COMMUNITY CARE LICENSING DIVISION

"Promoting Healthy, Safe and Supportive Community Care"

TECHNICAL SUPPORT PROGRAM

Self-Assessment Guide

MEDICATIONS

CDSS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

TECHNICAL SUPPORT PROGRAM

MEDICATIONS

Medication handling represents an area of great responsibility. If not managed properly, medications intended to help a client's/resident's health condition may place that individual's health and safety at risk. The information contained in this handout outlines medication procedures you are required to perform by regulation, as well as some procedures not required by regulation which, if implemented, will provide additional safeguards in the management of medications in your facility. If you operate a Community Care Facility (CCF), the specific medication regulations you must comply with are in section 80075. If you operate a Residential Care Facility for the Elderly (RCFE), the specific medication regulations you must comply with are in section 87575. ***This guide cannot be used as a substitute for having a good working knowledge of all the regulations.***

WHAT YOU (CARE PROVIDERS) SHOULD DO WHEN:

1. Client/resident arrives with medication:

    - Contact the physician(s) to ensure that they are aware of all medications currently taken by the client/resident.
    - Verify medications that are currently taken by the client/resident and dispensing instructions.
    - Inspect containers to ensure the labeling is accurate.
    - Log medications accurately on forms for client/resident records. The Centrally Stored Medication and Destruction Record (LIC 622) is available for this purpose.
    - Discuss medications with the client/resident or the responsible person/authorized representative.
    - Store medications in a locked compartment.

2. Medication is refilled:

    - Communicate with the physician or others involved (for example, discuss procedures for payment of medications, who will order the medications, etc. with the responsible person.)
    - Never let medications run out unless directed to by the physician.
    - Make sure refills are ordered promptly.
    - Inspect containers to ensure all information on the label is correct.
    - Note any changes in instructions and/or medication (for example, change in dosage, change to generic brand, etc.)
    - Log medication when received on the LIC 622.
    - Discuss any changes in medications with the client/resident, responsible person/authorized representative and appropriate staff.

3. A dosage is changed between refills:

   - Confirm with the physician. Obtain written documentation of the change from the physician or document the date, time, and person talked to in client's/resident's record.

   - Prescription labels cannot be altered by facility staff.

   - Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the change.

   - Discuss the change with client/resident and/or responsible person/authorized representative.

4. Medication is permanently discontinued:

   - Confirm with the physician. Obtain written documentation of the discontinuation from the physician or document the date, time, and person talked to in client's/resident's record.

   - Discuss the discontinuation with the client/resident and/or responsible person/authorized representative.

   - Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the discontinuation.

   - Destroy the medications. Medication must be destroyed by the facility administrator or designee and one other adult who is not a client/resident. (See destruction requirements for pre-packaged medications in section #17.)

   - Sign the medication destruction record/log. (The reverse side of LIC 622, Centrally Stored Medication Record, may be used for this purpose.)

5. Medications are temporarily discontinued ("dc") and/or placed on hold:

   - Medications temporarily discontinued by the physician may be held by the facility.

   - Discuss the change with client/resident and/or responsible person/authorized representative.

   - Obtain a written order from the physician to HOLD the medication, or document in the client's/resident's file the date, time, and name of person talked to regarding the HOLD order.

   - Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the discontinuation and restart date.

   - Without altering the label, mark or identify in a consistent manner medication containers that have HOLD orders.

   - Be sure to contact the physician after the discontinuation/hold order expires to receive new instructions regarding the use of the medication.

6. Medication reaches expiration date:

   - Check containers regularly for expiration dates.
   - Communicate with physician and pharmacy promptly if a medication expires.
   - Do not use expired medications. Obtain a refill as soon as possible if needed.
   - Over-the-counter medications and ointments also have expiration dates (for ointments the expiration date is usually at the bottom of the tube).
   - Destroy expired medications according to regulations.
   - Log/record the destruction of prescription medications as required. The LIC 622 may be used for this purpose.

7. Client/resident transfers, dies, or leaves medication behind:

   - All medications, including over-the-counters, should go with client/resident when possible.
   - If the client/resident dies, prescription medications must be destroyed.
   - Log/record the destruction as required. The LIC 622 may be used for this purpose.
   - Document when medication is transferred with the client/resident. Obtain the signature of the person accepting the medications (i.e., responsible person/authorized representative.)
   - Maintain medication records for at least 3 years (RCFE) section 87575 (h)(6),(i) or 1 year (CCF) section 80075 (n)(7),(o).

8. Client/resident missed or refused medications:

   - No client/resident can be forced to take any medication.
   - Missed/refused medications must be documented in the client's/resident's medication record and the prescribing physician contacted immediately.
   - Notify the responsible person/authorized representative.
   - Refusal of medications may indicate changes in the client/resident that require a reassessment of his/her needs. Continued refusal of medications may require the client's/resident's relocation from the facility.

9. Medications need to be crushed or altered:

   - Medications may be crushed or altered to enhance swallowing or taste, but never to disguise or "slip" them to a client/resident without his or her knowledge.

- The following written documentation must be in the client's/resident's file if the medication is to be crushed or altered:

    1. A physician's order specifying the name and dosage of the medication to be crushed;

    2. Verification of consultation with a pharmacist or physician that the medication can be safely crushed, identification of foods and liquids that can be mixed with the medications, and instructions for crushing or mixing medications;

    3. A form consenting to crushing the medication signed by the client/resident. If the client/resident has a conservator with authority over his/her medical decisions, the consent form must be signed by that conservator.

10. Medications are PRN or "as needed":

    Facility staff may assist the client/resident with self-administration of his/her **prescription and nonprescription** PRN medication, when:

    - The client's/resident's physician has stated in writing that the client/resident can determine and clearly communicate his/her need for a prescription or nonprescription PRN medication.

    - The physician provides a signed, dated, written order for the medication on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.

    - The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription labels display this information.

    Facility staff may also assist the client/resident with self-administration of his/her **nonprescription** PRN medication if the client/resident cannot determine his/her need for a nonprescription PRN medication, but can communicate his/her symptoms clearly, when:

    - The client's/resident's physician has stated in writing that the client/resident cannot determine his/her need for nonprescription medication, but can communicate his/her symptoms clearly.

    - The client's/resident's physician provides a signed, dated, written order on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.

    - The written order identifies the name of the client/resident, the name of the PRN medication, instructions regarding when the medication should be stopped, and an indication when the physician should be contacted for re-evaluation.

    - The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription medication labels display this information.

- A record of each dose is maintained in the client's/resident's record and includes the date, time, and dosage taken, and the client's/resident's response.

Facility staff may also assist the client/resident with self-administration of his/her **prescription or nonprescription** PRN medication if the client/resident cannot determine his/her need for a prescription or nonprescription PRN medication, and cannot communicate his/her symptoms when:

- Facility staff contact the client's/resident's physician before giving each dose, describe the client's/resident's symptoms, and receive permission to give the client/resident each dose.

- The date and time of each contact with the physician and the physician's directions are documented and maintained in the client's/resident's facility record.

- The physician provides a signed, dated, written order on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.

- The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period.

- A record of each dose is maintained in the client's/resident's records and includes the date, time, and dosage taken, and the client's/resident's response.

SMALL FAMILY HOMES AND CERTIFIED FAMILY HOMES

Small Family Home staff may assist a child with **prescription or nonprescription** PRN medication without contacting the child's physician before each dose if the child cannot determine and/or communicate his/her need for a prescription or nonprescription PRN medication when (section 83075 (d)):

- The child's physician has recommended or prescribed the medication and provided written instructions for its use on a prescription blank or the physician's letterhead stationery.

- Written instructions include the name of the child, the name of the PRN medication, instructions regarding when the medication should be stopped, and an indication when the physician should be contacted for re-evaluation.

- The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses allowed in a 24-hour period. Most nonprescription medication labels display this information.

- The date, time, and content of the physician contact made to obtain the required information is documented and maintained in the child's file.

- The date, time, dosage taken, symptoms for which the PRN medication was given and the child's response are documented and maintained in the child's records.

11. Medications are injectables:

- Injections can only be administered by the client/resident or by a licensed medical professional. Licensed medical professional includes Doctors of Medicine (M.D.), Registered Nurses (R.N.), and Licensed Vocational Nurses (L.V.N.) or a Psychiatric Technician (P.T.). P.T.s can only administer subcutaneous and intramuscular injections to clients/residents with developmental or mental disabilities and in accordance with a physician's order.

- Family members are not allowed to draw up or administer injections in CCFs or RCFEs unless they are licensed medical professionals.

- Facility personnel who are not licensed medical professionals cannot draw up or administer injections in CCFs or RCFEs.

- Licensed medical professionals may not administer medications/insulin injections that have been pre-drawn by another licensed medical professional.

- Injections administered by a licensed medical professional must be provided in accordance with the physician's orders.

- The physician's medical assessment must contain documentation of the need for injected medication.

- If the client/resident does administer his/her own injections, physician verification of the client's/resident's ability to do so must be in the file.

- Sufficient amounts of medications, test equipment, syringes, needles, and other supplies must be maintained in the facility and stored properly.

- Syringes and needles should be disposed of in a "container for sharps", and the container must be kept inaccessible to clients/residents (locked).

- Only the client/resident or the licensed medical professional can mix medications to be injected or fill the syringe with the prescribed dose.

- Insulin and other injectable medications must be kept in the original containers until the prescribed single dose is measured into a syringe for immediate injection.

- Insulin or other injectable medications may be packaged in pre-measured doses in individual syringes prepared by a pharmacist or the manufacturer.

- Syringes may be pre-filled under the following circumstances:

    - Clients of Adult Residential, Social Rehabilitation, Adult Day and Adult Day Support Centers can self-administer pre-filled syringes prepared by a registered nurse, pharmacist or drug manufacturer.

    - Residential Care Facilities for the Elderly, Group Homes and Small Family Homes must obtain exceptions from the licensing office for clients/residents to use pre-filled syringes prepared by a registered nurse.

    - The registered nurse (R.N.) must not set up insulin syringes for more than seven days in advance.

- Injectable medications that require refrigeration must be kept locked.

12. Over-the-counter (OTC) medications, including herbal remedies, are present:

    - OTC medications (e.g., aspirin, cold medications, etc.) can be dangerous.
    - They must be centrally stored to the same extent that prescription medications are centrally stored (see criteria for central storage in section 80075 (m) for CCFs and section 87575 (h) for RCFEs.)
    - Over-the-counter medication(s) that are given on a PRN basis must meet all PRN requirements. (See section #10)
    - Physicians must approve the use of all OTC medications that are or may be taken by the client/resident on a regular basis (e.g., aspirin for heart condition, vitamins, etc.) as well as those used on a PRN basis. Have documentation.
    - Client's/resident's name should be on the over-the-counter medication container when: (1) it is purchased for that individual's sole use; (2) it is purchased by client's/resident's family or (3) the client's/resident's personal funds were used to purchase the medication.

13. You "set up" or "pour" medications:

    - Have clean, sanitary conditions. (i.e., containers, counting trays, pill cutters, pill crushers and storage/setup areas.)
    - Pour medications from the bottle to the individual client's/resident's cup/utensil to avoid touching or contaminating medication.
    - Medications must be stored in their original containers and not transferred between containers.
    - The name of the client/resident should be on each cup/utensil used in the distribution of medications.
    - Have written procedures for situations such as spillage, contamination, assisting with liquid medication, interactions of medications, etc.
    - Have written procedures for facility staff regarding assisting with administration of medication, required documentation, and destruction procedures.

14. Assisting with medications (passing):

    - Staff dispensing medications need to ensure that the client/resident actually swallows the medication (not "cheeking" the medication); mouth checks are an option for staff.
    - Cups or envelopes containing medications should not be left unattended in the dining room, bathrooms, bedrooms or anywhere in the facility.

15. You designate staff to handle medications:

    - Have written policies and procedures.
    - Train all staff who will be responsible for medications.
    - Ensure that staff know what they are expected to do (i.e., keys, storage, set up, clean-up, documentation, notification, etc.)
    - Ensure designated staff know what procedures can and cannot be done (i.e., injections, enemas, suppositories, etc.)

16. Medications are received or destroyed:

    - Every prescription medication that is centrally stored or destroyed in the facility must be logged.
    - A record of prescription medications that are disposed of in the facility must be maintained for at least 3 years in a Residential Care Facility for the Elderly and 1 year in a Community Care Facility (Group Homes, Adult Residential Facilities, etc.)
    - A record of centrally stored medications for each client/resident must be maintained for at least 1 year.

17. Medications are prepackaged:

    - Prepackaged medications (bubble packs, trays, cassettes, etc.) are allowed if they are packed and labeled by a pharmacy.
    - Licensees and/or facility staff cannot remove discontinued medications from customized medication packages.
    - Multi-dose packages must be returned to the pharmacy for changes in doses or discontinuation of a medication.
    - Facilities should have procedures in case one dose is contaminated and must be destroyed.
    - Facilities (EXCEPT RCFEs) utilizing prepackaged medications must obtain a waiver from the licensing office if medications are to be returned to the pharmacy for disposal.
    - RCFEs do not need to obtain a waiver if the medications are returned to the issuing pharmacy or disposed of according to the approved hospice procedures.

18. Sample medications are used:

    - Sample medications may be used if given by the prescribing physician.
    - Sample medications must have all the information required on a regular prescription label except pharmacy name and prescription number.

19. Transferring medications for home visits, outings, etc.

- When a client/resident leaves the facility for a short period of time during which only one dose of medication is needed, the facility may give the medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, client's/resident's name, name of medication(s), and instructions for administering the dose.

- If client/resident is to be gone for more than one dosage period, the facility may:

  a. Give the full prescription container to the client/resident or responsible person/authorized representative,

  or

  b. Have the pharmacy either fill a separate prescription or separate the existing prescription into two bottles,

  or

  c. Have the client's/resident's family obtain a separate supply of the medication for use when the client/resident visits the family.

- If it is not safe to give the medications to the client/resident, the medications must be entrusted to the person who is escorting the client/resident off the facility premises.

- If medications are being sent with the client/resident off the facility premises, check the Physician's Report (LIC 602 or 602a) to ensure that they are given only to clients/residents whose doctors have indicated that they may control their own medications.

- Always have the person entrusted with the medications sign a receipt which identifies the number and type of medications sent out and returned.

20. House medications/stock supplies of over-the-counter medications are used:

- Centrally stored, stock supplies of over-the-counter medications may be used in CCFs and in RCFEs.

- Licensees cannot require clients/residents to use or purchase house supply medications.

- Clients/residents may use personal funds to purchase individual doses of OTC medications from the licensee's stock if each dose is sold at the licensee's cost and accurate written records are maintained of each transaction.

- All regulations regarding the use of OTC medications must be followed (see section #12).

- Be sure to verify that the client's/resident's physician has approved the use of the OTC before giving him/her a dose from the house supply.

21. Clients/residents use emergency medication(s) (e.g., nitroglycerin, inhaler, etc.):

Clients/residents who have a medical condition requiring the immediate availability of emergency medication may maintain the medication in their possession if all of the following conditions are met:

- The physician has ordered the PRN medication, and has determined and documented in writing that the client/resident is capable of determining his/her need for a dosage of the medication and that possession of the medication by the client/resident is safe.
- This determination by the physician is maintained in the individual's file and available for inspection by Licensing.
- The physician's determination clearly indicates the dosage and quantity of medication that should be maintained by the client/resident.
- Neither the facility administrator nor the Department has determined that the medications must be centrally stored in the facility due to risks to others or other specified reasons.

If the physician has determined it is necessary for a client/resident to have medication immediately available in an emergency but has also determined that possession of the medication by the client/resident is dangerous, then that client/resident may be inappropriately placed and may require a higher level of care.

22. Blood pressure and pulse readings are taken:

The following persons are allowed to take blood pressure and pulse readings to determine the need for medications:

- The client/resident when his/her physician has stated in writing that the client/resident is physically and mentally capable of performing the procedure.
- A physician or registered nurse.
- A licensed vocational nurse under the direction of a registered nurse or physician.
- A psychiatric technician under the direction of a physician, surgeon, psychiatrist, or registered nurse. Psych Techs may take blood pressure and pulse readings of clients/residents in any community care licensed facility. The Psych Tech injection restrictions noted in section #11 do not apply to taking vital signs.

The licensee must ensure that the following items are documented when the client's/resident's vital signs are taken to determine the need for administration of medications:

- The name of the skilled professional who takes the reading.

- The date and time and name of the person who gave the medication.

- The client's/resident's response to the medication.

Lay staff may perform vital sign readings as long as the readings are not used to determine a need for medication.

23. Clients/residents need assistance with the administration of ear, nose and eye drops:

    - The client/resident must be unable to self-administer his/her own eye, ear or nose drops due to tremors, failing eyesight or other similar conditions.

    - The client's/resident's condition must be chronic and resistant to sudden change (stable) or temporary in nature and expected to return to a condition normal for the client/resident.

    - The client's/resident's Needs and Services Plan (CCF), Pre-Admission Appraisal (RCFE) or Individual Services Plan (RCF-CI) must state that he/she cannot self administer his/her own drops and specify how staff will handle the situation.

    - The client's/resident's physician must document in writing the reasons that the client/resident cannot self-administer the drops, the stability of the medical condition and must provide authorization for the staff to be trained to assist the client/resident.

    - Staff providing the client/resident with assistance must be trained by a licensed professional and names of trained staff must be maintained in the staff files. This training must be completed prior to providing the service, must include hands-on instruction in general and client/resident specific procedures, and must be reviewed and updated by the licensed professional at least annually or more often if the condition changes.

    - Staff must be trained by a licensed professional to recognize objective symptoms observable by a lay person and to respond to the client's/resident's health problem.

    - Staff must be trained in and follow universal precautions and any other procedures recommended by the licensed professional.

    - Written documentation outlining the procedures to be used in assisting the client/resident with the drops and all aspects of care to be performed by the licensed professional and facility staff must be maintained in the client's/resident's file.

    Prior to providing ongoing client/resident assistance with drops, facility staff should consider the use of assistive devices, such as an eye cup, which would enable the client/resident to self-administer the drops.

24. Medications need to be stored:

    - All medications, including over-the-counters, must be locked at all times.
    - All medications must be stored in accordance with label instructions (refrigerate, room temperature, out of direct sunlight, etc.).
    - Medication in refrigerators needs to be locked in a receptacle, drawer, or container, separate from food items. (Caution should be used in selecting storage containers as metal may rust.)
    - If one client/resident is allowed to keep his/her own medications, the medications need to be locked to prevent access by other clients/residents.

25. Miscellaneous:

    - Medications are one of the most potentially dangerous aspects of providing care and supervision.
    - Educate yourself and staff (signs, symptoms, side effects).
    - Train staff.
    - Develop a plan to evaluate staff's ability to comply with the facility's medication procedures.
    - Communicate with physicians, pharmacists, and appropriately skilled professionals.
    - Develop a system to communicate changes in client/resident medications to staff and to the client/resident.
    - Staff should be trained on universal precautions to prevent contamination and the spread of disease.
    - Document.
    - Know your clients/residents.
    - Be careful.