Medication Administration

Section 4.2

OPWDD regulations in Title 14 New York Codes, Rules and Regulations (NYCRR) section 633.17 include requirements for the prescription, administration, storage, documentation, receipt, and disposal of medications in Family Care Homes (FCHs). This policy includes details for implementation of these requirements and ensuring that medications are administered and maintained in the safest manner possible by Family Care Providers (FCPs) and Substitute Providers.

Who can Administer Medication in a Family Care Home?

1. An individual who has been assessed by the Family Care RN and found capable of taking his or her own medication
2. An individual's own natural family member
3. A nurse with a current license and registration from New York State
4. A FCP whose name appears on the operating certificate for the Family Care Home and who has successfully completed the Office for People With Developmental Disabilities (OPWDD) approved training curriculum
5. An approved or certified Substitute Provider who has successfully completed the OPWDD approved training curriculum. Substitute Providers who are approved by more than one Sponsoring Agency, must have their competency to administer medications assessed by the RN at each Sponsoring Agency.

If a FCP is required to give medication via a feeding tube or administer medications by injection such as insulin, additional training must be provided by the RN.

Training

All FCPs and Substitute Providers must receive training on medication administration at the time of the initial certification of the FCH or initial approval of the Substitute Provider, and annually thereafter, using the OPWDD approved medication administration curriculum and post test. Providers must score 80 percent or above on the post test to pass the medication administration training. If the Provider scores below 80, the RN may provide additional one-on-one training and allow the Provider to retest. If the Provider does not pass the test a second time, the Provider will need to repeat the full medication administration training curriculum. Training records, including the post-test, must be maintained by the Sponsoring Agency in accordance with record retention requirements.

Medication Pours

An RN must observe each new FCP pour and administer medications to an individual receiving services after the FCP's successful completion of the OPWDD approved training curriculum and post-test. A supervised pour may also be required any time the RN and/or treatment team determines additional support or monitoring is necessary (e.g., significant change in medication routine, medication errors). The pour should occur before the first individual moves into the FCH, while the individual is completing a trial visit. If a supervised pour cannot be completed prior to the move (e.g., emergency

admission or trial visit only occurred over one weekend), it will need to be completed within 30 days of the individual's admission.

Supervised medication pours are also required for newly approved Substitute Providers. Supervised pours may also be required at any time the RN and/or treatment team deems additional support or monitoring is necessary. A supervised pour must be conducted by the RN within 30 days of the start of providing respite services.

For Substitute Providers who may support different individuals throughout the year, a supervised medication pour is NOT required for each specific individual. Substitute Providers who are approved to provide respite services through multiple Sponsoring Agencies must have their competency evaluated and documented by the Family Care RN at each Sponsoring Agency.

For new Family Care Providers and Substitute Providers, mock pours cannot substitute for a supervised pour. Mock pours are included as part of the initial training and may be used to provide supplemental training to FCPs and Substitute Providers, as needed.

Prescriptions

All medications administered by a FCP or Substitute Provider must be prescribed, ordered, or authorized by a Physician, Nurse Practitioner, Physician's Assistant, Dentist, or other licensed medical professional who is authorized to prescribe medication.

Prescriptions, orders, or approvals for medications must be written at least once a year or more frequently as required. This includes medications that can be purchased over the counter (OTC) such as vitamins, herbal medications, aspirin, Tylenol, cold preparations, allergy medications, cough syrup, and topical ointments/creams.

The FCP must keep the most current order in the Family Care Home.

Orders or authorizations are written directions from the practitioner that may not always be written on an official New York State prescription form but are found on other written forms. These written forms may include a consult sheet, a hospital discharge sheet from an emergency room, or a form used by the Sponsoring Agency and signed by a Physician, Physician's Assistant, Nurse Practitioner, or other licensed professional who can prescribe medication.

Any time a new medication is prescribed during a medical or emergency room visit, the FCP must obtain a copy of the order that clearly identifies the name of the medication and administration instructions, before leaving the visit.

Medication Information

It is important that a FCP and individuals receiving services in a Family Care Home have information about the medications administered in the home. The FCP should be aware of the following information before administering any medication to an individual in Family Care:

a. Name of each medication
b. The reason the individual is taking the medication
c. The expected effects of the medication and common side effects
d. The common interactions, such as with other drugs, supplements, food, and alcohol
e. Any special ways the medication needs to be taken or stored
f. Any special monitoring that may be needed
g. What to report to the Family Care RN and prescriber including any unusual changes in the individual

The FCP must carefully read the medication information sheet supplied by the pharmacy or the individual specific medication information sheet provided by the RN for every medication prescribed for the individuals in the home. The FCP must be aware of all adverse effects that any medication may have on the individual receiving services. Any observed changes in the individual must be reported promptly to the prescriber and RN.

Medication Changes
The FCP must notify the RN of any medication changes such as:

a. New medication
b. New dosage
c. New frequency of medication administration
d. Discontinued medication

The RN will review information about the medication changes with the FCP including what issues or changes would be important to call and report to the RN and/or prescriber. In addition to this review, the RN will also review medication changes during the next visit to the home.

Any medications that are intended to modify behaviors or to address psychiatric conditions require special approval/consent before administration. These include medications ordered for daily administration and medication specifically prescribed to help a person relax before going to a medical or dental appointment. The FCP must speak directly with the RN before administering the first dose of any of these medications.

After Hours Notification
If a medication change occurs after business hours or on a weekend or holiday, the FCP must notify the Sponsoring Agency in accordance with the Sponsoring Agency's established policy. The Sponsoring Agency must train the FCP on the Sponsoring Agency's policy for after-hours notification. This training should be provided during initial and annual medication administration training and any other times deemed necessary.

Non-Prescription Medications also known as 'Over-The-Counter' (OTC) Medications

Approval for a specific individual to use a non-prescription medication must be received in writing from that individual's healthcare practitioner on an annual basis. It must include the condition for which the medication is to be used, the dosage, frequency, and any specific instructions related to the medication.

An individual who is capable of self-medication management may obtain and use non-prescription medication at his or her discretion. However, the individual must be given appropriate guidance relative to obtaining, storing, and self-administering non-prescription medications.

The administration of OTC medications for illness or injury should not exceed two (2) days unless specified by a prescribing practitioner. Exceptions are certain vitamins and OTC medication that a practitioner instructs to be given daily.

If there is an adverse reaction, a significant change in behavior, or any other significant indication of a problem, this needs to be reported immediately to the individual's primary physician/prescriber and the Sponsoring Agency RN. The medication should be suspended, and the prescriber or physician will direct the FCP on how to proceed.

If at any time the FCP is concerned that symptoms being experienced by an individual may require more immediate attention or could be life threatening, 911 should be used as an emergency response. The prescriber, physician, and RN should be notified of the symptoms and outcome after emergency treatment is sought.

Medication Administration Records (MAR)

The FCP must maintain a separate record of the administration of medication for each individual in the FCH who receives medication (including non-prescription medication, vitamins, etc.).

If a Substitute Provider will be administering medications in the FCP home during respite services, the Substitute Provider must document all medications given on the MAR. The full name and initials of the Substitute Provider must be noted on the MAR as well.

If an individual is receiving respite services outside of the FCH, the Substitute Provider must still document all medications administered to individuals in the Family Care program. The FCP can choose to give the original MAR from the FCH to the Substitute Provider or the FCP can choose to create a separate MAR that the Substitute Provider can complete. If a second MAR is used, it must be attached to the original MAR and follow all guidelines as indicated below.

The MAR must include at least the following information:

a. The name of the individual receiving the medication

b. The name of the medication, the dose, how often it is to be given, and how it is to be given
c. The time and date the medication was given
d. The signature or initials of the person who gave the medication. (When using initials, there must be a way to identify the initials of the person who administered the medication).

There should never be any blanks on a MAR. If an individual is out of the home, a code must be used to explain the reason for the missed medication.

If an individual in Family Care can take his or her own medication (as determined by the annual evaluation of the individual's ability to self-administer medications), it is the responsibility of the FCP to make sure that the individual is taking it correctly. The FCP and the Family Care RN must discuss this for each individual and develop a plan to monitor the self-administration of the medication. Some examples include occasional verbal checks or checking the amount of medication that is remaining.

While an individual who is capable of taking his or her own medications is not required to have a MAR, the MAR is a good tool to assist the individual to accurately take the medications. An individual who self-administers medication and uses a MAR can document self-administration using a mark or other method, (e.g., sticker), as long as the mark is known to represent that individual.

Storage of Medication
All medication must be stored so that it cannot be accessed by any unauthorized person. Internal and external medication must be stored separately, either on separate shelves or separate storage units. Medication removed from the storage area should never be left unattended.

Controlled medications must be kept in a locked container. The locked container for controlled medications that are used for emergencies must be stored in a way that makes the medications easily accessible to the FCP or individual who self-administers medication in an emergency, but not accessible to other people.

Medication that must be stored in the refrigerator should be placed in a covered container and should be labeled "medication." The medication container should not resemble a container used for food storage. Controlled substances that are stored in the refrigerator must be in a locked container.

Only the FCP, approved Substitute Provider, the RN, and an individual who is capable of self-administration are authorized to have access to medications.

Medication must be kept in its original container with the following exceptions:
a. Medications may be placed in a pill organizer or medication bar when an individual is capable of self-administering medication, or when an individual is

being taught to self-administer medication. The day minder must be labeled with the individual's name.

b. When insulin is pre-drawn into syringes for an individual to self-administer. The insulin syringe must be labeled with the individual's name, the strength and dose of the insulin, and the date it was drawn.
c. When the medication is packaged for administration away from the Family Care Home. One dose of each medication may be placed in an envelope by the person authorized to administer the medication. The envelope must be labeled with the individual's name, the medication name, strength, dose, route, and time it is to be given.

When *more than one dose* of a medication is to be given away from home, the following applies:

a. The entire supply of medication in its original container must go with the individual, *or*
b. The pharmacy can pre-package that portion of the prescription needed by the individual away from home, *or*
c. When an individual is going on home leave or vacation with his or her own family, it may be acceptable to place up to a full week supply of medication in a pill organizer/med bar that is labeled with the individual's name. A list must accompany the medication containing the name, strength, and physical description of each medication, as well as the frequency, dose, time, and route of administration. The signature of the person preparing the medication is also required on the list, *or*
d. For medication administered by injection, (e.g., insulin, if an insulin pen is not used), up to a seven-day supply of the medication may be pre-drawn into a syringe that is labeled with the individual's name, along with the name, strength and dose of the medication.

NOTE: If more than a 7-day supply is needed, the entire supply of medication (in its original container) must be sent with the individual, see #1, above.

Medication Counts for Controlled Substances

All FCP must ensure that controlled substances are carefully monitored so they are not accessed by anyone other than those people who are allowed to have access to medications in the home.

If an individual is prescribed a controlled substance, the RN will count the medication to ensure accuracy at each 90-day visit. This count must be documented by the RN.

Labels

Original medication containers for prescription medication must be labeled clearly and legibly with the individual's name, the name and strength of the medication, directions for use including the amount and frequency, the name of the prescribing practitioner, pharmacy, and the prescription number.

Containers for non-prescription medications must have the original manufacturer's label.

Syringes, Needles, and Lancets
Syringes and needles must be kept in a secure, locked container (not including epi-pens or other emergency medications given by injection or insulin pens without the needle attached). Although not required, it is best practice to keep lancets in a locked container as well.

Needles, lancets, and syringes are to be placed in approved sharps containers immediately after use. When not in use, the container should be kept in a secure location that is easily accessible to the FCP and any individual who self-administers medications, when needed. The RN will instruct the FCP in the proper use and disposal of sharps containers.

Emergency medications given by injections (like epi-pens used for allergic reactions) are to be stored in a way that makes them easily accessible in an emergency but safe from other persons. This should be discussed with the RN for each individual situation.

Disposal of Medication
Outdated medications should not be kept by the FCP. Discontinued medications should not be kept by the FCP *unless* the prescribing practitioner has provided written guidance to keep the medication for possible future use.

Medication that is **not** controlled must be destroyed per the Sponsoring Agency's policy.

Controlled medications must be disposed of by two people. This includes the FCP along with either a:

- Sponsoring Agency Registered Nurse (RN)
- Sponsoring Agency Licensed Practical Nurse (LPN)
- Physician or Physician's Assistant
- Pharmacist
- Approved Medication Administration Personnel (AMAP) from the Sponsoring Agency *NOTE: FCP and Substitute Providers are <u>not</u> AMAP

Documentation of the disposal must be completed and signed by both parties disposing of the controlled medication. All medication that is either going to be disposed of or retained for future use should be kept separate from the current medications.

Medication Administration Errors
All Medication Administration Errors and Procedural Medication Errors must be reported immediately upon discovery and must be managed in accordance with Sponsoring Agency policy.

There are two types of errors involving medications:

1. *Medication Administration Errors:* When a medication is not given the way it was ordered (i.e., the wrong medication was given**;** the wrong amount was given; the wrong route; the wrong time; the wrong individual, or the medication was not given at all).

2. *Procedural Medication Error:* When the established procedures for administering and/or securing medication are not followed (e.g., not signing for medications on the MAR; not storing or locking medications as required).

The FCP and Sponsoring Agency staff must also report medication related incidents in a timely manner in accordance with Part 624 regulations and the Sponsoring Agency's incident reporting policy and procedures.

Sponsoring Agency Policy

Sponsoring Agencies must ensure that all FCP and Substitute Providers are trained on any Sponsoring Agency policies and procedures that may impact the Provider's ability to safely and effectively administer medication and treatment (e.g., Sponsoring Agencies policy for after-hours notifications for medication changes or Emergency Room visits).

Oversight

Medication records must be reviewed monthly. The Family Care Home Liaison must review the questions on the Form 239 Family Care Program Monthly Checklist each month and the Family Care Registered Nurse (RN) must complete a comprehensive review at least once every 90 days, or more often as needed. A qualified medical professional must review each individual's medication regimen every six months.