference to dosage of prescribed medication that is not scheduled at a specific time or on a routine basis. Instead, the decision is left to the care giver/staff to administer when they see symptoms arise. NEVER give a PRN as an ongoing daily dosage. If they continue to have symptoms (usually no longer than 3 days unless the physician says otherwise) then the person needs to be seen by a physician immediately.
    - **NON-PRN** - therefore means medication that is taken on a scheduled, routine basis; usually daily.
    - **TREATMENT** – means a specific ordered treatment for a person supported that may be routine or may not be routine, i.e., could be both non-prn and prn so staff need to ensure to follow the specific directions. These may be documented on an actual 'Treatment Record' and/or on the NON-PRN or PRN Record. Examples of treatments may be taking blood pressure, nebulizers, inhalers, diabetic blood sugar check, dandruff shampoo, weekly weight check, etc.
- The major routes of medication are oral, injectable, topical, inhalants, rectal, and vaginal. Always know what technique and/or route that medication is to be given.
- Common dosage forms are capsules, tablets, liquid, ointments/creams, inhalants, suppositories, and elixirs.
- All medications must be stored in the original containers in which a licensed pharmacist dispensed them and/or original packaging.
- All medications must be stored in locked compartments under proper temperature controls in LADD Programs.
- Only one (1) employee/staff holds the key who is responsible at all times for medications and safety/security.
- Internal and external medications must be stored in separate compartments/shelves.

- Medications requiring refrigeration must be stored in a locked box in the refrigerator.
- Employees will not touch medications with bare hands.
- Employees will follow all the L.A.D.D, Inc. Medication Procedures.
- Transcribing is an important part of administering medications safely. Information from the pharmacy label must be accurately transcribed on the paper Medication Record back-up version located within the Medication Record Book, as well as electronically on the Medication Administration Record (MAR) within the electronic health record (EHR) system.
- Medications documented on the electronic Medication Administration Record (MAR) within the EHR system must be completed by the person administering them at that time of administration.
- Never administer a medication prepared by another staff person.
- Abbreviations and symbols are shortened forms of words. Common abbreviations and symbols used will be trained to staff and available for reference at the end of this document.
- This Medication Policy and Procedures need to be in the Medications Record Book for staff reference. It is also located in the On-Line Resources within the electronic LADD Directory for review.

PSYCHOTROPIC MEDICATIONS AND INFORMED CONSENT

"Psychotropic medication" means a prescription drug, as defined as a medication that is used to treat or manage a psychiatric symptom or challenging behavior.

Some psychotropic medications fall into specific medication classes like antipsychotics or antidepressants. In other cases, the medications may be primarily used for other diseases but have been found effective in controlling behaviors thus making that specific use a psychotropic medication.

Sometimes people we support will receive an injection at the Contract Agency. These medications should be entered into the individual's Medication History within the EHR system.

Informed Consent

DO NOT FILL THE SCRIPT UNTIL THE FOLLOWING IS COMPLETED

1. When a person is prescribed a new psychotropic medication management must be notified.
2. If not already indicated, management must contact the prescribing doctor to obtain the diagnosis and condition that the medication is treating and note it on the Informed Consent Form and in the person's record.
3. Management must obtain information regarding the medication including adverse side effects and ensure this information is explained to the person or their parent or guardian prior to the person receiving the medication.
4. Have the person, parent or guardian review the information and sign the Informed Consent Form.
5. Give a copy of the information on the drug and its side effect to the person, parent or guardian. If a copy of the drug information is not given at this time, tell them where they may obtain the information for future reference.
6. If the Contract Agency does not provide an Informed Consent Form, the LADD form is available online under Medication Forms.

Informed Consent is required as part of the Michigan Mental Health Code.

PRESCRIPTIONS

When the physician decides that a person requires treatment with a medication, the physician writes the prescription to be taken to the pharmacy (also known as a 'script' for short). A copy of the prescription is necessary for each site where the medication will be given and is kept in the Medication Record Book and available within the EHR system for staff to reference. If the prescription has been electronically transferred to the pharmacy by the physician a copy must be obtained from the pharmacy or the physician for the person's records. If a person is receiving Hospice Services, then Hospice would be the prescribing physician/approved health care provider. See Hospice Checklist.

The labeling of the medication will match the prescription and note if the medication is Non-PRN, PRN, and/or a Treatment. The script, medication label, and Medication Administration Record (electronic and paper back-up) should all match to ensure the correct medication was dispensed and given.

The additional following information about each medication must be obtained before it is given:

1. Purpose of the medication and Therapeutic effect.
2. When should the desired effects be expected to occur?
3. Are there any unwanted side effects? What actions should be taken if they occur?
4. Are there any known drug interactions with drugs the person is currently taking? Are there special administration or storage instructions?

5. Make sure that you inform the physician of the routine of the person so that the time of the medication is given as the physician prescribes as well as meets the person's usual routine, i.e. if medication is to be given with dinner, do not have it scheduled and prescribed at 8pm.
6. Physician considered the "Medication History Report (printed from the EHR system)" of the person supported so they know what medications the person has taken in the past and results.

LABELING OF MEDICATION

All Pharmacist Dispensed Medication must contain the following information:

1. Name of the Person
2. Name of Prescribing Doctor
3. Name of Medication- brand and generic name if applicable
4. Dosage of the Medication (Strength)
5. Directions for Use
6. Name and phone number of the dispensing pharmacy
7. Date Dispensed
8. Number of Pills dispensed
9. Expiration Date
10. There will often times be a 'C' on the package for 'Controlled' substances

MEDICATION ADMINISTRATION RECORD (Medication Records Book, Electronic MAR within EHR)

The Medication Records Book contains back-up Medication Administration Records (MAR) and other medication information on all the people supported at that program. Review the Table of Contents and be very familiar with this book. It will contain items such as copies of prescriptions, pictures of people supported, and medication records for each person. This information is also located within the EHR system on the electronic Medication Administration Record (MAR). The Medication Administration Record (electronic and paper back-up) is used to check thoroughly while administrating medication to ensure you are following the **6 Rights** and will indicate the following:

1. Name of the **Person**
2. **Drug** Name/Brand name and generic name of the medication if applicable.
3. **Dosage** of the Medication
4. **Time** to take the medication.
5. **Technique or Route;** how the person is to take the medication (orally, by injection, etc.)
6. Purpose of the Medication is listed on the medication record.
7. The number of times to take the medication per day (B.I.D., Q.I.D., etc.)
8. If a short-term medication, the number of days to take the medication is clearly marked on the record.
9. **Document** immediately after the medication is given on that person's electronic Medication Administration Record (MAR) within the EHR system. All allergies and medical precautions must be noted in RED on the back-up Medication Administration Record in the Medication Records Book.

STORAGE AND SECURITY OF MEDICATION

1. All medications shall be stored in the original containers in which a licensed pharmacist dispensed them or original package for over-the-counter medications purchased.
2. An area must be identified for the safe, secure storage of medications. Closets or cupboards must be lockable.
3. Medication cabinets:
   a. Shall not be located over heated areas (heat can change the chemical properties).
   b. Shall be kept clean and orderly.
   c. Shall have sufficient storage space and adequate lighting.
   d. Shall be kept locked except when putting in or taking out medication.
4. Medications requiring refrigeration are stored in a locked box in the refrigerator.
5. The designated person on duty must hold and be responsible for the safe keeping of keys. Only 1 staff person can hold the key. A spare set of keys may be held for emergencies but must be locked away by Management.
6. In the event of an emergency while medications are being administered, the medications will be put back into the cabinet and locked before attending to another situation. Medications must never be left unattended/unlocked.
7. Preparations for applicators, syringes, plungers etc. for internal medication use must be stored separately as directed under medication storage instructions and labeled appropriately if the medication has a risk associated, e.g. hazardous if consumed or contact with skin. Reagents (a product used in preparing a medication) must be stored in a locked cupboard.
8. Each person's medication must be stored in a separate, clearly labeled container, basket or other storage unit.

9. Blister Pack storage of multiple NON-PRN Medications should be secured preferably via a large metal ring (can be purchased at any office supply) by each dosage time; i.e., all 8am blister packs are secured by 1 ring, 8pm separate ring, etc., or within in a separate container clearly labeled with times medications are to be administered and dispensed.
10. All external medications including topicals (i.e., ointments, salves, etc.) must be stored separately from internal/oral medications. This means in a separate basket and/or container from orals so no creams, etc. leak onto other medications and then could be ingested.
11. Liquid medications must be stored in a separate basket on a lower shelf (if applicable) to prevent spillage into or on other medications to prevent it from accidentally being ingested.

ADVICE ON MEDICATIONS AND ADVERSE REACTIONS

1. If there is any confusion or question about what medications or doses are to be given, Management or PCT should make every effort to clarify the details with the Health Care Professional who prescribed the medication. Advice can also be sought from the pharmacist if the Health Care Professional or Nurse cannot be contacted.
2. Each location should have one pharmacy designated as the program's main pharmacy to supply medication. If the pharmacy is not open on weekends, then a secondary pharmacy option must be available for emergencies.
3. The Patient Information Leaflet (PIL) within the medication packet contains information about the medicine and how it works. This information is entered into the EHR system so that all medications have information regarding effects, overdose, etc. This information can also be obtained by utilizing online resources, such as from the pharmacy website or other reputable medication websites.
4. Side effects for each medication are listed on the electronic Medication Administration Record (MAR) within the EHR system.
5. When a person is displaying adverse drug reactions to the medication(s) he/she was given, the doctor who prescribed the medication must be notified immediately. If the person is having difficulty breathing or displaying a life-threatening reaction **911 is to be called immediately**.
6. In notifying the doctor, the staff will have the following information available for the doctor:
   a. Dosage given
   b. Date & time the medication was given
   c. What kind of an effect the medication had on the person
   d. Name, dosage, and time of the other medication(s) the person is taking.
7. The staff is to document within the HCC and electronically within that person's individual T-Log within the EHR system and follow the doctor's recommendations.
8. The doctor will be reporting the adverse reaction to the Federal Food and Drug Administration.
9. The Manager must be notified immediately.
10. An Incident Report must be written immediately and submitted.
11. The Guardian, Contract Agency nurse and Supports Coordinator/CSM are notified if applicable.
12. Any discontinued medications must be noted in the EHR Medication History to maintain a current ongoing medications list, as well as the Person's HCC. This is also documented within that person's individual electronic T-Log within the EHR system. Make sure to document all adverse reactions so the person never receives this drug again. The Ongoing List of Medications that is printed from the EHR Medication History needs to be reviewed by the person's physician.

CONTROLLED SUBSTANCES

******It is EXTREMELY important that Controlled Substance counts are verified by a 2nd staff. Any Controlled Substances or medications missing at any time require immediate investigation which may include contacting Police. It is against the law to take any prescribed medications of a person supported.

1. All medications are checked in using the Medication Check-In sheet, the HCC, and entered electronically within that person's individual T-Log within the EHR system. The delivery count is also to be added to the Controlled Substance Count Sheet on the line of the date of delivery. Controlled Substances are labeled as such on the packaging. Ask the pharmacy if you are unsure if a medication is a controlled substance and also check the controlled substance list in the Medication Records Book Some pharmacies may have their own medication check in forms that we may also use.
2. Controlled substances delivered to a program must be signed by the delivery person on the Check-In sheet. Staff should initial beside that record of all controlled substances received and include date of receipt, name and address of vendor, type, (capsule, liquid, solid, etc.) and quantity of drug received**.** This includes from a parent/guardian upon the return of person supported from a visit away from the program.

3. When possible, two staff will check the controlled substance at the time of receipt. (Some programs only have one staff on duty so the medications will be counted by the next shift staff person when they arrive, and documentation will occur on the Controlled Substance Count Sheet.)
4. The staff is to check and see if this medication is listed on the Medication Record Sheet in the Medication Records Book; if not it must be added to the paper back-up version, and Management is to be notified to ensure medication is added to the EHR Medication History to maintain a current ongoing medications list. Management will also update the Medication Administration Record (MAR) within the EHR system.
5. The assigned medication person will count controlled substances at the end of each shift with the new staff coming on as well as anytime the medication key changes hands. 2 employees must sign off verifying the count.
6. Controlled substances should only be counted by one blister pack/bottle/prescription at a time and must be kept in original packaging.
7. Pharmacy recommended count procedure for blister packs is to count backwards, starting at the bottom right corner of the card. When administering medications, staff should initial and date the card as well as the electronic Medication Administration Record (MAR) within the EHR system to help with the count process. This is an excellent double check system.
8. Once medication has been counted, it is to be placed back into the medication cabinet in the correct medication tray. Staff should never count more than one controlled substance at a time, and 2 staff must sign acknowledging that all controlled substances are present with no missing doses.
9. All necessary consents and acknowledgements must be obtained prior to the administration of the first dose.
10. Medication is to be administered as prescribed and documented accordingly as trained.

MEDICATION FOR NEW ADMISSIONS

1. An adequate supply of medications must be brought by the person, guardian or Contract Agency upon admission to any programs that require LADD Personnel to administer medications. The list of medications must be signed of what was received.
2. All medications must be in the original containers following our labeling of medications procedure.
3. All medications must have a copy of the prescription from the prescribing physician.
4. Within thirty days of admission to a licensed facility each person will attend an Annual Health Review with the Primary Care Physician. If the person is moving into a Supported Independent Living program and has already received a physical within the last year, then LADD will just need to obtain a copy of the Annual Health Review and does not have to attend another Health Review until the next due date.
5. If medications are not brought to LADD in the approved manner or are unable to be verified, Management will contact the prescribing physician or Primary Care Physician immediately.
6. All medical information will be documented in the Health Care Chronological (HCC).
7. A list of current Medications is reviewed upon admission with the person, guardian, and Contract Agency, and is to be documented in the person's record.
8. Management is to enter the medications into the person's EHR Medication History and configure the electronic Medication Administration Record (MAR).
9. Scripts are to be scanned into each person's electronic Medication History, and the hardcopy is placed in the Medication Records Book.

ORDERING

1. The routine ordering of the repeat prescriptions should be done by the Manager or designated member of staff if needed. Some pharmacies deliver medications each month without ordering.
2. Prescriptions must be sent to the pharmacy within 24 hours for the medication to be prepared and delivered in time to start the new supply. The pharmacist will be able to advise how long this will normally take. It is important not to over-order as this can happen such as when medications are taken infrequently; for example, pain relief prescribed PRN or as needed.
3. Check the amount already in stock. If there is enough of the medicine to last until the next weekly or monthly order, do not reorder. It is unacceptable to return unused medicine each month to the supplier and at the same time request more supplies.
4. When medications are received from the pharmacy they should be checked against the medication list that was used for ordering (if applicable). Some pharmacies deliver each month without having an order placed.
5. Medications received should be checked:
    a. To ensure that all medications ordered have been received and the correct number of pills is in bottle/on card. (Quantity)
    b. To ensure that no new medication has been added by mistake.
    c. To ensure that the prescription matches the medication bottles. If the medication received is different from what was expected, check with the Pharmacist before giving it. (i.e. Color, shape, etc.)

6. If a supply of someone's medicine cannot be found:
    a. Is it in the extra supply basket?
    b. Has it really run out, or has it just been put back in the wrong place?
    c. What will happen if the person misses a dose? (Verify using the Standing Missed Medication Orders.)
    d. If the new supply of the medicine is really out immediately contact the pharmacy.
    e. If the Prescription has expired contact the Health Care Professional immediately. Medications cannot be given without a current prescription.

TELEPHONE MEDICATION ORDERS

Occasionally in emergency situations a physician may need to give an order for medication without seeing the person. Since only persons licensed to do so can receive telephone orders for medication, the procedure is as follows:

1. Ask the physician to call the medication order in to the pharmacist. (The pharmacist records the order, dispenses the medication and then files the order for future reference.)
2. Carefully document in the person's record/HCC:
    a. Time and date of emergency
    b. Detailed description of the emergency
    c. Name of physician contacted, and any instructions given
3. Obtain the medication from the pharmacy.
4. Ask the pharmacist for a copy of the phone in prescription for the person's record.
5. After obtaining the medication from the pharmacy, record in the person's Med Check In sheet all the information on the prescription pharmacy label, as well as within that person's electronic individual T-Log in the EHR system. Management will enter the medication and all the information on the prescription pharmacy label within the person's EHR Medication History and update the electronic Medication Administration Record (MAR)

RECEIPT OF MEDICATIONS

1. It is the responsibility of the manager or designated member of staff to review, and log-in medication required for each person for whom medication is prescribed. If this happens on the weekend, the staff who took medications needs to sign it in and let the manager know.
2. All medications brought into a service area must be checked against the person's Medication Administration Record (MAR) to ensure that it corresponds with their current medication and adhere to the following:
    a. The medication in the container supplied by the pharmacist is the correct medication. You need to look at a picture of the medication and the name. Make sure to question anything that does not look correct. Pharmacists are people and can make mistakes!
    b. A correct and legible (able to read) label on the container.
    c. A written physician's order/prescription for the medication.
    d. Any additional instructions the physician or pharmacist has given you.
3. All medications brought into a service location must be recorded on the Medication Check in Sheet and the HCC that is kept in the program, or by using the delivery manifest received from the pharmacy. Medications delivered are also recorded within that person's individual electronic T-Log within the EHR system.
    a. Date medication was received
    b. Name and strength of medication
    c. Quantity received
    d. Name of the person the medication is for
    e. Signature of management or PCT who received and checked the medication in.
4. All medications must be stored in a separate locked area/basket until they are needed and then they must be transferred to the appropriate basket.
5. Bulk supplies must not be kept or ordered.
6. The manager or designated staff at the service location must ensure continuity of supplies by requesting repeat prescriptions when necessary.
7. Medications that are prescribed for 'PRN' (as needed) use may not need to be ordered every month. The Protocol Orders signed annually by the physician are considered the prescription for the use of any PRN medications. Only medications on the Protocol Orders may be used.

AUTOMATIC STOP ORDERS ON MEDICATION

All prescribed medications, which are not time limited or prescribed for a certain number of days or dosages must have an automatic stop order. An automatic stop order is a date the medication will be discontinued unless renewed by the physician with a NEW script. Protocol Orders are generally over the counter medications for non-emergent conditions.

1. All prescribed medications will be reordered every ninety days unless otherwise indicated.
2. Protocol Orders will be renewed annually unless otherwise indicated.
3. No Medications will be discontinued without authorization from the physician.

SAMPLES

Occasionally a physician gives out samples. All procedures should be followed.

1. Ensure that the MAIR is filled out completely listing all the information regarding the medications.
2. It is the responsibility of the manager or designated member of staff to review, and log-in medications required for each person for whom medication is prescribed.
3. The sample medication, for storage purposes, will remain in the container supplied by the physician's office.
4. Ensure an identified sample medication container is labeled with a copy of the MAIR or physician's order.
5. A written physician's order for the sample medication or a copy of the prescription from the prescribing physician is maintained in the Medication Book and scanned into each person's EHR Medication History.
6. Any additional instructions the physician or pharmacist has given are included in with the sample medication container and maintained in the Medication Book.
7. All medications brought into a service location must be recorded on the Medication Check in Sheet and the HCC kept in the program. This is also recorded within that person's individual electronic T-Log within the EHR system.
    a. Date medication was received
    b. Name and strength of medication
    c. Quantity received
    d. Name of the person the medication is for
8. Signature of management or PCT who received and checked the medication in.
9. All medications must be stored in a separate locked area/basket until they are needed and then they must be transferred to the appropriate basket.
10. A count sheet should be started for all Samples since they are not in a Blister packet or labeled bottle to ensure an accurate count of medication at all times. Make sure the samples are clearly labeled with information needed for administering them per the prescription order.

MEDICATION/DRUG RECALL

Every bottle of medication has a lot number on it. The pharmacist will contact the Program or Manager when the Pharmacy receives notification that a batch of medication has been contaminated or any other errors. The medication will be returned in the bottle and receive a new refill. It is important to ask what side effects the person could display from the medication. The Manager must be notified immediately. Prescribing Physician, Guardian, Contract Agency nurse/Supports Coordinator (if applicable) must be informed as soon as possible and Incident Report written. This must also be noted in the HCC of the person supported, as well as recorded within that person's individual electronic T-Log within the EHR system.

MEDICATION ADMINISTRATION

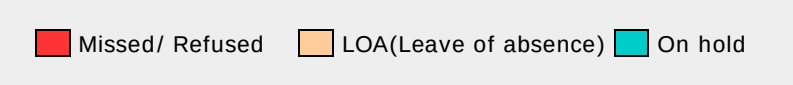
Medication will be dispensed only by staff that have attended and successfully completed the PIHP/Contract Agency/LADD approved medication training. If requested by the person -supported or their guardian LADD will advocate or set up advocacy training for the person receiving supports to assist them in being actively involved in making decisions related to the use of their medications. Each person supported attends medical appointments and prescribed medications are reviewed at that time with the person, LADD staff and/or guardian.

The following procedure **MUST** be followed during **MEDICATION ADMINISTRATION:**

1. Wash your hands! Make sure hands are clean before preparing and administering medication. Medications are not handled with bare hands. The area in which you are preparing medications must also be clean.
2. Make sure others know you are about to administer medications and cannot be interrupted.
3. Do not administer a prescribed medication no more than 30 minutes before scheduled medication time, or 30 minutes after that time. If numerous attempts have been made and the 1/2-hour limit has passed, then follow the Missed Medication Procedure (SMMO).
4. Do not prepare more than one medication at a time.

5. If at any time you must leave the area in the process of giving medications, you must lock all medications in the cabinet before leaving the area.
6. Make sure you have the electronic device in front of you to complete data entry on the Medication Administration Record (MAR) within the EHR system, using the Medication Records Book as back-up in the event of power or internet outage.
7. Check the electronic Medication Administration Record (MAR) within the EHR system to make sure another staff has not already given the medication. If there is a documentation error, follow the Medication Error Procedure in this document.
8. Check the electronic Medication Administration Record (MAR) within the EHR system for the **Right Person,** the **Right Drug** in the **Right Dose** at the **Right Time** via the **Right Technique** or route, and **Right Documentation**. (P, double D, double T, D)
9. Check the label of the medication container to make sure that this matches the Medication Record so that you give the **Right Person** the **Right Drug** in the **Right Dose** at the **Right Time** via the **Right Technique** or route and it was the **Right Documentation**. (P, double D, double T, D)
10. Dispense medication into approved vessel; examples: top of medication bottle cap, paper cup, liquid medication measured cups, and/or as indicated by person specific medication instructions.
11. Follow directions for dispensing the medication. (There may be instructions such as "Shake Well" or "Give with a full glass of water.") If a measured dose is to be given (such as liquid medication), always use a measuring spoon/cup/dropper designed for that purpose, never a kitchen teaspoon or tablespoon. When using a cup to measure liquid medications, place the cup on a level surface at eye level before pouring the liquid and pour the liquid away from the label of the bottle so if it drips, it does not obstruct the label.
12. Make sure the medication does not appear different from the last time you administered this medication; if it does, **STOP**, double check with the pharmacy to ensure it is the correct medication.
13. If medication comes in prepackaged dose form (examples: bubble pack, blister pack), ensure that the package indicates the date the medication was last administered.
14. Once a medication leaves its original packaging it cannot be returned, it must be disposed of following Medication Disposal Procedure in this document.
15. Make sure you have the **right Person**. Have the person come or be brought to you, if possible. Check for a picture of the person on the electronic Medication Administration Record (MAR) within the EHR system, or the Medication Records Book.
16. Assist (as needed) the person in taking his/her medication, letting them know what medication they are taking and why it is prescribed to them.
17. Position the head correctly if necessary to aid in the swallowing process. Pills should be ingested while in an upright position.
18. Give 4-8 ounces of water or other approved fluid/food to aid in swallowing tablets, capsules or liquids.
19. If a person has difficulties swallowing the tablet, capsule or liquid, notify the nurse (if there is one) or call the pharmacy.
20. Remain with the person until you are sure he/she swallows the medication. Notice if they are keeping it in their cheek or not swallowing it completely.
21. Medications should be followed by at least 8 oz of water, and person supported should avoid the supine position i.e. laying down for at least 30 minutes after ingesting a medication to prevent pill Esophagitis (oral medication residue causing inflammation or chemical burn to the esophagus lining, due to the residue from medication not being washed down with water).
22. Some medication is not meant to be swallowed but must be held in the mouth (such as lozenges, nitroglycerin capsules.) Stay with the person to be sure they just hold the medication in their mouth and do not spit it out or swallow it whole.
23. Make sure that after medication is given, the container is secured and the medication is returned to the proper place. If it is a bubble pack; staff date and initial the back of the card above the corresponding number/day before returning to storage. See Documenting Medication for more information.
24. All medications must be administered according to a physician's written order (i.e. prescription). No medication will be discontinued without written order of a physician (i.e. Discontinued prescription, MAIR, After Visit Summary, Hospital Discharge Instructions)
25. A person has a right to refuse medication. If person refuses or does not take their medication at the specified time for some reason, try re-approaching within the time frame of the Standing Missed Medication Orders (SMMO) located in the Medication Record Book and document on the electronic Medication Administration Record (MAR) within the EHR system and in the Health Care Chronological (HCC). If Person refuses medication or does not get medication in the specified time limits, write an Incident Report and record within that person's individual electronic T-Log within the EHR system so that Management can follow up with the doctor as necessary. If this is an ongoing problem, make sure it is addressed with the person's physician, guardian, and case management/coordinator.
26. **DOCUMENT** - The first time you document the administration of a medication, sign your name, title, and initials once at the designated location on the Administering & Dispensing Medication Signature Sheet.

27. **DOCUMENT** - Immediately after the medication is given staff must complete entry on the electronic Medication Administration Record (MAR) within the EHR system.
28. For documenting on the electronic Medication Administration Record (MAR) **- DOCUMENT** the following codes as warranted are to be used:



When using these codes an explanation must entered by using the "Detail Mode" on the electronic Medication Administration Record (MAR) within the comments section. When using codes for missed medications documentation is necessary in the HCC, as well as on that person's individual electronic T-Log within the EHR system.

General Procedure for Documenting Medication Administration – (the 6th Right)

1. Documentation must be legible when using the paper back-up. Observe the rules of general documentation, i.e., never erase, scribble, or use white out/only write in Blue/Black ink. Red ink is only used for Allergies or dis-continued (DC), or other important order changes. All forms must have the name of the person receiving the medication on them.
2. Medications must be used only for the people they are prescribed.
3. All medications administered, prescription and over the counter, must be documented electronically within the EHR system by the person administering them.
4. FOR BUBBLE PACK DOCUMENTING:
   a. Bubble packs come prepared by the number of days in the month so the number next to the medication bubble should correspond with the date of the month it is administered. Staff must initial and date the back of the bubble pack above the corresponding number as well as complete entry on the electronic Medication Administration Record (MAR) within the EHR system. If a person is in the hospital/away during a med administration time in which they will not receive the medication; leave medication in the proper bottle/pack, then it should be noted on the card, in the HCC, and entering the explanation on the electronic Medication Administration Record (MAR) by using "Detail Mode" so they all correspond. This is also recorded within that person's individual electronic T-Log within the EHR system.
   b. Controlled Substances only are dispensed by the pharmacy in a 30-day supply regardless of the number days in a month.
   c. Documentation for Controlled Substances occurs 'reversed'; i.e. 30 to 1 rather than 1 to 30 on a card and **will NOT** necessarily correspond with the date. It is meant to **ALWAYS** match the count sheet. Therefore, the date the staff places on the back of the card next to the number of the pill may NOT be the same date/day administered.
   d. The Controlled Substance Count Sheet must be completed from 1 shift to the next by 2 Staff who are the responsible medication person who is also receiving the key confirming that all Controlled Substance Medications are present/ in place. If working more than one scheduled shift, i.e. double, this needs to be documented in the comments section of the Controlled Substance Count Sheet.

See the following **Medication Administering Step by Step Instructions* located in this document for more details:

1. Oral Medications
2. Topical Medications
3. Eye Drops/Ointment
4. Ear Drops
5. Nose Drops or Spray
6. Rectal Suppository Medications
7. Vaginal Medications
8. Medical Abbreviations commonly used

PROTOCOL ORDERS/ PRN

Protocol Orders/PRN (sometimes called Standing Medication Orders) is a list of orders that are to be used only 'as needed' based on specific signs & symptoms that person may be experiencing. PRN is an abbreviation that stands for the Latin phrase 'pro re nata' meaning 'in the circumstances or as circumstances arise' (Wikipedia). Protocol Orders are a list of medications that the physician has approved to be given 'as needed' or 'as circumstances arise'. Protocol Orders are periodically reviewed (at a minimum annually) and signed by a health care physician and/or may be on a separate prescription. These are usually over the counter medications that are signed by a health care professional for approval for the person's use during non-medical emergency illnesses or treatments needed.

These can also be treatments/medications that have separate prescriptions written for them if they are to be used as needed' (PRN) rather than an ongoing treatment/prescription (NON-PRN). These are important to be reviewed since the Health Care Professional will review any allergies the person may have and their current prescribed medications for any adverse side effects before approving. Examples of times protocol orders may be used are for headaches, nausea, bowel movements, applying lotions, ointments for re-occurring rashes, etc. Signed Protocol Orders and/or prescriptions are located in the Medication Records Book, as well as within the individual's electronic Medication History within the EHR system. They may be documented on the electronic Medication Administration Record (MAR) within the EHR system. If a person supported is experiencing symptoms of any non-medical emergency illness or need a specific 'as needed'/PRN medication/treatment staff are to:

1. Check the person's Protocol Orders for which medication to use based on the symptoms. **NOTE:** If it is a prescription medication being used as a PRN; ask for a written order detailing the symptoms that must be observed prior to giving the medication. For example, Vicodin given for pain as needed must have a written order stating how pain is defined for this person, i.e., what a staff would look for in particular prior to giving the medication; especially working with a person who cannot speak. This would be a detailed description of how this person exhibits pain such as tightening of the face, moaning/crying, etc. Also ensure that the order includes maximum amounts per day/time, etc.
2. Follow the directions on the over-the-counter container and/or any other specific instructions noted on the written orders.
3. Follow the **6 Rights** of Medication Administration making sure you have the (**P, double D, double T, D**):
    1) **Right Person** who needs the medication
    2) **Right Drug**/medication based on their symptoms & protocol orders
    3) **Right Dose** as outlined on the medication containers instructions
    4) **Right Time** it is given by checking the electronic Medication Administration Record (MAR) within the EHR system and to make sure it is being given at the correct number of hours apart if prior dose given
    5) **Right Technique** or route referring to the General Procedures of Administration as needed for medications for oral/mouth, ears, eyes, nose, topicals/ointments (including the specific area where it was applied), vaginal, rectal/suppositories.
    6) **Right Documentation** is to be completed on the electronic Medication Administration Record within the EHR system, recorded within that person's individual electronic T-Log within the EHR system, and the HCC including the symptoms shown/why given, time, etc. Documentation needs to be detailed and also includes if the treatment/medication worked, i.e., stomachache is gone now, etc.
4. Make sure to seek medical treatment or emergency care (if warranted) for a person supported who does not seem to be responding timely to any protocol orders and/or extended illness or symptoms. Unless directions on the medication say otherwise; ensure to have the person seen by a physician if symptoms persist for 3 days and/or the person seems to be having increased discomfort or sickness (not responding to medication/treatment given). Contact Management immediately any time you are worried that the person is not getting better and they will assist you in making this decision.

OPENING/CLOSING OF PROTOCOL ORDERS

Any time a PRN protocol is given it must be listed as OPEN. Follow up must be done per the written Protocol orders. It is your job while administering Medications to follow up on protocols, if you are going to be off shift when the follow up is to be completed you are to write in the Staff Communication Book and the person's individual electronic T-Log within the EHR system to let the oncoming staff know a protocol is OPEN. When administering PRN medications, you must document on that person's electronic MAR and the person's individual electronic T-Log within the EHR system, and also in the HCC. *For every Open protocol there should be a Closed protocol to show the necessary follow up and treatment was given. If sudden adverse changes or symptoms persist, seek professional medical attention.

NON-PRN

These are medications that are prescribed by the physician on a routine (usually daily) basis. They will be listed on the electronic Medication Administration Record (MAR) within the EHR system, as well as on the paper back-up version within the Medication Record Book. Always follow the 6 Rights when administering these medications as well as all medications. If a medication time is missed for some reason or a person is refusing a medication; make sure to check the SMMO (Standing Missed Medication Orders) for the person which is located in the Medication Record Book. See below for explanation of how to use.

STANDING MISSED MEDICATION ORDERS (SMMO)

Standing Missed Medication Orders (SMMO) are written on each NON-PRN medication the person is currently prescribed. These orders specify what to do in the event that a medication time is missed for any reason. This includes if a person refuses

to take medication at the designated time. The SMMO will direct a staff when the medication can be re-offered. The Health Care Professional may have Standing Missed Medication Order and require that they need to be contacted for every missed medication. The SMMO is kept in the Medication Records Book and updated any time there are medication changes and/or at least annually. If medication was not able to be passed within the designated SMMO timeframes; then an Incident Report must be completed.

TREATMENTS

People supported may have treatments that need to be done by staff that may or may not be NON-PRN (routinely given) or PRN (as needed) such as diabetic check, inhalers, dandruff shampoo weekly, etc. These treatments are listed on the electronic Medication Administration Record (MAR) within the EHR System. The 6 Rights are also followed when giving any treatment to ensure it is properly administered.

MEDICATION ERRORS

A medication error has occurred if:

- The wrong **Person** was given a medication.
- The wrong **Drug**/medication was given to a person.
- The wrong **Dosage** was given to a person.
- The medication was administered at the wrong **Time** to a person, or a medication was not administered (omitted).
- The medication was administered by the wrong **Technique** or route.
- The correct **Documentation** did not occur.

A **medication error occurs** when any of the **6 rights** (P, double D, double T, D) of dispensing and administration of medications **is not followed.** Employees are to then follow the steps listed below:

1. A medication error occurring by not giving the appropriate Drug/medication on Time:
   a. Employees are to follow the Standing Missed Medication Orders (SMMO's).
   b. If error is beyond the time frame of the SMMO contact Management immediately and an Incident Report must be written.
2. A medication error occurring as a result from not following the 6 rights (P, double D, double T, D); if the wrong **Person**, wrong **Drug,** wrong **Dose**, wrong **Time**, wrong **Technique** or route occurred or wrong/no **Documentation** occurred:
   a. Contact Primary care physician/nurse, prescribing physician of the given medication, Pharmacist, – Contract Agency nurse, or if applicable the poison control phone number (listed on the emergency procedure)
   b. Have information available regarding **Person** served, **Drug**/medication prescribed: **Dosage, Time**, **Technique** as well as a list of other medications the person is on.
3. Employees are to follow instructions given to them by the Health Care Professionals and/or poison control.
4. Seek Medical Attention if needed and continue observing for any adverse effects.
5. Contact management with all of the information.
6. Complete all **Documentation** in the appropriate areas: Incident Reports, HCC, electronic Medication Administration Record (MAR) within the EHR system, and recorded within that person's individual electronic T-Log within the EHR system.

OVERDOSE (Accidental or Intentional – Including Person Supported Self-Medication Administration)

Contact Primary care physician/nurse, prescribing physician regarding the given medication, Pharmacist, – Contract Agency nurse, or if applicable the poison control phone number (listed on the emergency procedure). If the person is having difficulty breathing or displaying a life-threatening reaction 911 is to be called immediately. Contact management once medical personnel arrive.

Signs and symptoms of a drug overdose - A person may not exhibit all or even most of these signs, and the length of time of the overdose may vary depending on other factors such as how the body responds, type of substance, amount taken and how severe the overdose it. Even a few symptoms can indicate a person is experiencing an overdose. If this is the case, a person should take these symptoms very seriously.

a. Dilated pupils.
b. Unsteady walking.
c. Chest pain.
d. Severe difficulty breathing, shallow breathing, or complete cessation of breath.
e. Gurgling sounds that indicate the person's airway is blocked.

f. Blue lips or fingers.
g. Nausea or vomiting.
h. Abnormally high body temperature.
i. Violent or aggressive behavior.
j. Disorientation or confusion.
k. Paranoia.
l. Agitation.
m. Convulsions or tremors.
n. Seizures.
o. Unresponsiveness.
p. Unconsciousness.
q. Death.

Employees are to implement the following procedures while waiting for medical personnel to arrive.

a. Check the person's breathing and heart rate.
b. If the person is unconscious, try to get a response. Ask the person questions to assess their level of alertness and to calmly keep them engaged, if possible.
c. If the person is not breathing, turn them on their side.
d. Provide CPR if necessary.
e. Give first aid as directed by 911 operators.
f. Do not allow the person to take any more of the medication/substance.
g. Obtain as much information as possible, including the dose and the last time the person took the drug.
h. If prescription medications or otherwise labeled substances have been used, take the container with you to the ER, even if it is empty.
i. Make note of any identifying paraphernalia or bring along any containers of other drugs or substances the person may have taken.
j. Do not try to reason with the person or give your opinions about the situation.
k. Stay as calm as possible while waiting for medical personnel to arrive.
l. Assure the person that help is coming.
m. Contact management once medical personnel arrive.

EMERGENCIES AND WEEKENDS

If you discover a medication has not been renewed and there is not enough medication to cover the rest of the day or weekend, immediately notify management following the chain of command.

1. Management will give directions on how to proceed and make arrangements for the medication to be available.
2. Each location that provides 24-hour supports will set up and utilize a 24-hour pharmacy.
3. Transportation—Staff will use the company vehicle if available to drive to the pharmacy ensuring that staffing ratios are maintained. If a company vehicle is unavailable staff will drive their own vehicle and receive reimbursement for mileage.

EXTENDED VISITS – Home w/Family or Natural Supports

When a guardian/family member or natural support takes out a person from the program, a staff person must:

1. Fill out Medication Instruction Sheet and go over each medication and time it needs administered, a copy goes to the guardian/family member or natural support, and we keep a copy for the program with the guardian/family member signing receipt of the medications.
2. Review each medication and the time the medication is to be administered.
3. Code the electronic Medication Administration Record (MAR) within the EHR system with the proper codes to indicate that the medication will be given out of the program, using "Detail Mode" to leave an explanation within the comments section.
4. Remember, LADD requires 2 copies of the Medication Instruction Sheet: give the original to the guardian and we keep the copy. The guardian/family member or natural support must sign both copies.

COMMUNITY ACTIVITIES

Before leaving on community activities, staff must check the electronic Medication Administration Record (MAR) within the EHR system to see if any medication must be administered during the community activity. If yes, then the following must be completed:

1. Pack the medication in fully labeled med envelopes.

2. Ensure water or apple sauce, etc. is available for the person to take with his/her medication.
3. Pack medication in the lock box to bring with you in the van.
4. Documentation on the electronic Medication Administration Record (MAR) within the EHR system should take place immediately upon your return to the program, using "Detail Mode" to leave an explanation within the comments section.
5. Always remember to keep medication from extreme temperatures; getting too hot or too cold since it may alter the medication.

SCHOOL/WORK /OUTSIDE AGENCY DAY PROGRAM MEDICATION

If medication must be dispensed while a person is at school/work, the following procedure must be followed:

1. The Manager or Assistant Manager will communicate with the day program to obtain information regarding their policies concerning medication dispensation.
2. The Manager or Assistant Manager will arrange for medications to be properly labeled, taken to location by safe appropriate means having them sign for the medication and refill when necessary.
3. Medications given at any outside agency locations must be in a separate container, labeled by the pharmacist. (Staff will ask the pharmacist to prepare two identical containers: one for the home and one for school/work.)
4. Any unused medications must be documented as to why not used and returned to the home/location Once returned, the home/location needs to follow the disposal of medication procedure as necessary.
5. If the outside agency location refuses to give medication or to be responsible to observe that a person takes their medication, then the prescribing physician must be contacted to ask if she/he can adjust the times the medication is administered.

PERSON SUPPORTED/SELF-MEDICATION

A self-medication goal must be written and approved by the Contract Agency, Supports Coordinator/CSM, and guardian. They must also be written into their Person-Centered Plan for each individual with a self-medication goal and monitored appropriately. For best practices, teach the person supported the LADD Medication Procedures unless the treatment team provides a procedure to follow.

STAFF MEDICATIONS

If staff must take medication while at work, they must follow the procedure below:

1. Staff must notify the Human Resource Department of any prescriptions that may put the employee in jeopardy or harm (i.e. drowsiness, change in behavior, etc.) align with the Drug Policy. This is also to ensure staff's capability of being able to fulfill required Job Essentials and Responsibilities while on shift.
2. If applicable staff must fill out the ADA Accommodation Form.
3. Staff must ensure that any medications that they bring into the work location are secured so that they are not available to the people receiving support services.
4. Prescribed medication must be carried in a pharmacy labeled bottle.
5. If medications are given as sample or are OTC then staff must package pills so that sample (OTC) packet is available along with the medication.
6. Locked boxes will be provided at each location as needed; employees must obtain locked box through the Human Resource Department.

DISPOSAL OF MEDICATIONS

REASONS FOR DISPOSAL

1. Medications that have been prescribed for and dispensed to an individual remain their property.
    a. On discharge from the service, medication must be returned to the person/guardian (sent to new home) or returned to the dispensing pharmacy with the permission of the person/guardian. Signatures must be recorded as to who received the medications.
    b. Medications must not be used for any other person.
    c. The Destroyed/Returned Medication form must be completed and filed with the person's medical record prior to purging records and witnessed by 2 employees.
2. Medications must only be disposed of when:
    a. A course of treatment has been completed or discontinued
    b. The expiration date has been reached
    c. Medication was contaminated (dropped or spit out)
    d. Death of an individual. Medications are required to be retained for seven days following a death. In the event of sudden death, medications must not be destroyed until it is established whether these will be an inquest.

3. In the event of a person refusing a medication that has been taken from a container, it must be kept separately in a labeled container and disposed of as listed. Refusal of medication must be recorded on the electronic Medication Administration Record (MAR) and the HCC. If the refused medication has not been removed from the original container it can be left in the original container if the seal is not broken.
4. The Destroyed/Returned Medication form must be completed and filed with the person's medical record prior to purging records.
5. Any discarded medication must be kept separately in a labeled container disposed of using methods listed below. This applies even if it is not possible to identify which person discarded the medication.
6. Medications for disposal should be separated from those in use and kept in a locked cupboard.
7. All discontinued, outdated, refused and unwanted medications must be returned following the Disposal Procedure.
8. Biohazard materials are disposed of following the LADD Exposure Control Plan.

DISPOSAL PROCEDURE

For narcotic and non-narcotics, you must always have 2 employees sign off as witnesses:

1. Do not flush expired or discontinued medications down the toilet or drain.
2. Return them to the pharmacy if they will accept them, **or**
3. Two employees from Management will take them to the Sherriff/Police Department, Community Household Hazardous Waste if available in your city or other approved disposal site. If not available; then,
    a. Two employees from Management to witness, add water to dissolve the medication, add some absorbent material, such as wet coffee grounds or kitty litter. If the medication is in liquid form already then mix it directly with the absorbent material before proceeding with disposal steps. If the medication is in the form of a medication patch, then it must be cut into the smallest pieces possible, soaked in water and mixed with an absorbent material before proceeding with disposal steps. **Regardless of the form medication is in, all employees handling medications for disposal MUST wear gloves to prevent absorption through the skin.**
        1. Then double enclose in a bag or other waste container to prevent immediate identification and dispose of the bag in an outdoor garbage container immediately.
        2. The Destroyed/Returned Medication form must be completed. Once the form has been completed it is to be placed in the Medication Book with the appropriate Controlled Substance Count form.
        3. The Destroyed/Returned Medication form is to be purged along with the Controlled Substance Count form into the person's record book/medical.

MEDICAL ABBREVIATIONS commonly used:

@ = at	**IM**= intramuscular (injections)	**q.s.**= quantity sufficient
abd = abdomen	**IV=** intravenous (into vein)	**R**= right
ad lib = as desired	**K =** potassium	**R/rect**= rectal
ac= before meals	**L=** left	**re:** = regarding
ADL= activities of daily living	**LE =** lower extremity	**RLE**= right lower extremity
AM = morning	**LLE=** left lower extremity	**R/O**= rule out
amt.= amount	**LOA=** leave of absence	**Rx**. = prescription
ASA= Aspirin	**mcg** = micrograms	**s**= without
ASAP= as soon as possible	**mg** = milligrams	**ss**= one half
bid = twice a day	**ml**= milliliter (same as cc)	**Sig** = directions
BP = Blood Pressure	**MOM**= Milk of Magnesia	**SL**= sublingual (under tongue)
c= with	**N/A=** not applicable	**SOB**= shortness of breath
Cap= capsule	**NAS=** no added salt	**sq**= subcutaneous (insulin inject)
cc-cm = cubic centimeter	**NKA**= no known allergy	**stat**= immediately
c/o= complains of	**NPO**= nothing by mouth	**Supp** = suppository
Conc=concentrate	**O** = orally	**t - tsp** = teaspoon
d= day	**O2**= oxygen	**T – Tbsp** = Tablespoon
DC/ DC'd = discontinue or discontinued	**od/or**= medicine in right eye	**Tab**(s) = tablet
drng = drainage	**Oint** = ointment	**Temp** = temperature
drsg = dressing	**os/ol** = medicine in left eye	**tid**= three times a day (8a,4p,8p)
Dx = diagnosis	**ou** = medicine in each eye	**Top/T**= Topical
Elix. = elixir	**oz** = ounce	**TX.** = treatment
Exp= expiration/expired	**p**= after	**URI**= upper respiratory infection

Fx = fracture	**pc**= after meals	**UTI**= urinary tract infection
FBS = Fasting Blood Sugar	**PM** = afternoon/evening	**vag** = vaginal
Gm = gram	**po** = by mouth	**w/c** = wheelchair
gr= grain	**prn**= as needed	**Δ** = change
Gtt/gtts= drop(s) of medicine	**q/qd**= every day/once a day	**T**= one
h/hr = hour	**Q12**= every 12 hours	**TT**= two
H2O= water	**q 3 h**= every 3 hours	**TTT** = three
HOH= hard of hearing	**q4** = every 4 hours	**IV**= four
HR = Heart Rate	**q6** = every 6 hours	**V**= five
HS = hour of sleep (bedtime)	**qh** or **q%**= every hour	**X** = ten
Hx.= history	**qid** = four times a day (8a,12p,4p,8p)	**x**= times
I & O= intake and output	**qod** = every other day	

NOTE:
Medication Blank Forms/Documents referenced in this Medication Policy and Procedures are in an Adobe format within the Management Manual that can be downloaded and filled out accordingly.

GENERAL PROCEDURE FOR ADMINISTERING EYE, EAR, NOSE DROPS/SPRAY, TOPICAL, VAGINAL AND RECTAL MEDICATIONS, AS WELL AS INSULIN INJECTIONS, GLUCOMETER MEASUREMENT, CONTINUOS GLUCOSE MONITOR (CGM), AND KETONE URINALYSIS:
These medications have directions on or in the box/container. Follow all pharmaceutical directions. Below are general guidelines to assist you in making sure you are properly administering these types of medications. For these medications, ensure that you are **always washing your hands both before and after as well as using disposal gloves** during application. Gloves need to be taken off without touching your skin following your OSHA/Universal Precautions training and then properly discarded.

EYE DROPS/OINTMENTS
Drops:
1. **Wash hands** and put on disposable gloves.
2. Read and follow instructions that come with the medication.
3. If required, cleanse the affected closed eye with a clean cotton ball. Wipe from inner corner of eye outward once. If drops or ointments are to be instilled in both eyes, use a clean cotton ball for each eye.
4. Check the dropper to make sure it has not been cracked or chipped.
5. Draw the medicine into the dropper as prescribed. Recheck to ensure the label on the medication container matches the MAR.
6. Have the person lie down or tip their head back. (It may help to have them sitting down.)
7. Make a pocket by covering up the tear duct using middle finger and using index finger to pull the bottom lid out.
8. Hold the dropper level with the eye with the tip down at all times. Do not point the dropper toward the eye. Brace your hand on the person's forehead.
9. Apply from the inside of the face (by the nose) toward the outside. Approach the eye from below with the dropper remaining outside the individual's field of vision.
10. Apply the correct number of drops (prescribed amount) into the pocket of the lower lid, not directly onto the eye itself. Avoid touching the eye with the dropper. If they blink or move, drops will need to be redone.
11. If person's eye starts to make tears, a tissue can be used to absorb the tears on the cheek. DO NOT allow the tissue to be used on the other eye, as the infection can be transferred. Caution the person not to rub their eyes.
12. Replace the dropper and secure. NOTE: If you have touched the eye or other part of the body with the dropper, remember to clean and disinfect the dropper before putting it back in the bottle.
13. Leave the person in a comfortable position for a few minutes. Follow MAR regarding supervision of the individual during this time.
14. Remove and dispose of gloves properly and wash your hands thoroughly.
15. Complete the MAR documentation **immediately** after the medication is given.
16. Make sure that after the medication is given, the container is secured, any spills are cleaned up, and the medication is returned to the proper place following the storage procedures.

Ointments:
1. **Wash hands** and put on disposable gloves.

2. Read and follow instructions that come with the medication.
3. Have the person lie down or tip their head back. (It may help to have them sitting down.
4. Apply the ointment in a thin layer in or outside the eye as instructed on the medication. Apply from inner to outer in the amount prescribed.
5. If person's eye starts to make tears, a tissue can be used to absorb the tears on the cheek. DO NOT allow the tissue to be used on the other eye, as the infection can be transferred. Caution the person not to rub their eyes.
6. Break off the ribbon of ointment from the tube by relaxing the pressure and removing the tube. Do not use your fingers
7. If you have touched the eye or other part of the body with the ointment applicator, remember to sterilize it before putting the top back on.
8. Leave the person in a comfortable position for a few minutes. Follow MAR regarding supervision of the individual during this time.
9. Remove and dispose of gloves properly and wash your hands thoroughly.
10. Complete the MAR documentation **immediately** after the medication is given.
11. Make sure that after the medication is given, the container is secured, any spills are cleaned up, and the medication is returned to the proper place following the storage procedures.

For both Eyes:

1. If both eyes are involved, give the person a separate clean cotton ball for each eye.
2. Change your gloves between eyes to avoid transferring contamination from one eye to another.

EAR DROPS

1. **Wash hands** and put on disposable gloves.
2. Read and follow instructions that come with the medication.
3. Check the dropper for chips and cracks.
4. If the drops are a cloudy suspension, shake well for 10 seconds.
5. Have the person sit down where you can be above his/her ear; tilting head sideways until the ear is as horizontal as possible.
6. Cleanse the entry to the ear canal with a clean cotton ball. Clean just the entry to avoid forcing wax into the ear canal.
7. Draw the ordered amount of medicine into the dropper and check to ensure the label on the medication container matches the MAR.
8. Avoid touching the dropper to the ear or anything else to reduce chance of contamination or ear injury.
9. For an adult, gently pull the top of the ear back and upward. For a child, gently pull the ear back and slightly down.
10. Drop the number of drops ordered into the ear without touching the ear canal.
11. Massage in front of the ear for a few seconds to help the medicine go into the ear canal. Have the person hold their head in that position for 1-2 minutes.
12. Do not use a cotton ball in the ear unless it is specifically ordered by the doctor, as the drops could be absorbed by the cotton instead of going into the ear.
13. Replace the dropper and secure the bottle. NOTE: If you have touched the ear or other part of the body, remember to clean and disinfect the dropper before putting it back in the bottle.
14. Remove and dispose of gloves properly and wash your hands thoroughly.
15. Complete the MAR documentation **immediately** after the medication is given.
16. Make sure that after the medication is given, the container is secured, any spills are cleaned up, and the medication is returned to the proper place following the storage procedures.

NOSE DROPS OR SPRAY

1. **Wash hands** and put on disposable gloves.
2. Read and follow instructions that come with the medication.
3. Check the dropper for chips or cracks.
4. Provide a clean tissue to the person and have them blow nose gently.
5. Have the person sitting with head back or lying down.
6. Draw medicine into dropper and check to ensure the label on the medication container matches the MAR.
7. Avoid touching the nose or anything else.
8. Drop the number of prescribed drops or spray the number of sprays prescribed for each nostril. **DO NOT DROP OR SPRAY MORE, AS IT MAY CAUSE AN OVERDOES AND RESULT IN A SERIOUS ADVERSE REACTION.**
9. Encourage the person to hold their head back for 1-2 minutes. Follow the medication record regarding supervision time if longer. Provide a tissue for nasal drainage.

10. Put the dropper back in the bottle or put the cap on the spray. NOTE: If you have touched the nose or other part of the body, remember to clean and disinfect the dropper before putting it back in the bottle, or before capping the spray.
11. Remove and dispose of gloves properly and wash your hands thoroughly.
12. Complete the MAR documentation **immediately** after the medication is given.
13. Make sure that after the medication is given, the container is secured, any spills are cleaned up, and the medication is returned to the proper place following the storage procedures.

TOPICAL MEDICATIONS

1. **Wash hands** and put on disposable gloves.
2. Read and follow instructions that come with the medication.
3. If you must clean a wound before you apply medication, put on a clean pair of gloves to apply the medication. Do not use the same gloves for both procedures.
4. If the medication is in a jar, remove the medication with a tongue blade or cotton tipped applicator. DO NOT USE YOUR FINGERS
5. Apply the medication with cotton tipped applicator, sterile gauze, or a gloved hand.
6. Spread from the middle of the wound to the outer edges in four directions so as to not disturb healing or contaminate the wound if infection is present.
7. Never put the applicator back in the tube or jar for more medication. If more is required, get a fresh applicator. (Once the applicator has touched someone's skin, it is considered contaminated and must not touch the fresh medication or its container again.)
8. Cover the area with a bandage or dressing ONLY if directed to do so.
9. Remove and dispose of gloves properly and wash your hands thoroughly. Gloves must be placed in a double plastic bag labeled with a biohazard sticker and then placed in a covered bagged receptacle.
10. Complete the MAR documentation **immediately** after the medication is given.
11. Make sure that after the medication is given, the container is secured, any spills are cleaned up, and the medication is returned to the proper place following the storage procedures.

VAGINAL MEDICATIONS

NOTE: This is a very intrusive procedure and can be embarrassing and uncomfortable for the person. You need to be especially sensitive to privacy and comfort.

1. **Wash hands** thoroughly.
2. Remove vaginal medication from storage and review instructions on the container.
3. Bring with you disposable gloves, liner, double plastic bags, and the medication.
4. Take the person to a private area (i.e. bedroom.) Have the woman remove clothing from the waist down and lie on their back (soft surface or bed) with knees bent and legs apart. Cover exposed area with towel or sheet.
5. Place a disposable pad/liner underneath the person in case of body secretions.
6. Put on disposable gloves.
7. Remove the wrapper if there is one.
8. Lubricate the end of the applicator if the directions call for it. Use only water-soluble lubricant (such as K-Y jelly), never Vaseline.
9. Fill the applicator as directed on pharmacy label or manufacturer's packaging if it is not pre-filled.
10. Identify the vaginal opening, spread labia with one hand and gently insert the applicator about 2 inches into the vaginal canal with the other hand, or as directed. Angle applicator slightly downward toward tail bone. Do not force it in. Depress the plunger.
11. Have the woman stay on her back for at least 10-30 minutes as directed by pharmacy label or manufacturers packaging; providing supervision as indicated.
12. Protect clothing from drainage by giving the person a sanitary pad.
13. The bed liner and applicator must be placed in double plastic bags and disposed of appropriately.
14. Remove and dispose of gloves properly and wash your hands thoroughly.
15. Complete the MAR documentation **immediately** after the medication is given.
16. Make sure that after the medication is given, the medication ointment (if applicable) is secured and is returned to the proper place following the storage procedures.

RECTAL MEDICATIONS

NOTE: This is a very intrusive procedure and can be embarrassing and uncomfortable for the person. You need to be especially sensitive to privacy and comfort.

Suppository:

1. **Wash hands** thoroughly.
2. Remove suppository from storage and review instructions on the container. *Some suppositories must be kept refrigerated.*
3. Bring with you disposable gloves, liner, double plastic bags, and the medication.
4. Take the person to a private area (i.e. bedroom.) Have the person remove clothing from the waist down and lie on their side (soft surface or bed) with lower leg straightened out and upper leg bent toward stomach. Cover exposed area with towel or sheet. Do not give the suppository with the person in a sitting position.
5. Put on disposable gloves.
6. Place a disposable pad/liner under the person in case of a bowel movement or other secretions.
7. Unwrap the suppository if there is a wrapper.
8. Lubricate the suppository, one finger and the rectal opening with water soluble lubricant (such as K-Y Jelly.) Do not use Vaseline.
9. Lift upper buttock to expose rectal area. Instruct the person to exhale/relax then anal sphincter when administering.
10. Push the suppository into the rectum, about one inch past the tight sphincter muscle. (If not past this muscle, the suppository may pop back out.)
11. Hold the person's buttocks together for a few seconds.
12. Have the person remain lying down for 10-15 minutes until the suppository melts and to make sure it does not come out before it melts; providing supervision as indicated.
13. The bed liner must be placed in double plastic bags and disposed of appropriately.
14. Remove and dispose of gloves properly and WASH your hands thoroughly.
15. Complete the MAR documentation immediately after the medication is given.
16. Make sure that after the medication is given, the medication container is secured and is returned to the proper place following the storage procedures.

Enema:

1. **Wash hands** thoroughly.
2. Remove enema from storage and review instructions on the container.
3. Bring with you disposable gloves, liner, double plastic bags, and the medication.
4. Take the person to a private area (i.e. bedroom.) Have the person remove clothing from the waist down and lie on their side (soft surface or bed) with lower leg straightened out and upper leg bent toward stomach. Cover exposed area with towel or sheet. Do not give the enema with the person in a sitting position.
5. Put on disposable gloves.
6. Be sure to keep the person calm. It is very important they stay relaxed through the entire procedure.
7. Place a disposable pad/liner under the person in case of a bowel movement or other secretions.
8. Apply lubricant to the end of the enema (such as K-Y Jelly), if needed lubricant may also be applied to the anus. Do not use Vaseline.
9. Carefully insert the nozzle or rectal tube.
10. Slowly open the clamp. It takes as much as 15 minutes to administer a large volume enema. One-half to one cup per minute is about what you should be administering.
11. If cramping occurs slow or stop the flow of the enema.
12. Have the person hold the enema for 5 to 10 minutes before evacuating.
13. Massage the abdomen in a counterclockwise direction will help move the solution higher into the colon.
14. While the person is evacuating the solution into the toilet either massage their abdomen clockwise or have them lean forward towards their knees for an easier evacuation.
15. The bed liner must be placed in double plastic bags and disposed of appropriately.
16. Remove and dispose of gloves properly and wash your hands thoroughly.
17. Complete the MAR documentation immediately after the medication is given.

INHALERS

1. Check the equipment and clean if dirty.
2. **Wash hands** thoroughly and put on disposable gloves.
3. Make sure the person is in a comfortable position and provide a clean tissue to use if needed.
4. Load the dry medicine in the inhaler chamber as directed by the manufacturer.
5. Have person exhale normally away from the inhaler chamber.
6. Have the person place the mouthpiece in their mouth with lips sealed around the mouthpiece, forcefully inhaling through the mouth.

7. Direct the person to hold their breath for up to 10 seconds, then remove the mouthpiece and ask the person to exhale slowly. If more than 1 puff is ordered, wait 30 seconds, then repeat the steps for subsequent puffs. Be sure to wait 30 seconds between puffs.
8. Close the mouthpiece and replace protective cap and have the person rinse their mouth with water and then spit the water out (if able). Remind the person not to swallow the rinse water or they will get a systemic effect; causes medication to enter the bloodstream.
9. Leave the person in a comfortable position for a few minutes to observe.
10. Remove and dispose of gloves properly and wash your hands thoroughly.
11. Complete the MAR documentation **immediately** after the medication is given.
12. Make sure that after the medication is given, the container is clean and secured, and the medication is returned to the proper place following the storage procedures.

NEBULIZER TREATMENTS

1. Check equipment and clean it if dirty.
2. **Wash hands** thoroughly and put on disposable gloves.
3. Make sure the person is in a comfortable position and provide a clean tissue to use if needed.
4. Plug in the nebulizer and use according to the manufacturer's instructions.
5. Connect the hose to the air compressor.
6. Fill the medicine cup with prescribed medication dosage. To avoid spills, close the medicine cup tightly and always hold the mouthpiece straight up and down.
7. Attach the other end of the hose to the mouthpiece and medicine cup.
8. Have the person place the mouthpiece in his/her mouth having them use their lips to form a tight seal on the mouthpiece so that all the medicine goes into the lungs. If the person is using a mask instead of a mouthpiece, be sure the mask fits well.
9. Turn the machine on. Encourage the person to breathe normally during treatment with occasional deep breaths; the medication works better with deep inhalations but avoid hyperventilation.
10. Follow physician's instructions i.e., taking and documenting the person's pulse and respirations if ordered.
11. Continue the treatment until all medication is given, usually 5-20 minutes depending on the device and medicine used.
12. Turn the machine off.
13. Leave the person in a comfortable position for a few minutes to observe.
14. If needed, assist the person wiping their face and apply lip balm.
15. Remove and dispose of gloves properly and wash your hands thoroughly.
16. Complete the MAR documentation **immediately** after the medication is given.
17. Make sure that after the medication is given, clean up any spills and return the medication to the proper place following the storage procedures. Wash the medicine cup and mouthpiece with water and air dry. Once dry, secure equipment.
18. Cleaning after use:
    a. Wash the medicine cup and mouthpiece with warm running water.
    b. Let them air dry on clean paper towels.
    c. Later, hook up the nebulizer and run air through the machine for 20 seconds to make sure all of the parts are dry.
    d. Take apart and store the machine in a covered area until the next use.
    e. Once per day, you may add a mild dish soap to the cleaning routine above.

INSULIN PEN INEJCTIONS

1. For detailed instructions and to ensure accurate dosing, refer to the full instruction leaflet provided with the insulin pen. NOTE: Instructions may differ based on insulin model/type
2. **Wash hands** thoroughly and put on disposable gloves.
3. If the insulin in the pen appears cloudy, roll the pen in your hands and turn it from side to side for one full minute. You don't have to roll the pen if the insulin is completely clear. Do not shake the pen.
4. Choose where to give the injection as directed by the licensed healthcare professional, do not inject the insulin in the same place all the time to prevent skin damage.
5. The injection site should be clean and dry. If the person's skin is visibly dirty, clean it with soap and water. Antiseptic (like alcohol wipe) should be used to cleanse the site. Be sure to wipe the desired site and allow it to fully dry.
6. Prepare the Pen: Remove the pen cap, clean the pen tip with an alcohol swab, and allow it to air-dry. Attach the pen needle to the pen.
7. Prime the Pen: Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the

pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears.

8. Set the Dose: Dial to the number of insulin units as prescribed by the licensed healthcare professional. Check that the dose is correct.
9. Inject the Insulin: press the pen needle into the skin with a quick motion at a 90-degree angle. The needle should go all the way into your skin. Push the button down until the dose window reads zero. Remember to hold the pen at the site for 6 to 10 seconds and then pull the needle out.
10. Unscrew and remove the pen tip needle. Dispose of used supplies appropriately. Follow universal precautions, including disposing of all sharps in appropriate sharps container. Do not recap any sharps and always use a new needle with each injection. *For one-time use insulin pens, dispose of entire pen in the appropriate sharps container.
11. The person may bleed at the spot of the injection. If you notice bleeding, apply pressure with a clean alcohol wipe or cotton ball. Cover the injection site with a bandage if necessary.
12. Remove and dispose of gloves properly and wash your hands thoroughly.
13. Complete the MAR documentation **immediately** after the medication is given.
14. Store the Pen: Make sure that after the medication is given, the pen is returned to the proper place following the storage procedures. Keep the pen at room temperature.

INSULIN SYRINGE & VIAL INJECTIONS

1. **Wash hands** thoroughly and put on disposable gloves.
2. Check the insulin bottle label. Make sure it is the right insulin. Make sure it is not expired.
3. The insulin should not have any clumps on the sides of the bottle. If it does, throw it out and get another bottle.
4. Intermediate-acting insulin (N or NPH) is cloudy and must be rolled between your hands to mix it. Do not shake the bottle. This can make the insulin clump. Clear insulin does not need to be mixed.
5. If the insulin vial has a plastic cover, take it off. Wipe the top of the bottle with an alcohol wipe. Let it dry. Do not blow on it.
6. Follow the MAR for the amount of insulin the person is to take. Take the cap off the needle, being careful not to touch the needle to keep it sterile. Pull back the plunger of the syringe to put as much air in the syringe as the dose of medicine prescribed.
7. Put the needle into and through the rubber top of the insulin bottle. Push the plunger so the air goes into the bottle.
8. Keep the needle in the bottle and turn the bottle upside down.
9. With the tip of the needle in the liquid, pull back on the plunger to get the right dose of insulin into the syringe.
10. Check the syringe for air bubbles. If there are bubbles, hold both the bottle and syringe in one hand, and tap the syringe with your other hand. The bubbles will float to the top. Push the bubbles back into the insulin bottle, then pull back to get the right dose.
11. When there are no bubbles, take the syringe out of the bottle. Put the syringe down carefully so the needle does not touch anything.
12. Choose where to give the injection as directed by physician. Keep a chart of places previously used, so you do not inject the insulin in the same place all the time.
    a. Keep shots 1 inch (2.5 centimeters, cm) away from scars and 2 inches (5 cm) away from your navel.
    b. Do not put a shot in a spot that is bruised, swollen, or tender.
    c. Do not put a shot in a spot that is lumpy, firm, or numb (this is a very common cause of insulin not working the way it should).
13. The chosen injection site should be clean and dry. If the person's skin is visibly dirty, clean it with soap and water. Antiseptic (like alcohol wipe) should be used to cleanse the site. Be sure to wipe the desired site and allow it to fully dry.
14. The insulin needs to go into the fat layer under the skin.
    a. Pinch the skin and put the needle in at a 45º angle.
    b. If the person's skin tissues are thicker, you may be able to inject straight up and down (90º angle). Check with the provider before doing this.
    c. Push the needle all the way into the skin. Let go of the pinched skin. Inject the insulin slowly and steadily until it is all in.
    d. Leave the syringe in place for 5 seconds after injecting.
15. Pull the needle out at the same angle it went in. Dispose of used supplies appropriately. Follow universal precautions, including disposing of all sharps in appropriate sharps container. Do not recap any sharps!
16. If insulin tends to leak from the injection site, press the injection site for a few seconds after the injection. If this happens often, check with the person's provider. They may change the site or the injection angle.

17. The person may bleed at the spot of the injection. If you notice bleeding, apply pressure with a clean alcohol wipe or cotton ball. Cover the injection site with a bandage if necessary.
18. Remove and dispose of gloves properly and **wash** your hands thoroughly.
19. Complete the MAR documentation **immediately** after the medication is given.
20. Make sure that after the medication is given, the medication is returned to the proper place following the storage procedures.
    a. Unopened Insulin: Keep in the refrigerator in the lock box. It remains effective until the manufacturer's expiration date.
    b. Opened/In-Use Insulin: Can be stored in the locked medication cabinet at room temperature (59°F–86°F) or in the refrigerator's lock box.

INSULIN PUMP

1. For detailed instructions and to ensure accurate dosing, refer to the full instruction leaflet provided with the insulin pump. NOTE: Instructions may differ based on insulin pump model/type.
2. Wash hands thoroughly and put on disposable gloves.
3. Load the insulin. Use a vial or insulin cartridge to fill the pump with insulin, following the specific instructions included with the insulin pump.
4. Attach the tubing. Connect the infusion set to the person's skin, either by tubing or directory to the pump for patch pumps.
5. Program the basal dose rate. Set the pump to automatically adjust insulin doses based on blood glucose levels or program the dose manually.
6. Program the bolus dose rate. Decide if the pump will automatically deliver bolus insulin or manually deliver it when blood sugar levels are high.
7. Rotate the cannula site. Change the site of the cannula every 2-3 days to avoid complications.
8. Remove and dispose of gloves properly and **wash** your hands thoroughly.
9. Complete the MAR documentation **immediately** after the medication is given.
10. Make sure that after the medication is given, the medication is returned to the proper place following the storage procedures.

GLUCOMETER MEASUREMENTS

1. **Wash your hands** thoroughly and apply disposable gloves.
2. Assemble equipment. Make sure the meter is charged and ready to use. Ensure regular reagent testing for calibration, if indicated (per manufacturer's instructions). Make sure the appropriate strips are supplied. Check expiration dates.
3. Place lancet in pen if a pen is used for this procedure.
4. Set up the glucometer.
5. Have the person **wash their hand**s thoroughly. If there is no soap and water available, you may use hand sanitizer. Even after washing hands, an antiseptic (alcohol swab/wipe) should be used to cleanse the site. Be sure to wipe the desired site and allow to fully dry.
6. Massage or have the person shake out their hand to get blood into their finger. When hands are cold, this could restrict the blood flow to fingertips. (If you have trouble getting enough blood on the test strip, try warming up their hands, then have them rewash their hands.)
7. Turn glucometer on, then apply the lancet to side of the finger (never the finger pad).
8. Point your finger downward and gently squeeze to get an adequate blood sample.
9. Place blood drop on test strip and wipe finger with gauze pad and hold in place, applying gentle pressure until bleeding stops.
10. Clean equipment and dispose of used supplies appropriately. Follow universal precautions, including disposing of all sharps in appropriate sharps container. Do not recap any sharps and use self-retracting lancets.
11. Remove and dispose of gloves appropriately and wash your hands.
12. Document results! Read and record results; store results in glucometer if that is an option.
13. Follow the process for medication administration or request assistance if necessary.

CONTINUOUS GLUCOSE MONITOR

1. **Wash your hands thoroughly** and apply disposable gloves.
2. Remove the sensor by peeling off the adhesive. Peel the adhesive patch slowly, pulling it back over itself rather than pulling directly up (similar to as a bandage) and remove the unit. *Removal instructions may differ based on CGM model.
3. After removal, clean the area with warm water and soap or an adhesive remover to remove residue.

4. To prevent skin irritation, alter the site you put the new sensor on the person's body. Wash the sensor site with soap and water, then clean with an alcohol wipe to remove lotions or oils, allowing it to dry completely.
5. Place the applicator device firmly against the skin and press down to insert the sensor, which uses a tiny, flexible filament to measure glucose in the fluid under the skin. *Installation instructions may differ based on CGM model.
6. Follow instructions on the specific device app or reader to activate the new sensor (e.g., scanning the sensor with a phone).
7. Most sensors require a 30 to 60-minute warm-up period before showing data. Some systems require a fingerstick blood glucose check to calibrate.
8. Dispose of used alcohol wipe, sensor and supplies appropriately. Follow universal precautions, including disposing of all sharps in appropriate sharps container.
9. Remove and dispose of gloves appropriately and **wash** your hands.
10. View glucose levels, trends, and alerts on the smartphone or receiver, setting up alerts for when glucose is too high or too low.
11. **Document!** Read and record results as directed by the licensed healthcare professional.
12. Follow the process for medication administration or request assistance if necessary.

KETONE URINALYSIS

1. **Wash your hands** thoroughly and apply disposable gloves.
2. Assemble equipment. Make sure the appropriate ketone strips are supplied. Check expiration dates. Obtain a clean, dry container for the urine sample.
3. Ketone testing should be done anytime a person has a very high or very low glucose reading. The best time to test is often in the morning or 2 hours after a meal.
4. Collect a sample of urine in the container. If person is unable to do so independently, use a “hat” (a disposable, plastic container designed to fit under a toilet seat and over the rim to collect urine safely and hygienically). When using a hat:
5. Raise the toilet seat. Place the hat inside the toilet bowl so the wide, rounded lip rests on the rim of the toilet.
6. Lower the seat back down. Person should urinate directly into the container. Ensure that no toilet paper or stool contaminates the sample.
7. Once finished, remove the hat, and use the built-in spout to pour the urine into the clean collection container.
8. Dip the test strip into the urine, ensuring the testing pad is fully immersed.
9. Remove the strip and wait for the time specified in the instructions, usually around 15–60 seconds.
10. Compare the color change on the strip with the color chart provided on the strip bottle or box.
    a. Negative: No color change; no ketones are present.
    b. Trace/Small: Light color change; indicates low levels of ketones.
    c. Moderate/Large: Dark color change; indicates high levels of ketones.
11. Dispose of used supplies appropriately. Follow universal precautions, including disposing of urine cup and hat if used, in a double plastic bag.
12. Remove and dispose of gloves appropriately and wash your hands.
13. Keep strips in their original bottle to prevent damage from light or moisture. Store in medication cabinet.
14. **Document!** Read and record results as directed by the licensed healthcare professional.
15. Follow the process for medication administration or request assistance if necessary, checking every 6 hours until results are negative or as recommended by the licensed healthcare professional.