Recommendations on Personal Care Home Licensure and Enforcement Reform by the Licensing and Legislative Subcommittee of the DPW PCH Advisory Committee

January 10, 2002

The Licensing and Legislative Subcommittee of the DPW PCH Advisory Committee met three times, on November 28, 2001, December 14, 2001, and January 8, 2002. The purpose was to discuss the issues raised in the report of the Auditor General and other concerns about the licensure and regulation of personal care homes. The discussion was to focus on the adequacy of the current regulation and enforcement system and to determine what regulatory or statutory changes are necessary to insure the health and safety of residents in personal care homes.

The Subcommittee included the following participants:

Pam Walz, Chair	Elderly Law Project, Community Legal Services
William Gannon	DPW - OSP
Patsy Taylor-Moore	DPW – OSP – PCH Division
Ann Torregrossa	Pennsylvania Health Law Project
Aïssa Halperin	Pennsylvania Health Law Project
Christine Klejbuk	PANPHA
Lynn Fosnight	PALA
Beth Greenberg	PANPHA
Dale Laninga	Intra-Governmental Council on Long Term Care
Clarence Smith	CERCA
Pat McNamara	PHCA/CALM
Cindy Boyne	State Ombudsman

The Subcommittee discussed the following subjects:

A. **Overview of Licensure Process:**

1. Step 1: Apply for license. If applying for renewal license, apply 2-3 months in advance of license expiration.
2. Step 2: DPW comes out for unannounced inspection.
3. Step 3:
   - If in full compliance (meaning no class I, class II, or class III violations), will get full license.
   - If in substantial compliance (meaning have class III violations and acceptable plan of correction), will get provisional license unless submit and follow acceptable plan of correction – including demonstration of correction – before expiration of current license and then, will get full license.
   - If in non-compliance (meaning have class I or class II violations), will not get any license unless submit and follow acceptable plan of correction and correct violations within timeframes called for in statute. (Must correct Class 1 within 24 hours, class II within 5 days, etc.).

B. **Initial Issuance of License**

1. New licenses – Newly opened facilities found in full compliance will be issued a full "new" license, with a tag stating that is it "new" for a six month period. DPW will re-inspect within 3 months and will differentiate between a new facility license and a full license in their disclosure to the public, indicating that the facility was in full compliance with all aspects of the regulations for which it could be in compliance. It is should be made clear that the facility has no resident history, etc. and thus, there is no measure of its performance on resident related aspects of the regulations.
2. At the end of the "new" license period, must be in full compliance in order to get regular license. Don't get a provisional.

C. **Issuance of Subsequent Licenses**

1. No regular license shall be issued until the PCH is in full compliance at end of timeframe for correction. Law specifically requires PCHs to meet all requirements of law prior to licensure and this needs to be strictly adhered to.
2. A provisional license shall be issued only in cases which do not have violations which indicate a substantial probability that death or serious mental or physical harm to any resident may result or which have a substantial adverse effect upon the health, safety or well-being of any resident at the end of the timeframe for correction. (citation from P.S. §1085).
3. DPW should not issue subsequent provisional licenses after the first one, etc. if uncorrected violations or repeat violations from first provisional license. A facility can get a subsequent provisional license if new/different Class 3 violations are found.
4. A license shall be revoked or not renewed if violations exist which indicate a substantial probability that death or serious mental or physical harm to any resident may result or which have a substantial adverse effect upon the health, safety or well-being of any resident and violations are corrected and corrections validated within the approved specified time frame.
5. The DPW shall take pattern into consideration on the issuance of a provisional and will invoke 1087 (b). The law is clear on this and operational protocols must follow the law. On the 4th provisional, there should not be an assumption of continued business. They will either be in full compliance or out of business. 1087 (b).
6. When the Department decides not to issue or renew a full license or a provisional license, the Department must issue an emergency order to relocate residents while appeal proceeds.
7. When a Class I or Class II violation has been found, P.S. §1057.3 (a) (4) should be complied with (providing that each resident shall be provided by the administrator with notice of any Class I or II violations which remain uncorrected after five days).
8. Need to expand regulations on "responsible person" to cover prohibition on transfer of license to include that: "There shall be no transfer of license unless the department approves the transfer of license. The department may deny transfers to friends, relatives, business associates, etc. if it appears that purpose of transfer is to avoid licensure action or if it appears that the previous owner will continue to have involvement in the facility or business." There should be a presumption that the party is not a responsible person when one operator is changing legal names to avoid licensure.

D. Licensure Inspections

The Subcommittee thought the Department has done well in annual licensure renewal inspections. The Subcommittee did feel that there must be unannounced annual licensure inspections and that the overall licensure and licensure inspection process could be improved from a time and procedural standpoint. The recommendations are mostly included throughout the rest of this report however, the Subcommittee specifically recommended:

Recommendations:

1. Unannounced annual licensure inspections.
2. Annual inspections must include specific review for past violation (correction or continued existence of prior violations found and/or alleged).
3. Inspection visit must include opportunity for provider to develop a plan of correction (or collaborate on plan with inspector) to submit for approval at the time of inspection.

E. Classification of Violations

The Subcommittee strongly believes that the classification system currently outlined in Act 185 should be implemented and utilized. There was recognition that the suggested classification scheme could be improved. The subcommittee recognizes that alterations may be needed prospectively in the classification system to make it more workable, and would like to work further with DPW to come up with a classification system that would permit appropriate fining and address some of the past concerns. Past concerns with the existing classification system, e.g. that every violation would be appealed, and the Department would be willing to have a classification system provided it did not tie the department or industry up in extra litigation.

Even though DPW does not currently classify violations, it does have a section on how to classify violations (with examples) that is provided to inspectors in their procedures manual. The Subcommittee reviewed this and made the following recommendations:

Recommendations:

1. All violation should be classified and fines levied as specified by licensing statute.
2. This Subcommittee or another group should meet with Ombudsman, Protective Services, and DPW-OSP to come up with detailed guidelines on how to classify each violation of the regulations. The guidelines that DPW crafted for its procedures manual on how inspectors should classify violations might be a good starting point, although the Subcommittee feels that these guidelines as written are not adequate for establishing the whole classification scheme. The group that meets with Ombudsmen, PS, and DPW should craft a classification scheme that accounts for number and frequency of violations, updated laws and requirements, and the circumstances that surrounded and consequences that resulted from the violation.
3. The final product should be put into the appendix to the regulations on classification so that there is more consistency and uniformity of enforcement and so that there is less question as to what the penalty for any specific violation will be.
4. Amend statute to be less forward looking, so that conduct that "**has caused or** has a substantial probability of causing" death or serious mental or physical harm can be class 1 violations.

5. On Class 1, DPW needs to interpret mental health harm to include abandonment and financial exploitation, etc.

F. **Fines.**

The group agreed that the fining structure needs to be improved. There need to be some immediate fines imposed upon the finding of a violation plus additional fines imposed for the failure to correct or to timely correct violations, and thus for having continuing violations.

Recommendations:

1. Some fines should be immediate. There must be fines for the existence of the violation and additional fines for the failure to timely correct the cited violation. Thus, failing to have enough staff on duty should lead to a fine. Failing to correct this within the timeframe afforded under the statute, should lead to additional fining. This would require a statutory change.
2. Fines must be imposed for failure to comply with a plan of correction or for false documentation of compliance with plan of correction.
3. Presently, DPW does not believe it can fine for any day on which DPW staff have not checked that the violation still exists. There must be a rebuttable presumption that a violation still exists unless and until the provider demonstrates that it is fixed. All notices of violation and levying fine should state that the fines will continue on a daily basis until the facility notifies DPW that the violation has been corrected. If regulations are revised, they should explicitly establish this rebuttable presumption. Regulatory change should indicate that "the statute says the fine runs from date of violation to date of correction and presumption will be that violation exists until demonstration of correction."

G. **Plans of Correction**

The group discussed the importance of articulating how to define an acceptable plan of correction. In order for a plan of correction to be acceptable, it must address how the facility will resolve the root cause of the problems and not just the symptoms. For example, a violation for bulging cans: plan of correction must address how facility will make sure bulging cans don't happen (e.g. on the 1st and 15th of the month, Sally will check the cans) not just state what facility will do to get rid of existing bulging cans (will throw out the bulging cans found by inspector).

Once a plan of correction is submitted, the Department must promptly make and notify the provider of its determination as to whether the plan of correction is acceptable as a tool which, upon implementation, will bring the facility into compliance. POCs can be made jointly at time of inspection and approved on site.

Once a plan of correction has been accepted, the provider must demonstrate compliance with the plan and provide verification to the Department that compliance has been achieved. This must all take place before the license expires in order to get license renewed and within the timeframe for correction as set forth in the statute in order to avoid a fine.

Recommendations:

1. For a first violation, the citation should identify the violation and the end result that must be achieved and it is up to the provider to state how they will accomplish the

desired outcome. The proposed solution must reflect the provider's understanding of the health and safety risks posed by the violation. The PCH will state when and how the correction will be completed.

2. If there is a second recurrence of the violation, the licensing office will identify the end result that must be achieved, that the facility had proposed to do xyz about it, that the problem continues, and what the facility must now do to achieve the necessary end result. Failure to comply may result in loss of full licensure status. The corrective action that was acceptable first time, will not be accepted the next time because it failed to achieve sustained compliance.
3. The Department must develop uniform acceptable corrective measures for each violation (or violation type) that facilities can select to follow on first violation and that providers will be required to follow on second violation. These should include how the deficiency will be corrected, the specific completion dates for correction, the end that must be achieved, effect on resident or residents, specific protocols that should be included with this finding, and how the correction will take place.
4. We recommend the Dept submit a timely response to accept or disapprove POCs (within 2 to 3 business days is recommended).
5. DPW administrative personnel should oversee approval of POCs for an initial period of time.
6. Demonstration of correction shall be tailored to/consistent with the nature of the violation and may include:
    - revisit by inspector – for all class II and Class I
    - receipts
    - pictures
    - certification by administrator
7. Failure to meet the deadlines for compliance with POCs will result in revocation of full license and will revert to provisional license. There may be situations where compliance is out of the control of providers, where in order to be in technical compliance third party intervention is required (e.g., physician signature, etc.) In these cases, providing copies of certified letters might be treated as correction. If still not fully corrected (physician signature still not obtained) at next inspection, liability for violations increases. Something would have to change to alleviate the situation. Repeated violations warrant more severe consequences and shall be treated differently.

H. Ban on Admission Imposed and No Supersedeas

Not only was the Subcommittee concerned about the lengthy appeals process (as discussed in Section I below) but it was concerned about the ability of a facility to admit new residents while an appeal of a licensure revocation is pending. This is especially disconcerting where the residents or the agency referring the residents had inadequate information about the licensure status. For this reason, the Subcommittee made the following recommendations:

Recommendations:

1. In cases of PCHs for which DPW refuses to grant or reissue a license or where emergency relocation has been ordered, DPW should
    a. issue a ban on admissions and/or appointment of master,
    b. oppose any request for supersedeas, and
    c. if necessary seek injunction against continued operation.

d. temporarily suspend license as called for in statute.

2. Appeal of DPW action must not amount to continued operation on expired annual license.
3. DPW believes that it cannot interfere with a provider's admissions or operations until the matter has gone up to Commonwealth Court. Then DPW can oppose a supersedeas request. The Subcommittee does not interpret the law to mean this and questions the legal basis for this interpretation. To the contrary, the Subcommittee believes that the Department must prevent new admissions, work to relocate and oppose supersedeas' from the moment it seeks to revoke a license and that in order to get a supersedeas, provider must show substantial likelihood of success on the merits.

I. Appeals/Settlements

The Subcommittee expressed great concern about the appeals process and the practice of reaching settlement agreements. Generally, the group felt that appeals take too long. Additionally, the group felt that inappropriate settlement agreements are often reached with poor performing providers to end the appeal process. For these reasons, the Subcommittee makes the following recommendations:

Recommendations:

1. BHA shall make PCH appeals a top priority where residents are still in the home. Hearing decisions should be issued within 90 days, and reconsideration requests to the Secretary decided within 60 days.
2. DPW legal department needs to have adequate staff (and perhaps increase staff) dedicated to PCH issues to handle appeals more swiftly.
3. Settlement agreements shall only be used if (a) enforced-- time-specific as to what is required, (b) the PCH complies with the law and offers additional value, and (c) if there are financial and licensure consequences if the PCH does not comply.
4. No provider shall be advantaged by reason of settlement in the resolution of an appeal.
5. All settlement agreements must include a provision that a facility waives the right to appeal a citation for violation of anything they agreed to do or not to do in a settlement agreement.
6. In licensure revocation actions for bad actors, Department must reach out for amicus, etc. to help educate the courts and show support for need for department's action. Likewise, there must also be better coordination and support by Protective Services (PS) and Ombudsmen to help with appeals.
7. In using the classification of violations provision, the statute requires a provider to place $500 into an escrow account in order to set off a lengthy appeal of the fact or fine of a violation and stay in business. This fixed amount should be a minimum and DPW should come up with amounts that depend more on size and severity of violations. Additionally, there needs to be an amount also for the appeal of a revocation (not just for challenge of a violation).
8. DPW staff believe it can only recommend relocation, revocation of license, etc. and not actually revoke or relocate, etc. DPW staff also believe that no actions can be taken by them until their recommended actions are approved by BHA and the Secretary. The Subcommittee does not interpret the law to say this and cannot find a legal basis for this interpretation of the law. The Subcommittee believes that

what a licensing agent does is to take an action, not to make a recommendation. This may need to be resolved with legal counsel and should be discussed with them (legal office has told them that they cannot take a license, only BHA can - last 3-4 years).

9. Licensing staff cite for a present violation but appealing parties claim at the hearing (which may be years later) that they should not lose their license because they are now in compliance. To correct this, the Subcommittee recommends amending the law to state that the Court should support the licensure action unless the facility can establish through a preponderance of the evidence that the procedures, policies, staff resources have been and will continue to be in place to ensure full licensure compliance by the facility in the future.

J. Disclosure of Information to the Public

Overall, the Subcommittee agreed that there must be increased and improved disclosure to the public of information regarding PCHs. Informing the public and assuring accountability are important features that must be included in the PCH system. This should include making "internal" documents publicly accessible and improving the specificity of the information on the web site. The specific recommendations were as follows:

Recommendations:

1. Recommend that the DPW web site be modified to add: (1) which facilities have secured unit waivers, (2) whether the reason for a provisional license is that the facility is new or that the license has been reduced from a full license, (3) number of provisional licenses the facility has held, (4) types of violations, (5) opportunity for plans of correction to be posted, and (6) legal entity information
2. Any new changes to enforcement and licensing process must be relayed to providers and consumers in a timely fashion. Such changes should also be put into Operational guidelines manual, DPW bulletins, etc. for reference by the Department staff). These operating instructions should also be available to consumers and the public.
3. More public accountability – all inspection and redacted complaint reports must be made available as public records, especially monitoring records during cease and desist and other litigation.
4. When residents are relocated by DPW, they should never be placed in a facility with a provisional license.
5. Better steps should be taken to make sure all referral sources know the status of a provider's license. How to access current information on this must be made clear.

K. DPW Administrative Resources and Technology

Licensure problems exist that include systems problems. For example, there are obstacles to early licensure and inspection that result from internal co-ordination issues between DPW-OSP and OLRM.

Recommendations:

1. Notification of providers of upcoming licensure renewal and inspections should be done in a reasonable and timely fashion to allow for renewal of license. DPW needs to resolve the co-ordination problem with OLRM and Office of Social Programs which has led to delays. Timeliness in mailing, receipt, and notification of inspection office and scheduling of the inspection to insure that there is sufficient time after notice is sent out for the application to be returned, inspections conducted and plans of correction submitted and implemented.
2. For renewal inspection timing purposes, it might be worth creating a presumption that a provider intends to re-apply. Facilities would be required to have pre-licensure survey and census ready and available during the last three months of the licensure period so that they are prepared when inspectors arrive.
3. DPW licensing office should be allocated funds and resources (staff computers, etc.) to do their jobs (Implement PACTS).
4. Funds for adequate licensing staff should be allocated and grow or decline accordingly as the industry grows or declines, taking into consideration the facility demographics, number of beds in each facility, whether facilities have history of high number of complaints, geographic distance between facilities a licensing rep is responsible for, and special needs populations of residents. Recommend that a licensing rep never carry more than 60 homes, ideally 50 (or industry standard if developed).
5. Adequate technology to do real-time licensing.
6. DPW needs to utilize technology and photography, etc. to demonstrate/evidence the violations. This will assist in hearings and litigation.

L. Complaint System

The Subcommittee expressed concerns about the PCH Inspection staff's training/skill in conducting complaint investigations. The Subcommittee did not feel that licensing staff are adequately trained in investigative techniques and may have a bias for facilities under their purview. Licensing representatives tend to develop a cooperative relationship with facilities, which can interfere with their ability to investigate complaints effectively. For this reason, the Subcommittee recommends the following:

Recommendations

1. Complaint Investigation Team. The Commonwealth should establish a complaint investigation team that is multi-disciplinary, composed of separate staff from the licensing reps.
2. Timing. The complaint investigation team should follow the timeframes in the DPW Procedure Manual for Licensing Staff regarding immediate threat, potential threat, and no threat. In so doing, however, the complaint must be presumed to be founded.
3. Scope. The scope and end point of an investigation must be articulated.
   a. Complaints should trigger an oversight review of facility's overall compliance with requirements, regardless of whether there is a systemic or isolated problem. Even if the resident who was allegedly harmed is no longer in the facility (e.g., is in the hospital), complaint should be investigated by DPW to determine whether the conditions which gave rise to the complaint are a threat to other residents.

Recommendations on
Personal Care Home Licensing and Enforcement Reform
by the Licensing and Legislative Subcommittee
of the DPW PCH Advisory Committee

March 14, 2002

The Licensing and Legislative Subcommittee of the DPW PCH Advisory Committee met three times, on November 28 and December 14, 2001 and January 8, 2002. The purpose was to address the issues raised by the Auditor General's October 2001 report on "Oversight of Personal Care Homes in Pennsylvania" and other concerns about the licensure and regulation of personal care homes. The group explored the current regulatory and enforcement system to determine what changes should be made in order to ensure the health and safety of personal care home residents.

The Subcommittee included the following participants: Pam Walz (Chair), Community Legal Services; William Gannon, DPW-OSP; Patsy Taylor-Moore, DPW-OSP; Ann Torregrossa, Pennsylvania Health Law Project; Alissa Halperin, Pennsylvania Health Law Project; Christine Klejbuk, PANPHA; Lynn Fosnight, PALA; Beth Greenberg, PANPHA; Dale Laninga, Inter-Governmental Council on Long Term Care; Clarence Smith, CERCA; Pat McNamara, PHCA/CALM; Cindy Boyne, State Ombudsman.

The Subcommittee makes the following recommendations:

I. Licensing:

The subcommittee recommends changes to the licensing process *to ensure that facilities which are out of compliance with regulatory standards do not receive new or renewed licenses.*

Overview of Recommended Licensing Process:

1. Step 1: Facility applies for license. If applying to renew existing license, it will apply 2-3 months prior to expiration of current license.
2. Step 2: DPW makes unannounced inspection visit.
3. Step 3:
   - If facility is in full compliance (meaning no Class I, II or III violations), it will be issued a full license.
   - If facility is in substantial compliance (meaning it has Class III violations and has had an acceptable plan of correction approved), it will be issued a provisional license. If correction of violations is demonstrated prior to expiration of current license, full license will be issued.
   - If facility is in non-compliance (meaning that Class I or II violations exist), no license will be issued unless the facility submits an acceptable plan of correction and provides verification that violations have in fact been corrected prior to the end of the licensure period.

Additional Licensing Recommendations

4. Newly opened facilities which are found in full compliance should be issued a full "new" license (not a provisional license as is currently the practice), with a notation for a six month period stating that the license is "new". DPW should reinspect newly opened facilities within 3 months to check for compliance with requirements which can only be inspected once a facility is in operation and has admitted residents.

5. DPW should differentiate between a new facility license and a full license in providing information to the public. It should be made clear that a facility with a new license has no resident history and that there is thus no measure of its performance on resident-related aspects of the regulations. At the end of the new license period, a facility must be in full compliance in order to get a regular license.

6. Provisional licenses should be issued only in cases where Class III violations exist and the facility has submitted an acceptable plan of correction.

7. DPW should not issue second and subsequent provisional licenses if violations which resulted in the previous provisional license have not been corrected or if the same violations have been repeated. A facility could be issued a subsequent provisional license if new and different Class 3 violations occurred.

8. If a facility which has had four consecutive provisional licenses is not in full compliance prior to the beginning of the next licensing period, no license should be issued.

9. When the Department denies or revokes a license, it should issue an emergency order to relocate residents while any appeal proceeds.

10. The Department should interpret the requirement that applicants for a license be "responsible persons", 62 P.S. §1007, to prohibit transfer of license or issuance of new license for a facility to family members, friends, business associates, etc., where it appears that the purpose of the change in license holder is to avoid licensing action or if it appears that the former owner will continue to have involvement in the facility or business. Regulations should be promulgated to state this explicitly.

11. Licensure inspections should be unannounced and conducted annually.

12. Inspections should include review of whether past violations have been and continue to be corrected.

13. At the inspection visit, opportunity should be provided for the provider to develop a plan of correction (which may be in collaboration with licensing representative) to submit for approval during the visit.

II. Classification of Violations

1. The statutory classification system for violations set forth at 62 P.S. §1085 should be implemented and utilized, and fines should be imposed as required by 62 P.S. §1086.

2. The subcommittee recognized that the existing classification system could be improved to make it more workable, and would like to work with the Department to develop a classification system which would facilitate more effective enforcement action and address the Department's past concerns.

3. The current guidelines for classifying violations in the DPW Procedural Manual for Licensing Staff should be reviewed and amended by a work group including the Ombudsman,

Protective Services and Department staff. The guidelines should direct that in classifying violations, consideration be given to the number and frequency of violations, and the circumstances surrounding and consequences of violations.

4. After revision, the guidelines should be added as an appendix to the regulations in order to increase consistency of enforcement and certainty about the penalty for a particular violation.

5. The statutory provision at 62 P.S. §1085 should be amended to provide that a violation which "**has caused or** has a substantial probability of causing death or serious mental or physical harm to any resident" constitutes a Class 1 violation.

6. The term "serious mental harm" in 62 P.S. §1085 (defining Class 1 violations) should be interpreted to include the harm resulting from abandonment or financial exploitation.

7. The Department should enforce compliance with 62 P.S. §1057.3(a)(4), which requires that each resident be provided by the administrator with notice of any Class 1 or 2 violations which remain uncorrected after five days.

III. Fines

1. Fines should be imposed for failure to comply with a plan of correction or for false documentation of compliance with a plan of correction.

2. There should be a rebuttable presumption that a violation still exists (resulting in the continued imposition of fines) unless and until the provider demonstrates that it has been corrected. Notices of violations or of imposition of a fine should state that the fines will continue to accrue each day until the facility demonstrates to the Department that the violation has been corrected. Any revision of the personal care home regulations should explicitly state this presumption.

3. In certain circumstances, fines should be imposed irrespective of whether the violation(s) have been corrected. If the provider fails to correct the violation, additional fines should be imposed. The Department should seek the statutory change which appears necessary to implement this recommendation.

IV. Plans of Correction

1. For a plan of correction to be considered acceptable, it should address how the facility will correct the root cause of the violation and not just the resulting symptoms. For example, if a facility is cited for having bulging cans of food, the plan of correction should not just state that the bulging cans will be thrown away, but also provide a system for ensuring that the facility does not have bulging cans in the future (e.g., provider will check the cans at periodic intervals).

2. When a plan of correction is submitted, the Department should promptly determine and notify the provider whether it is acceptable as a tool which, upon implementation, will bring the facility into compliance.

3. The Department should facilitate the joint development of plans of correction by providers and licensing representatives, as well as approval, at the time of an inspection.

4. Once a plan of correction has been approved, the provider must demonstrate implementation of the plan and provide verification to the Department that compliance has been achieved. This must take place before expiration of a license in order for the license to be

renewed and within the time frames for correction set forth in 62 P.S. §1086 in order to avoid a fine.

5. When a violation recurs after having supposedly been resolved by a plan of correction, requirements for further plans of correction should be more prescriptive and stringent in order to ensure that the violation does not recur. For a first violation, the provider should determine how s/he will achieve compliance. The proposed plan of correction must reflect the provider's understanding of the health and safety risks posed by the violation. If there is a recurrence of the violation, the Department will direct what steps the facility must take in its plan of correction. The steps outlined in the first plan of correction should not be considered sufficient the second time because they failed to achieve sustained compliance.

6. The Department should develop uniform acceptable corrective measures for each type of violation which facilities can select on a first violation and which facilities will be required to follow on a subsequent violation. These measures should include protocols for correcting the violation, the anticipated effect on residents, and time frames for completion.

7. The Department should promptly respond to a request for approval of a plan of correction (we recommend within 2 to 3 business days).

8. After the above changes are implemented, supervisory-level staff within the Department should oversee approval of plans of correction for an initial period of time in order to ensure uniformity.

9. Demonstration that a violation has been corrected shall be consistent with the nature and seriousness of the violation and may include: revisit by inspector (should be required for all Class 1 and 2 violations), submission of receipts or photographs, or certification by the administrator.

10. Failure to meet deadlines for compliance with plans of correction should result in revocation of full licensure status. There may be situations in which compliance is not within the provider's control (e.g., getting physician's signature). In such cases, proof of acceptable efforts to comply (e.g., copies of certified letters sent to physician requesting the signature) should be treated as compliance. If, at next inspection, the violation is still uncorrected (e.g., physician signature still not obtained), more strenuous efforts will be expected of the facility (e.g., facility may be required to change to a more responsive house physician).

V. Appeals

1. A facility's appeal of a license revocation or denial of license renewal should not permit the facility to continue business as usual (admitting new residents, ongoing poor care and/or conditions) for long periods of time, as is currently the case. Where a facility appeals the loss of its license, the Department should take the following actions as necessary to protect the residents:

a. appoint a master pursuant to 62 P.S. §1057.1(b);

b. seek an injunction against new admissions or continued operation of the facility pursuant to 62 P.S. §1055; and

c. oppose any request for supersedeas.

2. The subcommittee has been informed that the Department considers an adverse licensing action only a "recommendation", not a "decision", until BHA has denied the provider's appeal. The result of this interpretation has been that the Department assumes that it cannot halt

a facility's admissions or operation until the matter has gone to Commonwealth Court, a step which currently takes years to reach. The subcommittee disagrees very strongly and questions the legal basis for this interpretation. A revocation or denial of a license is a decision of the Department, giving the Department the right and the duty to prevent further harm to residents while an appeal is pending. To this end, the Department should in appropriate cases relocate residents, ban new admissions and oppose supersedeas from the moment it revokes or denies renewal of a license. Supersedeas should not be granted during administrative appeals or at the Commonwealth Court level unless the provider can show a substantial likelihood of success on the merits.

3. BHA should make PCH appeals a top priority where residents are still in the facility. Hearing decisions should be issued within 90 days of the filing of an appeal, and reconsideration requests to the Secretary should be decided within 60 days.

4. The Department's Office of Legal Counsel needs to have adequate staff dedicated to PCH issues to be able to handle appeals with reasonable promptness.

5. Appeals should not routinely be settled with poorly performing providers, as currently appears to be the case. Settlements should only be used if they a) are specific as to what will be required from the provider and b) the terms are enforceable by the imposition of financial and/or licensure consequences if the provider does not comply.

6. To avoid giving an advantage to non-compliant providers, any settlement agreement must require the provider to do more than simply comply with the regulatory requirements which they were supposed to comply with in the first place; the provider must offer additional efforts above and beyond the baseline requirements.

7. All settlement agreements should provide that the facility waives the right to appeal citations for violations of anything they promised to do or not to do in the settlement agreement.

8. In licensing action appeals involving the worst actors, the Department should coordinate efforts with Protective Services and ombudsmen and seek amicus briefs from consumer advocates to help educate the courts about the harm caused by egregiously bad PCHs.

9. Providers who appeal fines are required to submit the assessed penalty, up to a maximum of $500, to the Department for placement in an escrow account. A higher payment, dependent on the severity of the violation, should be required in order to cut down on frivolous appeals. An escrow payment should also be required in appeals of license revocations.

10. The statute or regulations should be clarified to provide that a reviewing court should not sustain an appeal on the ground that the facility, although out of compliance at the time it was cited, is now in compliance unless the facility can show by a preponderance of the evidence that its procedures, policies and staff resources do and will continue to ensure full compliance in the future.

VI. Disclosure of Information to the Public

1. The public needs more and better information about PCHs in order to make knowledgeable decisions. Accordingly, the following should be added to the Department's web site: a) which facilities have secured unit waivers, b) whether the reason a facility has a provisional license is that it is new or that it has been reduced from a full license, c) number of consecutive provisional licenses a facility has had, d) types of violations found in recent

inspections, e) plans of correction, and f) information about the facility's legal entity.

2. Any changes to the licensing and enforcement process should be communicated to providers and consumers in a timely manner and should be memorialized in the DPW Procedure Manual for Licensing Staff and/or Department bulletins. These operating instructions should be available to the public.

3. All inspection and redacted complaint reports should be made available as public records, especially monitoring records during cease and desist and other litigation.

4. When residents are relocated by the Department, they should never be placed into facilities with less than full licensure status.

5. Referral sources (hospital social workers, etc.) need more information about the licensing status of facilities.

VII. Department Administrative and Technological Resources

1. The Department should resolve coordination problems between OLRM and the Office of Social Programs which have led to delays in the scheduling of inspections and completion of the licensing process. Notification of upcoming license renewal and inspections should be sent to providers sufficiently in advance to allow time for the license application to be returned, inspections to be conducted, and plans of correction to be submitted and implemented prior to the end of the licensing period.

2. For renewals of licenses, the Department should explore creating a presumption that the provider intends to reapply. Facilities would be required to have their pre-licensure survey and census ready and available during the last three months of the licensure period so that they are prepared when inspectors arrive.

3. Licensing offices should be allocated sufficient staff and resources to carry out their functions effectively.

4. Licensing staffing levels should reflect growth or decline in the size of the industry, with staffing in each regional office determined taking into consideration the region's facility demographics, number of beds in each facility, concentration of facilities with high numbers of complaints, geographic distance between facilities which licensing representatives must travel, and presence of special needs populations. We recommend that a licensing representative should never handle more than 60 homes, with 50 being preferable.

5. Delays in entering licensing status changes into computer systems have created delays in the licensing process and confusion. Adequate technological resources should be made available to provide for "real time licensing".

6. The Department should use technology and photography to demonstrate and provide evidence of violations to support its actions in appeals.

VIII. Complaint System

1. Licensing representatives are not adequately trained in investigative techniques and do not necessarily possess the skills needed to investigate complaints. In addition, licensing reps tend to develop a cooperative relationship with the facilities they license which may interfere with their ability to investigate a complaint with objectivity. The subcommittee therefore recommends that separate complaint investigation teams be created, composed of different staff

than the licensing reps. It is recommended that the teams be multi-disciplinary, including members with different knowledge bases.

2. Complaint investigations should take place in accordance with the DPW Procedure Manual for Licensing Staff, which sets forth different time frames depending on whether a complaint involves an immediate threat, a potential threat, or no threat. For the purpose of determining which of these three categories is applicable, the facts alleged should be taken as true.

3. Complaint investigations should focus not just on the individual circumstances of the complainant, but also on whether a systemic problem may exist which threatens harm to additional residents. For example, even if the complainant is hospitalized, consideration should be given to whether the facts as alleged reflect a threat to other residents who are still in the facility. If so, the complaint should be considered an immediate or potential threat even though the complainant is no longer in the facility.

4. The Department should create protocols articulating what steps a complaint investigation should include, how it is to proceed and at what point it will be considered completed. The protocols should specify the types of individuals who should be interviewed. All person with information pertinent to the complaint should be interviewed. This may include other residents, family, physicians and others. Investigators should make sure to speak with enough people to get both sides of the story. Interviews should be conducted confidentially. Where residents' rights violations are alleged, confidential interviews should be conducted with other residents in order to determine whether the alleged violations are occurring.

5. The Department should develop criteria for circumstances in which a complaint investigation may be performed by telephone and those in which there should be a site visit.

6. Site visits for complaint investigations should be unannounced except where immediate telephone contact with the provider is needed to avert an imminent risk to residents.

7. The Department should follow up after the investigation to verify that the conditions complained of have been corrected. Depending on the circumstances, this follow-up could take the form of calling the resident back to check whether the problem is resolved, making a site visit to verify compliance, etc.

8. The Department should notify the complainant in writing of its investigation findings, whether the complaint was founded, and any resulting actions which will take place.

9. During licensing inspections, attention should be paid to issues which have been the subject of complaints in a facility.

10. The Department should utilize a data base to track complaints better. Specifically, the Pennsylvania Automated Complaint Tracking System (PACTS) should promptly be made available to licensing staff. Complaint records should document, in a retrievable form, the nature of each complaint, actions and follow-up monitoring performed by the Department, and issues to be monitored at the next inspection.

IX. Waivers, Immobile Residents

1. No regulation which address the health, safety or well-being of residents (including residents' rights) should ever be waivable.

2. The Department should adopt the Personal Care Home Advisory Committee's

previous recommendations concerning waivers.

3. The Department should promulgate regulatory requirements for facilities housing immobile residents, including cognitively impaired residents. The areas which should be addressed in regulation include increased staffing, appropriate training and activities, environmental needs of physically immobile and cognitively impaired residents, ease of egress for emergency evacuation, and fire safety.

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October 18, 2002

Teleta Nevius, Director
Office of Licensing and Regulatory Management
Department of Public Welfare
Room 316 Health & Welfare Building
P.O. Box 2675
Harrisburg, Pa. 17120

Dear Teleta Nevius,

The Northern Area Personal Care Home Administrators Association would like to discuss one section in this memo today. **Medications 2600.181-2600.188** Last spring as NAPCHAA held meetings in 12 of the 15 Counties in Western Pennsylvania, the **Medication** section was the top issue discussed at every meeting. Furthermore, PROVIDERS made many suggestions in the form of solutions to you in writing and at meetings you attended in Western Pennsylvania.

NAPCHAA believes that this is one of the most important issues to upgrade and improve for the health, safety and welfare of the residents in Personal Care Homes in Pennsylvania. Department of Public Welfare Secretary Houstoun does affirm in her cover letter that much work needs to be done in this area and that work is continuing. The Office of Licensing and Regulatory Management, your office also admits the same.

The Pennsylvania Health Law Project and the PROVIDERS have agreed from the beginning that the **Medication** section was vital to the future of the Personal Care Home Profession. With this section so important, we would like to know from you, why the hurry in submitting the regulations when this section is incomplete? If it is truly the number one complaint area about Personal Care Homes, why submit the regulations when this is incomplete?

As you know, the Northern Area Personal Care Home Administrators Association felt there was a critical need for a **MEDICATION TRAINING PROGRAM.** And in fact, NAPCHAA started a committee to work on this very subject. The committee is made up of Pharmacist, Registered Nurses, License Practical Nurses, Administrators and employees of Personal Care Homes. The Committee even has two Doctors serving as ex-offico members reviewing all materials in the program. The committee has been meeting since September and is ready to do a dry run on the program. The Pennsylvania Personal care Home Advisory Board has appointed Matt Harvey, NAPCHAA President as Chairperson of a sub-committee on the state level as well.

What are the objectives of the **MEDICATION TRAINING PROGRAM:**

#1. Training tract for Administrators
#2. Training tract for key hourly employees

#3. Pre-Test in both tracts.

#4. Interactive classroom sessions covering:
(a) Describe the key components in assisting residents with medications
(b) Review assistance techniques for the various devices used to deliver medications
(c) Review the proper documents for medication assistance
(d) Identify possible risks that may lead top a medication dispensing error
(e) Recognize the key steps to take if a medication error has occurred
(f) Understand the legal responsibility if a medication error does occur.

#4 Post–Test in both tracts.

#5 Performance checklist/Practice at the Personal Care Home
#6 At completion of all 5 steps – a two year Certification as a Medication Personnel.

Medication Personnel may administer medications after successfully completing **the state approved training course that as you can see includes a written performance based competency examination. NAPCHAA is also recommending that an individual must be a high school graduate and have English language proficiency**

. A lot of work still has to be completed on the **MEDICATION TRAINING PROGRAM.** After the dry run in Western Pennsylvania, it will be torn apart. What needed more explanation, what had too much information, what needs to be added and what needs to be deleted. This session will be attended by thirty Administrators and employees. At the completion of this key part. It will then be brought to Harrisburg to be presented to the sub-committee of the Pennsylvania Personal Care Home Advisory Board.

NAPCHAA clearly understands that it may take Legislative action to adjust current statute. West Virginia has done this and has a wonderful program in effect. NAPCHAA is committed to putting this piece in place. The residents of Personal Care Homes deserve a good upgrade to safely ensure their health, safety and welfare. Let us add this **MEDICATION TRAINGING PROGRAM** to the proposed 2600 regulations. It is to important to leave out. Please find attached: DRAFT #2 of Medication Training Program attached and NAPCHAA members involved on the committee.

The remainder of this memo deals directly with **2600.181-2600.188.** We would like to start with **2600.181 (e) A resident is capable of self-administering medications if the resident can use the medication as prescribed in the manner prescribed. The resident shall be able to recognize and distinguish the medication and know the condition of the illness for which the medication is prescribed, the correct dosage and when the medication is to be taken. Examples include being capable of placing medication in the resident's own mouth and swallowing completely, applying topical medications and not disturbing the application site, properly placing drops in eyes, correctly inhaling inhalants and properly snorting nasal therapies.**

NAPCHAA would like to point out that many people who are not elderly or one of our special populations can't even tell you all of the items listed above about their medications. This is not meant to be "smart or out of line". It is the truth. But, we will require this of the elderly and special populations served in Personal Care Homes.

NAPCHAA would recommend the following: #! That this entire section be defined as being the Doctor's determination as to whether the resident is capable and able to self-administer medications. #2 That the MEDICATION TRAINING PROGRAM be added under this section. With the severe shortage of nurses across the Commonwealth and the extreme high cost to add a licensed professional to administer medications, it clearly speaks to the issue to train unlicensed staff to assist where needed.

NAPCHAA would like to address **2600.182 (a) (b) (c)**
Under all three letters it deals with CAM-Complementary and alternative medications – (definition) – practices, substances, and ideas used to prevent or treat illness or promote health and well being outside the realm of modern conventional medicine. Alternative medicine is used alone or instead of conventional medicine. Complementary medicine is used along with or in addition to conventional medicine.
CAM should be eliminated from (a) (b) (c).

Their Doctor's give out complimentary and alternative medicines to residents as a courtesy. The courtesy is to SAVE the residents MONEY. Doctors realize that many residents are on fixed and set incomes and have no extra money. Therefore, they supply them with these complimentary medicines. Personal Care Homes do not have enough room to store CAM's and more importantly CAM's are not always labeled correctly when received by the Personal Care Home. They are supplied by the Doctor as they receive them from the Drug Companies.

2600.182 (d) Prescription, OTC, CAM shall be stored separately. NAPCHAA has asked for clarification or reasoning for this regulation.
NAPCHAA would recommend eliminating (d).

It is a fact in all of the time-use studies courses that the more steps it takes to complete a task, the higher the risk of mistakes. Keeping/storing of medications, OTC's, and CAM's together under each residents names, identification, and Doctor's order sheet along with the MAR (medication administration record) is the safest and most used procedure in the health care field.

2600.183 (b) OTC, CAM and sample medications shall be labeled with the original label.
NAPCHAA would recommend the following:
(b) OTC, shall be labeled with the original label.
As stated above Complementary and alternative medicines are not dispensed by a pharmacy and are not handles the same way. Why take these medications away from the residents?

2600.183 (d) Sample medications shall be identified, the particular residents use and accompanied by a physician's order.
NAPCHAA believes this should be at the option of the Personal Care Home. Many do not use them for various reasons. First, many residents go to the Doctor's on their own. They return with the samples without physician's order. Second, do you realize how busy many physicians are. Also that they would have to be called and asked to complete the task if the resident returned without it. In speaking with many Doctor's, it is almost impossible to get this. They don't do it for any other facility. They wondered why it had to be done in just Personal Care Homes? Please consider this.

2600.184 (3) Limited access to medication storage areas.
NAPCHAA would recommend modify to add: Medication storage for controlled substances shall be locked with limited access.

2600.186 (b) If the home helps the resident with self-administration, a medication record shall be kept to include the following for each resident's prescription, OTC and CAM.
NAPCHAA agrees 110% with the creation of a MAR (Medicine Administration Record). Why not use it as intended though. Add: medications ordered by those prescribed, approved of order by a licensed physician, certified registered nurse practitioner, licensed dentist or physicians assistant within their scope of practice. Eliminate the end and put this in its place.

2600.186 (2) (3) Add: as provided by the pharmacy. The reason being that they are the PROFESSIONAL that notifies Personal Care Homes of these areas currently.

2600.186 (7) © Both contradict definition of self-administration in the definition section of the 2600 regulations. Please clarify ?

2600.186 (d) by the end of the shift.
NAPCHAA would recommend promptly. Residents do have the right to refuse medications. Currently most homes have set orders with their Physician's on what they expect when a resident refuses their medications. Physician's do not want to be bothered at all hours and times. This is a vital and important issue. NAPCHAA does not mean to trivialize it. Please consider this.

In closing, NAPCHAA believes that the regulations should not have gone forward until this section was completed with a MEDICATION TRAINING PROGRAM and the rewriting of the entire section. Please do not ignore this. Please consider our input. I look forward to your written response. I'll see you in Harrisburg soon.

Sincerely yours,

Matthew C. Harvey
President
Northern Area Personal Care Home Administrators Association
df

Medication

Objectives:

1. Describe the key components in assisting residents with medications.
2. Review assistance techniques for the various devices used to deliver medications.
3. Review the proper documentation for medication assistance.
4. Identify possible risks that may lead to a medication dispensing error.
5. Recognize the key steps to take if a medication error has occurred.
6. Understand the legal responsibility if a medication error does occur.

A. Med safety tips – TIP: stay focused with minimal interruptions

1. follow manufacturers' recommendations
    a. shake well - suspensions
    b. give med with food ex. NSAIDS
    c. give med with 8oz. fluid ex. bulk laxatives, NSAIDS. Potassium supplements
    d. roll cloudy insulin (no air bubbles)
    e. Fosamax - Do not lie down for 30 minutes; no food or drink for 30 minutes; take with 6oz. of water
2. crushing guide followed
    a. be sure an up-to-date crush list is readily available
    b. common abbreviations for extended release drugs (see handout)
3. 7 rights followed
    a. right resident
    b. right medication
    c. right dosage
        1. **TIP**: if liquid is an odd dose that is not on a med cup (ex. 3ml, 7.5ml) use a syringe.
    d. right time
    e. right route
    f. right method
        1. ex: inhaler technique
    g. right position
4. vital signs are taken if parameters ordered
5. "with food" meds given with food
6. is there an allergy history?

B. Specific Assistance Technique

1. Inhalers
2. Oral
3. Nasal
4. Ophthalmic
5. Otic
6. Rectal
7. Vaginal
8. Topical
9. Injection – Sub-Q
10. Sublingual

C. **Profile of a new med**
   1. What is the purpose and desired effect of the medication?
   2. What is the response time?
   3. Are there any unwanted effects that should be specifically monitored?
   4. Are there any possible interactions with other medications or food, including PRN medications?
   5. Are there any special administration / storage instructions?
   6. Is the medication a controlled substance?
   7. What is the range of time before and after a prescribed dose medication in which it can be safely administered?
   8. What should the staff do if the following occurs:
      a. A dose is missed?
      b. A dose is refused?
      c. A dose is regurgitated?
      d. A dose is expelled or spit out?
   9. Is the medication intended to be an antipsychotic? Can it have effects on behavior?
   10. Does the medication require blood level monitoring? How often?

D. **Storage / safety**
   1. medications are locked in a secure area
   2. refrigerator meds are kept between 36° F and 46° F and locked
   3. Miacalcins are stored upright after priming
   4. Biohazard / Sharps containers are being utilized and stored safely away from residents
   5. Self administered medication
      a. resident demonstrates compliance

E. **DPW Compliance**
   1. residents are given meds from their own supply, no borrowing
   2. No discontinued or expired meds
   3. No Emergency Drug Boxes
   4. Labeling meets DOH requirements
      a. Prescription
      b. OTC
   5. Right to privacy
      a. HIPAA
   6. Vacation / LOA medications
   7. Disposal of medications / DEP
   8. Drug information sheets
   9. Right to refuse medication

F. **Accountability**
   1. Tracking systems are in place to assure accountability
   2. Diversion (theft) prevention
      a. how to handle a diversion
   3. Medication errors
      a. how to handle an error
      b. prevention
      c. reporting
      d. follow-up

G. Documentation

1. Recommend utilizing a Medication Assistance Record (MAR)
2. Record and track use of PRN medications, including reason
3. Note changes on MAR by highlighting discontinued orders
4. Medications should be documented after the resident has taken the medication, don't pre-sign meds
5. Make sure label, MAR and physician's order (prescription) all match
6. Initials are circled and reason is noted on the MAR for refused or withheld medications.
7. Recommend documenting sites for Insulin Inj. and topical patches so areas can be rotated.
8. Recommend documenting vital signs if parameters are ordered with medication
9. "Change of Direction" stickers should be used when a time, frequency, or dosage changes and the dose can safely be made using the existing medication.

H. Infection Control

1. Hand washing is thought to be the single most important step in infection control
2. Hand sanitizers are a good augmentation to hand washing, but they do not replace soap and water. **TIP:** Some hand sanitizers recommend only using product no more than 5 times in a row without washing hands with soap & water

I. Emergency Medication

1. When is an order an emergency?
2. How to obtain an emergency medication
   a. including controlled medications

J. Weights and Measures

1. 1 teaspoon (tsp) = 5 milliliter (ml) = 5 cubic centimeter (cc)
2. 1 Tablespoon (Tbsp) = 3 teaspoons (tsp) = 15 milliliter (ml) = 15 cubic centimeter (cc)
3. 1 ounce (oz) = 30 milliliter (ml) = 30 cubic centimeter (cc)
4. 1milligram (mg) = .001 gram (gm)
5. 1 milliliter (ml) = 1 cubic centimeter (cc)
6. 1 cup = 8 ounces (oz) = 240 milliliter (ml) = 240 cubic centimeter (cc)
7. 1 pint (pt) = 2 cups = 16 ounces (oz) = 480 milliliter (ml) = 480 cubic centimeter (cc)
8. 1 quart (qt) = 2 pints (pt) = 4 cups = 32 ounces (oz) 960 milliliter (ml) = 960 cubic centimeter (cc)
9. 1 gallon = 4 quarts (qt) = 128 ounces (oz) = 3.8 liters = 3840 cubic centimeter (cc)
10. 1 liter (L) = 1000 milliliter (ml) = 1000 cubic centimeter (cc) = 1 kilogram (kg)
11. 5 grain (gr) = 65 milligrams (mg)
12. ½ grain (gr) = 16 milligrams (mg)
13. ¼ grain (gr) = 16 milligrams (mg)
14. 1/100 grain (gr) = 0.6 milligrams (mg)
15. 1/150 grain (gr) = 0.4 milligrams (mg)
16. 1/200 grain (gr) = 0.3 milligrams (mg)
17. 15 grain (gr) = 1 gram (Gm)
18. 95 Fahrenheit (F) = 35 Centigrade (C)
19. 32 Fahrenheit (F) = 0 Centigrade (C)

TIP: To compute Fahrenheit: Multiply Centigrade by 1.8 and add 32
To compute Centigrade: Subtract 32 from Fahrenheit and divide by 1.8

Medication Pre-Test

1. You should check the following before you administer Lanoxin (Digoxin):
   a. Pulse
   b. Blood pressure
   c. Respirations
   d. None of the above

2. The abreviation Bid means:
   a. Take with water
   b. Twice a day
   c. Check blood pressure
   d. None of the above

3. A nebulizer is used for:
   a. Foot massages
   b. Breathing treatments
   c. Oxygen
   d. Injections

4. Any tablet or capsule maybe crushed and mixed with food if resident is unable to swallow the medication whole.
   a. True
   b. False

5. If the manufacturer recommends that a medication be stored in the refrigerator, it is acceptable to leave the medication out of the refrigerator for:
   a. 24 hours
   b. 72 hours
   c. 1 week
   d. None of the above

6. OTC stands for:
   a. Only take chronic
   b. One time consult
   c. Open the capsule
   d. Over the counter

7. If you find a medication that is expired, you should:
   a. Give it to the resident
   b. Notify the pharmacy
   c. Throw it out
   d. Call 911

8. To insure residents safety, you should:
   a. Keep all medication storage areas locked when not in use
   b. Keep Poison Control phone number posted for quick reference
   c. Keep the keys to the medication storage area with you at all times during your shift.
   d. All of the above

9. If the doctor orders a medication to be given HS (at bedtime) but the resident will only take it in the morning, you should:
   a. Follow the residents wishes and change the time on the MAR to morning
   b. Notify either the doctor or your supervisor
   c. Keep the time on the MAR as bedtime and document every time the resident refuses the medication.
   d. Have the medication discontinued

10. A plain Aspirin can irritate your stomach
   a. True
   b. False

11. If you are assisting a resident with a new medication, Ampicillin, and the residents states "I think I'm allergic to that," you should:
   a. Have the resident take the medication and watch them carefully for a reaction
   b. Hold the medication and notify the doctor or supervisor
   c. Have the resident take the medication and leave a note for the next shift
   d. Have the resident take the medication and call 911, just in case

12. If a medication is ordered to be given "with meals," the resident should take the medication:
   a. ½ hour before a meal
   b. 1 hour after a meal
   c. while they are eating a meal
   d. at bedtime

13. If a resident is NPO, they should:
   a. Stay awake as long as they can
   b. Consume no liquids
   c. Consume only liquids
   d. Consume nothing by mouth

14. Antacids are used for:
   a. The heart
   b. The stomach
   c. Pain
   d. Blood pressure

15. If the doctor orders a 3ml dose of liquid medication, the best way to accurately measure it is:
   a. with a syringe
   b. with a plastic medicine cup
   c. with a teaspoon
   d. any of the above

Monitoring Medications and Diseases in Elderly Residents

I. What is monitoring?

a. Resident monitoring is helpful to nurses, physicians, and pharmacists because it allows to see if the desired effect of medications is being obtained to control diseases
b. Resident monitoring is helpful that is allows to make sure that no side effects to medications are occurring, or the disease itself is getting worse from medications failure to control, cure, or prevent disease state symptoms.

II. Obtaining a medication history from a resident

a. Obtaining a complete medication history is essential when a new resident arrives because it allows everybody to get a detail history of what medications have worked in the past, what medications have failed in the past, and what medications may have caused side effects or allergies in the past.
b. Obtaining a medication history for the facility is important, because studies have shown that information sources available to an admitting physicians may be inaccurate, potentially resulting in incomplete drug histories.

c. Several potential difficulties may occur while taking medication histories from the elderly. They include the following:

i. Communication problems (hearing and vision)
ii. Underreporting of medication usage due to health beliefs or memory impairment
iii. Reliance on family member or caregiver to give report on history of medications
iv. Failure to report over-the-counter medications, because they do not recognize these as true medications
v. Failure to report herbal or vitamins usage
vi. Residents are many times unaware of indications for all medications due to multiple diseases and multiple medications

d. The importance of inquiring about over-the-counter medications
i. It can not be stressed enough to record this information because one-third of all medications used by the elderly are sold without prescriptions
ii. Over-the-counter medications are also very high risk for side effects.

e. Collect information for all prescription, non-prescription, and herbal medication and nutritional supplements the patient has taken during the past month:
    i. Name, dose, frequency, indication for medication, how long have they used it.
    ii. History of past medications used, and why were they stopped.

f. It is important to collect data that has been shown to contribute to increase risk of medication-related problems.
    i. Ask patient to they see multiple physicians
        1. If the answer yes, inquire about the question is all of the physicians aware of all the medications the resident is taking.
        2. The risk of drug interactions and side effects has been shown to be higher in residents with multiple physicians
    ii. Ask the resident do they have any problems in being compliant with their medications.

    iii. Examples of things that may contribute to residents have trouble with compliance are as follows:
        1. impaired hearing, vision
        2. Memory problems
        3. Ability to open medication safety caps
        4. Ability to pay for medications
        5. Ability to swallow medications (e.g. pills, capsules)

g. When completing a medication history we want to assess if any problems, maybe contributing to medications.
    i. Key questions to ask for this is the following:
        1. Do you have difficulty dressing yourself, getting out of bed?
        2. Have you fallen in the past few weeks at home, or do you have history of falls? History of fractures?
        3. Do you ever lose your urine and get wet? If yes , ask frequency, amount, time of day, situation?
        4. Do you have problems with constipation? If yes, what is the frequency of this? What have you done in the past to relieve this problem?
        5. Do you every feel sad or depressed?
        6. Do you notice having any memory problems? Have you noticed any problem with forgetting your medications?
        7. Have you noticed any problems with sleep? If yes, what problem do you have difficulty fallen asleep or staying asleep. What is your caffeine consumption during the day, and at what times do you drink caffeine beverages?

8. Have you noticed any problems with your appetite? If yes, what is the problem decreased appetite, difficulty in chewing, difficulty in swallowing?

III. Key Monitoring Parameters for Common Diseases

a. Hypertension (High Blood Pressure)
   i. Definition – Having a systolic pressure (top number) above 140mm Hg, a diastolic pressure (bottom number) above 90 mm Hg, or both.
   ii. It is common for older patients to have a high systolic (top number) with a normal diastolic (bottom number) blood pressure. This is called isolated systolic blood pressure, which is just as serious as having both numbers high.
   iii. Evaluating blood pressure is the key component in monitoring this disease.
   iv. Goal of treatment for high blood pressure is to obtain a target goal blood pressure to prevent or worsen complications such as congestive heart failure, retinopathy (eye disease), cerebrovascular accidents (Stroke), or renal insufficiency (Kidney disease)
   v. Examples of target goal for high blood pressure

Target Blood Pressure	Disease state
140/90	High blood pressure with no diabetes or kidney disease
130/80	Diabetes
125/75	Severe kidney disease

   vi. Tips on Blood Pressure Measuring
      1. Blood Pressure taking should be done on a consistent time each day. (Preferably in the early morning hours after arising and taking a few minutes to relax)
      2. Resident should refrain from using any kind of stimulant that can raise blood pressure, including tobacco or caffeine-containing beverages, for at least 30 minutes prior to blood pressure measurement.
      3. Similarly, the resident should wait at least 10 to 15 minutes after a bath or shower and at least 30 minutes after eating before measurement, as these activities can lower blood pressure.
      4. The resident should be in a sitting position and should use a cuff size appropriate to his or her arm circumference.

Geriatric Resident Medication Assessment

Name: SSN_____ Room #_____

Sex_____ Race:_____ AGE:____

Date: / / Provider:_____ Pharmacy:_____

Medications (Record for all OTC,herbals and RX Meds)

Name of Medication	Strength	Dosage	Directions	Purpose	Compliance

Geriatric assessment questions

"Medication Management"

Do you have any history of allergies or bad reactions to any medications? If yes please explain?

Does the Resident see multiple MD's?_____(Y/N)

Does the Resident see multiple pharmacies?_____(Y/N)

Is the Resident able to read prescription label(s)?_____(Y/N)
Is the Resident able to open childproof caps?_____(Y/N)
Is the Resident able to interpret medication directions of three times daily regimen?_____(Y/N)
Is the Resident able to move tablets from medication vial?_____(Y/N)
Is the Resident able to differentiate colors of capsules, tablets, etc?_____(Y/N)

Does the Resident report any problems with active medications?

Does the Resident report any problems with managing their medications?

Does the Resident receive or need assistance with meds?_____(Y/N)
If yes, please describe(i.e. caregiver/ pillbox reminder)

Do you have any difficulty paying for your medications? If yes explain

"Impaired mobility"

Have you fallen in the past few weeks. (If yes, describe the event) (e.g. is due to dizziness, patient loses balance)

Do you have any problems with getting out of bed yourself, walking, or bathing?

"Incontinence & Constipation"

Do you have any problems with your bowels? (e.g. constipation, incontinence)? What kind of things do you do to correct this problem?

"Impairment of mental status"

Have you noticed any problems with your memory lately? If yes what have you noticed and how long?

"Insomnia"

Do you have difficulty sleepy? If Yes what do you do? What is your caffeine intake?

"Nutrition"

How is your appetite? Has the patient noticed any weight loss or weight gain in the past year? Does the patient report any difficulty chewing or swallowing?

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Vice President of Clinical Consulting Services

Mission Pharmacy

Understanding Side effects of medications in our elderly residents

I. Introduction

A. Side Effects of Medications in Older Adults
- Generally the benefits of medications exceed their risks, however sometimes medication may cause side effects or unwanted problems.

B. What are the reasons for side effects of medications in older adults?

1. Many older adults have several medical problems in which they take medications
    a. Medications for one medical problem may worsen the symptoms of another medical problem for which they take medications

2. Side effects may occur when medications affect or interact with each other.
3. There is a risk an increase risk of medication side effects with the more medications a resident may take.
4. Medications in older adults may have more side effects, due to changes in the body as a person ages.

C. Sometimes it may be hard to tell the difference between side effects, the symptoms of common illnesses, or changes that occur with aging
1. An example is say a resident starts to become confused or forgetful or having constipation, dizziness or dry mouth. These symptoms may be caused by a certain medication, illness, or changes that occur with aging.
2. Ways to prevent side effects from getting worse is to notify a nurse, physician, pharmacist that you notice a change in the health or daily functioning of the resident.
3. Changing the medication, lowering the dose, or finding out tips to reduce the side effects are many ways of solving these problems.

II. The Aging Factor – Affecting the way medications work

A. Facts on aging and medications
1. Multiple diseases equals multiple prescriptions. The elderly account for approximately 35% of all drug prescriptions in the U.S.

2. Side effects can impact common problems in the elderly such as :

Mobility (Risk for falls)	Affecting Appetite
Affecting Memory	Affecting Mood (Causing Depression)
Affecting Sleep	Affecting bladder (Incontience)
Affecting risk of infections	Afftecting Senses (taste, touch, smell, hearing, vision)
Affecting problems with constipation	

3.The impact and cost of medication side effects in the elderly

i. That for every dollar spent on drugs in the ambulatory setting, $1.00 is consumed in the treatment of problems with medications in the elderly resident

ii. That for every dollar spent on drugs in nursing facilities, $1.33 is consumed in the treatment of problems with medications in the elderly resident

B. Changes in the body that affect aging.

- As a person grows older, many changes in the body may occur
- Changes usually occur gradually an may happen slowly and may go unnoticed for years.
- Changes that often we can not physically see in an elderly resident are the following

  - How well the kidneys, liver or other organs of the body are working

  - These changes can effect how an elderly resident handles a medication because many medications rely on the kidney, liver and other organs to allow medications to break down and leave the body safely when they are done working.

C. What happens when an elderly resident takes a medication?

- After a pill (tablet or capsule) is swallowed it goes into the stomach where it is broken down into small particles.
- Medication then passes through the stomach and intestines and goes into the bloodstream
- The blood carries the medication to the part of the body it is intended to act.
- Later the medication is removed from the body
- The kidneys and liver are the organs that remove most medications from the body.

D. Changes that occur in the kidneys with aging

- Certain diseases may affect the kidney (example high blood pressure or diabetes may damage the kidneys)
- Certain medications may prevent other medications or the kidney itself from removing medications properly
- If the kidneys slow down the removal of some medications slows down. If a resident continues to take the same dose of medication, medication blood levels may become higher, because the medication is not removed as fast as it should
- Due to kidneys not properly functioning, high blood levels of medications then may cause side effects. If you know a drug is going to be cleared from the body by the kidneys carefully watch for side effects.
- Examples of drugs that are effected by changes in the kidney
  - Diamox (acetazolamide)
  - Symetrel (amanatadine)
  - Capoten (captopril)
  - Tagamet (cimetidine)
  - Lanoxin (digoxin)
  - Eskalith (lithium)
  - Procan (procainamide)
  - Macrodantin (nitrofurantoin)
  - Penicillin

E. Changes that occur with the liver with aging

- The liver is important in breaking down many medications.
- Medications that are removed from the kidneys, are often needed to be broken down by the liver before the kidney can filter and remove them from the body.
- Liver disease caused by things such as chronic drinking of alcohol can affect the way medications are broken down.
- Certain medications may also prevent other medications from being broken down in the liver properly. If you know a drug is broken down by the liver carefully watch for side effects.
- Examples of drugs who are affected by changes in the liver
  - Valium (diazepam)
  - Tofranil (imipramine)
  - Demerol (meperidine)
  - MS Contin (morphine)
  - Inderal (propranolol)
  - Feldene (piroxicam)
  - Quinidine
  - Theodur (theophylline)

F. Prevention of side effects in residents with impaired kidneys, liver, or function response to medications
   - To prevent side effects doctors may use lower doses or
   - May start with lower doses and work on increasing the dose slowly to allow the body to get use to the medications

III. Side effects (Adverse Drug Reactions in the Elderly Resident)

A. Adverse Drug Reactions (ADRs)

1. Adverse Drug Reactions in the elderly can occur in any setting.

2. Definition

   .→ An effect produced by a drug that is bad and unintended and which occurs in doses normally used in people for the prevention, diagnosis or treatment of a disease.

3. Types of ADRs

   a. Type A: ("increased effect or augmented") common, predictable, less serious, dose-related, extension of usual effect of the drug. Side effects are predictable with causing problems with an elderly resident's function, but low risk for death by these side effects. This type of reactions contribute to 95% of all adverse drug reactions.

   b. Type B: ("Bizarre") uncommon, cause of reaction is usually not known, potentially serious, at what dose of the drug does not have an effect, rashes type of reactions, difficult breathing, shock, blood problems are examples of these reactions. Reactions are not predictable and associated with high risk of death. This type of reaction contributes to 5% of all ADRS

4. Up to 25% of all hospital admissions in elderly residents are related to side-effects of medications.

5. Examples of medications that cause adverse drug reactions:

   a. Drug classes associated with psychiatric disorders such as memory, behavioral problems, hallucinations.
      Anticholinergics (examples Benadryl (diphenhydramine); oxybutynin (Ditropan)
      Anticonvulsants (examples Phenobarbital, Dilantin(phenytoin), Neurontin (gabapentin))
      Antiparkinsonian (examples Sinemet (carbidopa/levodopa), Permax (pergolide))
      Cardiovascular (examples Aldomet(methyldopa), Catapress (Clonidine))
      Gastrointestinal (examples Pepcid (famotidine), Tagamet (cimetidine))
      NSAIDS (examples Indocin(Indomethacin)
      Psychotropics (examples Haldol (haloperidol), Zyprexa (olanzapine)

   b. Drug classes associated with risk of falls
      Psychotropics (examples Haldol (haloperidol), Zyprexa (olanzapine)
      Antihypertensives (examples Tenormin(atenolol), Lopressor (metoprolol)
      Vasodilators (examples Apresoline (Hydralazine)
      Antiparkinsonian (examples Sinemet (carbidopa/levodopa), Permax (pergolide))
      NSAIDs (examples Indocin(Indomethacin), Naprosyn(Naproxen))
      Antidiabetic agents (examples Glucotrol (glipizide), Micronase (glyburide)
      Diuretics (examples Hydrodiuril (Hydrochlorthiazide), Lasix(furosemide))
      Antiarrhythmics (examples Procan(procainamide), Cordarone (Amiodarone)

   c. Drug classes associated with urinary incontinence
      Alpha-antagonists (Hytrin(terazosin), Cardura (doxazosin)

Anticholinergics (examples Benadryl (diphenhydramine;
Chlor-Trimeton (chlorpheneramine)
CNS anti-depressants (examples Elavil (amitriptyline), Tofranil (imipramine)
Diuretics (examples Procan(procainamide), Cordarone (Amiodarone)

IV. Assessing the risk of side effects in elderly residents

A. In considering whether a medication is causing a side effect one must consider the following questions:

- What is the percentage chance of the medication causing the side effect? How do we find out this information.
  - Refer to a medication book or call your pharmacist.

- What time was the side effect noted? Did it occur recently with the addition of the drug?
- Was the drug dose changed, increased or decreased?
- Was a new medication added that may cause drug interactions?
- Was there any error in dosing administration?

B. In identifying a side effect in a medication one must consider the following:
   - Determine whether a sign, symptom, syndrome, or decline in function is medication related.
   - Medications should be consider a cause of a change in function unless proven differently
   - Become aware of common medications or classes of medications that may aggravate common geriatric problems.

C. Please see example of assessment form side effects in elderly residents.

Adverse Drug Reaction Report

In the event of an adverse drug reaction, the following information should be completed as accurately as possible.

Facility:_____ Date of Report:_____

Resident:_____ Date of Incident:_____

Describe Reaction:_____

Check All That Apply

Fluid/Electrolyte Imbalance

_____Edema (swelling)

_____Dehydration

Skin Effects

_____Itching

_____Rash

Anticholinergic

_____ Dry mouth

_____ Blurring vision

_____ Constipation

_____ Difficulty in urinating

Hepatic Effects

_____Jaudice (Skin turns yellow)

Other

_____Please discribe:_____

Heart / Circulation

_____Irregular heart beat

_____Fast heart beat

_____Slow heart beat

_____Low blood pressur

_____Edema (swelling)

_____High blood pressure

_____Angina (chest pain)

Gastrointestinal Effects

_____Constipation

_____Heart burn

_____Diarrhea

_____Nausea/Vomiting

_____Other

Respiratory Effects

_____ Asthmatic episodes trigger

_____ Difficulty breathing

Brain Effects

_____ Depression

_____ Confusion

_____ Headache

_____ Ringing in the ear

_____ Dizziness

_____ Involuntary muscle movement

_____ Seizures

Parkinsonian Effects

_____ Rigidity

_____ Loss of balance

_____ Tremor

Tardive Dyskinesia Effects

_____Lip smacking

_____ Uncontrolled chewing

_____ Uncontrolled body movement

_____ Pill rolling

List suspected drugs, route of administration and directions:_____

Outcome: Check all that apply

Resident died_____ Resident hospitalized_____ Resident permanently disabled_____

Reaction treated with other medication (List):_____

Resolved without additional treatment (Date of resolution):_____

Signature and title of person completeing form: _____

Strategies to limiting adverse drug reactions in Personal Care

- Organized, readable documentation that allows physicians and other healthcare professionals to pull out important drug information easily
- Required staff meetings to discuss medication issues, identified cases of adverse drug reactions and related concerns.
- Better resident monitoring and prompt action when signs of toxicity occur
- Reduced reliance on memory by the ordering physician
- More physician/staff interactions with the pharmacist

Resident Assessment Parameters to Improve Medication Care

Parameter	Example of a resident assessment method
Disease Control and Complications	Asking a resident with diabetes about blood sugar levels or checking the blood sugar Asking a patient who just had a hip replaced about pain or sleep Observing agitated behaviors secondary to dementia
Drug Therapy	Observing level of consciousness in residents receiving medications that may effect the brain Asking a resident who is taking a pain medication such as ibuprofen, whether they are suffering any stomach pains.
Resident-related CAPS **C**ognitive **A**ffective **P**hysical Social/psychological	 Asking resident to state year,month Observing flat affect Observing amount of movement or movement disorder Observing resident interacting with other residents

Guidelines for Correct Supervision of Medications

PREPARATION

Wash hands before assisting with supervision of medications.
Check for drug allergies.
Check medication order with health care provider's orders, and MAR (medicine record)
Check label on drug container three times.
Check expiration date on drug label, use only current dated drugs
Recheck drug dose.
If you have questions about a dose change check with the physician.
Assist with opening of container or unit dose package as necessary.
Assist with pouring the liquid, the lower curve of the liquid, should be at the line of desired dose.
Assist with diluting the liquids that may irritate the stomach(potassium, aspirin) or make sure taken with meals.

ASSISTANCE WITH ADMINISTRATING MEDICATIONS

Read the MAR, know your resident, read the label, assist as needed.
Offer ice chips to numb taste buds when giving bad-tasting drugs.
When possible, assist with giving bad-tasting medications first, followed by pleasant-tasting liquids. Assist the resident to an appropriate position, depending on the route of medication to be given. Provide only liquids allowed on the diet.
Stay with the resident until the medications are taken.
Assist with administering drugs to only one resident at a time.
If resident is self administering insulin, dispose of the syringes in appropriate containers.
Drug disposal is dependent on agency policy and state law. For example,
Discard drugs in the sink or toilet, *not* in the trash can. Controlled substances must be returned to the pharmacy.
Appropriately store (some require refrigeration) drugs in locked medication closet with individual cubicles for each resident.
Keep drugs in a safe place, out of reach of children and others in the home.

RECORDING

Report drug error immediately to resident's health care provider and to the Administrator. Complete an incident report.
Charting: record drug assisted with, dose, time, route, and your initials.
Record drugs promptly after given, especially STAT doses.
Record effectiveness/results of medication administered, especially PRN medications, according to facilities policy.
Report to health care provider and record drugs that were refused with reason for refusal.

Behaviors to Avoid with Supervision of Medication

Do not be distracted when supervising medications.

Do *not* supervise drugs from containers with labels that are difficult to read, or whose labels are partially removed or have fallen off.

Do *not* allow resident to transfer drugs from one container to another.

Do *not* allow resident to pour drugs into their hand if they are shaky.

Do *not* supervise medications for which the expiration date has passed.

Do *not* guess about drugs and drug doses. Ask when in doubt.

Do *not* allow the resident to use drugs that have sediment, are discolored, or are cloudy (and should not be).

Do *not* allow the resident to leave medications by the bedside or with visitors.

Do *not* allow resident to remove prepared medications from sight, they should take in front of you.

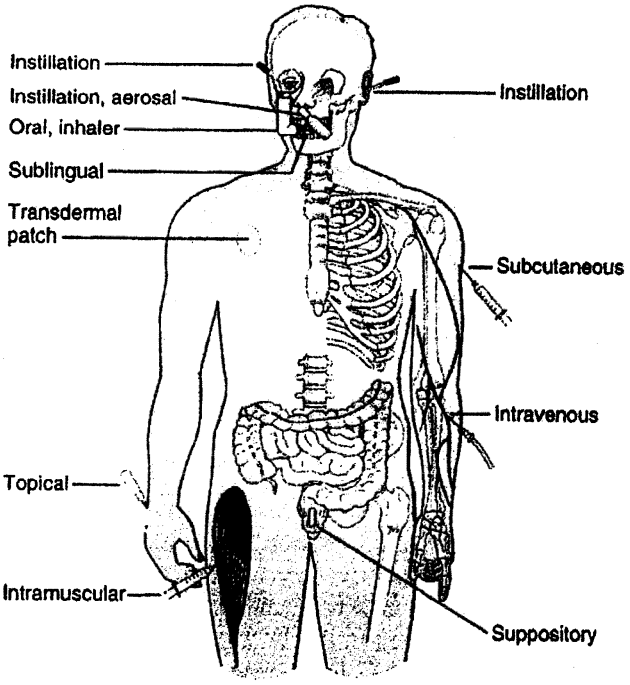
Do *not* allow resident to take drugs if the resident says he or she has allergies to the drug or drug group.

Do *not* allow the resident to take the drug if the client states the drug is different from the drug he or she has been receiving.

Check the order.

If the resident is self-administrating insulin, do not allow them to recap needles, have them place in correct container. Use universal precautions.

Do *not* allow the resident to mix with large amount of food/beverage or foods that are contraindicated.

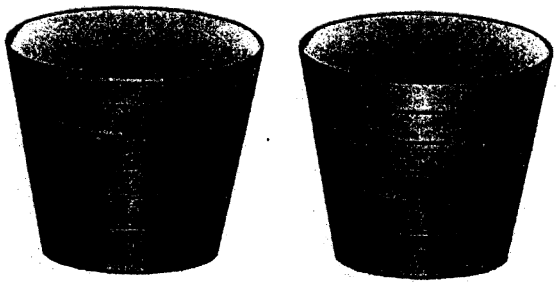


Some of the routes for medication administration

There are a variety of forms and routes for the administration of medications, including oral (tablets, capsules, liquids, suspensions, elixirs); sublingual (under the tongue); buccal (inside the cheek); transdermal (on the skin); topical; instillation (drops and sprays); inhalations; nasogastric and gastrostomy tubes; suppositories (vaginal and rectal); and parenteral (intravenous). A brief description of each follows.

- Do not assist with oral medications in residents who are vomiting, lack a gag reflex. Residents who gag may need a brief rest before proceeding with further intake of medications.
- Do not mix with a large amount of food/beverage or with contraindicated food. Residents may not be able to eat all the food and will not get the full dose of medication.
- Remind the resident that enteric-coated and timed-release capsules *must* be swallowed whole to be effective.
- Assisting with irritating drugs give *with food* to decrease GI discomfort.
- Remind the resident to take drugs on an empty stomach if food interferes with medication absorption.
- Remind the resident that drugs taken **sublingually** (placed under tongue) or **buccally** (placed between cheek and gum) remain in place until fully absorbed. No food or fluids should be taken while the medication is in place.
- Encourage the use of child-resistant caps. The Consumer Public Safety Commission has ordered a redesign of these caps because the current caps are difficult for elderly clients. This has contributed to a safety hazard for children and others because many people, in an effort to have easy access to their medications, leave the caps off. The new design requires a person to lightly squeeze the two side bottle tabs and turn the cap. Non-child-resistant caps are available on request.

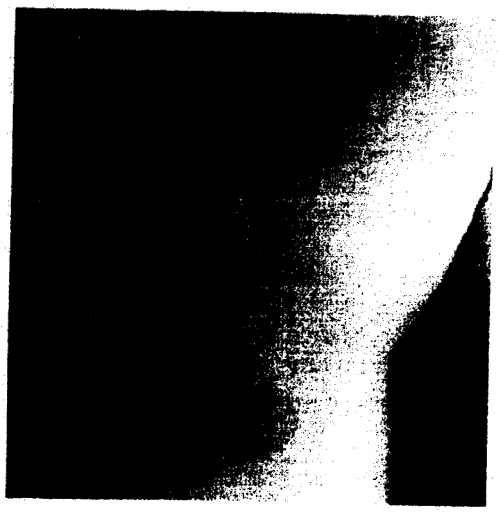
Liquids



To read the correct amount of liquid, locate the lowest fluid mark.

- There are several forms of liquid medication, including elixirs, emulsions, and suspensions.
- Assist in reading the labels to determine whether dilution or shaking is required.
- Many liquids require refrigeration once reconstituted (mixed).

Transdermal



Transdermal nitroglycerin patch.

- **Transdermal** medication is stored in a patch placed on the skin and absorbed through skin, thereby having systemic effect. There was widespread use of such patches beginning in the 1980s. Patches for cardiovascular drugs, neoplastic drugs, hormones, drugs to treat allergic reactions, and insulin are in production or being developed. Transdermal drugs provide more consistent blood levels and avoid GI absorption problems associated with oral products.
- A common question is whether to cut the patches in half. Depending on the resident's situation and the type of patch, it may be appropriate to cut the patch. If the drug is embedded in a *matrix patch* and diffuses into the skin (e.g., Climara, Vivelle, Nicotrol, Nitro-Dur, and Testoderm), the drug is spread over the entire surface of the patch and probably may be cut. Residents must be alert for underdosing or overdosing. The drug is pooled in a *reservoir patch* and is released via a semipermeable membrane (e.g., Catapres-TTS, Duragesic, Estraderm, Transderm Sc6p, Transderm-Nitro, and Androderm). These patches should not be cut because too much drug may be released. However, it is possible to peel back the protective layer half-way. Advise residents to secure the patch with tape, being careful not to apply it too tightly, which could alter the drug delivery. For legal and financial reasons, manufacturers do not recommend cutting the patches.

Topical

- **Topical** medications can be applied to the skin in a number of ways, such as with a glove, tongue blade, or cotton-tipped applicator. Never apply with one's own skin unprotected.
- Use appropriate technique to remove medication from container and apply to clean, dry skin, when possible. Do not contaminate medication in container; use gloves or an applicator.
- Observe sterile technique when the skin is broken. Take precautions to avoid medication stains.
- Use firm strokes if medication is to be rubbed in.

Instillations

Instillations are liquid medications usually administered as drops, ointment, or sprays in the following forms:

Administration of Eye Drops

WASH HANDS
Instruct resident to lie or sit down and to look up toward the ceiling. Have resident gently draw skin down below the affected eye to expose the conjunctival (inner portion) sac.
Have the resident administer the prescribed number of drops into the center of the sac. Medication placed directly on the cornea can cause discomfort or damage. Do not touch eyelids or eye lashes with dropper. Self-administration of drops is enhanced with the use of Drop-eze, a cuplike device that holds the eyelids open.
Have the resident gently press on tear duct with sterile cotton ball or tissue for 1-2 min after instillation to prevent systemic absorption through tear duct canal.
Resident should keep eyes closed for 1-2 min following application to promote absorption.

To assist with self-administering eye drops, gently pull down the skin below the eye to expose the conjunctival (inner portion) sac.

Administration of Eye Ointment

WASH HANDS

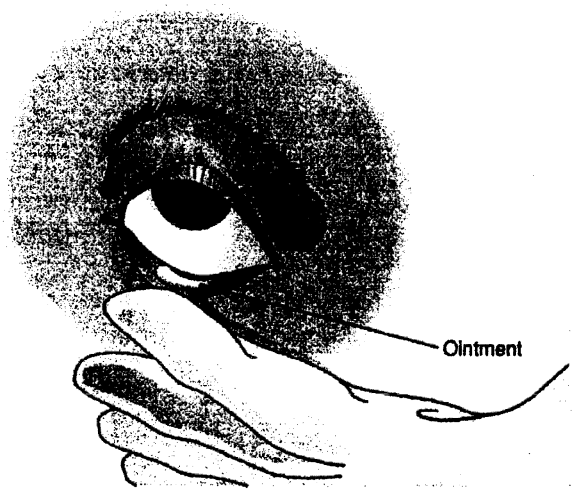
Instruct resident to lie or sit down and to look up toward the ceiling.

Have resident gently draw skin down below the affected eye to expose the conjunctival (inner portion) sac.

Have or assist resident in squeezing strip of ointment (about ¼-inch unless stated otherwise) onto conjunctival (inner portion) sac. Medication placed directly on cornea can cause discomfort or damage.

Instruct resident to close eyes for 2-3 min.

Instruct resident to expect blurred vision for a short time. Assist with applying at bedtime, if possible.



To assist with the administering of eye ointment, squeeze a ¼-inch wide strip of ointment onto the conjunctival (inner portion)sac.

Administration of Ear Drops

WASH HANDS

Medication should be at room temperature.

Resident should sit up with head tilted slightly toward the unaffected side. To straighten the external ear canal for better chance of the drops reaching the affected area, assist or have resident pull back on outer portion of ear.

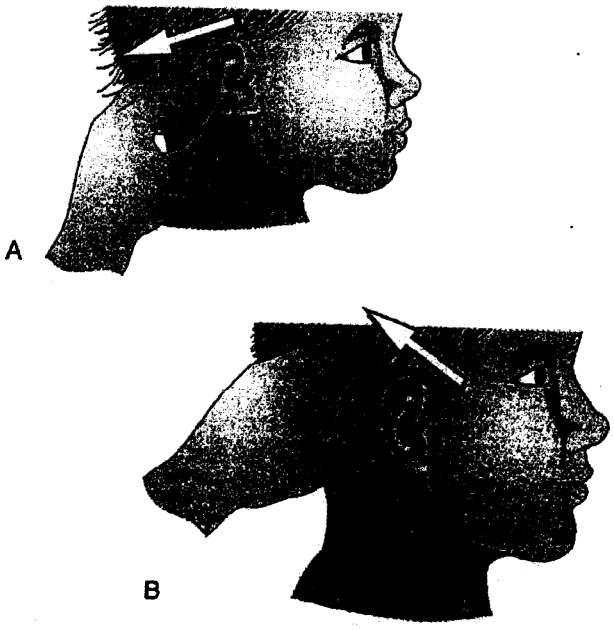
Child: pull down and back on outer bottom portion of ear. After 3 years of age, same as adult.

Adult: pull up and back on outer middle portion of ear.

Assist or have the resident instill prescribed number of drops.

Take care not to contaminate dropper.

Have resident maintain position for 2-3 min.



To administer ear drops, straighten the external ear canal *by (A)* pulling down on the auricle in children and *IB)* pulling up and back on the auricle in adults.

Nose Drops and Sprays

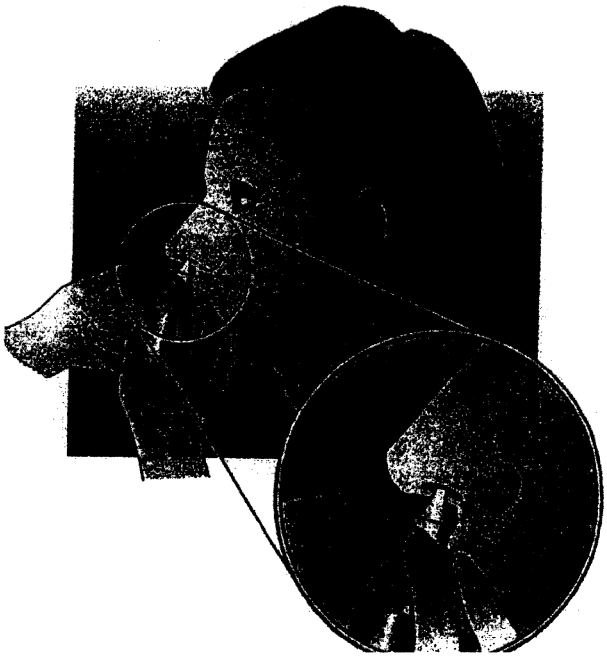
Administrating nose drops
Have resident blow nose.

Have resident tilt head back for drops to reach frontal sinus and tilted to affected side to reach the side sinus.

Assist or have resident administer prescribed number of drops or sprays. Some sprays have instructions to close one nostril, tilt head to closed side, and hold breath or breathe through nose for a minute.

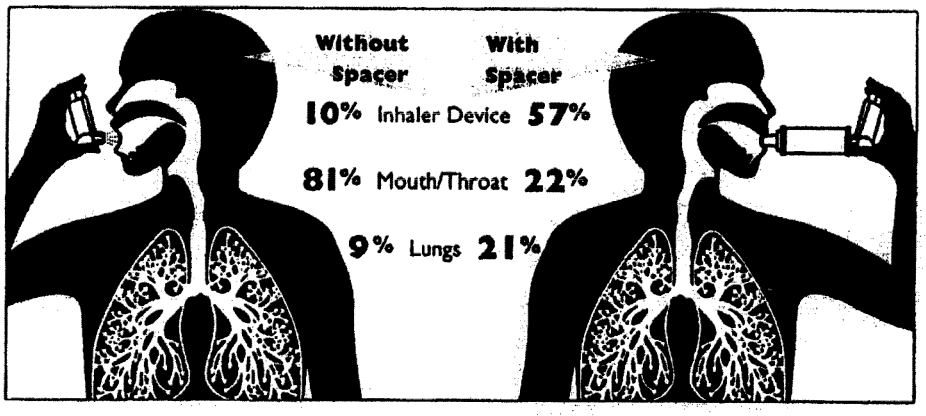
Have resident keep head tilted backward for 5 min. after instillation of drops.

Administering nose drops and nasal spray.



Inhalations

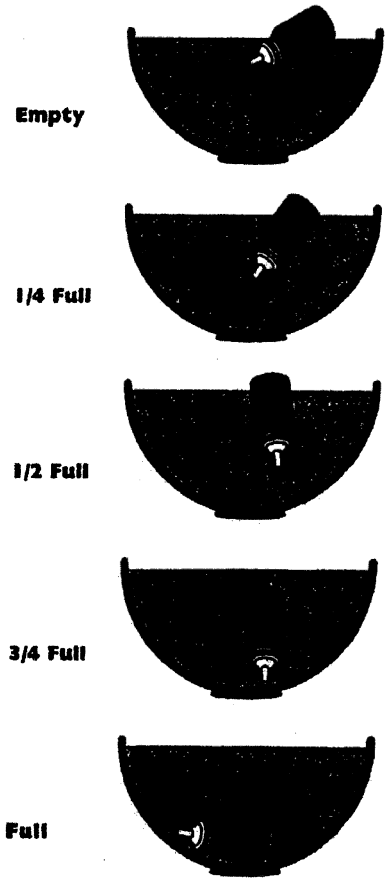
- Hand-held nebulizers
- Hand-held metered-dose devices are a convenient method of administration of these medications.
- Picture below shows distribution of medication with and without a spacer.



- **Spacers** are devices used to enhance the delivery of medications from the MDI. Figure 3-14 illustrates the distribution of medication with and without a spacer. AeroChamber (distributed by Forest Pharmaceuticals, St. Louis, MO) and Inspirease (distributed by Key Pharmaceuticals, Kenilworth, NJ) are examples of spacers available.
- Preferred resident position is sitting in a 45 degree angle or sitting straight up in a chair.
- Teach resident correct use of equipment.
- Nebulizer (aerosol) changes a liquid medication into a fine mist.

Correct Use of Metered Dose Inhaler

1. Assist or have resident insert the medication canister into the plastic holder.
2. Have resident shake the inhaler well before using. Remove cap from mouthpiece.
3. Resident is to breathe out through the mouth. Open mouth wide and hold the mouthpiece 1-2 inches from the mouth. Do *not* put mouthpiece in the mouth unless using a spacer. Discuss techniques with the health care provider.
4. With mouth open, have resident take slow, deep breath through mouth and at same time push the top of the medication canister once. Autohalers (e.g., Maxair) do not require coordination of pushing down top of canister and taking deep breath. A resident should use an autohaler in upright position, raise lever and shake. Inhale deeply through mouthpiece with steady, moderate force, which triggers the release of medicine, making a click sound and puffing out the medicine. Resident is to continue to take deep breaths.
5. Have resident hold breath for a few seconds; exhale slowly through pursed lips.
6. If a second dose is required, have the resident wait 2 min and repeat the procedure by first shaking the canister in the plastic holder with the cap on.
7. If the inhaler has not been used recently or when it is first used, have the resident "test spray" before administering the metered dose.
8. If a steriod inhalant is to be used with a bronchodilator, wait 5 min before using the inhaler containing the steroid.
9. Teach resident to monitor pulse rate.
10. Caution against overuse, because side effects and tolerance may result.
11. Teach resident to monitor amount of medication remaining in the canister. Advise the resident to ask his or her health care provider or pharmacist to estimate when a new inhaler will be needed based on dosing schedule. A common practice of placing the canister in water to determine the amount of drug remaining is not appropriate for all inhalers.
12. Instruct resident to avoid smoking.
13. Teach resident to do daily cleaning of the equipment including: wash hands; take apart all washable parts of equipment and wash with warm water; rinse; place on clean towel and cover with another clean towel to air dry; store in clean plastic bag when *completely* dry. It is a good idea to have two sets of washable equipment to make this process easier.

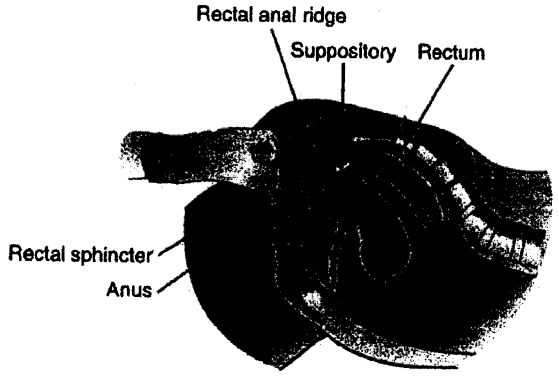


Testing a medication inhaler canister for the amount of medication remaining.

Suppositories

RECTAL

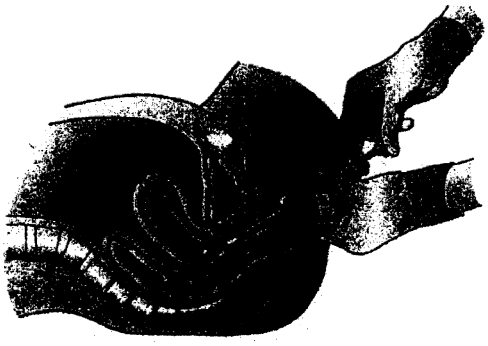
- Medications administered as **suppositories** or enemas can be given rectally for both local and systemic absorption. The numerous small capillaries in the rectal area promote absorption.
- The foil around the suppository is removed, and the suppository may be lubricated before insertion. When medications such as Tylenol suppositories and bronchodilators are given, the resident must be reminded to retain the medication and not to expel it.
- Suppositories tend to soften at room temperature and, therefore, need to be refrigerated.
- Explain the procedure to the resident and provide for privacy.
  Assist or give resident a glove for insertion.
- Instruct resident to lie on left side and breathe through the mouth to relax the anal sphincter, or to bend at waist to open buttocks.
- Assist or have resident apply a small amount of water-soluble lubricant to tip of the unwrapped suppository and gently insert the suppository beyond the internal sphincter.
- Have the resident remain on his or her side for 20 min after insertion.
- Teach the resident how to self-administer suppositories and observe return demonstration for effectiveness.



Inserting a rectal suppository.

VAGINAL

- Vaginal suppositories are similar to rectal suppositories. They are generally inserted into the vagina with an applicator. Give resident gloves to wear. Resident should be in laying position with legs spread open. After insertion of medication, provide resident with sanitary pad.



Inserting a vaginal suppository.

Common Abbreviations for Extended-Release Products

CR	Controlled release
CRT	Controlled release tablet
LA	Long acting
SR	Sustained release
TR	Time release
TD	Time delay
SA	Sustained action
XL	Extended release
XR	Extended release
EC	Enteric coated
CC	Controlled release

Other key words

8-hour

12-hour

Sequels

Extentab

Dur

APPENDIX 21: TABLE OF WEIGHTS AND MEASURES

1 milligram	EQUALS	.001 gram (gm)
1 milliliter	EQUALS	1 cc
1 pint	EQUALS	16 ounces (oz)
1 quart	EQUALS	2 pints
1 gallon	EQUALS	4 qts
5 grains (gr)	EQUALS	325 mg
1 grain	EQUALS	65 mg
1/2 grain	EQUALS	32 mg
1/4 grain	EQUALS	16 mg
1/100 grain	EQUALS	0.6 mg
1/150 grain	EQUALS	0.4 mg
1/200 grain	EQUALS	0.3 mg
1 teaspoonful (tsp)	EQUALS	5 ml
1 tablespoonful (tbsp)	EQUALS	15 ml
1 fluid ounce (oz)	EQUALS	30 ml

Pharmacy:_____ Effective Date:_____

Medication Post-Test

1. As a general rule you should shake the following liquid(s):
   a. Solutions
   b. Suspensions
   c. Elixirs
   d. Syrups
   e. All of the above

2. According to the manufacturers' recommendations, Metamucil should be:
   a. Swallowed as a dry powder, with no water
   b. Mixed with 8oz. of water
   c. Made into a paste and spread on crackers
   d. None of the above

3. Name the 7 rights of medications:
   1. Right _____
   2. Right _____
   3. Right _____
   4. Right _____
   5. Right _____
   6. Right _____
   7. Right _____

4. Which drug needs to be stored upright after "priming"?
   a. Vitamin B12 injection
   b. Miacalcin nasal spray
   c. Dilantin suspension
   d. Xalantan eye drops

5. When a medication error has occurred, the first person you should notify is:
   a. The resident's immediate family
   b. The Pharmacist
   c. 911
   d. The Physician

6. Controlled medication should be monitored to assure accountability and prevent diversion
   a. True
   b. False

7. The following medications are normally ordered for a specific length of time (ex: 7-days or 10-days):
   a. Antibiotics
   b. Blood pressure medications
   c. Liquid medication
   d. Diabetic medication

8. When two or more different eye drops are ordered at the same time, you should wait at least 5 minutes between each drop
   a. True
   b. False

9. When a resident takes a dose of Fosamax he or she should:
   a. Not lie down for at least ½ hour
   b. Not eat or drink any thing for ½ hour
   c. Take the medication with at least 6oz. of water
   d. All of the above

10. The following medication (s) should be given with at least 6oz. of fluid:
   a. NSAIDS (ex: Motrin)
   b. Bulk laxatives (ex: Metamucil)
   c. Potassium supplements (ex: Liquid Potassium Cloride)
   d. All of the above

11. A good reference source when you have a question about a drug is:
   a. The pharmacy
   b. A drug hand book
   c. Drug information sheets provided by the pharmacy
   d. All of the above

12. If a medication is ordered to be held if the blood pressure is 120/60, you must check the blood pressure before <u>each</u> dose.
   a. True
   b. False

13. If a medication is ordered to be given sublingually, the resident can either place it under his / her tongue or swallows it.
   a. True
   b. False

14. As a general rule, you need to shake most inhalers:
   a. True
   b. False

15. In most cases if a resident has nausea and vomiting you should:
   a. Still encourage them to take their medication, so they can stay on schedule
   b. Give them Ginger Ale with their medications
   c. Give them milk with their medications
   d. Hold their medications and call the physician or supervisor

Performance Checklist

Assistance with Oral Medications	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Assess medication record to identify whether the resident needs assistance with medications.				
2. Check medications listed against physician's or nurse's orders.				
3. Review information regarding the medications.				
4. Assess resident's ability to swallow medications.				
5. Assess resident's for need for prn medications.				
Planning				
6. Determine what equipment you will need.				
7. Wash your hands.				
8. Gather equipment.				
Implementation				
9. Read name of medication to be assisted from MAR.				
10. Check label on medication and take from shelf or drawer.				
11. Check label again, before assisting in removing the medication from the container as needed.				
12. Assist in the remove correct amount of medication: a. Tablet or capsule				
(1) Assist in pouring correct dose from bottle into bottle cap.				
(2) Assist in transfering to the medication cup as needed.				
b. Liquid				
(1) Assisting in removing bottle cap as needed.				
(2) Holding cup at eye level, assist in pouring liquid to desired level.				
(3) Pour with label facing up.				
(4) Wipe neck of bottle before replacing cap.				
c. Unit-dose medication				
(1) Assist in placing package containing medication in med cup.				

Performance Checklist

Assistance withOral Medications (continued)	**Unsat**	**Needs More Practice**	**Sat**	**Comments**
13. Return bottom to shelf or drawer, checking label a third time.				
14. Give resident a glass of water.				
15. Make sure resident has swallowed medicine.				
16. Dispose of container properly.				
17. Wash your hands.				
Evaluation				
18. Evaluate, using the following criteria: a. The right resident received the right medication in the right dose by the right route at the right time.				
b. The criteria established for ascertaining the effectiveness of a specific drug were used.				
c. Side effects, if present, were promptly identified.				
Documentation				
19. Record accurately according to the policy of the Facility. Include: a. Name of the medication				
b. Dosage				
c. Route				
d. Time of administration				
e. Signature				

Performance Checklist

Assistance with instilling Ophthalmic Medications	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Follow Checklist steps 1-3, Assistance with Administering Oral Medications (check MAR, compare with physician's order, review medication information).				
Planning				
2. Follow Checklist steps 6-8 Assistance with Oral Medications (determine equipment needed, wash hands, gather equipment).				
Implementation				
3. Follow Checklist steps 9-17 Assistance with Oral Medications (read MAR, check label, take medication from storage, check label, prepare medication, return container, check label, explain to resident).				
4. Assistance with administering the eye medication.				
a. Wash your hands.				
b. Assistance with cleaning eyelids and lashes.				
c. Position resident with head slightly to affected side and tipped back.				
d. Have resident look up.				
e. Have resident pull down on lower lid to open eye wide with nondominant hand.				
f. Assist with administering medication.				
(1) Eye drops.				
(a) Assist with drawing solution into eye dropper.				
(b) Have resident hold bulb end up.				
(c) Without touching eye, have resident instill drops.				
(2) Ointment				
(a) Assist with squeezing out medication.				
(b) Discontinue ribbon by twisting tube.				
(c) Wipe excess off tube.				

Performance Checklist

Assistance with Instilling Ophthalmic Medications (continued)	**Unsat**	**Needs More Practice**	**Sat**	**Comments**
g. Ask resident to close the eye gently and move eyeball or keep eye closed as appropriate.				
h. Have resident press inner angle of eye against nose if necessary.				
5. Follow Checklist steps 20-22 Assistance with Oral Medication (make resident comfortable, dispose of equipment, wash your hands).				
Evaluation				
6. Evaluate as in Checklist step 23 of oral medication procedure (five rights, desired effects, and side effects). Add that correct eye was treated.				
Documentation				
7. Document as in Checklist step 24 of oral medication procedure (name of medication, dosage, route, time, and signature), plus which eye was treated.				

Performance Checklist

Assistance with Instilling Otic Medications	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Follow Checklist steps 1-3 Assistance with Administering Oral Medications (MAR, compare with physician's order, review medication information).				
Planning				
2. Follow Checklist steps 6-8 Assistance with Oral Medications (determine equipment needed, wash hands, gather equipment).				
Implementation				
3. Follow Checklist steps 9-17 in Assistance with Oral Medications (read medication record, check label, take medication from storage, check label, prepare medication, return container, check label, explain to resident).				
4. Assist with administering the ear medication. a. Warm medication to body temperature.				
b. Examine and assist with filling glass dropper.				
c. Have resident lie on opposite side of ear being medicated.				
d. Have resident pull auricle of ear to straighten canal.				
e. Hand resident the ear dropper and have resident instill drops.				
f. Have resident remain as positioned for 5-10 minutes.				
g. Assist with inserting cotton loosely in canal if ordered.				
5. Follow Checklist steps 20-22 of oral medication procedure (make resident comfortable, dispose of equipment, wash your hands).				

Performance Checklist

Evaluation				
6. Evaluate as in Checklist step 23 of oral medication procedure (five rights, desired effects, and side effects). Add that correct ear was treated.				
Documentation				
7. Document as in Checklist step 24 of oral medication procedure (name of medication, dosage, route, time, and signature), plus which ear was treated.				

Performance Checklist

Assistance with Instilling Nasal Medications	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Follow Checklist steps 1-3 Assistance with Administering Oral Medications (MAR, compare with physician's order, review medication information).				
Planning				
2. Follow Checklist steps 6-8 Assistance with Oral Medications (determine equipment needed, wash hands, gather equipment).				
Implementation				
3. Follow Checklist steps 9-17 Assistance with Oral Medications (read MAR, check label, take medication from storage, check label, assist with prepare medication, return container, check label, explain to resident).				
4. Assist with administer the nasal medication. a. Have resident clear nasal passages.				
b. Assist in positioning resident.				
(1) Dropper: according to area resident wants to reach				
(2) Nasal spray: in chair with head tilted back				
c. Assist with administer medication.				
(1) Dropper				
(a) Assist with drawing sufficient medication for both nostrils.				
(b) Have resident insert tip and instill drops.				
(c) Have resident remain in position for 5 minutes.				
(2) Nasal spray				
(a) Assist with spraying medication into nostril with resident holding the other closed.				
(b) Have resident inhale.				
(c) Repeat on other nostril.				
(d) Have resident keep head back for 1 or 2 minutes.				

Performance Checklist

5. Follow Checklist steps 20-22 Assistance with Oral Medications(make resident comfortable, dispose of equipment, wash your hands).				
Evaluation				
6. Evaluate as in Checklist step 23 of oral medication procedure (five rights, desired effects, and side effects).				
Documentation				
7. Document as in Checklist step 24 of oral medication procedure (name of medication, dosage, route, time, and signature).				

Performance Checklist

Assistance in Applying Medications to the Skin or Mucous Membranes	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Follow Checklist steps 1-3 Assisting with Oral Medications (check MAR, compare with physician's order, review medication information).				
Planning				
2. Follow Checklist steps 6-8 Assisting with Oral Medications (determine equipment needed, wash hands, gather equipment).				
Implementation				
3. Follow Checklist steps 9-17 Assisting with Oral Medications (read MAR, check label, take medication from storage, check label, prepare medication, return container, check label).				
4. Assist with applying the dermal medication. a. Provide for resident's privacy.				
b. Provide adequate lighting..				
c. Assist with proper positioning.				
d. Be sure area being treated is clean.				
e. Assist with application if necessary.				
f. Assist with light dressing if ordered.				
g. Follow Checklist steps 20-22 Assisting with Oral Medications (dispose of equipment, wash your hands).				
Evaluation				
5. Evaluate as in Checklist step 23 of oral medication procedure (five rights, desired effects, and side effects). Add correct area.				
Documentation				
6. Document as in Checklist step 24 of oral medication procedure (name of medication, dosage, route, time, and signature). Include also the area treated and the appearance of the area before treatment.				

Performance Checklist

Assistance with inserting Vaginal Medications	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Follow Checklist steps 1-3 Assistance with Oral Medications (check MAR, compare with physician's order, review medication information).				
Planning				
2. Follow Checklist steps 6-8 Assistance with Oral Medications (determine equipment needed, wash hands, gather equipment).				
Implementation				
3. Follow Checklist steps 9-17 Assistance with Oral Medications (read MAR, check label, take medication from storage, check label, prepare medication, return container, check label, approach and identify resident, explain to resident).				
4. Assist with insertion of the vaginal medication. a. Provide for resdient's privacy.				
b. Provide adequate lighting..				
c. Place resident in dorsal recumbent position with knees flexed. (Sim's position can also be used).				
d. Drape resident.				
e. Put on clean gloves.				
f. Instill medication.				
5. Follow Checklist steps 20-22 Assistance with Oral Medications (make resident comfortable, dispose of equipment, wash your hands).				
Evaluation				
6. Evaluate as in Checklist step 23 of Assistance with Oral Medication procedure (five rights, desired effects, and side effects).				
Documentation				
7. Document as in Checklist step 24 of Assistance with Oral Medication procedure (name of medication, dosage, route, time, and signature).				

Performance Checklist

Assistance with Inserting Rectal Medications	Unsat	Needs More Practice	Sat	Comments
Assessment				
1. Follow Checklist steps 1-3 Assistance with Administering Oral Medications (check MAR, compare with physician's order, review medication information).				
Planning				
2. Follow Checklist steps 6-8 Assistance with Oral Medications (determine equipment needed, wash hands, gather equipment).				
Implementation				
3. Follow Checklist steps 9-17 Assistance with Oral Medications (read MAR, check label, take medication from storage, check label, prepare medication, return container, check label, explain to resident).				
4. Assist with administering the rectal medication. a. Provide for resident's privacy				
b. Provide adequate lighting.				
c. Place resident in side-lying position or bend from waist.				
d. Have resident and self put on clean gloves.				
e. Assist with instilling medication.				
f. Assist with cleaning anal area.				
5. Follow Checklist steps 20-22 of oral medication procedure (make resident comfortable, dispose of equipment, wash your hands).				
Evaluation				
6. Evaluate as in Checklist step 23 of oral medication procedure (five rights, desired effects, and side effects).				
Documentation				
7. Document as in Checklist step 24 of oral medication procedure (name of medication, dosage, route, time, and signature).				

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Medication Administration: A System of Best Practice

USERS' GUIDE

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USERS' GUIDE

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OCYF MEDICATION ADMINISTRATION

USERS' GUIDE

INTRODUCTION

Medication plays an ever-larger role in treating children who present with a broad spectrum of problems and in a wide variety of settings. Treatment interventions are never risk-free, and this is certainly true of all medications. Trained, experienced staff members are important to successful outcomes, particularly when medication use is recommended. However, the number of available licensed health professionals to administer that medication has not kept up with the demand, adding to the concern about possible risks in medication use. Therefore, a recognized need to identify, develop and deploy best practices in medication administration to children exists, both because of the increase in medication use and the decline in available staff with experience and training,

Title 55 PA Code Chapter 3800, *Child Residential and Day Treatment Facilities Regulations* were adopted in 1999. From first development through the final legislative approval, all interested stakeholders acknowledged the need for careful attention to medication administration. Many different groups have functioning medication administration programs involving staff, including mental retardation service providers and the state-operated Youth Development Center/ Youth Forestry Camp system. Nonetheless, debate over essential core training topics, insuring ongoing system quality, and approving training curricula over a wide geographic expanse and programmatic variety ensued. Widely available training for staff on medication administration did not materialize as expected. As a final deadline for compliance with regulations for staff training on medication administration arrived, few §3800 licensees had access to approved training sources. Concern over content and process was prevalent.

Therefore, the Office of Children, Youth and Families (OCYF) of the Department of Public Welfare (DPW) offers this newly revised curriculum to meet a broad and pervasive need for training. Most importantly, there is an overview of the fundamental areas critical to safe and effective medication administration by staff working in a wide variety of settings, regardless of the sophistication of health care services on site. The content complies with the regulations, and the training goals meet the specific requirements of §3800.181-189. The system framework is flexible but robust, as it allows for program variations and updated revisions to content over time without major rewrites.

The curriculum lessons can be used as a stand alone training module or combined in a sequence of health care related topics such as first aid or special needs care. Reviews of local policy and procedures are an integral part of the training. The curriculum is suitable for use in both Train-The-Trainer settings or in Direct Training mode as described later in this Guide to allow quick dissemination to all affected agencies across the Commonwealth. It transmits values that establish an atmosphere for maintaining the dignity and safety of the child, while enhancing the continuous monitoring and reporting of conditions. Children can be as involved in the process as agency policy and the children's ages and circumstances allow. Finally, this complete medication administration curriculum incorporates simple but reliable methods

consistent with recognized health care industry best practices to monitor, maintain, and improve quality in a manner directly tied to licensing processes. Widespread adoption of this program will assist facilities operating under §3800 licensure to reduce their agency risks to a minimum, while making it possible for the children they serve to safely receive the greatest benefit possible from medication when health care professionals recommend its use.

OCYF Medication Administration – PACKAGE COMPONENTS

Four separate documents comprise this complete package of medication administration:

1) ***Users' Guide.*** This section outlines the basic principles necessary for understanding a complete system of medication administration that meets both the letter and the spirit of the regulatory requirements. It is designed to guide an agency in implementing the system and outlines the training procedures to prepare and maintain staff skills and knowledge. It describes each of the actors in the system and delineates responsibilities.

2) ***Lessons.*** This is the core curriculum content of the package. It not only provides the complete outline for training sessions, but also provides the details for necessary operations and for the underpinning values necessary to follow the procedures well.

3) ***Resources.*** These materials illustrate and amplify important points in the Lessons. Adding local policy and procedures is the means of making the generic materials agency-specific, as well as allowing updates to reflect evolving best practice and service population needs. Together with the *Lessons*, trainees will receive a complete set of information for both learning and reference later.

4) ***Trainer Materials.*** Training preparations, delivery of the *Lessons* contents, means of providing hands-on practical experiences, test questions and methodologies, and a standardized certificate to record successful completion of trainings will be found in this final section of the package for a medication administration system based upon best practices.

MEDICATION ADMINISTRATION SYSTEM REQUIREMENTS

Appearing on the next page, Figure 1, *Who and How: Actors and Actions in Medication Administration Systems Under §3800 Regulations*, diagrams the components and interactions that are necessary to perform medication administration as required by the regulations in §3800. It includes the definitions and references in regulation for each of these elements in the medication administration system.

The child (lower right hand oval) can receive medication via one of three possible but related routes following directions specified by a health care professional licensed to prescribe, per the regulation listed in the upper left hand corner of Figure 1. Routes for medication administration appear as three different arrows in the diagram. Licensed medical professionals, defined in the bottom middle oval, may administer medications to the child. Under the regulations cited in the upper left oval, staff trained in medication administration also may administer medication to

the child. Finally, according to the regulations cited in the gray box, children may self-administer medication provided they are supervised by one of the other two classes of actors who are permitted to administer medication.

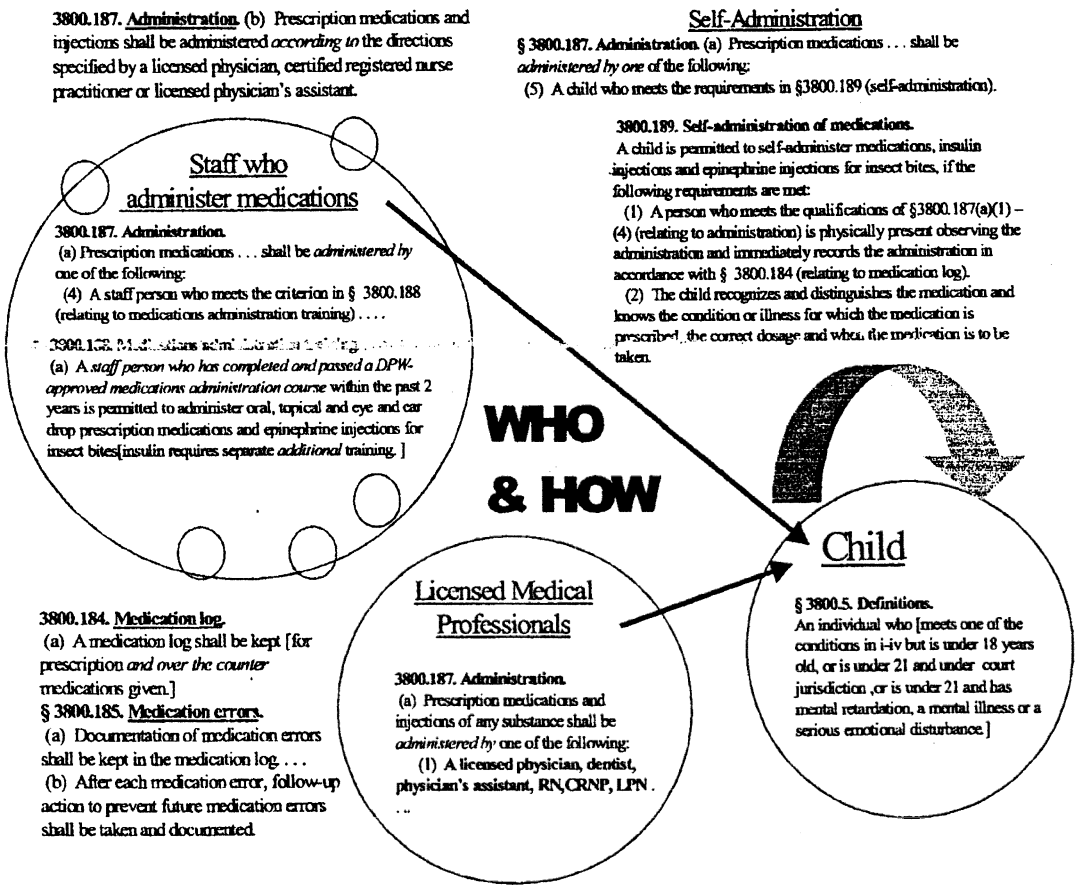

Figure 1. Actors and Actions in Medication Administration Systems Under §3800 Regulations

Two other essential components in a system for medication administration are referred to in the regulations and appear in the diagram. One of these is a record of the medication orders and related details needed to safely and accurately administer medication as it is prescribed and the actual administration of each dose. This medication log (or medication administration record) is defined in the citation appearing in the lower left of Figure 1.

Note that regulations require up-to-date training for staff without medical licenses who administer prescription medications, but that all staff who administer medication must log both prescription and non-prescription medication use. To insure correct logging in the medication administration record, agencies would be wise to train any and all staff who administer any

medications who are not licensed health care professionals in order that they perform the task of medication administration thoroughly and correctly. In fact, all medications deserve to be handled in the safest manner which means uniform, consistent procedures by a trained staff.

This block also includes the citation for another basic component, a requirement concerning medication errors. The regulation states that certain errors are noted and recorded. Although not stated in the regulation, but logical and practical, is that additional action should be taken to reduce the risks of further incidents. This component serves as a minimum effort for insuring standards and improving quality in the system.

The final component that is required by the regulations for a medication administration system is regular training for staff members who administer medications. Unmentioned are specific written agency policy and procedures that translate the regulatory requirements into actual practice. Staff who never administer medications do not need to be trained. If only licensed health care professionals administer medication at an agency, then staff training in medication administration is not required. Nonetheless, if medication is in use, agency staff who are not licensed health care professionals but are trained with this curriculum in observational and reporting skills and recognize opportunities to effectively address medication-related issues will provide better and safer care to children receiving services from that agency.

TRAIN-THE-TRAINER OR DIRECT TRAINING VERSIONS

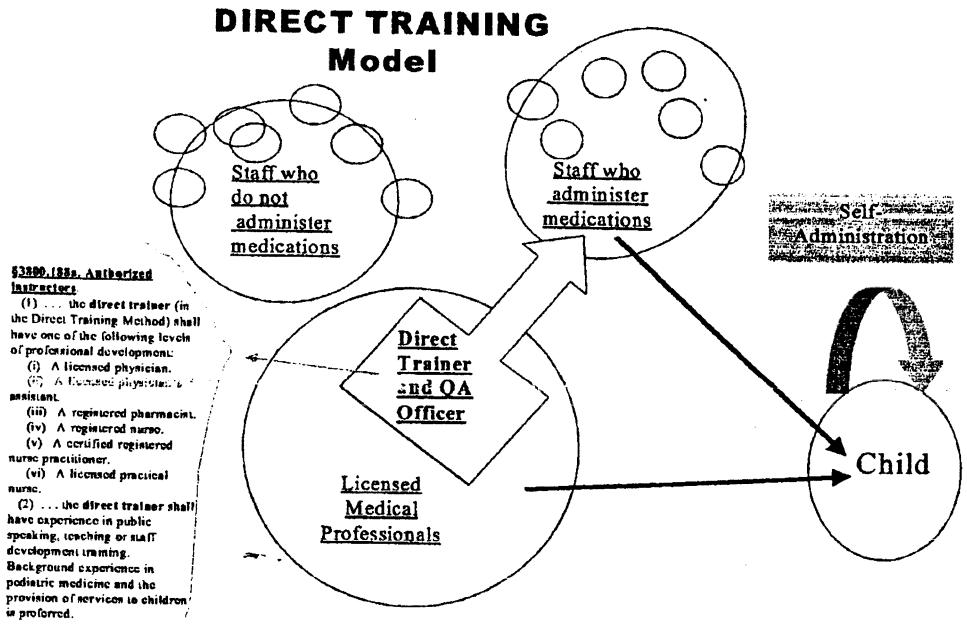

Figure 2. Medication Administration System Using Direct Training

The Lessons in this curriculum package may be used in one of two versions, Train-the-Trainer (TTT) or Direct Training (DT). The major difference is that TTT and DT trainers must be licensed health care professionals. Mid Level Trainers in TTT are not required to be health care professionals, but can be agency staff in child care supervisor or higher positions. This difference—the availability of medical expertise—is also taken into consideration in suggesting quality controls and ongoing performance monitoring.

Figure 2, *Medication Administration System Using Direct Training* on the previous page, shows how the training in this method is provided by a licensed health care professional. These requirements were published in OCYF bulletin 3800-99-01 which was incorporated in the regulations as a statement of policy in §3800.188a. Persons acting as Direct Trainers must be individually approved by the OCYF regional office as part of the requirement for curriculum approval. They can also perform the tasks of the QA officer for medication administration defined later in this Guide. These licensed professionals can be existing members of agency staff or contracted from an outside source.

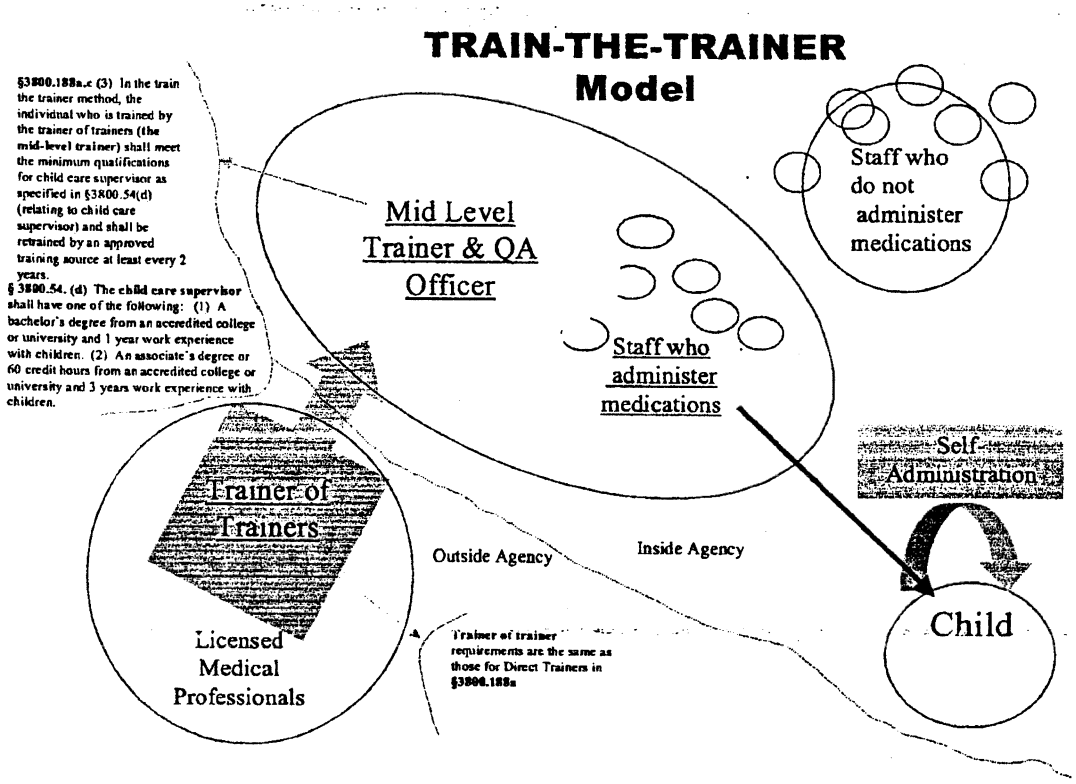

Figure 3. Medication Administration Using Trainer-of-Trainers and Mid Level Trainers

The TTT model, diagrammed in Figure 3 above, is useful for agencies that lack licensed health care professionals as regular staff members. The trainer-of-trainers (TOT) in this model, who must be a licensed health care professional, must be approved by the OCYF Medical Director.

The TOT trains Mid Level Trainers (MLT) who in turn then train the actual child care staff members who will then be able to administer medication. In most circumstances, the TOT will be contracted from an outside training source, but could be an internal resource shared between various facilities operated by a single parent agency. Mid Level Trainers will most likely be employees of the agency in supervisory positions as required by the regulations.

The TTT variation of the OCYF Medication Administration Training Curriculum does not relieve an agency of its responsibility for maintaining quality and implementing practices to insure compliance and accuracy. It does provide an agency without medical professionals on its staff a methodology that enables them to do so more easily. This curriculum uses designated Quality Assurance monitors, called *QA officers for medication administration*, who perform tasks described further in the *Lessons* sections on QA. MLT can handle the routine aspects of these duties for QA monitoring, including being able to recognize the need to have health care professional assistance should concerns arise. The regional offices of OCYF can be contacted in instances where outside professional help is unavailable or unable to assist.

In summary, agencies interested in using this medication administration package will need to determine whether they will use a DT or TTT version. The actual training content is the same, but it comes from different sources, which in turn entails slightly different methods for maintaining quality in actual practice. The key issue is availability of licensed medical professionals. Those agencies that choose Direct Training may wish to have their DT undergo initial preparation by attending one of the training sessions for TOT to insure a complete understanding of the program.

QUALITY MANAGEMENT

§3800.185 addresses medication errors, and the OCYF bulletin defining §3800.188a scope and implementation included requirements for ongoing quality assurance. This package incorporates these requirements in a manner that makes quality an integral part of the system, while recognizing the differences between agencies in the availability of resources. It is based upon values transmitted during training that emphasize honesty and timeliness as the source of accountability rather than the avoidance of blame.

The lessons describe and teach a basic approach to total quality management (TQM) as it relates to medication administration. TQM incorporates methods to maintain consistent levels of quality, called Quality Assurance (QA), as well as methods to raise the quality level over time, a process called Quality Improvement. Both TTT and DT models in this training program use a similar approach to these components, but differ in the source of professional health care oversight. TQM is integrated into the entire medication cycle. Staff learn TQM as a critical philosophy during the training, and it becomes an expected behavior of trained staff when administering medications.

Facilities using this program incorporate Quality Assurance by complying with the requirement that one staff person be held accountable for monitoring and directing the TQM process. This QA officer for medication administration must hold up-to-date qualifications as a trainer (DT or MLT) of this curriculum and preferably performs current agency staff training. S/he regularly shall review the records of staff performing medication administration. That individual will also directly observe the performance of certified staff at least every six months, either by direct on-

the-job observation or in a practice session, using the practicum exercise included in the package of materials.

Medication errors are always accounted for immediately. Policy and procedure require a review of the error to identify root causes and determine a plan of prevention for the future. In situations where the QA officer is not a licensed health care professional, outside consultation if necessary can be accessed from available sources such as the agency health care provider, another physician caring for children, or a pharmacist. If no other source of professional expertise can be found, or in the most complex situations, assistance can be requested from the regional office of OCYF. This is the Quality Improvement component of this training.

Medication errors are discussed completely and extensively within the *Lessons* and are those circumstances where a child is placed at undue and increased risk by medication administration. Type I errors occur when failure to follow the prescription exactly is noted just in time so that medication does not actually reach the child incorrectly. Type II errors are those where the child either receives a medication dose incorrectly or fails completely to receive a dose of medication. When using this curriculum, agencies will add Type I medication errors to the list of recordable incidents in §3800.17, handling them as directed in §3800.185 by recording them in the medication administration record. They will report deaths and injuries or illnesses which require outside medical evaluation in accordance with §3800.16, when these reportable events occur as the result of problems in medication administration, most likely Type II errors. Uniform practices for handling all types of medication errors can improve safety and reduce liability risk for the agencies using this curriculum. The recording and reporting practices allow linking quality management measures across a broad base in order to provide data useful in determining best practices and curriculum modifications. This mirrors current practices in health care organizations, among other industries with highly sophisticated and complex systems, which seek to maintain and improve quality while managing the inherent risk of technology's benefits.

DPW RESPONSIBILITIES THROUGH OCYF

OCYF, as originator of this curriculum based upon best practices, will develop, deploy and nurture the training methods. It will:

1) Monitor credentials of qualified Trainers-of-Trainers with professional over-sight available from the OCYF Medical Director.

2) Record and track agencies which elect to use one of the two delivery methods of this training program.

3) Provide technical assistance when requested in situations requiring expert consultation for quality improvement, discussed in the section above on Quality Management.

4) Maintain records of medication errors which result in death, illness or injury as discussed in the section above on Quality Management and explained in the *Lessons*.

5) Review facility records including medication administration logs, medication errors and follow-up measures, and staff certifications and licenses pertaining to medication administration during inspections.

6) Make revisions of the materials related to this medications administration system available on the Internet and by USPS mail upon request to the regional office.

RESPONSIBILITIES FOR AGENCIES USING THIS CURRICULUM

Agencies that choose to use this curriculum to meet the requirements of §3800 pertaining to medication administration shall:

1) Notify regional OCYF office in writing of their intent to comply with either the TTT or the DT versions of this curriculum.

2) Insure that agency trainers, either direct in DT or MLT in TTT, are currently qualified to do the training and perform the TQM responsibilities.

3) Provide documentation demonstrating the instructor qualifications of the trainers of their non-health care licensed staff upon request by OCYF. This documentation will consist of copies of appropriate licenses, certifications and resumes.

4) Assure that all appropriate staff receive the required training and maintain records to verify the medication administration training status of trained staff using the standard form located in the *Trainer Materials* section.

5) Assume costs associated with the training.

6) Not distribute changes in the content of the *Lessons* and related materials without written permission from OCYF except as provided for in the directions to trainers.

7) Comply with the measures of quality management as described above and in the *Lessons*.

METHODOLOGY

Trainers (direct in DT or MLT in TTT) of staff who administer medication receive a package of materials that contains the information conveying the full array of skills in the *Lessons* and *Resources* sections. To this they add the policy statements and procedures used in the individual agency, reflecting circumstances in the local facilities. This provides a useful reference tool for the staff in the future when they administer medication and insures consistency and continuity. MLT can receive assistance from the TOT in preparing these additional materials. Additional training modules on subjects such as psychotropic medications, special care needs of particular populations, or other health care topics, such as first aid or standard precautions that are important to a particular agency's program or mission, may precede or follow the delivery and completion of the *Lessons*.

The training is done in a face-to-face manner and may be performed with individual learners or a group. Didactic portions may be delivered to larger groups, but the demonstrations and discussions should involve no more than eight persons at one time. Complete training will take at least seven hours for first time students, excluding the time required to prepare the

materials. The six lessons may be divided into several sessions, but it is recommended that the entire sequence be completed within two weeks.

There is a pretest to determine existing staff knowledge and establish interest. Each lesson concludes with a written objective exam that tests for the goals of that section and demonstrates progress and comprehension to trainer and trainees. The last lesson practices the skills and techniques of administering medications. A final written examination uses items selected from a pool of possible questions to objectively confirm retention and synthesis of the information, and a practicum observation tests for the necessary skill development. Test materials and methodologies will be found in the *Trainer Materials* section of this package.

Trainees who pass the final tests receive a certificate to demonstrate successful completion of the course. These certificates also record and monitor ongoing performance levels as part of the quality assurance process described above. The standardized blank forms provided with the curriculum package insure that the correct information is recorded when training is satisfactorily completed. The standard forms make proof of training compliance easily accessible during licensing activities. Agencies may choose to reward satisfactory completion of the course with more tangible rewards such as a decorative certificate for framing, but the standard forms will constitute the necessary proof of up to date training in agencies using this curriculum.

RESPONSIBILITIES FOR THE TRAINER-OF-TRAINERS

The Trainer-of-Trainers in the Train-the-Train method shall:

1) Be currently licensed health care professionals as listed in §3800.187a1.

2) Be reviewed and approved by OCYF Medical Director or designee.

3) Present copies of written certification issued by OCYF to agencies to verify this status when requested.

4) Maintain accessible records of those trained by them as Mid Level Trainers to confirm agency records as needed by OCYF during licensing operations.

5) Assist the Mid Level Trainers that they train by helping them to prepare materials for use in training staff who administer medication in the agency.

6) Use up to date versions of the curriculum materials by checking the OCYF postings on the DPW website at www.dpw.state.pa.us or by inquiring at the regional offices quarterly.

RESPONSIBILITIES FOR TRAINERS OF CHILD CARE WORKERS

Trainers of child care staff who administer medications –Mid Level Trainer (MLT) in the TTT model or the Direct Trainer in the DT model– shall:

1) Maintain the necessary credentials and certification as required to function in this role.

   - For a DT, s/he must be a licensed health care professional as listed in §3800.187a1, while an MLT, if not a licensed health care professional, must be a staff member who meets the minimum qualifications specified at §3800.54d for child care supervisor.

   - They must have been approved for these roles by submitting written credentials to the regional office of OCYF prior to performing any training.

2) Tailor the instructional materials to the facility by adding specific information and forms to the *Lessons*.

3) Schedule and conduct training.

4) Administer and score the examinations.

5) Administer the practicum exercises.

6) Insure completion of the standard certification forms for trainees as provided in the *Trainer Materials*, presenting a copy to the agency's training records system.

7) Conduct, or insure that the Quality Management activities are appropriately delegated, as required by this curriculum for the QA officer for medication administration.

SKILLS AND CONCEPTS TAUGHT

Child care staff are trained in the following areas important to medication administration, using the *medication cycle* as a frame of reference:

Instruction on reporting and observation skills. Staff receive information necessary to perform and then practice skills in observing and reporting changes in physical appearance, emotional adjustment and behavioral activity. They will be expected to report significant changes to the appropriate person within the appropriate time frames and procedures.

Types of medications and their effects. Staff trained in this program will understand and be able to recognize through observation skills, the desired, unwanted (both expected and unexpected), or absence of desired, effects of medications including potential medication interactions. They will recognize that their level of responsibility is to observe and report suspected problems rather than to diagnose with certainty. They should be cognizant of the various categories of medicine, including prescription and non-prescrip-

tion medicines. They shall know the difference between medications identified as controlled and non-controlled. They should know when, where and how to seek information to add to their existing knowledge.

Staff responsibilities in the medication process. Staff who have successfully completed training shall know the limits of their ability to administer medications to children. They shall be able to recognize and distinguish an individual and his or her correct medication, and they shall administer the proper dosage of medicine at the proper time. They shall be skilled in the proper handling techniques during medication administration so that infection control measures, including hand-washing, are consistently followed. Staff shall recognize circumstances under which they should contact the agency health care authority with questions regarding the administration of medications.

Handling emergency and health-threatening situations. Staff shall be able to respond to both emergency and non-emergency conditions that may involve medication. They shall know how to access an immediate and direct response to an emergency. They also shall know how to access regular medical support and how to communicate other notable observations.

Facility specific policy and procedures. Staff shall be able to state the minimum policy and procedure requirements contained within the *Lessons* of this curriculum as a baseline of quality medication administration functions in the context of the medication cycle. They will also have a thorough understanding of unique agency policies and procedures regarding medication administration that refine or add to this baseline for maximizing safety and benefits to children who are administered medication by trained staff.

Patterns of communication and interaction within the facility and facility supports that are outside of the facility but have a direct responsibility to protect the health of children. Successful trainees understand how to elicit and convey information regarding medication administration. For example, they can communicate information about a newly prescribed medication to other staff and other key adults who have responsibility for the child, including situations where the child is outside of the agency. They are able to provide multidisciplinary team support by noting and communicating suspected medication-related issues and concerns to health care professionals.

Administration of Medication. Staff become familiar with information they receive from the prescribing entity and know how to request and receive necessary clarifying information if needed. Staff shall understand and be able to list the seven Rights Of Medication administration. They should consistently demonstrate proper procedures for administering medications. They can recognize when a medication error has occurred and know what action shall be taken in their agency.

Self-administration. Staff shall know their responsibilities to support and assist the child in self-administration of medications under the requirements of §3800.189. They can state their agency policy on who can determine that a child may participate and to what extent. The staff person should demonstrate an ability and willingness to appropriately instruct the child in the name, purpose and administration of his/her medications and actively encourage child participation in medication activities.

Regulatory Requirements. Staff must understand and be able to carry out the requirements of the regulations specified in §3800.181 through 3800.189.

Quality Management Principles. Staff shall state an absolute obligation to report suspected medication variances and errors immediately upon recognition. They will learn how those reports are used to reduce the likelihood of similar errors in the future. They are aware of the need for performance monitoring and can state how it is performed, including the basic functions of the agency QA officer for medication administration.

Values and Beliefs As Determinants of Medication Administration Culture. Staff know that they must consider the rights and human dignity of the child when administering medications, and that values and beliefs impact medication use and outcomes. They are taught to value honesty, timeliness and accountability and to appreciate the value of continuous quality control and improvement to maximize safe and benefit. They gain an appreciation for each staff member's contribution toward success of a multidisciplinary team.

CONCLUSIONS

This complete system recognizes and uses strategies that are regarded as best practices when staff administer medication to children. It allows staff to be trained in these methods through a variety of means, regardless of agency variations in resource availability and children's circumstances. It includes workable methods for insuring quality based on standards currently favored in health care organizations and that are now adapted for the wide variety of children's programs licensed under Chapter 3800 regulations. It allows easy revision and updating as standards for best practice in administering medication to children evolve.

The primary objectives of this curriculum include:

- Developing attitudes appropriate to achieve the maximum benefit and toreduce to a minimum the risk of medication administration to children.
- Fostering a culture that seeks and sustains best practice standards.
- Receiving the baseline knowledge necessary to accurately recognize, report and communicate information related to the medication cycle in a timely fashion.
- Learning how to identify and obtain additional specific information as needed and how to apply it to a licensed medical provider's orders to insure safe administration of medications.
- Documenting medication administration properly.
- Recognizing and handling medication errors promptly by the specific requirements and directives of this curriculum package.
- Incorporating principles of total quality management as outlined in the curriculum package.
- Staff members will function best when they understand and value the role that they play as part of a treatment team.

Users' Guide

GLOSSARY

This is a list of selected terms used within §3800 regulations as applied to this system of medication administration. Like the *Users' Guide* and accompanying sections, it is intended to improve understanding of how to achieve compliance, rather than to state official policy of the Pennsylvania Department of Public Welfare.

abbreviations Contractions or symbols used in place of complete terms or words. These are strongly discouraged in modern health care as they can contribute to confusion and cause error.

abuse potential The chance that a medication will be used for non-*therapeutic* purposes.

adrenaline See *epinephrine*.

adverse reaction Significant or unexpected *unwanted effect* of medication. See §3800.186.

allergies Strictly speaking, an immune reaction, but used almost invariably to indicate hypersensitivity or potential of a severe reaction to a specific substance. May or may not be predictable with each exposure.

anaphylaxis Severe and sudden allergic reaction characterized by hives, swelling, shortness of breath and requiring immediate treatment. See *epinephrine*.

as-needed medications Medication taken as conditions determine, often to relieve or control episodic symptoms that may recur from a known condition. See *PRN medication* and Lesson 2 for more.

auto-injector Device for delivering an injection with minimal skill or involvement by the user. See *epinephrine*, which may be administered by someone trained in this system of medication administration if it is delivered by these devices. Brands include Epi-pen®, Anakit®.

best practice The continuous process of learning, feedback, reflection and analysis, and application of what works (or does not work) and why. Applied to medication administration, it refers to policies, procedures and environment that enable staff to reduce risk to a minimum while maximizing the benefit of medication when its use is recommended by a health care professional.

brand name Also called a *trade name* or a *proprietary name*. Trade mark or patent name used by a manufacturer.

Chapter 3800 55 PA Code Chapter 3800, *Child Residential and Day Treatment Facilities*. Rules to protect the health, safety and well being of children receiving care in a child residential facility through the formulation, application and enforcement of minimum licensing requirements.

comfort medications Medications given for specific physical complaints they might relieve such as pain or nausea. Note that they make symptoms better (fever) rather than treat the illness (flu) causing the symptom. Often given *PRN (as-needed).*

controlled substance Appears in the Federal Drug Administration's schedule (table) of medications that have the potential for misuse. See *abuse potential.*

current medical conditions Physical and behavioral issues that are active sources of concern for a health care professional about a child.

current medications The list of medications now in regular use by a child, either taken *routinely* or *as needed.*

curriculum Complete outline for training staff in a given functional area such as medication administration. May also include policy and procedure necessary for trained staff to carry out the functions for which they are trained.

direct training (DT) Training staff members who administer medication using this curriculum by a nurse or other licensed health care professional qualified in §3800.188a to be Direct Trainers.

dispense To prepare medication by placing it into a suitable container appropriately labeled for use by a patient.

disposing of medication Discarding medication that is expired, damaged, or no longer needed. Must be done according to agency policy to avoid danger to the environment or other persons.

dosage One of the Rights of Medication. Refers to the correct quantity to be given at one time or at intervals as prescribed.

dose As a verb, to give medication or as a noun, one episode of administering a medication in the correct amount—often used for "dosage" as one of the Rights of Medication.

DT See Direct Training. May refer to the training method or the trainer.

effect, no apparent The absence of the desired effect, after allowing sufficient time for the medication to work.

effects of medications May be *desired, unwanted or no apparent effect.*

effects, desired The beneficial and sought after effect of the medication.

effects, unwanted Undesired effects, any effects other than the desired effect. Sometimes called *side effects*, but this can be confusing, since what is desired in one case may be unwanted in another. Examples of unwanted medication effects are listed in Exhibit 5.

emergency A serious situation or occurrence that happens unexpectedly and demands immediate action to protect life or function.

epinephrine Also called adrenaline. A neurotransmitter that can quickly relieve or block certain severe allergic reactions (See *anaphylaxis*) until more medical care is available. Must be given by injection since it is broken down in the stomach before it is absorbed. May be given in emergency by staff trained to administer medications with an *auto-injector* under §3800 regulations.

error, medication See *Medication Error.*

expired medication Out of date. Usually manufacturer determines that safety can no longer be guaranteed since either chemical breakdown or contamination may have occurred by this time. *Use-by* is different than *best-if-purchased-by* on OTC medication labels.

first aid Emergency treatment administered to an injured or sick person before professional medical care is available.

formulary List of medications in common use by a prescriber or an agency.

generic name Common name for a medication, usually a simplified version of the main chemical component. Opposite of *brand name.*

health care authority Individual primarily responsible for making medical care decisions concerning children cared for by an agency, a *licensed health care professional.*

hives A skin condition characterized by intensely itching welts and caused by a reaction to internal or external agents, an infection, or a nervous condition. Also called urticaria. If onset appears quickly and comes with facial swelling or shortness of breath may herald a serious *emergency,* See *anaphylaxis.*

inhaler A device for administering medication to the nose, lungs or other part of the respiratory tract (See *method*) by breathing it (See *route*).

injection To introduce a medication into a body part, often using a hollow needle inserted into skin or muscle. A *route* (See *Rights of Medication*) commonly used for medications that cannot be given orally because they are broken down by digestion before they have their desired effect. Regulations require separate training for staff to perform injections.

interactions, medication Special types of *unwanted effects* resulting from taking two or more medications. May increase or decrease the effects (desired or unwanted) of one or more medications or produce new and unique effects.

labels, medication Identifier on medication that should list the Rights of Medication for its use. Specific requirements appear in §3800.182.

licensed health care professional Doctors, dentists, nurses, or pharmacists. See §3800.187.

licensing instrument The current interpretation of regulations such as §3800 which define the exact application to given situations by facility inspectors and others with enforcement powers.

MAR See *Medication Administration Record*

medication administration For training purposes, the complete process of obtaining and using medications, observing and reporting effects, and reviewing each step to maximize benefit and reduce risk as described by the *medication cycle*. The system rather than just the introduction or application of a medicine into or upon the body.

Medication Administration Record The log in which data about medication use is written as required and described by §3800.184.

medication cycle A means of visualizing the various steps in performing the process of *medication administration*.

medication error Any situation where a child is placed at increased risk because of medication administration. See *Lessons*, Chapter 5 and 6 and §3800.185.

medication log See *Medication Administration Record*

medication Any non-food substance placed into the body for therapeutic purposes (American Society of Health-System Pharmacists, ASHP

mental status The state or condition of a person's thinking and feeling. May be affected by medications other than those prescribed to be *psychotropic*.

method One of 7 *Rights of Medication*. The manner of administering a medication. For example, with oral medications, they are given by mouth (*route*) but the method may be on an empty stomach or with food.

mid level trainer (MLT) The trainer for staff who administer medication in an agency using *Train-the-Trainer* delivery for training. May be a *licensed health professional* or staff who are child care supervisors or above as defined by §3800.54d.

missing medication Medication that is not available when needed for whatever reason, but could include those not ordered, misplaced or stolen.

MLT See *Mid Level Trainer*.

monitored self-administration A version of *medication administration* where the child is involved in some or all of the *medication cycle*, but is always supervised by staff who must be trained in medication administration to assist when needed. See §3800.189 and Lesson 6.

non-emergency, possibly health threatening, conditions Those changes in a child's physical condition or behavior that are significant enough to warrant reporting in a timely fashion to a *health care authority*, but which do not seem to be as urgent or critical as an *emergency* which requires an immediate response to protect life or function.

nurse A person educated and trained to care for the sick or disabled and currently licensed in PA by the Board of Nursing in the Department of State, Professional and Occupational Affairs Bureau.

order Information given by a medication prescriber that directs what, when and how medication is to be given. Includes most of the *Rights of Medication.* Differs from *prescription* in that it does not describe how the medication is compounded or how much is to be dispensed in the package.

OTC See *over the counter medications.*

over the counter medications Medications that can be obtained without a prescription from a *licensed health care professional*; *non-prescription* medication.

overdose Too much medication, either at one time or over time, or medication not intended for the child.

pharmacist Health care professional trained in pharmacy, also called a druggist. Licensed to dispense medication (as prescribed by a physician or other professional licensed to prescribe) by PA Board of Pharmacy.

Poison Control Center Source of information on toxic or other materials, available by phone and usually associated with a hospital, medical school or emergency room. Located in many areas, but now available through one national phone number, 800-222-1222, which automatically routes calls to nearest regional center. See *Lesson* 3.

position One of the 7 Rights of medication. Generally refers to how the child's body is to be arranged, often sitting or standing, for swallowing oral medication.

prescribe An expert's recommendation for the use of medication, required by law for some categories of medicine. Actual medication is obtained when it is *dispensed.*

prescription Recommendation from a physician or other health care professional who may legally prescribe that states what medication is to be used and directs in what way, using the *Rights of Medication.* Often referred to as Rx, which is a short form of the Latin, *recipere*, which means "to take". Differs from an *order* because it tells how *medication* is mixed or packaged and how much is to be *dispensed* at one time when it is given to the consumer/child.

prescription medications Require licensed health care professional's recommendation or order to obtain, opposite of *over-the-counter.*

PRN Abbreviation for Latin *pro re nata,* meaning as needed. Medication may not be used as a chemical restraint, see §3800.209. This does not prevent medication from being used to relieve symptoms as part of an ongoing treatment or evaluation.

psychotropic Medication whose intended or desired effects are to change behavior or emotional symptoms.

QA officer for medication administration Agency staff member responsible for quality assurance tasks defined by this curriculum in Lesson 6 and in the *Users' Guide*.

QA See *Quality Assurance.*

QI See *Quality Improvement.*

quality assurance QA. A system of procedures carried out to ensure that a product, service or a system adheres or conforms to established standards.

quality improvement QI. Policy and procedures to raise the established standards maintained by *quality assurance*.

rash A skin eruption.

reaction, adverse See *Adverse Reaction* to Medication.

recordable incident Situations that must be documented in records maintained at an agency—see §3800.17. §3800.185, which concerns medication errors, requires that they be recorded in the MAR.

referral form Information sheet used to convey medical history and other important data about a child to an outside health care provider or agency.

refusal of medication Occurs when a child objects to a dose of medication; refusal is often called the unwritten "Right" of Medication.

regulations In this context usually refers to 55 PA Code Chapter 3800, *Child Residential and Day Treatment Facilities Regulations.*

reportable incident Situations that must be reported to OCYF in a timely fashion by the agency—see §3800.16. Users of this curriculum will report outcomes of the most serious *medication errors*—deaths and hospitalizations—under this regulation.

reporting The process of communicating observations about behavior and physical condition that may be related to medication administration to the appropriate persons.

Rights of Medication Seven pieces of information necessary to administer medication correctly: *Individual, medication, dosage, time, method, route, and position.*

root causes Those system issues or actions that resulted in a medication error. There is usually not one specific thing or person to blame, and preventing similar errors in the future requires a systems approach.

route One of 7 *Rights of Medication*. The point of entry for medication into the body, such as oral (through the mouth), transdermal (through the skin), or by injection.

routine A category of medication in which the doses are given at the same time each day consistently. Opposite of *as-needed*.

scheduled drugs See *controlled substances*.

seizure A sudden attack, spasm, extreme emotional change, change in consciousness, or convulsion, as in epilepsy or another disorder

self-administration Situations where the child participates at least to some degree in the *medication cycle*. See *monitored self-administration*, which is the type of self-administration permitted under the §3800 regulations if the conditions are met.

side effects See *effects, unwanted*.

standing orders Orders prepared in advance by the physician or other health care provider licensed to prescribe. Often used to give comfort medications for the sudden onset of symptoms with minor illnesses. See Attachment 1 in the *Resources* document of this package.

storage Details related to obtaining and keeping medications available for use. See §3800.181 and Lesson 5.

suppository A form of medication designed to be inserted into body cavities other than the mouth.

team The group organized to work together in an agency on the care of a specific child. Often called *multidisciplinary team* to reflect that the necessary people will have a variety of different backgrounds, experience and skills.

theft of medication One possible cause of *missing medication*.

therapeutic Possessing health, restorative or preventive properties.

TOT See *trainer-of-trainers*.

total quality management TQM, which is a system of policy and procedures to maintain standards (QA) and also improve them (QI)

TQM See *Total Quality Management*.

train the trainer (TTT) One of the methods for delivering the training in this curriculum that uses a *TOT* to train an *MLT* who then trains the staff who administer medications.

trainer of trainers (TOT) The upper level trainer in *TTT* training delivery.

trainer, direct See *direct trainer*.

trainer, mid level See *mid level trainer*.

Type I medication error	Any medication delivery problem that has potential for a negative effect on the child that is noted and corrected before the medication reaches the child. Sometimes called *medication variances.*
Type II medication error	Problems in medication administration which have occurred when the wrong child was given a medication, the wrong medication was given to a child, the wrong dosage was given to a child, a medication was administered at the wrong time to a child or a medication was not given at all. Note that in all except the last, one of the *Rights of Medication* was not followed correctly.
unused medications	Medication left over because a child has left the agency or because its use was discontinued by order of a licensed health care professional.
variances, medication	See *Type I medication error.*