I. PURPOSE
The purpose of this policy is to establish guidelines to promote the health and safety of persons served by ensuring the safe assistance and administration of medication and treatments or other necessary procedures.

II. POLICY
Options is responsible for meeting health service needs including medication-related services of persons as assigned in the Coordinated Service and Support Plan and/or Addendum. Coordination of health service needs related to medication and treatment will occur between Options and the residential provider or home of the person served.

Persons served will be encouraged to participate in the process of medication administration to the fullest extent of their abilities, unless otherwise noted in the Coordinated Service and Support Plan and/or Addendum. The following procedures contain information on medication-related services for the administration of medication as well as the assistance staff may provide to a person who self-administers their own medication.

All medications and treatments will be administered according to this policy and procedure and Option’s medication administration training curriculum.

III. PROCEDURE
Staff training on medication administration
A. When medication set up and/or administration has been assigned to Options as stated in the Coordinated Service and Support Plan and/or Addendum, staff who will set up or administer medications to persons served will receive training and demonstrate competency as well as reviewing this policy and procedure.

B. Unlicensed staff, prior to the set up and/or administration of medication, must successfully complete a medication set up or medication administration training course developed by a registered nurse or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures. The course must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician’s assistant, or physician, if at the time of service initiation or any time thereafter. This may occur if the person has or develops a health care condition that affects the service options available to the person because the condition requires specialized or intensive medical or nursing supervision and nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

C. Upon completion of this course and prior to the setting up and/or administering medications, staff will be required to demonstrate medication set up and/or administration established specifically for each person served at their location, if this has not already been completed.
D. This training will be completed for each staff person during orientation, within the first 60 days of hire, and annually thereafter and will include a review of this policy and procedure. However, staff that demonstrate a pattern of difficulty with accurate medication administration may be required to complete retraining at a greater frequency and/or be denied the responsibility of administering medications. Staff who do not have direct service responsibility are not required to complete the medication administration training.

E. Documentation for this training and the demonstrated competency will be maintained in each staff person’s personnel file.

**Medication set up**

A. Medication setup means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when the company is assigned responsibility in the *Coordinated Service and Support Plan or the CSSP Addendum*. A prescription label or the prescriber’s written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber.

B. Staff will document the following information in the person’s served medication administration record:
   1. Dates of medication set up.
   2. Name of medication.
   3. Quantity of dose.
   4. Times to be administered.
   5. Route of administration at the time of set up.
   6. When the person will be away from the service location
   7. To whom the medication was given.

**Medication assistance**

A. There may be occasions when Options is assigned responsibility solely for medication assistance to enable a person served to self-administer medication or treatments when the person is capable of directing their own care or when the person’s legal representative is present and able to direct care for the person.

B. If medication assistance is assigned in the *Coordinated Service and Support Plan* and/or *Addendum*, staff may:
   1. Bring to the person and open a container of previously set up medications, empty the container into the person’s hand, or open and give the medication in the original container to the person under the direction of the person.
   2. Bring to the person food or liquids to accompany the medication.
   3. Provide reminders in person, remotely, or through programming devices such as telephones, alarms, or medication boxes to take regularly scheduled medication or perform regularly scheduled treatments and exercises. All medications will be kept locked in the medication room cupboard during the day.
Medication administration
A. Medication may be administered within 30 minutes before or after the prescribed time. For example, a medication ordered to be given at 12:00 pm may be administered between 11:30 am and 12:30 pm.

B. Medications ordered to be given as an “AM medication” and/or “PM medication” may be administered at a routine daily time. The routine time will be established with the residence to follow their established time.

C. Staff administering medication must know or be able to locate medication information on the intended purpose, side effects, dosage, and special instructions.

D. General and specific procedures on administration of medication by routes are located in the Health Counseling procedure binder in the front office and each medication room. Routes included are:
   2. Liquid medication.
   4. Inhaled medication.
   6. Eye medication.
   7. Eardrop medication.
   8. Topical medication.

Medication Authorization
A. Prior to administering medication for the person served, Options will obtain written authorization from the person served and/or legal representative to administer medications or treatments, including psychotropic medications.

B. The written authorization to administer medication or treatments will be reviewed and obtained annually from the person served and/or legal representative.

C. If authorization by the person served and/or legal representative is refused, the company will not administer the medication or treatment. This refusal will be immediately reported to the person’s prescriber and staff will follow any directives or orders given by the prescriber.

Injectable medications
A. Injectable medications may be administered to a person served according to their prescriber’s order and written instructions when one of the following conditions has been met:
   1. A registered nurse or licensed practical nurse will administer injections.
   2. A supervising registered nurse with a prescriber’s order can delegate the administration of an injectable medication to unlicensed staff persons and provide the necessary training.
   3. There is an agreement that must be signed by Options, the prescriber, and the person served and/or legal representative that will be maintained in the service recipient record. This agreement will specify:
      a. What injection may be given.
      b. When and how the injection may be given.
      c. That the prescriber retains responsibility for the company to give the
injection.

B. Only a licensed health care professional is allowed to administer psychotropic medications by injection. This responsibility will not be delegated to unlicensed staff.

**Psychotropic medication**

A. When a person served is prescribed a psychotropic medication and Options is assigned responsibility for the medication administration, the requirements for medication administration will be followed.

B. **Options** will develop, implement, and maintain the following information in the person’s *Coordinated Service and Support Plan Addendum* according to MN Statutes, sections 245D.07 and 245D.071. This information includes:

1. A description of the target symptoms that the psychotropic medication is to alleviate.
2. Documentation methods that Options will use to monitor and measure changes to these target symptoms, if required by the prescriber and the expanded support team.
3. Data collection of target symptoms and reporting on the medication and symptom-related data, as instructed by the prescriber, a minimum of quarterly or as requested by their person and/or legal representative. This reporting will be made to the expanded support team.

C. If the person and/or legal representative refuse to authorize the administration of a psychotropic medication as ordered by the prescriber, Options will not administer the medication and will notify the case manager as expeditiously as possible. After reporting the refusal to the case manager, Options must follow any directives or orders given by the prescriber. A refusal may not be overridden without a court order. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency.

**Documentation requirements on the Medication Administration Record (MAR)**

The following information will be documented on a person’s medication administration record:

1. Information on the current prescription labels or the prescriber’s current written or electronically recorded order or prescription that includes the:
   a. Person’s name
   b. Description of the medication or treatment to be provided
   c. Frequency of administration
   d. Other information needed to safely and correctly administer medication or treatment to ensure effectiveness

2. Easily accessible information on risks and other side effects that are reasonable to expect and any contraindications to the medications use.
3. Possible consequences if the medication or treatment is not taken or administered as directed.
4. Instruction on when and to whom to report:
   a. If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person’s error, or by the person’s refusal
   b. The occurrence of possible adverse reactions to the medication or treatment
5. Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by staff error, the person’s error, or by the person’s refusal, or of adverse reactions, and when and to whom the report was made.

6. Notation of when a medication or treatment is started, administered, changed, or discontinued.

Medication documentation and charting

A. Staff will transcribe a prescriber’s new, changed, and discontinued medication/treatment orders to the monthly medication sheet by:
   1. Comparing the label on the medication with the prescriber’s to ensure they match. Any discrepancy must be reported to the pharmacy immediately.
   2. Copying any new medication/treatment or change from the original prescriber’s orders to the monthly medication sheet.
   3. When there is a change in a current medication/treatment, the revision is written on the MAR in order to implement the medication change.
   4. Entering the medication/treatment name, dose, route, frequency, and times to be administered.
   5. Drawing an arrow to the start date for each assigned time.
   6. Writing the date the medication is to start, the name of the prescriber who ordered the medication, and the initials of the person making the entry, on the line just below the arrows or under the order on a separate line.
   7. Discontinuing a medication/treatment as ordered by writing “D/C” or “Discontinued,” the date, the prescriber’s name, and the initials of the person making the entry on the line just below the arrow.
   8. Completing any applicable health documentation regarding the entry and notifying the necessary personnel.

B. Staff will document a medication given from the Standing Order Medications List form by:
   1. Writing the medication on the monthly medication sheet exactly as it is written on the Standing Order Medications List.
   2. Initialing in the correct box for the date the medication was administered and the time.
   3. Documenting what medication/treatment was administered, the dose, the reason it was given, and the effect in the health documentation one hour after the medication was given.
   4. Following any special instructions noted on the Standing Order Medications form, notifying the assigned nurse consultant or prescriber as directed.

C. Staff will document administration of medications/treatments on the monthly medication sheet by:
   1. Ensuring the person’s name, allergies, prescriber’s name, month, and year are on the monthly medication sheet.
   2. Completing documentation on the monthly medication sheet in black ink.
   3. Ensuring whiteout, erasing, or disfigurement, such as scratching out are not used at any time.

D. Each month, staff administering and documenting medication/treatment administration will enter their initials, full name, and title initials in the designated location on the monthly medication sheet.
Coordination and communication with prescriber
A. As part of medication set up and administration, Options will ensure that clear and accurate documentation of prescription orders has been obtained by the prescriber in written format.

B. Initiations, dosage changes, or discontinuations of medications will be coordinated with the residential provider and prescriber and discussed as needed to ensure staff and/or the person served has a clear understanding of the order. If the order has only been done verbally, staff will request a written or electronically recorded copy from the prescriber. Staff will not make any changes to medications or treatment orders unless there is a written or electronically recorded copy.

C. All prescriber instructions will be implemented as directed and within required timelines by staff and/or the person served and documented in related health documentation.

D. Concerns regarding medication purpose, dosage, potential or present side effects, or other medication-related issues will be promptly communicated to the residential provider and prescriber by staff, the manager and nurse consultant.

E. Any changes to the physical or mental needs of the person as related to medication will be promptly made to the residential provider in addition to the legal representative and case manager.

Coordination of medication refills and communicating with the residence
A. The designated staff person for medication administration will be responsible for checking medication supply routinely to ensure adequate amount for administration. A request for more medication will be made to the residential provider in an adequate amount of time to prevent running out of the medication. If there is no medication available, the designated staff person will contact the residential provider to bring the medication into Options and administer it.

Handling changes to prescriptions and implementation of those changes
A. All written instructions regarding changes to medications and treatments are required to be documented through a prescription label or the prescriber’s written or electronically recorded order for the prescription.

B. Changes made to prescriptions will be immediately communicated to the Designated Coordinator and/or Designated Manager, the designated staff person for medication administration, and the nurse consultant, as applicable.

C. Any concerns regarding these changes and the order will be resolved prior to administration of the medication to ensure safety and accuracy.

D. Staff will implement changes and document appropriately on the monthly medication sheet according to the above procedure in Medication documentation and charting.

E. Discontinued medications or medications that the dosage is no longer accurate due to the changes will be returned to the residential provider for them to discard.
Verification and monitoring of effectiveness of systems to ensure safe medication handling and administration (reporting and reviewing)

A. The designated person will be responsible for reviewing each person’s medication administration record to ensure information is current and accurate. This will include a review of the monthly medication sheets, referrals, medication orders, etc.

B. At a minimum, this review will occur quarterly or more frequently if directed by the person and/or legal representative or the Coordinated Service and Support Plan or Coordinated Service and Support Plan Addendum.

C. Based upon this quarterly or more frequent review, the reviewer will notify the and/or manager, as needed, of any issues. Collaboratively, a plan must be developed and implemented to correct patterns of medication administration errors or systemic errors when identified. When needed, staff training will be included as part of this plan to correct identified errors.

D. The following information will be reported to the legal representative and case manager as they occur or as directed by the Coordinated Service and Support Plan or Coordinated Service and Support Plan Addendum:
   1. Concerns about a person’s self-administration of medication or treatment.
   2. A person’s refusal or failure to take or receive medication or treatment as prescribed.
   3. Any reports as required regarding:
      a. If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person’s error, or by the person’s refusal
      b. Occurrence of possible adverse reactions to the medication or treatment

Medication storage and security including Schedule II medication storage; Medication Destruction

A. The medication storage area/container will be locked at all times when unattended by staff and will be kept clean, dry, and within the appropriate temperature range.

B. Medication will not be left unattended or administered by a separate staff in lieu of the staff that prepared them for administration.

C. Each person served will have a separate container for their internal medications and a separate container for their external medications. External standing order medications will be in a separate container from internal standing order medications.

D. Medication will not be kept in the same area as food or chemicals (in the case of refrigerated medications, they will be kept in a locked container and separated from food).

E. Schedule II controlled substances, names in MN Statutes, section 152.02, subdivision 3, will be stored in a locked storage area permitting access to the person served and staff authorized to administer medications.

F. Medications will be disposed of according to the Environmental Protection Agency
recommendations.

IV. GENERAL AND SPECIFIC PROCEDURES ON ADMINISTRATION OF MEDICATION BY ROUTES

A. General procedures completed before administering medication by any route
   1. Staff must begin by washing their hands and assembling equipment necessary for administration.
   2. The person’s monthly medication sheet is reviewed to determine what medications are to be administered and staff remove the medication from the storage area.
   3. Staff will compare the medication sheet with the label of each medication for the following:
      a. Right person
      b. Right medication
      c. Right date
      d. Right time
      e. Right route
      f. Right dose
      g. Expiration date
   4. If there is a discrepancy, the medication will not be administered. Instructions will be verified by contacting the assigned nurse, nurse consultant, pharmacist, or prescriber.
   5. Staff will compare the label with the medication sheet for the second time.
   6. Immediately prior to the administration of any medication or treatment, staff will identify the person and will explain to the person what is to be done.
   7. Staff will compare the label with the medication sheet for the third time before administering it, according to the specific procedures below, to the person.
   8. After administration, staff will document the administration of the medication or treatment or the reason for not administering the medication or treatment.
   9. Staff will contact the nurse consultant, residential provider, or prescriber regarding any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed.
  10. Adverse reactions will be immediately reported to the assigned nurse, nurse consultant, or prescriber.
  11. Staff will remain with the person to ensure that the medication has been absorbed into the cheek and that they have not drank any liquids.
  12. Staff will throw away all disposable supplies and place all medications in the locked medication storage area/container prior to leaving the area.
  13. Staff will wash their hands.