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Medication Administration: A System of Best Practice

LESSONS

For Training Staff Who Administer Medications

Lessons

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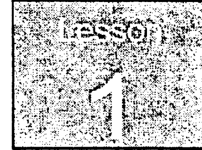
WHY MEDICATION TRAINING?



Maximizing safety for children and youth who might benefit from medication as part of their treatment plan.

OBJECTIVES

After completing this lesson, you will be able to:

1) List reasons for medication administration training.
2) Explain staff responsibilities in the medication cycle.
3) Describe common child and staff attitudes about medication and how these affect outcomes.
4) Predict benefits of a child's participation in the medication cycle.
5) Summarize Pennsylvania regulations as stated in §3800 for medication administration to children in residential and day treatment settings.

WHY HAVE TRAINING IN MEDICATION ADMINISTRATION?

- Many of the children will need prescribed medications to benefit fully from this program. You may not be familiar with some of these. All medications, including ones available over the counter (OTC) without prescription, can have undesired effects or cause rare responses in some people. All medications are potentially dangerous and no medication is absolutely safe.
- When an agency assumes responsibility for the care and protection of its children, it is required to make special efforts to protect their safety.
- In addition to protecting the health and well being of the children that you serve, your knowledge of appropriate medication procedures for administering medications will serve to protect you and your agency from faulty medication practices, which may have serious consequences.
- It is required by regulations. Although staff who administer OTC medications do not require training, they are required to document administration of OTC medications just like prescription medications. Knowing how to document medication administration correctly requires training.
- The more you know about medications and their proper use, the better you will become at performing your job.

MEDICATION CYCLE

As a staff person providing care to children, you may be required to administer medications or assist children in the use of medications. Proper use of medication is a process that involves more than simply taking a pill or applying a liquid. The medication cycle is illustrated in Exhibit 1, *Resources*, page 2, and consists of several important steps:

- Observe children for changes in physical and behavioral signs.
- Report significant changes to the right person at the right time by the right means.
- Communicate with physicians, pharmacists and the agency health care professional staff.
- Record medication information on appropriate forms.
- Administer medications.
- Review steps regularly to maintain and improve quality throughout the medication cycle.

Exhibit 1 MEDICATION CYCLE

ADMINISTRATION – BE AWARE THAT

Failure to correctly perform each step in the medication cycle can result in negative consequences:

- Persons go to a doctor because of a change in physical or behavior signs. Children may not receive needed medical attention unless you conscientiously observe him/her and report any significant changes.
- A medication may be prescribed that a child is allergic to unless you communicate important information to the physician or other health care providers.
- A child may not receive a prescribed medication unless you receive a prescription at a visit to an outside provider and follow the proper procedure.
- A child may receive the wrong amount of medication unless you follow procedures and the medication administration record correctly. Always be honest with the child and answer any questions to the best of your ability or refer him/her to the agency health care provider.
- A child may suffer an undesirable drug effect unless you observe and report significant physical and behavioral changes to the right person at the right time by the right means.

VALUES, ATTITUDES and CONCERNS

Everyone holds differing beliefs and ideas about using medication.

- Agency policies cannot always allow for medication practices which might be used in typical homes or vocational settings. However, staff should make every effort to use procedures that are as normative as possible within the rules and regulations.

- Children have the right to refuse any and all medications. All refusals must be properly documented and reported according to your agency's policy on Refusal of Medication.

- You can anticipate some types of concerns from children as they are common for many people who must take medication, especially for behavioral problems. It can be helpful to have an idea of what to say when these issues arise. See Exhibit 2, *Resources,* page 3.

OPPORTUNITIES FOR LEARNING and INTERACTION

Having the child participate in the process of administering their own medication varies from agency to agency, depending on the population of children, their ages, and their ability to be responsible and involved in their own care. The medication administration process can be used as an age-appropriate learning opportunity.for all children, no matter how necessary or how limited your involvement may be. This process can also provide more opportunities for social interaction and improve self-esteem.

The child can learn to be more responsible for their medication by participating in the medication cycle. The child can participate by asking questions of the nurse, physician, or staff administering medication about the name of the drug, its purpose and possible side effects. The child can also assist in the cycle by remembering the time the medication is to be given. They can eventually progress into structured, supervised, self-medication. This reinforces appropriate and necessary behavior for successfully helping themselves in the future to the best of their strengths and abilities.

Deciding to what degree the child is capable of participating in self-administration is the responsibility of health care professionals by policy in most agencies. However, they depend upon information from you and other staff directly involved in the care of the child to make that decision appropriately and to carry it out. Information exchanged between health professionals and staff is found in Lessons 3 and 4, which emphasizes the need to work as a team in these parts of the medication cycle.

Self-administration as part of child or youth involvement in the medication cycle is discussed further in Lesson 6.

Chapter 3800 – Regulations Concerning Medication Administration

Your agency abides by a set of regulations that directs how medication administration must be taught, performed and monitored in order to maintain its license to operate under Pennsylvania law. It is necessary for you to know these rules. The complete set of regulations for child residential and day treatment programs is referred to as Title 55 PA Code Chapter 3800, *Child Residential and Day Treatment Facilities*. These can be obtained from the Internet at:

http://www.pacode.com/secure/data/055/chapter3800/chap3800toc.html.

The symbol § is shorthand for the word "Chapter" when referring to regulations. It will appear in this text in references to the regulations affecting medication administration.

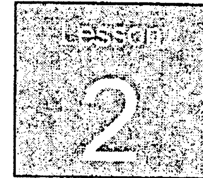
Important rules are:

- Only licensed health care professionals or persons who have up to date medication administration training may administer prescription medications.
- Approved training, such as this course, prepares non-medical agency staff to administer only oral, topical (skin), eye and ear preparations and epinephrine (adrenaline) injections for allergic reactions.
- Special training is required for administering injections, especially insulin shots.
- Children who are capable of and approved to self-administer medications must still have a staff person trained in medication administration to assist, observe and record each dose.

In addition, your agency using this medication administration program must adhere to certain requirements for quality assurance and handling medication errors. You will be taught the details in the final Lesson. These requirements cite other sections of the regulations that describe reportable and recordable incident procedures.

The exhibit displays the regulations related to medication use as well as the interpretation currently being used when your agency is inspected by OCYF staff for licensing purposes. These interpretations are updated as needed and published in a document called the Licensing Measurement Instrument (LMI): See Exhibit 3, *Resources*, page 5.

Exhibit 3 §3800 MEDICATION REGULATIONS



CATEGORIES AND EFFECTS OF MEDICATIONS

Knowing the categories a medication falls under provides helpful clues about its appropriate use and intended effects.

OBJECTIVES

After completing this lesson, you will be able to:

1) Classify and describe important types of medications.
2) List and define the three primary possible effects of medications.
3) Describe the three possible results of medication interactions.
4) Name the person(s) obligated to report possible effects of medication.
5) Review and assess medications that you will commonly encounter in your agency.

CATEGORIES OF MEDICATIONS

A *medication* is any non-food substance placed into the body for therapeutic purposes (American Society of Health-System Pharmacists, ASHP). To understand medications better, they can be divided into several important categories based on their differences and similarities, such as:

Availability and source:

Prescription (Rx) medication—Available only upon the order of a licensed health care professional such as a physician, dentist, certified nurse practitioner or physician's assistant.

Over-the-counter (OTC)—Does not require a prescription, but in most institutions cannot be given without an order from a licensed health care professional.

Abuse potential:

The abuse potential of any medicine is the chance that it might be used for non-therapeutic purposes. ." Controlled medications are also called *scheduled drugs*, because the Federal Drug Administration (FDA) uses a schedule or table which assigns numbers using Roman numerals from I (Roman numeral 1, for most dangerous and not allowed for use in the US) to V (Roman numeral 5, for least dangerous)

to rank the abuse potential. Exhibit 4, page 10, in *Resources* has more details about each level of risk and examples.

Controlled medications—Prescription medications that have been legally designated because they contain "controlled substances." Packages for these medications often display symbols like this that show the abuse potential:

Exhibit 4 SOME SCHEDULED DRUGS

Non-controlled or non-schedule medications—Prescription medications that do not appear on the schedule of controlled substances.

Name and number of manufacturers:

Branded—One manufacturer has patent protection, and the brand name, usually a made up word, is capitalized. Examples: Emycin™, Tylenol®, Motrin®, Depakote®, Ritalin®, Remeron® or Zyprexa®. Also called a *trade name* or a *proprietary name.*

Generic—Usually produced by a number of companies. Often, the <u>generic name</u> is a simplified version of the active chemical written in lower case. Examples: erythromycin, acetaminophen, ibuprofen, valproate, methylphenidate, mirtazapine, or olanzapine. In the past, these were also called *ethical drugs.*

Over time, brand names often come to be used as short hand for the generic name. Aspirin was originally the trade name for acetylsalicylic acid.

Time of use:

PRN—comes from the Latin phrase *pro re nata* and means "as needed." See the second bullet in the section, Categories with Special Rules below.

Routine—Medication given consistently at specific times.

Desired effects:

Antibiotic—To prevent or treat infections.

Psychotropic—To change behavior or to treat emotional symptoms.

Anti-seizure—To prevent seizures or treat epilepsy.

Part of the body affected or route it is given:

Ophthalmic—For the eye.

Oral—For the mouth or by mouth.

Otic—For the ear.

Nasal—For the nose.

Suppository—Placed in a body cavity, usually the rectum.

Nowadays, *suppositories* are not often used because newer types of tablets and other formulations exist for most medications that are more acceptable and easier to use. Suppositories can be used in circumstances when swallowing is a problem, such as medications to treat nausea, or when the medication is used for its local effect.

CATEGORIES WITH SPECIAL RULES

- **Psychotropics** may not be used on a PRN basis solely to control behavior, that is, as a chemical restraint. See §3800.209e.
- **PRN medications** may be given for specific physical complaints they might relieve such as pain or nausea and are sometimes called *comfort medications*. Note that they make symptoms better (fever) rather than treat the illness (flu) causing the symptom.
- Even if comfort medications are **OTC medications**, most agencies require an order from a health care professional before they may be used. PRN meds policy and procedures for your agency appears in Attachment 1, *Resources*, page 18.
  Sometimes the agency physician has a list of reasonably safe medications that can be used as needed without special request using a health care policy called *standing orders*. The symptoms treated by PRN comfort medications should have further investigation by a health care professional if they persist.

  Attachment 1 PRN MEDICATION POLICY

- **Controlled medications** are subject to strict inventory and storage controls.

EFFECTS OF MEDICATION

Medication, when properly prescribed and administered, can have several outcomes:

- **Desired** effects—The beneficial and desired effect of the medication.

- **Unwanted** effects—Undesired effects, any results other than the desired effect. Examples of unwanted medication effects are listed in Exhibit 5.

Exhibit 5 UNWANTED MEDICATION EFFECTS

- **No apparent effect**—The absence of the desired effect, after allowing sufficient time for the medication to work.

Unwanted effects are sometimes called side effects, but what might be an unwanted effect in one case may be a desired effect in another. Some OTC allergy medicines make people sleepy, so the same chemical (diphenhydramine) is sold under a different brand name as a sleep aid. Read more about medication effects in Exhibit 5, *Resources*, page 11.

- **MEDICATION INTERACTIONS**—A special type of unwanted effects which are a result of taking two or more medications at the same time. The resulting interaction may:
  - Increase the effects of one or more medications.
  - Decrease the effects of one or more of the medications.
  - Produce new and unique unwanted effects.

OBSERVING AND COMMUNICATING THE EFFECTS OF MEDICATION

This step in the medication cycle is an important responsibility of all staff caring for children.

Staff (you) are best able to observe and report any and all suspected effects of medications.

MEDICATIONS REVIEW

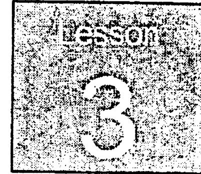
Medical care providers tend to use regularly only a limited number of all the medications available. This list of commonly used medications is often called a formulary. You will review the most common medications at your agency (Attachment 2, *Resources* p. 19) with special emphasis to be placed upon discussing the following characteristics:

- Expected action
- Possible adverse reaction
- Possible drug and/or treatment interaction
- Restrictions
-

Attachment 2 AGENCY FORMULARY

Remember — **your job is to watch for and report important changes.** You are responsible for noting changes in the children under your care, **not to determine if the change you see is actually the result of a given medication.**

If you see something that is different and it concerns you, be prepared to report it. More detailed information about recognizing those important changes, how to report them, and to whom you should report will be covered in depth in the next lesson.



OBSERVING AND REPORTING

Watching for important changes that may be related to medication and communicating that information effectively and appropriately.

OBJECTIVES

After completing this lesson, you will be able to:

1) List three levels of severity of physical and behavioral changes that require reporting and give an example of each.
2) Specify when, to whom, and how an emergency situation should be reported.
3) Name five conditions that are reported as emergencies that may be caused by medication.
4) State when, to whom and how a non-emergency, potentially health-threatening situation should be reported.
5) Explain when and how other changes in an individual's physical and behavioral signs should be reported.
6) Complete written practice reports to the appropriate person(s) on the correct agency forms with accurate and appropriate descriptions of behavioral and/or physical signs.
7) Define total quality management and recognize its components in the medication cycle.

INTRODUCTION

Observing and reporting physical and behavioral changes in children is an important responsibility for all staff. It is an important phase of the medication cycle that makes understanding medication administration more than just "passing out meds."

Reviewing your agency formulary in the last lesson suggested some observations that might make you suspect medication as a cause, but there may be other causes for the changes that you will need to note. Your job is to watch and report.

In order to do this, you need to know:

- WHAT to report.
- WHEN to report it.
- TO WHOM it should be reported.
- HOW to report it.

There are three levels of things to report, from most severe and urgent to the least::

- Health emergencies.
- Non-emergency, possibly health threatening conditions.
- Other notable conditions.

Attachment 3 REPORTING PROCEDURE & FORMS

Every agency will have different procedures and policies, but this lesson provides some general rules. You will first review your agency policies for reporting, and then you should practice writing reports. Examples of reporting forms are in Attachment 3, *Resources*, page 20, and your trainer should tell you where you may obtain them as they are needed and how to file or handle them.

HEALTH EMERGENCIES

WATCH FOR:

- Sudden wide-spread hives, especially if there is facial swelling.
- Breathing difficulty.
- Problems with the heart or blood circulation, for example rapid pulse or fainting.
- Uncontrolled pain.
- Uncontrolled bleeding.
- Marked behavior change.
- Change in mental status.
- Seizures, especially new or unexpected.
- Medication overdose.

Mental status refers to a person's mood and the way they appear to be thinking and feeling. Medications other than psychotropics may cause mental status changes or other behavioral effects, especially when medication interactions occur.

WHEN TO REPORT IT: Immediately.

TO WHOM:

- Local Emergency Number: ______________________________(write in yours)
- Poison Control (for suspected overdoses, adverse reactions or accidental ingestions): **800-222-1222** (now a single national number, easily remembered, reaches your closest center)
- Designated agency personnel: ______________________________(write in info)

ALSO CONSIDER:

- Provide first aid if necessary until help arrives.
- Follow directions from emergency personnel during contact phone calls to the above numbers.

AFTER ALL EMERGENCIES:

- Call the appropriate designated agency authority and inform him or her of what happened.
- Follow-up with a written report according to agency policies and procedures.
- If more than one staff person is involved, each person should write an individual report of the facts –what they saw and observed, not impressions or suspicions!

NON-EMERGENCY, POSSIBLY HEALTH THREATENING CONDITIONS

WATCH FOR:

- A fever which is not reduced by normal procedures.
- Diarrhea that is not affected by approved relief medicines.
- A rash that lasts for several days, or a rash that appears to be getting worse.
- A persistent sore throat.
- A change in the type of seizure an individual typically experiences.
- An increase in seizure activity.
- Repeated episodes of angry or aggressive behavior, which may be manageable, but are not typical for the person.
- Unusually withdrawn behavior on the part of a person who ordinarily has frequent interactions with others.
- Refusal to take prescribed medications.
- Other behavior changes that are greatly out of character for a child as you have come to know him or her.

WHEN TO REPORT IT: As soon as possible after the condition is observed.

TO WHOM:

- Call the agency nurse or other agency health care authority and any other designated agency personnel.
- Follow-up with a written report.

OTHER NOTABLE CHANGES

WATCH FOR:

- Report anything that could be significant such as changes in sleep patterns, unexplained bruises, slight rash, or upset stomach.
- Remember to report anything that is out of the ordinary, especially if medications were recently changed.

WHEN TO REPORT: As soon as possible after the condition is observed.

HOW TO REPORT AND TO WHOM:

- Write a report.
- Send it to designated agency personnel.
- Also, copy the agency nurse or health care authority.

WHEN IN DOUBT: BE ON THE SAFE SIDE and MAKE THE CALL!

INTRODUCTION TO QUALITY ASSURANCE

Attention to quality is vitally important in such industries as aviation and manufacturing where there is not much room for error. It also is a fine tool for keeping medical care safe. *Total quality management* consists of two parts: *Quality assurance* refers to keeping each part or process the best, and *quality improvement* means finding ways to make things or do things even better. See Exhibit 6, *Resources*, page 12.

Quality assurance (QA), also called quality control, is a system of procedures to ensure that a process adheres or conforms to established standards. The underlying process that incorporates medication administration is the medication cycle. As you have learned so far, this process includes tasks which are far more than giving or applying medicines. QA is a requirement at each step of the cycle. Observing and reporting what you see and do is important to make sure that the whole cycle is being done correctly.

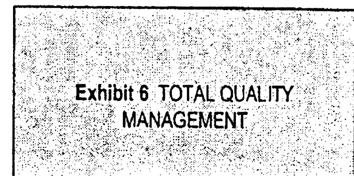
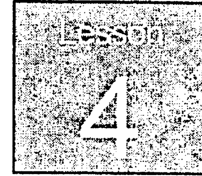


Exhibit 6 TOTAL QUALITY MANAGEMENT

Local policy and procedure determines who is ultimately responsible for the quality assurance in this agency. That person, often the agency nurse or other health care authority, is called the QA officer for medication administration and will review all medication-related reports and communications to be sure that high quality is being maintained.

You are responsible for maintaining the highest standards when you perform the steps in medication administration, so you, too, are responsible for quality assurance. Future lessons will include more information about medication administration QA as required in this system for medication administration.



OBTAINING AND USING MEDICATION

Giving medication information to health care providers and understanding medication orders. Getting the facts about medication for safe and beneficial administration.

OBJECTIVES

After completing this lesson, you will be able to:

1) State the types of information that must accompany a child when going to the doctor, and describe your agency's policy for acquiring this information.
2) Specify the written information which must be obtained from the physician when a new medication is prescribed.
3) List the necessary information for properly administering a medication as ordered or prescribed.
4) Describe the questions which must be asked of the physician and the pharmacist since the answers are not usually included in the order for a medication.

IMPORTANCE OF INFORMATION

Information plays an important role in the medication cycle as you have seen in the previous lessons. Information about what you see and report is extremely important. Health care professionals on your agency staff or outside health care providers need accurate and complete information as they try to insure that medication is being used to the best benefit of the child as safely as possible.

This lesson focuses on how specific types of information related to medication are an essential part of the basic health record for a child. This information is important for a doctor to safely prescribe medication to a child.

This lesson also teaches the types of information about a child's medication that will be necessary to administer it correctly. Basic directions are always given for administration on the labels for medication, and these directions must be followed exactly. However, other knowledge about both prescription medications and OTC medicines is all too often assumed. You must either be sure you know it already or find it out when needed, usually by asking or looking it up, in order to understand completely a new medication's benefits and risks and to use it wisely. Patients have always been told when and how to take a medicine, but knowing what to expect or what to do when certain events might happen is very important with the many different and powerful medicines now available. The fact is, even health care professional frequently find themselves double checking details to be sure.

INFORMATION FOR THE DOCTOR

Information should be provided to the physician or other health care provider to assist in determining the cause of a health problem and whether medication is necessary. A child's referral should contain the following:

Attachment 4 AGENCY REFERRAL FORM

- Reason for the visit.
- History of allergies (medications, food, etc.).
- Current medications being administered, and for what purpose (including PRN medications).
- Current medical and dental conditions not being treated by medications.
- Written observations of recent changes in physical symptoms or behavioral signs.

As with all forms, agencies usually develop their own which vary slightly in content and appearance. Your trainer will tell you where to find them when needed. A sample referral form, or the actual form used by your agency, appears in Attachment 4, *Resources*, page 21.

INFORMATION FROM THE DOCTOR:

When a doctor or other health care professional licensed to prescribe decides that a medication is needed, s/he "orders" its use. The information in that order is called a *prescription*. Remember from Lesson 2 that in most agencies, even nonprescription (OTC) medications usually require orders from a licensed health care provider before they may be administered. These orders contain the same information as those for prescription medication.

The pieces of information needed to give each dose correctly are the Rights of Medication. Everyone who administers medications should know the seven "Rights." Note that these pieces of information are usually written on the prescription or order form by a doctor and then printed on the medication label when dispensed by the pharmacist.

1) Right individual – Be sure you have the right child—some names can be more common than you think within one facility!
2) Right medication – Some of the new brand names can be very confusing and many drugs appear in different formats, such as long-acting or slow release which can have quite different effects.
3) Right dosage – Make sure the numbers have the decimal point at the right place (some pills are 0.1 and others 100 mg) and the units (milligrams or tablets for example) are correct.
4) Right time – Usually, by the clock and within a certain time frame of that set hour.
5) Right method – Should you shake the bottle? Do you have to wait between drops or puffs? Should it be diluted first in water or taken with food?

6) Right route – Be doubly certain those are the eye drops.

7) Right position – Does the child need to be sitting or standing?

Following these directions exactly is absolutely necessary to administer each dose correctly and will be discussed more in Chapter 5. Failure to follow these directions carefully each and every time leads to mistakes which can be harmful or even deadly.

NINE MEDICATION QUESTIONS – GO BEYOND THE RIGHTS

Just as important as the rights, are other pieces of information you want to know to be sure you are administering medication safely. These do not usually appear in doctors' orders or on prescription labels:

1) What is the purpose and desired effect of the medication?

2) What is the response time?

3) Are there any unwanted effects to watch for specifically?

4) Are there any possible interactions with other medications or foods, including PRN medications? (This may also be obtained from the pharmacist/medication information sheet.)

5) Are there any special administration and/or storage instructions?

6) Is this medication a controlled substance?

7) What is the period during which a prescribed dose of medication can be given to the child and still be considered on time?

8) What should staff do if the following occurs?
   - A dose is missed?
   - A dose is refused?
   - A dose is regurgitated?
   - A dose is spit out?

9) Is the medication intended to be a psychotropic? Can it have effects on behavior?

Many times, the pharmacy will put stickers on the pill bottle with important reminders that include this information. Also, pharmacists might supply an information sheet with this data and if you are not given one when you pick up a prescription, you should ask. You should always ask your doctor and pharmacist about any medication with which you are not familiar. Your agency might also have other references you can use to learn more about a given medication, a class of medication, or medications in general.

STARTING A NEW MEDICATION—APPLYING THOSE ANSWERS

Exhibit 7 NEW MEDICATION QUESTIONS

In your agency, you might encounter situations where you should ask for the answers to questions that are part of good and complete medication administration practices. One example might occur when you accompany a child on a visit to a doctor who prescribes a new medication.

You can take a copy of Exhibit 7, *Resources,* page 13, to aid you in asking question that may be answered by the medical professional or the pharmacist. Take notes on their responses - do not rely on memory. Remember to always ask the physician for the prescription or order sheet before leaving the office, depending upon your agency's method of obtaining medications.

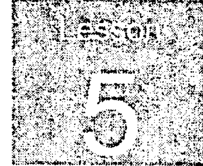
Before returning from the pharmacy, make sure that you have the written information to the nine medication related questions, and that the medication is in a container with a legible and correct label.

Although taking a child outside to a doctor's office and then going to the drug store might not be common practice in your agency, you should understand how this situation demonstrates the importance of information which goes beyond the directions of the seven "rights" to administer a new medication. This same information you will want to know when you administer medication to the child as part of your duties in your agency after you complete this training successfully.

A Note About ABBREVIATIONS

Regulations (3800.182) require that medications be kept in their original containers and have original labels that should be easily read and understood to avoid misunderstanding which could lead to mistakes. Abbreviations are discouraged in modern pharmacy practice and all directions are to be spelled out for clarity. Therefore, you do not have to memorize abbreviations as part of this training.

Never try to guess what abbreviations mean when administering medications—it can be dangerous.



DOCUMENTATION AND STORAGE

Keeping medication administration records. Knowing how medication is safely and legally stored. Recognizing and handling medication errors.

OBJECTIVES

After completing this lesson, you will be able to:

1) Describe the medication documents used in your agency.
2) Specify proper and improper storage practices for medications.
3) State where the agency documentation forms are kept.
4) Apply commonly used directions for administering the types of medication commonly used in your agency.
5) Recognize when a medication error has occurred.
6) Describe the proper procedure to follow if a medication error has occurred.

MEDICATION LOG – MAR

A medication log listing all medications prescribed, all medications given, the staff person administering or monitoring the self-administration of the medication, and the time and date of administration must be kept by the agency. The child who self-administers, or staff who administers the medication, needs to sign and initial the Medication Administration Record (MAR) each time medication is given to or taken by the child.

An MAR is required by §3800 regulations. This is the major record used to maintain the quality of each step throughout the whole medication cycle. The person responsible for quality assurance in your agency regularly reviews the log for all medications administered in the agency. It is also the place to record details when errors occur according to the regulations. Errors must be reviewed and changes may need to be made to procedures to prevent the same thing from happening again, a part of the quality improvement process. Medication errors are described later in this lesson.

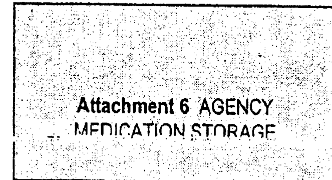
Your trainer will review the actual forms you should use in your agency and where they are to be kept, as well as the policies and procedures for its completion. A sample MAR and your agency's form is located at Attachment 5, page 22 in *Resources*.

Attachment 5 MAR POLICY & PROCEDURES

STORAGE OF MEDICATIONS

§ 3800 and good pharmacy practice requires that:

- All medications shall be kept in their original containers.
- All medications shall be kept in a locked area or in a container that is locked.
- Medications stored in a refrigerator not used exclusively for medication storage are to be kept in a separate locked container.
- Prescription and nonprescription medications shall be stored separately and under proper conditions of sanitation, temperature, moisture and light.
- Always separate oral medications from other treatments.



If your agency has other details that you need to know concerning storage, your trainer will review them and they should appear in Attachment 6, Resources p. 24. Agencies might have specific procedures for medication storage issues such as controlled substances, missing or suspected theft of medication, and disposing of medication. The following paragraphs discuss some of these special situations.

CONTROLLED SUBSTANCES

Every agency usually has separate policies and procedures for medications that appear on the Federal schedule of controlled substances. Although it is not a matter of government regulation, many agencies, especially those certified by medical reviewers, keep controlled substances double-locked and prepare strict inventory reports of medications in this category. Your trainer should review your agency policies with you.

MISSING OR SUSPECTED THEFT OF MEDICATION

Your agency policy and procedures should address missing medication. In general, if a child's medication is missing, staff will immediately:

- Notify the supervisor on duty or designated administrator on call.
- Complete a written report.
- Seek instructions from the agency health care authority or supervisor as to what should be done regarding medication administration for the missing dose(s).

DISPOSING OF MEDICATION

§3800 requires that discontinued, expired, or otherwise unused medications be disposed of safely. At no time are staff to dispose of any medications. Medications that are not administered are to be handled according to your agency procedures and policy. In general, pharmacists can always advise if there are any questions about safely disposing of medications.

MEDICATION ERRORS

A *medication error* occurs any time a child is placed at risk because medication administration procedures were ignored, usually because one of the seven "rights" was not correct. Medication errors occur 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.**
- Any other medication delivery problem that has the potential to negatively effect the child.

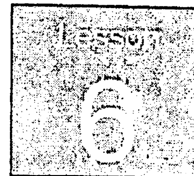
Attachment 7 AGENCY MEDICATION ERRORS POLICY

It is extremely important and wise to regard all deviations from the seven medication rights as situations that require prompt action following policy and procedure to the letter to minimize the chance of harm. Prompt recognition and reporting, rather than trying to hide an error, could also reduce the possibility of legal consequences. You must handle medication errors as directed by your agency policy and procedures which should be found as Attachment 7, *Resources*, page 25..

Some agencies refer to the types of errors in the last bullet item above, which are noted and corrected before the child is involved, as *medication variances*. Other agencies call these *Type I medication errors*. Those errors that actually go far enough to reach or involve a child are called *Type II medication errors* and are therefore considered much more serious.

In addition to your agency policy and procedures on medication errors, agencies using this curriculum program must record both Type II errors and Type I errors in the MAR. Agencies also must report medication problems that result in illness or injury that requires medical attention or death. See the next lesson's section on QA for details.

All medication errors and variances should be carefully reviewed following agency procedures---usually under the direction of the agency person in charge of medication administration quality assurance. The purpose of the review is to find and correct the root causes, rather than to find someone to blame. Correcting the causes of mediation errors or variances will help prevent future errors. Therefore, reviewing errors carefully and thoughtfully is an important component of the total quality management process to make sure that mistakes are not repeated.



ADMINISTERING MEDICATIONS

How to administer medication safely and how to maintain quality.

OBJECTIVES

After completing this lesson, you will be able to:

1) Apply the seven rights of medication administration.
2) List the conditions when a medication should not be administered
3) Summarize your agency policy concerning as-needed (PRN) medications.
4) Specify safe practices when monitoring self-administered medications.
5) Explain the importance of and be able to describe quality assurance procedures.

WHEN NOT TO GIVE MEDICATIONS

Do not give a medication

- If any one or more of the following required items are missing:
  - Your agency's medication log (MAR)
  - Original and legible pharmacy label
  - Other agency required forms
- If the child exhibits a dramatic change in status.
- If you have any doubt regarding the seven R's.
- If the child refuses to take medication. See Attachment 8, *Resources*, page 26, for your agency's specific policy and procedures.
- If the child has difficulty in taking the medication.

Attachment 8 AGENCY POLICY ON REFUSAL

MEDICATIONS WHILE "OFF GROUNDS"

In certain agencies with §3800 licenses, children may go "off grounds" or "leave campus." If this happens as part of the agency program, such as on a field trip or other outing, then the children will be accompanied by agency staff who are responsible for their care. Arrangements must be made to insure that medication is administered appropriately if it is part of a child's ongoing treatment plan.

Likewise, if the children are temporarily away and other adults are responsible for their well-being and care, such as parents or guardians on a home visit, then those adults must be given information about those medications that are needed while away from the agency. They also need a means of obtaining any prescription medications.

Attachment 9 POLICY AND PROCEDURES FOR OFF GROUNDS ADMINISTRATION

If administration "off grounds" could be part of your agency's program, your trainer will review specific policy and procedure which appears in Attachment 9, *Resources*, page 27.

USING OVER THE COUNTER AND PRN / COMFORT MEDICATIONS

In Lesson 2, you learned that usually in an agency setting you must have a licensed health care professional's order to give over the counter medication to children. Your trainer will review your agency policy and procedures for PRN and OTC medications again now.

RULES FOR SELF-ADMINISTERING MEDICATION

Only a staff member who has completed and passed this course is permitted to administer oral, skin, eye, or ear medication or monitor a child's self-administration.

To be considered capable of self-administration of medications with staff observation a child shall:

- Be able to recognize and distinguish their medication. They should be able to name each medication and the indication or reason for taking it.
- Know how much and when the medication is to be taken.

The degree of self-administration depends upon the child's mental capacity/behavior. In all cases, staff must ensure that the child took the medication properly.

Attachment 10 AGENCY POLICY ON SELF-ADMINISTRATION

Staff who have completed and passed this course may also administer or monitor the self-administration of epinephrine injections for severe allergic reactions.

Only staff who have completed a separate course may administer insulin or other injections. **This course does not meet the §3800 requirements for administering insulin injections or for monitoring children who may self-administer injections.**

Review the specific policies and procedures for your agency in Attachment 10, *Resources*, page 28.

PRACTICE MEDICATION ADMINISTRATION SKILLS

Remember your first time driving a car? Then perhaps you remember having a teacher, parent or friend first talk you through how it was done before you got behind the wheel. You probably discussed how to use the steering wheel and the gas pedal and where the controls were before you were allowed to turn the key. It is just about time to "get behind the wheel." Remember that the instructions are the doctor's orders. Watching out for the Seven Rights Of Medication (Lesson 4) are the best way to keep your eyes on the road.

Your trainer will review the steps for administering each of the types of medication allowed under §3800 regulations. Cards to help you learn these steps are provided in Exhibit 8, beginning on page 14 of the *Resources* section.

Exhibit 8 HOW TO ADMINISTER MEDICATIONS

Attachment 2

Formulary

Every agency will have a different list of commonly used medications depending upon its population. You trainer should review the list at your agency. This is a good time to get some understanding, not just of what the potential unwanted effects are, but also to find out what the desired benefits might be and how long it takes until those benefits should be noticeable. Use the Medication Questions in Exhibit 7, p.13 in the *Resources* section to ask more questions.

Remember that no one can expect to know everything about any given medication—even doctors and nurses look things up daily to be sure. You should always look up the details if you do not know or you are not sure. The key points of the discussion while doing this review are to

- Get a background picture of what to expect when you are a staff member administering medications in your agency.
- Become familiar with the different categories of medication.
- Learn new terms and practice using them to describe the conditions and medications you will commonly encounter.
- Find out how the medications used in your agency work and learn why they are used.
- Become familiar with the most important unwanted effects of those medications.

Attachment 3

Reporting Procedures and Forms

Every agency has a different set of forms for reporting issues associated with the medication cycle. Your trainer should give you some examples and have you practice writing some samples. You certainly should know where to find the report forms when you need them and how to process them after you have filled them out. Here is one example an agency uses to report serious incidents. Note the types of information that are requested – facts that were observed, not speculation about causes.

DATE OF INCIDENT

SPECIAL INCIDENT REPORT

All Incidents Must Be Recorded Before Going Off Duty

NAMES AND LIVING UNITS OF PERSONS INVOLVED

TYPES OF INCIDENT

☐ ACCIDENT ☐ BIZARRE BEHAVIOR ☐ DESTRUCTION ☐ FIGHT ☐ RUNAWAY ☐ OTHER

PLACE OF INCIDENT (ROOM, BUILDING, OUTSIDE AREA) | TIME

DESCRIPTION OF WHAT HAPPENED INCLUDING STAFF ACTION AND DECISIONS

CC: File

Signature | Title

Comments of Report Received

Attachment 4

Referral Form

Your agency probably has a special form that is used to convey information to outside health care providers. If so, your trainer will show it to you and discuss how to use it according to your agency policy and procedures. You should find that it includes the same information listed in Lesson 4 on page 18:

- Reason for the visit
- History of allergies (medications, food, etc.).
- Current medications being administered, and for what purpose (including PRN medications).
- Current medical and dental conditions not being treated by medications.
- Written observations of recent changes in physical symptoms or behavioral signs.

Since some agencies do not take children off grounds for medical evaluations and might not have such a form for routine use, here is a copy of a sample form.

PROFESSIONAL REFERRAL SHEET

DATE:

RESIDENT NAME:
FROM ATTENDING PHYSICIAN:
TO REFERRAL PHYSICIAN:
REASON FOR REFERRAL:

ALLERGIES:
MEDICATION:
MEDICAL CONDITIONS:

FINDINGS:

DIAGNOSIS:

RECOMMENDATIONS:

PHYSICIAN SIGNATURE DATE:

Attachment 5

Medication Administration Record (MAR) Form

Example 1 –Here is an example of a medication administration record for a single medication to a child.

MEDICATION RECORD

NAME: FACILITY

Dr. Mo: Year

To insure accurate administration of medication, each dose MUST BE accounted for. Liquid: Tablet Cream

SPECIAL INSTRUCTIONS: *Pharmacy Info MUST be attached to this sheet

Medication and Dosage

SIDE EFFECTS: CONTRAINDICATIONS:

Scheduled Times		DATES															
AM	PM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Supervisor Sign Off																	

Scheduled Times		DATES														
AM	PM	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Supervisor Sign Off																

Staff Signature and Initials

S = School HV = Home Vis R = Refused Time Differential = Actual time given over initials ie: 9:30 / JK

I - ILL DC = discontinued H = Hospital

Missed meds - Initials in circle (JK)

*Reason for missed dose should be noted on back of form

Example 2—Both sides of a form designed for multiple medications.

MEDICATION SHEET

MONTH ____________ YEAR ______

	MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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	INITIALS	SIGNATURE
STUDENT NAME:		
BIRTH DATE:		
PHYSICIAN NAME:		
PHYSICIAN PHONE NUMBER:		
ALLERGIES:		

DRUG	SPECIAL INSTRUCTIONS	SERIOUS SIDE EFFECTS	NON-PRESCRIPTION & PRN MEDS					
			DATE	TIME	DOSAGE	REASON	EFFECT	INITIAL
EXAMPLE: *Name*	*Take With Meals*	*[illegible]*						

DATE	TIME	REASON HELD OR REFUSED

Attachment 6

Medication Storage

Your trainer will include your agency policy and procedures that deal with storing medications and the other related topics in Lesson 5. Important topics that you will want to know more about are how your agency handles:

- Receipt of medications into the facility.
- Controlled substances.
- Missing medications.
- Disposing of medications.
- Special storage situations like refrigeration or liquids.

Attachment 7

Medication Errors

Any agency using this training curriculum must record all errors including medication variances (Type I errors) and Type II errors.

Medication errors must be followed up to determine the factors that lead to the problem. Then there must be a plan to correct the situations so that the error does not happen again. This is often called "root cause analysis."

Medication problems that result in a child's death or an illness or injury that requires medical attention must be reported to the regional Office of Children, Youth and Families.

Your trainer will discuss how these actions are to be carried out through your agency policy and procedures which should be included here.

Attachment 8

Medication Refusal

Every child has the right to refuse medication. Your agency should have a policy and procedure for handling these refusals. Certainly a refusal should be entered into the medication log but there may be more to the process. Here is a sample form that could be used both to report and record the refusal. Obviously, staff will want to be involved in handling any such situation appropriately.

MEDICATION REFUSAL FORM

Student________________________________, refused to take his prescribed medication

named________________________________. The refused medication was to be

administered at ______________________ on _________________________.

Student's admittance of refusal _______________________________.

Staff signature ____.

Reason for refusal:

Note that the pieces of information recorded here include the name of the medication and the details (Rights Of Medication) about the dose that was refused. The reason that the medication was refused is noted for review by the treatment team later. Also, the child (student) and the staff member who administers medication both sign the form so that the facts are clear to all.

Attachment 9

Policy and Procedures For "Off-Grounds" Medication Administration

In many agencies with §3800 licenses, children may go "off grounds" or "leave campus." If this happens as part of the agency program, such as on a field trip or other outing, then the children will be accompanied by agency staff who are responsible for their care. Arrangements must be made to insure that medication is administered appropriately if it is part of a child's ongoing treatment plan. The most appropriate way to do this is for staff to take the medication records and supplies with them.

Of course this can be cumbersome, but it underscores that medication administration in an agency is very different from what we would do with our own family members. It also has the disadvantage of drawing attention to the children and makes the experience outside less satisfyingly realistic and normative. Several solutions can be used to avoid having the whole medicine cart accompany the group of children.

The most obvious is to schedule medications so that there is a fairly wide timeframe for administering a medication. There is no regulatory requirement for administering at an exact clock time unless those are the exact directions in the order of the prescriber. Administering medication intended for twice a day dosing at 8 AM and 8 PM stems from the way medication traditionally was administered in institutions such a hospitals, but it is not necessary for most modern medications which are developed for ease of use in an outpatient setting. The assistance of the physician or other agency prescriber is necessary for the success of this approach. For an occasional event, a special order could be written to hold a dose or give it before or after the event. In circumstances where children are frequently off grounds or involved in activities that make clock scheduling difficult, prescribers can write directions such as "twice daily, one in AM after breakfast and before 11 AM and one in PM between dinner and bedtime." Each child and medication will require some thought to come up with the best solutions. It must be done in advance of the time away.

If the children are temporarily away from the agency and other adults are responsible for their well-being and care, such as parents or guardians on a home visit, then those adults must be given information about those medications that are needed while away from the agency. They also need a means of obtaining any prescription medications. It makes sense to have the responsible adults sign a receipt of understanding the directions and to indicate that they received any supplies from the agency.

The easiest way to provide the medication is using individually labeled unit doses and if children frequently are away, the extra cost is justified. Many agencies however receive their medications with a month's supply in a single pack. This makes it difficult to separate out a few days supply. It may not be a good idea to give the complete month's supply to the responsible adult and then expect it to be returned safely, although the blister packs can indicate if there is tampering. Remember that only certain medical professionals may dispense medication and prepare labels for separate packaging. If gone only for a short period, it may be possible to use the method with an extended time for dosing as discussed above. For longer periods away and with sufficient notice, it might be possible for the agency to have their pharmacy supplier, or one of the professionals legally allowed to do so, such as doctor, pharmacist, physician assistant or certified nurse practitioner, prepare specially labeled packages to give to the parent. This also would work for longer trips away with agency staff. Finally, there is always the alternative of giving the parent a separate written prescription to obtain medications at their own expense from their own choose of pharmacy.

While it might seem difficult at first, it is possible to enable children to receive medications safely and without interruption when away from the agency grounds.

Attachment 10

Monitoring Self-Administration

Every agency will have a different population of children who have varying needs and strengths. All children can benefit from participating in the medication cycle to the extent that they are able.

Agencies which allow staff members trained in medication administration to administer medication should have clear directives for who decides how involved a child can be in the medication cycle and how the determination is made.

There should be a clear means of communicating these child-specific issues to staff members who administer medication.

Your trainer will review child participation in self-administration at your agency, as well as the other issues you need to know to maintain minimum risk and maximum benefit when you assist children with self-administration.

Attachment 11

Medication Administration Policy and Procedures on Quality Assurance

Agencies using this training curriculum will adhere to certain standards for maintaining and improving quality. Your agency's methods for carrying this out should be reviewed.

Office of Children, Youth and Families

Department of Public Welfare
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Phone (717) 787-4756
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Medication Administration: A System of Best Practice

TRAINER MATERIALS

TRAINER MATERIALS

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SPECIAL NOTE: Answers to sample test questions will be provided to Direct Trainers And Trainers-Of-Trainers who have been identified to the regional Office Of Children, Youth And Families, as part of the curriculum approval process. Mid-Level Ttrainers will receive the correct answers from their Trainer-Of-Trainers.

OCYF MEDICATION ADMINISTRATION TRAINING CURRICULUM

INTRODUCTION

Training staff who administer medication is necessary for compliance with 55 PA Code, Chapter 3800 regulations. It is important, however, before planning any training to be certain that all the relevant agency policy and procedures have been reviewed and revised in order that the agency methods are consistent with best practice that in its most basic essence aims to maximize the benefit from and reduce the risk of medication use. Three other sections, *Users' Guide, Lessons*, and *Resources*, which together describe a system of best practice, accompany this document and can be used for that review. This fourth section of the OCYF materials describes in detail the activities supervised by the trainers in agencies who choose to implement this model in their staff training. It also outlines how to prepare materials for distribution to, and use by, the trainees.

The same basic materials and activities can be used by Direct Trainers in the DT method and by the Mid Level Trainers in the Train-the-Trainer delivery methods of the OCYF model. An important preparatory task for the trainer is to add material that reflects actual agency practice. Training will transmit not just facts about medication, but also cultivate an appropriate philosophy. Successful training requires an objective measure of final trainee performance and understanding through tests, which are provided in this section along with suggestions for their use. The final skill test by practicum observation will also play a role in the ongoing quality assurance process as required for best practice and outlined in the *Users' Guide* and *Lesson sections*. Finally, there is a certificate included for trainees that can be used to easily track ongoing quality assurance performance evaluationsa nd assist in periodicr etraining and continued certification activity.

TRAINING SEQUENCE

One question that cannot be answered prescriptively is, How long should the training take? This will vary with the previous experience of the staff to be trained and with the trainer's own approach among other factors. However, it is reasonable to assume a minimum of seven or eight hours of contact time for first-time through with staff previously unfamiliar with medication, but with knowledge of child residential procedures in general. Extra time might be required for the demonstrations, final testing and observations with such a group, while experienced staff who are being retrained should take less time to grasp and then demonstrate the necessary knowledge and skills. Likewise, preparation time will take longer with the first training in an agency for any trainer orm ethod. It is advisable, but not necessary, to break the training of

new staff up into at least two separate sessions with no more than a week in between to get maximum integration, retention and continuity.

Specific steps in the training process are as follows:

ACTIVITY #1: Trainer prepares to do the training.

- Review the Trainer's Manual.
- Review printed Lessons and Exhibits in the Resources.
- Read and familiarize yourself with the following:
  - o Chapter 3800.181-189, especially most recent interpretive guidelines.
  - o Agency policy and procedures related to medication administration.

ACTIVITY #2: Assemble Training Materials (next section)

ACTIVITY #3: At the first training session:

- Pass out materials.
- Explain training and testing procedures.
- Set training schedule if there is to be more than one session to complete all activities.
- Administer the pre-training test (see page 5)

ACTIVITY #4: Present Lessons 1 through 4 using the *Lessons* section as the guide for activities and discussion.

- It may be useful to involve other agency personnel at appropriate points. The formulary review in Lesson 2, for example, could involve a discussion with an agency prescriber or pharmacist.
- Several Lessons suggest activities such as completing agency forms for reporting that will need to be tailored to local circumstances.
- At the conclusion of each Lesson, administer an end-of-lesson quiz using model questions and following guidelines given later, see page 8.

ACTIVITY #5: Documentation and Storage –Lesson 5

- During Lesson 5, demonstrate the correct agency procedures for storage and documentation of medications.
- Administer an end-of-lesson quiz for Lesson 5.

ACTIVITY #6: Administration/Monitored Self-Administered Medications—Lesson 6

- During Lesson 6, demonstrate and practice the correct procedures for administering medications using practicum exercises or equivalent experiences, page 9.

ACTIVITY #7: Administer the Written Final Examination as described on page 8 of this section.

ACTIVITY #8: Administer the Practicum Examination following the guidelines on page 9 and using the form provided at page 11 or its equivalent with the addition of local process steps.

ACTIVITY #9: Complete the Training Verification Record forms on page 15. Trainees who successfully complete the course may receive a decorative certificate as well.

ACTIVITY #10: Perform or appropriately delegate ongoing steps for total quality management as QA officer for medication administration.

- Perform periodic observations of performance or administer the practicum under sham conditions.
- Review medication administration records regularly.
- Be certain that medication errors are recorded and reported as required, and lead or assist in evaluation of root causes and corrective actions.

INSTRUCTIONS FOR MATERIAL ASSEMBLY

Each staff person being trained in medication administration should receive a completed set of the Lessons along with the Resources enhanced with the appropriate agency materials. Note that:

- Curriculum sections distributed by OCYF are printed on 8-1/2" x 11" paper, which can be punched to fit into a three-ring binder.
- Exhibit 8, How To Administer Medications is formatted to copy onto Avery® forms 5388, 8389 or 3611 which can then be easily separated into individual cards with instruction reminders for each medication type.

Trainers will add the following material:

✓ Local emergency number and other contact information in Lesson 3.

✓ Appropriate materials to illustrate local formulary for discussion (which occurs during Lesson 2) will go into Attachment 2, including a list of references available at the local facility and where they might be found.

✓ Add to, or substitute for, provided examples the page(s) of agency specific policy and procedures to Attachments 1-10. Additional pages if needed may be numbered as 3, 3A, 4, 5, 5A, 5B, 6, etc.

Trainers will prepare any desired additional materials including:

✓ Practice reporting forms as used by the agency.

✓ Sample medication log pages (MARs)

✓ Sham unit dose packs or other medication props approved in the agency for demonstrating and practicing the practical lessons, see page 9.

✓ Agency specific quiz and test questions as described on page 8

✓ Agency specific practicum exercise scenarios as described on page 9.

✓ Tests and answer forms.

✓ Certificates for successful completion.

PRETEST USE

A written test which covers the most important cognitive (factual) information should be administered to trainees at the beginning of the first meeting during the training period. This is to prepare the staff to recognize those elements that will be necessary for them to learn and retain during the training. First-time trainees should be told that this is not something to fear failing, but simply a chance to jump in and get started. For that reason, it is quite appropriate to let staff who are being trained grade their own answers, and there is no reason to record the results.

A sample pre-training test follows on the next page. This exercise will probably not be easy for first-time trainees, but they may be reassured that all of the information is quite easy to pick up during the subsequent training, as well as to retain when put to regular use.

References / *Answers* for Pre-test

1. Lesson 4, pages 18-19.
2. *medication error* (extra credit—*Type II*) Lesson 5, p. 23. Minimum answer should include 1) *report ASAP*, 2) *get directions for immediate next steps from health authority*, 3) *participate in follow up/prevention effort*
3. Lesson 3, p. 14
4. 1) *licensed health care professionals(nurses)* & 2) *staff trained in approved course within past two years.*
5. Lesson 6, page 24.
6. Lesson 1, page 5.
7. *controlled/scheduled substance/medication*, p.8-9.
8. *Brand, generic, chemical*—Lesson 2.
9. *desired, unwanted, no apparent effect* – Lesson 2.
10. *medication log/MAR*
11. *QI/QA*, Lesson 3, p. 16.
12. Lesson 1, p. 7. Also p. 25.
13. Lesson 4, page 19.
14. Lesson 6, page 25.
15. You're not sure? True, p. 22.
16. *I am* or *Trained staff / who administer meds*, p. 16

OCYF MEDICATION ADMINISTRATION

Maximizing safety for children and youth who might benefit from medication as part of their treatment plan.

PRE-TRAINING TEST

Please write your answers to the questions below in the spaces provided. In all cases you should assume that you are currently trained to administer medication. This exercise will not be graded and is simply a way for you to find out more about what you will need to learn in order that you can perform medication administration well as an important part of your job.

2. How many Rights of Medication are there? _____. List them in the space below.

3. John is supposed to receive 200 mg of carbamazepin twice daily at 8 AM and 8 PM. At 1 PM, you discover he did not receive the morning dose. This is an example of what type of event in medication administration? ________________________. In the space below write what step(s) you will take.

4. List below at least three examples of situations that would be medical emergencies which could be related to medication.

5. What two groups of people may administer medication to children according to Pennsylvania regulations?

   ______________________________ ______________________________

6. List three circumstances when you would not give a child prescribed routine medication.

(over)

7. List at least four staff responsibilities in the medication cycle.

8. A medication which has the potential for abuse as determined by the U.S. Drug Enforcement Administration (DEA) is called a ______________________________.

9. Medications can have three different names—list at least two and give an example.

<u>Type of Name</u>	<u>Example</u>

10. List three possible effects of medication and give an example of each.

<u>Type of Effect</u>	<u>Example</u>

11. Records of when and how medication was administered are kept in the

    ____

12. Total quality management consists of two parts. Name them.

    ______________________________ ______________________________

13. After you have passed your medication administration training, regulations allow you to administer what types of medication? (List)

14. List at least five pieces of information that you should know about a new medication that are not part of the prescription instructions.

15. Name three things that a child must be able to do to safely participate in administering their own medications.

16. All medications must be kept locked and away from children. True or False?

17. Who is responsible for observing and reporting changes in a child?

END OF LESSON QUIZZES

There will be a pooled set of questions that are derived from each of the lessons—see the next section and a description of the final examination. The trainer shall choose a subset of these at the conclusion of each lesson and administer to the trainees either orally or in written form to provide feedback that cognitive material has been retained. Performance on these end-of-lesson quizzes is only to determine progress to that point. If they are scored, the results at the immediate conclusion of an individual lesson should not be used to determine satisfactory completion of the overall training as successful training requires integration of all the material into both cognitive and skill knowledge sets.

FINAL WRITTEN EXAMINATION

The same pool of questions from which quizzes are drawn will be used to prepare the final examinations for trainees. Trainers will want to develop a subset of questions that probe knowledge of important local policy and procedure where appropriate, in addition to any samples provided by OCYF which are based on the generic medication administration system of best practices. Either a selection of all questions, or all questions fore ach lesson, should be chosen and administered as a written examination using a simple response form that allows the right answer to be circled or written.

The same questions may be asked at the end of the lessons as well as on the final examination. However, trainees should take the examination with no sources of information available (i.e. closed book) and should be offered sufficient time to complete it.

Questions will be of the one-correct or one-or-more-correct multiple response or true-or-false types. One-correct response questions will be scored as two points each. True/false questions count as one point. One-or-more-correct multiple response questions are worth a number of points equal to the number of options, so that each option is actually a true/false question and worth one point apiece.

Questions chosen for the exam should reflect the important cognitive topics and be sufficient in number to add up to a reasonable number of points since passing the exam will require attaining 85% of the possible points for all the questions. A passing grade will demonstrate a grasp of important concepts, rather than any particular set of facts, especially those of the sort that even a medical professional might want to look up in actual practice; for example, none but the most common medication brand and generic equivalents, nor unwanted effects except the most likely, should be memorized.

Trainees who fail the first time should be allowed additional time to study and an opportunity to retake the test, possibly using a different set of questions, as the trainer deems necessary. Ultimate decision as to whether a trainee has reached the appropriate level of cognitive proficiency in medication administration shall remain with the trainer. No one will receive a certificate of training until they have passed both a written test and a practicum, as determined by the trainer.

Pending the development of a larger pool of questions, a sample final exam follows on page 16 with questions that can be used by agencies who are now adopting this as their training curriculum for end-of-lesson quizzes as well as the final examination. A sample answer sheet is also provided

to illustrate the scoring method. Correct answers are available to registered trainers of the curriculum—see SPECIAL NOTE at bottom of Table of Contents on page 1.

PRACTICUM TRAINING EXERCISES

Appropriate training in the medication cycle must include an opportunity to practice skills involved in each step. Perhaps none is more vital than actually administering medication doses which should be done as realistically as possible. Certainly for most people, there is a level of discomfort in doing this initially, and a chance to practice and get feedback before familiarity with on the job performance helps to alleviate that discomfort, as well as to underscore the importance of doing it correctly for the safety of the child. These exercises are also the opportunity to integrate the cognitive knowledge into the processes requiring skill.

Specific training sessions should make every effort to present the practicum as realistically as possible by incorporating common experiences to be expected within the agency by staff who administer medication. Trainers will want to use scenarios such as the following examples beginning on page 13, which are based on the generic model of best practices for medication administration to children. It is also important for staff to get hands on experience with the medication, related materials and in similar settings.

Pharmacists should be consulted to provide training materials as identical to actual medication used in the facility as possible. Hard candies can easily be run through the same packaging devices as are used for prescriptions prepared into unit doses. Many agencies find miniature packets of M&Ms® very similar in feel and difficulty of opening as their regular packing for medications. Pharmaceutical representatives can provide special devices made for training in the use of inhalers, auto injectors and other items. Other items may also be used with appropriate caution and respect. Each trainer and agency will need to determine what is appropriate and safe in their environment, and no trainee or other model/actor should be the recipient of such sham treatments without expressly consenting to be the subject. Saline solution (artificial tears) can be used as eye drops, plain rubbing alcohol can be prepared in dropper bottles for imitating ear drops, and petroleum jelly or other skin moisturizers make good practice for applying skin medications. It is always possible to demonstrate the motions without using actual containers or substances.

Finally, these exercises are designed to prepare the trainees for the skills observation of the final practicum observation and the ongoing periodic monitoring of performance after completing the training. They should go through at least one experience with each of the medication forms permitted under the regulations before the practicum final is administered, described in the next section, and have their performance observed using the practicum checklist form.

PRACTICUM EXAMINATION / ONGOING PERIODIC OBSERVATION

The same process is used to administer a final examination of skills as well as to do periodic quality assurance checks of performance. The latter may be done while observing actual medication administration sessions or in a practice role-playing session. Rose-playing may make use of a scenario as described in the previous section, or may simply be based upon the statement, "Show me how you would give a child a (type of medication)."

Use copies of forms beginning on page 11 to note actual required steps for performance. The forms may be copied as one two-sided page. Tick each step as performed. Leave blank if step was missed. Mark any skill types that were not observed as NA, otherwise observer shall mark as PASS or FAIL and sign form upon completion. Forms can be saved with the training certificates in

case issues arrive later. PREPARATION steps should be noted and marked at least once at each observation session.

SUCCESSFUL COMPLETION OF TRAINING

Ultimate decision as to whether a trainee has reached the appropriate level of cognitive proficiency in medication administration shall remain with the trainer. No one will receive a certificate of training until they have passed both the written test and the practicum, as determined by the trainer.

TRAINING CERTIFICATE USE

A Training Verification Form (printed on page 15) shall be completed by the trainer for each individual who successfully completes the entire training and passes the written and practicum portions.

The form also is used to record the periodic observation of performance as part of the quality assurance for this system.

Forms may be filed by an employee ID or last name, written on the very top at the field "FILE ID"for easy viewing in a vertical file. They can also be tickled by a next-action date that is written on the top line and crossed out or erased and changed with each update.

Location of expiration date on far right of the main body of data fields allows for easy scanning for those in need of training renewal. Use of this common form will expedite proof of agency compliance with regulations during licensing operations by OCYF as well.

Grid at the bottom with dates partially completed is to be used for periodic monitoring of performance for QA. Comments should be used to mark whether the observation was of direct performance or by practicum and passed. If the monitoring is failed, comments should note remediation that is recommended and next entry is used to recheck after the intervention has occurred before resuming administration responsibilities.

PRACTICUM / QA OBSERVATION CHECKLIST

STAFF MEMBER'S NAME: ______________________ DATE: ____________

Observer______________________

==================================

PREPARATION FOR ALL MEDICATION ADMINISTRATION

____1. Clean Medication Administration Area.
____2. Wash hands with soap and water.
____3. Assemble needed supplies – cups, pen, Medication Log.
____4. Review Medication Schedule.
____5. Call children individually to Medication Administration area.
____6. Check the medication package with the MAR to determine correct medication, dose, route, time and child (7 Rights) to receive the medication.

PASS FAIL (Required) COMMENTS:

==================================

ORAL MEDICATIONS

____1. Compare the medication package with the MAR again to double check the seven rights.
____2. Give the package to the child without touching the pill, tablet, or liquid.
____3. Medications are to be crushed only if ordered by the physician and recorded on the MAR
____4. Observe the child as medication is swallowed
____5. Do a check of the mouth cavity after swallowing to ensure the medication has been swallowed.
____6. Initial the MAR and document any pertinent info on the back of the MAR immediately after each medication.
____7. Ensure that your signature or initials are on each MAR after each child.

PASS FAIL NA COMMENTS:

==================================

==================================

TOPICAL MEDICATIONS

____1. Compare the medication package with the MAR again to double check the seven rights.
____2. Wash hands.
____3. Apply amount prescribed to specific area of skin as directed with tongue blade or gloves
____4. Close container and dispose of tongue blade or gloves appropriately.
____5. Document dose appropriately on MAR.

PASS FAIL NA COMMENTS:

==================================

EYE DROPS

____1. Compare the medication package with the MAR again to double check the seven rights.
____2. Wash hands.
____3. Obtain container and check dropper to assure it is not dirty, chipped or cracked.
____4. Tilt head back or have child look at the ceiling.
____5. Pull down lower lid of correct eye with index finger to form a pocket.
____6. Dispense correct number of drops without touching dropper to eye while holding hand against forehead to steady it.
____7. Instruct child to close eye for 2-3 minutes.
____8. Child or staff may wipe any spill from cheeks.
____9. Replace cap and tighten immediately.
____10. Wash hands to remove any medication and document dose.

PASS FAIL NA COMMENTS:

==================================

EAR DROPS

____1. Compare the medication package with the MAR again to double check the seven rights.
____2. Wash hands.
____3. Obtain container and warm ear drops to near body temperature.
____4. Shake the bottle for 10 seconds if drops are a cloudy suspension, then check dropper tip if dirty, chipped or cracked.
____5. Draw medication into dropper and tilt affected ear(s) up and place correct number of drops in each ear(s) while tugging on outer ear to allow drops to run in.
____6. Keep ear tilted several minutes or insert soft cotton plug as directed.
____7. Replace cap and tighten immediately.
____8. Wash hands to remove any medication and document dose.

PASS FAIL NA COMMENTS:

==================================

AUTO-INJECTOR (EPINEPHRINE) FOR ALLERGIC EMERGENCIES

____1. Can state symptoms and signs of impending serious allergy reaction(facial swelling, hives, difficulty breathing.
____2. States need to have someone call emergency number (usually 911) for immediate assistance/transport while preparing to inject..
____3. Pull off safety cap if present.
____4. Place tip of Epi-pen® or needle at right angle to front of and just to the outside of the leg in the fleshiest part of the front of the thigh.
____5. Press into thigh hard (Epi-pen ®)or push plunger (Anakit®)to release medication and hold for a few seconds before removing the needle.
____6. Massage area for ten seconds.
____7.Dispose of sharps appropriately
____8. Document/report following all appropriate policies.

PASS FAIL NA COMMENTS:

==================================

==================================

INHALER USE

____1. Shake inhaler 5 seconds if directed to do so.
____2. Attach spacer to inhaler if directed.
____3. Hold inhaler between index finger and thumb and remove cap.
____4. Insert inhaler mouthpiece or spacer into mouth and close lips around it.
____5. Exhale normally with head tilted back slightly.
____6. Press down inhaler to release spray and inhale deeply and slowly one time over 3 to 5 seconds.
____7. Hold breath for 10 seconds then exhale.
____8. Wait 2-3 minutes and repeat aforementioned steps if directed.
____9. Child may rinse mouth with water after using the inhaler to remove the medication taste.
____10. Replace cap and document.

PASS FAIL NA COMMENTS:

==================================

Signatures:

____
Observer/QA Officer

____
Staff Member Who Was Observed

PRACTICUM SCENARIO EXAMPLES

The following scenarios give a context to practicing not just the actual administering of medication, but a variety of other skills that could be worked into the role playing, including the educational steps involved in supervising self-administration, the counseling sometimes necessary to deal with reluctant children, documentation and communication, and the recognition of medication errors. Note that most assign three different roles but that the observer is optional. Thanks to Connie Hollingshead, RN, for sharing these.

Practicum Example #1 - Oral Medication

1. Staff – Is to properly administer erythromycin, 250 mg , 1 tablet four times daily for ten days: to Jesse Martinez for a subacute bronchitis. This is the sixth day of the medication cycle month. This medication was ordered by Dr . Killem.

2. Observer - Check the list and make sure all steps were properly completed

3. Jesse Martinez- You are on erythromycin 250 mg- 4 times a day for 10 days —- This is the sixth day of your medicine, you are feeling better and can't understand why you have to keep taking this medication - You don't want to get "hooked" on drugs - You don't even understand what this drug is for, or why you must keep taking it - You are just generally having an 'attitude" day

Practicum Example #2 - Inhaler Use

1. Staff - Properly educate Heidi Smith in the correct use of her newly prescribed Ventolin Inhalation Aerosol. Her doctor, Doctor Wheeze, placed her on this medication for symptoms of exercise-induced bronchospasm. Heidi has never used an inhaler before and the past two days since she has been on it, she can't seem to get the hang of it. The prescription reads "2 inhalations 15 minutes before exercise and every 4 hours as needed for wheezing or shortness of breath."

2. Observer - Check the list to make sure all steps were properly taught and followed

3. Heidi - You don't want the other teenagers in your gym class to see you using some kind of stupid medicine - Even though you are instructed not to leave this medication out in the cold, you do just that, and now it's not working right - You never remember to shake it before using it - You always spray 3 or 4 sprays into the air before using just "to make sure it is working" - you never wait between puffss, you take them rapidly together - Nothing comes out of the canister, so you decide it is empty

Practicum Example #3 - Eye Drops

1. Staff - Properly educate and supervise Robert Dull in the installation of 2 drops of Cortisporin Ophthalmic Suspension into his right eye every 4 hours for 5 days. Dr. Seeright just saw Robert because the 16 year old otherwise healthy and active youth received a corneal abrasion from a piece of metal that fortunately was easily flushed from his right eye during welding class.

2. Observer- Check the list to make sure all steps were properly taught and followed

3. Robert Dull- You have very touchy eyes, and every attempt to place drops in your eye, ends up with the drops running down your cheek. You don't particularly trust adults, especially adults in authority. Rather than learn how to self administer the drops, you want the staff to just put the drops in his eye!

Variations: 1) Robert is six years old. 2) It is the third day and Robert says everything is fine. He has no pain and can see fine. Why should he continue? 3) You are at Dr. Seeright's ophthalmology office with Robert and the doctor has just handed you the prescription. Now what do you do?

Practicum Example #4 - Ear Drops

1. Staff: Properly administer YoYo-mycin* S Otic drops - 4 drops-3 times a day into James' left ear - for a bacterial infection of the external auditory canal . These drops need refrigeration when they are stored. A sterilized dropper-cap assembly for use on the bottle of suspension is included in the package which has a sticker on it: Shake well before using. The medication was ordered by Dr. Hearwell and is to be continued for 10 days. (*NOTE You will not find this in a reference!)

2. Observer- Check the list to make sure all steps were properly taught

4. Child - James Bank - You are a very hyperactive child of 8. You repeatedly interrupt your Mother's conversations, and are generally not a very well behaved child.

Variation: Add a fourth character: Mother of James Bank - You are having much difficulty understanding exactly when and how and for what reason your stepson, James Bank, needs this medication. He hears just fine according to your standards. You feel Doctors order too many medications and they just want to make money. Your reading level is only that of a 4th grader. Staff: Mother just arrived after a two hour drive to visit and wants to take James off campus for the afternoon.

Practicum Example #5 - Topical Medicine

I. Staff: Properly apply a thin film of Diprolene Ointment 0.05%- a brand of augmented betamethasone dipropionate - to Sandra Sullen's inflammatory dermatosis on her right arm. This medication was ordered yesterday by Dr. Clearskin, and is to be used twice daily for 7 days. Diprolene Ointment is not to be used with an occlusive dressing.

2. Observer- Check the list and make sure all steps were properly completed

3. Sandra Sullen -Dr. Clearskin started you on Diprolene Ointment yesterday for an inflammatory dermatosis on your right arm. You were instructed to use a thin film of ointment twice a day for 7 days, and not to cover it with a dressing. You don't like what it looks like, how it smells, and how messy it is! ! ! ! ! You come to the medicine room with a big bandage over the area of inflammation and get very annoyed when staff inform you that you should not have a dressing over this medication.

Practicum Example #6 Auto-Injector For Allergic Emergencies

As a group - list every objection, concern, or worry that you have ever heard untrained staff or other people voice, regarding the use of an Epi-Pen ® Then develop an appropriate response to each noted concern, including but not limited to the proper use of auto-injectors and why you may need to use it.

FILE ID: ______________ TICKLE FOR ACTION DATE(S): ______________________________

Medication Administration Curriculum

TRAINING VERIFICATION FORM

INDIVIDUAL TRAINED: ____ B

____ A

Please Print Above (line A) and Sign Name Above That (line B)

AGENCY/FACILITY: ____

DATE TRAINING COMPLETED: ______________________ EXPIRES (2 years after training date) ON: ______________

TRAINER'S NAME (PRINT): ____

TRAINER CLASSIFICATION: (Circle One) DIRECT MID LEVEL

This is to verify that the individual named above has successfully completed the Lessons and the written and practical examinations required for staff who administer medication.

TRAINER'S SIGNATURE: ____

QA PERFORMANCE REVIEW RECORD

Date	Reviewer	Comments	Date	Reviewer	Comments
/ /20__			/ /20__		
/ /20__			/ /20__		
/ /20__			/ /20__		
/ /20__			/ /20__		
/ /20__			/ /20__		
/ /20__			/ /20__		

AN OCYF MEDICATION

TRAINING CURRICULUM

Maximizing safety for children and youth who might benefit from medication as part of their treatment plan.

EXAMINATION QUESTIONS

One BEST RESPONSE Questions

This section consists of questions with several suggested answers. Circle the letter of the best response on your answer sheet.

1) Which is the one medication this training does not prepare you to administer under the §3800 regulations:

   A. Tylenol® for a headache
   B. Albuterol inhaler for asthma
   C. Benzyl peroxide gel for severe acne on a youth's back
   D. Insulin injection for a diabetic child
   E. Acetaminophen with codeine for a child with a wrist fracture

2) Child care staff will need to be trained every ____ years to be in compliance with the §3800 regulations. Choose one:

   A. 1
   B. 2
   C. 5
   D. 10

3) Harry received a prescription and has been taking the medication for three days. He has developed a urine discoloration. This might be an example of

   A. Desired effects
   B. Unwanted effects
   C. No apparent desired effects

4) A medication has been prescribed to relieve Megan's sore throat. After taking the medication as directed for five days, Megan no longer has a sore throat. This might be an example of

A. Desired effects
B. Unwanted effects
C. No apparent desired effects

5) According to the medication cycle in this course, who is primarily responsible for first noticing that, after taking a new medicine for a rash, Diane, age 8, is always asking for something to drink?

A. Diane's doctor
B. Staff member who keeps filling the glass
C. Agency nurse
D. Unit supervisor

6) Bryan has a temperature of 101. The health care professional, through the agency's PRN orders for comfort medicines, allows you to give Bryan acetaminophen every four hours to lower his temperature. Twenty-four hours later Bryan still has a temperature of 101 at supper time. This might be an example of:

A. Desired effects
B. Unwanted effects
C. No apparent desired effects

7) Bryan was complaining of some headache and vomited some of his lunch but seemed okay at supper except for the fever. Now you find that he does not awaken when you call his name during a bed check in the agency. In fact, he just moans when you shake his shoulder vigorously and does not even try to speak or open his eyes. The situation should be reported as:

A. An emergency condition
B. A non-emergency, health threatening condition
C. A notation in the unit log for the next shift
D. Not reported at this time

8) Who in this list should be contacted first concerning Bryan's condition?

A. Bryan's parents
B. Local emergency response (911)
C. Bryan's priest
D. Bryan's play therapist who is gone for the night but left a home phone number

9) During lunch with Teri, you observed a slight rash on her right inner arm. When you ask, she has not even noticed it herself. The situation should be reported as

A. An emergency condition
B. A non-emergency, health threatening condition
C. Notable change
D. Not reported at all

10) A student left yesterday but you note that his medication remains in the med box. What should you do?

A. Keep it for the future
B. Use it for another student taking the same thing
C. Wrap in paper and put in the trash
D. Flush it down the toilet
E. Give it to the agency nurse.

11) Which has the highest potential for abuse?

A. Schedule I
B. Schedule II
C. Schedule III
D. Schedule IV
E. Schedule V

12) Someone realized at supper that staff did not give John his morning Celexa® tablet. What kind of a medication error is this?

A. Type I (medication variance)
B. Type II

TRUE FALSE Questions

This section consists of questions with severals uggested answers. Circle the best response, True or False, on your answer sheet.

13) Keeping an exact inventory of tablets and medication packages is an important part of the medication cycle.

14) Otic medications go in the nose.

15) Agencies can not always give medications the same way parent might at home.

16) Someone who is currently trained in this curriculum or who is a licensed health professional must observe when a child in the agency and who is capable to self-administer gives himself his Ritalin® before going to school.

17) Medications might be a necessary first choice to treat some conditions.

18) Everyone should feel the same way about medication to administer it properly.

19) Staff who administer medications should have an order from a licensed health care professional to give a child a comfort (PRN) medication in an agency.

20) Regulations allow agencies to give medications to children to stop sudden disruptive behavior.

21) Opthalmic medications go in the ear.

22) All children are capable of participating to some degree in the process of administering medications.

23) Medications are always kept in a locked area or a locked container.

24) You can always buy uncontrolled medications without a prescription.

25) An example of OTC medication is Tylenol® with codeine.

26) An example of an OTC medication is Rolaids™.

27) If you think you gave a child a medication in error, you should wait until you are sure about all the details before reporting it.

MULTIPLE CORRECT RESPONSE Questions

This section consists of questions with several suggested answers. At least one and perhaps more of the choices may be correct. Circle the letters of the correct responses on your answer sheet.

28) The following person(s) may administer medications in an agency under §3800 regulations: (based on info given in the response only, i.e. don't suppose they are trained in meds administration unless you are told)

- **A.** An agency nurse
- **B.** Agency staff trained as EMT
- **C.** Contract physician
- **D.** Social worker supervisor
- **E.** Staff with up to date training in this curriculum

29) Child care staff responsibilities listed in the medication cycle include:

- **A.** Observing for changes in physical condition.
- **B.** Diagnosis of medication side effects.

C. Reporting changes to the right person at the right time by the right means.
D. Recording medication information on the correct forms.
E. Participating in quality improvement

30) You are doing the evening med pass and one of the children says, "I don't want to take my pills tonight." Good response(s) might be:

A. I noticed that you seem to be doing better at school when you take the medication.
B. Can you tell me why you don't want to take the medicine?
C. You have to take this pill now because the doctor said so.
D. Perhaps you might change your mind. I'll be back in a half hour.
E. You certainly can refuse this dose if that is what you wish to do.

31) Statements about controlled medication that are true include:

A. Subject to regulations about dispensing from Food and Drug Administration (FDA).
B. Always carry some risk of abuse.
C. Subject to regulations about dispensing from Drug Enforcement Administration (DEA).
D. Always have a high risk of overdose.
E. Requires a prescription in PA to purchase.

32) Effects that might be observed in a child started on medication include:

A. Desired beneficial effects
B. Unwanted effects
C. No effect
D. Interactions with another drug
E. None of the above

33) Examples of generic medications include:

A. Ibuprofen
B. Ritalin
C. Amoxicillin
D. Zyprexa
E. Lithium

34) Items of information to provide to a physician seeing child for the first time include

- **A.** History of allergies
- **B.** Copy of any court orders
- **C.** Reason for the visit
- **D.** List of past and present medical conditions
- **E.** List of current medications

35) People whose signatures will most likely appear in the med log when a teenager is able to self-administer include

- **A.** Agency nurse
- **B.** The youth
- **C.** One of the parents
- **D.** Staff persons who assist/observe
- **E.** Outside specialist physician

36) Assume you were trained in medication administration. You do not give a student medication when which of the following circumstances are present?

- **A.** Agency nurse is off grounds when you are assigned to pass meds at lunch.
- **B.** Your last medication administration training was three years ago next month.
- **C.** Child refuses the medication.
- **D.** Child says that is not his medication.
- **E.** Dose is scheduled for 8 PM and it is now 7:55 PM.

OCYF MEDICATION TRAINING CURRICULUM

Examination Answer Sheet

Date: ____________

Name: ____

Some questions are multiple choice with one right answer and some have more than one correct answer. Some are True False, so be sure to read carefully the directions in each section!

Numbers 1 - 12 have ONE right answer

1. A B C D E
2. A B C D E
3. A B C D E
4. A B C D E
5. A B C D E
6. A B C D E
7. A B C D E
8. A B C D E
9. A B C D E
10. A B C D E
11. A B C D E
12. A B C D E

13-27 are TRUE/FALSE

13. T F
14. T F
15. T F
16. T F
17. T F
18. T F
19. T F
20. T F
21. T F
22. T F
23. T F
24. T F
25. T F
26. T F
27. T F

28-36 have one OR MORE right answers!

28. A B C D E
29. A B C D E
30. A B C D E
31. A B C D E
32. A B C D E
33. A B C D E
34. A B C D E
35. A B C D E
36. A B C D E

NOTES ON SCORING EXAMPLE FINAL EXAM

There are three types of questions on this sample final exam. Multiple choice questions with ONE right answer are worth 2 points. True/False questions are worth one point. Each possible choice in multiple choice questions with one OR MORE right answers is actually a True/False type question, so the maximum number of points for each is the number of possible choices offered as responses.

Questions 1-12 are multiple choice with ONE right answer each for a section total of 24 points.

Questions 13-27 are True/False and give a point each for a section total of 15 points.

Questions 28 –36 are multiple choice with one OR MORE right answers. Each has 5 responses, and each response is worth a point, so each question is worth five points. These 9 questions are worth 45 points.

This is a grand total of 84 points possible, and to pass someone would need to score at least 85% of 84 – 71 points – to pass.

Incidentally, it is easy to grade these types of exams quickly using a template. Use a magic marker to make a blot on each correct response on a blank answer sheet to make the scoring template. Then hold the sheet you are correcting on top of the template over a window or other light source and it will be obvious which answers are incorrect on the form being graded.

ADDITIONAL SAFEGUARDS TO HELP MINIMIZE MEDICATION RISKS

DO - Follow all agency policies.

DO - Ask the child if s/he recognizes this as his/her medication.

DO - Wash hands with soap, warm water and friction for at least 10 seconds prior to administering each child's medication.

DO - Give your full attention to the task.

DO - Remain with the child until the medication has been swallowed and then check to ensure that it was indeed swallowed.

DO - Administer medication for only one person at a time.

DON'T - Give a medication from a container that has a label that cannot be read.

DON'T - Try to hide a medication error.

DON'T - Sign the medication log until the medication has been administered.

DON'T - Give a medication from another person's container.

DON'T - Give a medication if a child does not recognize the medication.

MAINTAINING QUALITY – QA REQUIREMENTS

Throughout all of the medication cycle steps, there should be a process for quality assurance. Every agency will have its own methods for a QA process, but these are the essential elements for quality assurance:

- Someone shall be designated as QA officer for medication administration and is to be directly responsible for medication administration quality assurance. This should be a licensed medical professional (registered nurse) or someone in a child care supervisor or higher position who holds current certification as a trainer for this program.
- The QA officer shall review the medication log at least weekly when staff are administering medications. This can be documented by dating and signing off on the child's MAR. This individual is also responsible for reviewing medication errors and variances and should seek professional expertise if not medically trained and licensed.

- The QA officer will also observe directly the performance of staff who are approved to administer medications either: 1) while actively participating in medication administration, or 2) by using the practicum checklist exam in the *Trainer Materials* section of this curriculum package. Direct observation or the practicum administration shall be performed at least every six months. Results of these periodic performance checks shall be documented on the staff certificates included in this curriculum package (the *Trainer Materials* section) and kept in the training files.

- If and when the QA officer determines that proper procedures are not being followed, then that particular staff person will not be permitted to continue administering medications to children. They must be retrained on the appropriate steps of the medication cycle until they can adequately demonstrate sufficient proficiency so as not to jeopardize the safety of the children.

- Type I as well as Type II medication errors must be recorded in the MAR as described in §3800.185a, and all suspensions of staff previously certified for training as described in the paragraph above must be recorded as described in §3800.17, *Recordable Incidents*.

- Type II medication errors as defined in Lesson 5 must be reported to the regional office of OCYF when they result in illness or injury that requires medical attention, or if death occurs, following the requirements of §3800.16, *Reportable Incidents*.

- The QA officer for medication administration is responsible for insuring that recording and reporting take place.

Your trainer will review with you your agency policy and procedures on medication administration quality assurance, which appear in Attachment 11, *Resources*, page 29.

Attachment 11 AGENCY MED ADMINISTRATION QUALITY ASSURANCE

CONCLUSION

Medication administration is a privilege that must be earned and maintained; it is not a right. However, it uses skill that can be practiced and knowledge that can be acquired. Both the skill and the knowledge can be a tremendous advantage to you in your work and will provide great benefit to the children who are in your care if consistently applied well.

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Medication Administration: A System of Best Practice

RESOURCES

For Policy And Procedures Development & Staff Training

Resources

TABLE OF CONTENTS

These materials support medication administration systems and training. The intent is to improve compliance with regulations, rather than to state official policy of the Pennsylvania Department of Public Welfare. Exhibits illustrate and add to material in the *Lessons*, while Attachments provide suggestions and space for local agency policy and procedures.

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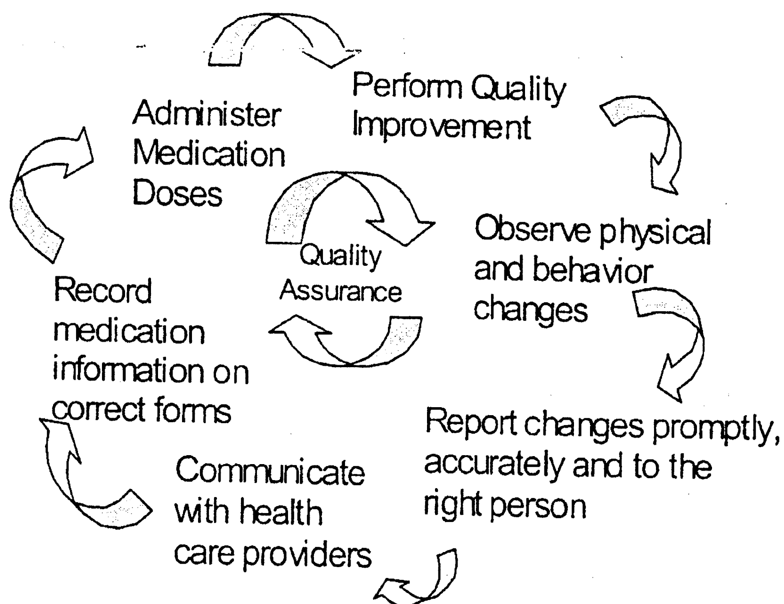
Exhibits Appear in Lessons Like This

Attachments Appear Like This

Samples provided by OCYF as examples only. Local policy, procedures & forms should be included at trainings.

Exhibit 1

The Medication Cycle



The diagram shows each step in the context of a complete system of medication usage, so that medication administration training becomes more than the step of simply giving medication to a child. Understanding and skill at each step is essential to insure benefit and maintain safety.

Exhibit 2

Medication Concerns and Appropriate Responses

There are a number of common concerns you might hear from people who must take medications, especially psychotropics. When performing medication administration, your response to statements like the ones below can be either helpful or harmful. Many times, this is an opportunity to relieve fears with a bit of education. It helps to know some positive responses in advance.

1) *I am not going to take drugs because that is bad.* There are differences between prescribed medications and drugs that people misuse on their own. These medications are to help you with a specific problem under a doctor's guidance; illegal drugs create problems and make things worse.

2) *Medication will hurt me.* Many other people have used these medications and are using them now without problems. Generally these medications can do much good and no harm and your doctor and the staff are keeping watch to be sure.

3) *People will think I am crazy if I must take medication.* If you work on taking care of a medical problem it shows that you are responsible, that you understand what to do and that you are serious about taking care of yourself.

4) *Medication will change my personality.* The medication is to help you change behaviors that are causing problems. You are still the same person and still feel happy or sad.

5) *All I need is my medication and I will get better.* Medication helps with medical problems in the brain but problems often have many causes acting together. Other things can better help you work out problems with stress or other people for example.

6) *I won't be able to get off this medication and I will be hooked.* If you take medications under medical orders and supervision rather than trying to control them yourself then they are not addictive. Some medications can be stopped abruptly but others must be slowly decreased before you stop them.

7) *I heard that someone took this medication and "something bad" happened.* Everyone is different and lots more people with a problem like yours have benefited from this medication. You can ask your doctor about what you heard the next time you see her.

8) *I don't want to be on medication forever.* There are lots of medical conditions that people take medications for long periods, even a lifetime like diabetes or allergies. Behavior problems take a long time to develop and often take just as long or longer to get better and go away.

9) *I won't be able to learn in school/play sports/ go on dates/ etc. because of this medication.* People who are anxious, depressed, or having trouble thinking clearly at times also have those kinds of difficulties. The medication will make it easier for you to do what you want to do without having those problems interfering with your goals.

10) *I just do not want to take medication.* Every child has the right to refuse their medication and forcing them to do something against their will is not helpful. Teenagers in particular might want to show some control by refusing. It is always helpful to point out how the medications have helped them so far or have helped other people, even if no one likes taking medicine.

Remember to never give any information that you do not know or are unable to provide. Always be open and honest but realize that there usually are not best answers. Try to use these moments as an opportunity to encourage the child to discuss these concerns and any others s/he might have with the health care provider.

Exhibit 3

§3800 Medication Regulations

Reprinted from OCYF Bulletin 3800-00-01, Licensing Measurement Instrument, May 30, 2000.

3800.181. Storage of medications

181a	**Prescription and over-the-counter medications shall be kept in their original containers.**

APPLICATION: Original containers include blister packs or other unit dose containers that are packaged and labeled by the pharmacist.

Only a pharmacist, physician, physician's assistant, or certified registered nurse practitioner may remove medication from the original container and place it in another labeled container. If the child has a need to take the medication at various locations, and the original container cannot safely be transported with the child, duplicate prescription containers may be requested through the pharmacist. Neither a staff person nor a nurse may take medication out of the original container and place it in another container for later administration. This includes medication that is self-administered by children, as permitted in 189.

181b	**Prescription and potentially poisonous over-the-counter medications shall be kept in an area or container that is locked.**

APPLICATION: Children who self-administer medication as permitted in 189 may store and lock their own medications; the child may have the key to their medications box.

181c Prescription and potentially poisonous over-the-counter medications stored in a refrigerator shall be kept in a separate locked container.

181d	**Prescription and over-the-counter medications shall be stored separately.**

APPLICATION: This means that prescription and over-the-counter medications must be stored separately from each other. This can be separate shelves in the same cabinet, drawer or a divider on the same shelf.

181e	**Prescription and over-the-counter medications shall be stored under proper conditions of sanitation, temperature, moisture and light.**

181f Discontinue and expired medications, and prescription medications for children who are no longer served at the facility, shall be disposed of in a safe manner.

APPLICATION: For information about safe disposal, contact the pharmacist.

3800.182. **Labeling of medications.**

182a	The original container for prescription medications shall be labeled with a pharmacy label that includes the child's name, the name of the medication, the date the prescription was issued, the prescribed dosage and the name of the prescribing physician.

APPLICATION: The original container must contain the original label. The label may not be altered except by a pharmacist, physician, physician's assistant, or certified registered nurse practitioner. The dosage includes the amount of the medication as well as the time/frequency of administration.

If blister packs or unit dose packets are used, each separate blister pack or unit dose package must have a complete original label. If individual blister packs are separated for later use and distribution, each blister pack must include an original pharmacy label (not a copy of the label).

182b	**Over-the-counter medications shall be labeled with the original label.**

3800.183. **Use of prescription medications.**

183	**Prescription medications shall be used only by the child for whom the medication was prescribed.**

3800.184. **Medication Log.**

184a1	**A medication log shall be kept to include the following for each child:**

APPLICATION: This includes all prescribed medications, including oral, topical, eye/ear/nose drops, inhalants, etc.

The log must include the child's full name (not just initials).

Several model medication logs are available through the OCYF Regional Office. Use of the model medication logs is optional.

In accordance in 189, a medication log must be kept for children who self-administer medications and a staff person must immediately record the administration.

184a2	**A medication log shall be kept to include the prescribed dosage for each child's medication.**

184a3	**A medication log shall be kept to include possible side effects for each child's medication.**

184a4	**A medication log shall be kept to include contraindicated medications for each child.**
184a5	**A medication log shall be kept to include specific administration instructions, if applicable, for each child's medication.**

184a6	**A medication log shall be kept to include the name of the prescribing physician for each medication.**

APPLICATION: This may also include the prescribing physician's assistant or certified registered nurse practitioner.

184b For each prescription and over-the-counter medication including insulin administered or self-administered, documentation in the log shall include the medication that was administered, dosage, date, time, and the name of the person who administered or self-administered the medication.

APPLICATION: Staff initials can be used for individual staff entries in the log as long as there is a Key indicating the full signature and corresponding initials for each staff person.

The time of administration must include the precise clock time to the minute (such as 9:55 am).

This does not apply during home visits.

184c The information in subsection (b) shall be logged at the same time each dosage of medication is administered or self-administered.

APPLICATION: **The person administering the medication must complete and sign the log after each dose is administered and not as a group of medications are administered.**

This does not apply during home visits.

3800.185. Medication errors.

185a Documentation of medication errors shall be kept in the medication log. Medication errors include the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage or administering the correct medication at the incorrect time.

APPLICATION: Medication errors include the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage, administering the correct medication in an incorrect manner, or administering the correct medication at the incorrect time. If a medication is administered more than 60 minutes prior to or after the prescribed time, it is considered a medication error. (Note: This applies only if the prescription includes a precise clock time – e.g., 1:00 p.m.)

This includes medication that is self-administered by children, as permitted in 189.

185b. After each medication error, follow-up action to prevent future medication errors shall be taken and documented.

3800.186. Adverse reaction.

186. If a child has a suspected adverse reaction to a medication, the facility shall notify the prescribing physician, the child's parent and, if applicable, the child's guardian or custodian, immediately. Documentation of adverse reactions and the physician's response shall be kept in the child's record.

3800.187. Administration.

187a. Prescription medications and injections of any substance shall be administered by one of the following:

1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the facility.
3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the facility.
4) A staff person who meets the criterion in 188 (relating to medications administration training) for the administration of oral, topical and eye and ear drop prescriptions, insulin injections and epinephrine injections for insect bites.
5) A child who meets the requirements in 189 (relating to self-administration of medications).

APPLICATION: This requirement is effective June 26, 2000.

Staff persons who are paramedics (including EMT) paramedics) cannot administer medications unless authorized by a licensed physician, and then only in emergency situations. Staff persons who are certified emergency medical technicians (EMT's) cannot administer medications.

These regulations do not govern emergency medical personnel who are performing emergency services who do not work for the facility.

187b Prescription medications and injections shall be administered according to the directions specified by a licensed physician certified registered nurse practitioner or licensed physician's assistant.

APPLICATION: This requirement is effective June 26, 2000.

Any change to the administration instructions on the pharmacy label requires a new pharmacy label from the pharmacist or a corrected pharmacy label from a physician, physician's assistant, or certified registered nurse practitioner.

Oral instructions from a physician are not acceptable, with special exception for registered nurses who may take oral orders from a physician under extraordinary circumstances, with the following:

(a) immediate written documentation by a registered nurse in the medication log,
(b) communication of the change to all staff persons responsible for the administration of the medication, and
(c) follow-up correction of the pharmacy label by a physician or issuance of a new label by a pharmacist within a reasonable period of time.

3800.188. Medications administration training.

188a A staff person who has completed and passed a Department-approved medications administration course within the past 2 years is permitted to administer oral, topical and eye and ear drop prescription medications and epinephrine injections for insect bites.

APPLICATION: This requirement is effective June 26, 2000.

This also includes inhalant, nose drop, suppository, and enema medications.

This also includes epinephrine injections for food allergies.

This training can be counted towards the training requirements in 58b and 58d.

3800.188. Medications administration training

For mental retardation facilities funded through the Office of Mental Retardation (OMR) Medicaid Waiver, staff persons must obtain the training through the OMR approved medication administration program offered by Temple University. The Temple University training is a Department-approved medications administration course as required by 188a.

188b A staff person who has completed and passed a Department-approved medications administration course and who has completed and passed a diabetes patient education program within the past 12 months that meets the Standards for Diabetes Patient Education Programs of the Pennsylvania Department of Health is permitted to administer insulin injections.

APPLICATION: This requirement is effective June 26, 2000.

A list of training programs that meet the Standards for Diabetes Patient Education Programs of the Pennsylvania Department of Health is available from the regional office.

188c A record of the training shall be kept including the person trained, the date, source, name of trainer, content and length of training.

3800.189. Self-administration of medications.

189 A child is permitted to self-administer medications, insulin injections and epinephrine injections for insect bites, if the following requirements are met: (1) A person who meets the qualifications of 187a1-4 (relating to administration) is physically present observing the administration and immediately records the administration in accordance with 184 (relating to medication log). (2) The child recognizes and distinguishes the medicine and knows the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken.

APPLICATION: **This applies only to prescription medications. This includes prescription inhalers.**

Exhibit 4

Controlled Substances / Scheduled Medication Examples

The schedule is defined by the Drug Enforcement Administration, U.S. Department of Justice. That agency has jurisdiction for the manufacturing, distribution, and dispensing of drugs that have potential for abuse according to the Federal Controlled Substance Act of 1970.

	Category	Description	Prescribing Rules	Examples Grouped By Class of Compound			
				Narcotics	Stimulants	Depressants/Antianxiety	Other
Schedule I	Highest abuse potential.	Most potent narcotic and all hallucinogens	Use in U.S. limited to research only.	Heroin			marijuana LSD "ecstasy" PCP
Schedule II	High abuse potential with high probability of dependence.	Narcotics, potent stimulants and sedatives with highest withdrawal dangers	No telephone prescriptions and no refills	Morphine, oxycodone (in Percodan©, Percocet©, OxyContin©, Tylox™) meperidine (Demerol™)	cocaine, amphetamines, methamphetamine (Desoxyn®), methylphenidate (Ritalin®, Concerta©)	Most barbiturates	dronabinol (Marinol®, marijuana derivative)
Schedule III	Less abuse potential than Schedule 2 and moderate dependence probability	Lower doses per unit or less potent narcotics, stimulants and sedatives.	Up to 5 monthly refills, prescription must be rewritten after six months	codeine (<90 mg/tab) hydrocodeine (in Vicodin©, Lortab©, Hycodan©)	phendimetrazine	Mixtures of barbiturates	
Schedule IV	Less abuse potential than Schedule 3 and limited dependence probability.	Low potency sedatives and anti-anxiety agents and non-narcotic analgesics (pain relievers).	Up to 5 monthly refills, prescription must be rewritten after six months	pentazocine (Talwin©) propoxyphene (Darvon©) butorphenol (Stadol®)	pemoline (Cylert®) phentermine, fenfluramine	chloral hydrate phenobarbital benzodiazepines alprazolam (Xanax©) chlordiazepoxide (Librium©) clonazepam (Klonopin©) chlorazepate (Tranxene©) diazepam(Valium™) lorazepam(Ativan©) oxazepam(Serax©) temazepam (Restoril©) triazolam(Halcion©) zolpicem(Ambien®)	
Schedule V	Lowest abuse potential.	Low dose narcotics for relieving cough (anti-tussive) and diarrhea symptoms.	In some states, not PA, limited quantities may be purchased without prescription by persons 18 years old or older.	codeine (<2 mg / ml) hydrocodeine (<1mg /ml) diphenoxylate (Lomotil©)			

Exhibit 5

Unwanted Medication Effects

Some undesired effects grouped by affected part with common medications that might be the cause:

Skin
- Hives (Raised blebs/welts/urticaria) - many
- Rashes – many, especially anti-seizure meds
- Increased Sweating – Ritalin®
- Decreased Sweating – Haldol®, Zyprexa®, lithium
- Acne - prednisone

Digestive System
- Diarrhea – Antibiotics
- Nausea/vomiting – codeine, other narcotics, lithium
- Heartburn – anti-inflmmatories (ibuprofen, naprosyn)
- Gum/teeth problems – Diltantin ® (phenytoin)
- Dry mouth – antihistamines (Benadryl®, etc)

Nervous System
- Dizzy/Lightheaded
- Seizures – Wellbutrin™, other antidepressants
- Muscle tighteness/ abnormal movements – antipsychotics (thorazine, Haldol ®)
- Tics – methylphenidate (Ritalin®)
- Hallucinations/delusions - many
- Agitation – Prozac®, Zoloft©, Ritalin®, amphetamines
- Sleepiness - antidepressants, antipsychotics, antihistamines, narcotics
- Malaise (feeling ill or "out of it"), unpleasant sensations–antibiotics

Special Senses
- Vision Changes
- Ringing in the Ears (Tinnitus) – aspirin

Respiratory System
- Irregular breathing – Prozac®
- Wheezing - inhalers

Cardiovascular System
- Fainting – blood pressure medications
- Faster/slower/irregular pulse – Ritalin®

Blood
- Easy bruising - aspirin
- Low red cell counts (anemia) – anti-inflammatories
- Low white cell counts—valproate (Depakote®), carbemazepine (Tegretol®

Endocrine (Hormones)
- Changes in menses – birth control pills
- Hair growth - prednisone
- Hair loss - prednisone
- Thyroid problems – Lithium

Urinary System
- Trouble voiding – antihistamines, older antidepressants

General / Constitutional
- Increased appetite/Weight gain – Prozac®
- Decreased appetite / Weight loss amphetamine (Adderal©)
- Fever- antibiotics
- Muscle cramps – blood pressure medications, lithium
- Itch – narcotics, especially Demerol®

Exhibit 6

Total Quality Management

TQM = QA + QI

Total Quality Management

Total Quality Management (TQM) refers to an approach or process that both maintains and constantly improves quality. First applied to manufacturing, it has long been used in industries like aviation and is now used in hospitals and clinics.

equals

Quality Assurance

QA, also called quality control, is a system of procedures to ensure that a process adheres or conforms to established standards.

plus

Quality Improvement

QI is a setting or culture that constantly tries to do things better than before.

Terms used above related to quality management refer only to basic concepts for promoting understanding. Use does not imply endorsement of any particular approach, solution or product.

Exhibit 7

New Medication Questions

In Lesson 4, you learned that there is information that you need to know in order to administer medications safely. This is information that is not normally included in a doctor's order or a prescription. Here are the questions you need answered. You may want to copy these to remind you what to ask when you take children to see a provider. You will also want to know these facts about the medications that you will be administering.

1. What is the purpose and desired effect of the medication?
2. What is the response time?
3. Are there any unwanted effects to watch for specifically?
4. Are there any possible interactions with other medications or foods, including PRN medications?
5. Are there any special administration and/or storage instructions?
6. Is this medication a controlled substance?
7. What is the period during which a prescribed dose of medication can be given to the child and still be considered on time?
8. What should 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 spit out?
9. Is the medication intended to be a psychotropic? Can it have effects on behavior?

Exhibit 8

HOW TO Administer Medications

Here are the instructions, step-by-step, to administer each of the different types of medication as allowed by the §3800 regulations for those who successfully complete this training. You will find that they appear on these pages so that they can easily be copied onto 3 by 5 inch index cards (such as Avery® Product # 5388) for future reference as needed. These are also the steps that you will need to follow to successfully complete your skill test at the end of the training and as part of the observations required for Quality Assurance. First are the steps to begin each session of medication administration.

PREPARATION FOR ALL MEDICATION ADMINISTRATION

1. Clean Medication Administration Area.
2. Wash hands with soap and water.
3. Assemble needed supplies – cups, pen, Medication Log with MARs.
4. Review Medication Schedule.
5. Call children individually to Medication Administration area.
6. Check the medication package with the MAR to determine correct medication, dose, route, time and child (7 Rights) to receive the medication.

ORAL MEDICATIONS

1. Compare the medication package with the MAR again to double check the seven rights.
2. Give the package to the child without touching the pill, tablet, or liquid.
3. Medications are to be crushed only if ordered by the physician and recorded on the MAR
4. Observe the child as medication is swallowed
5. Do a check of the mouth cavity after swallowing to ensure the medication has been swallowed.
6. Initial the MAR and document any pertinent info on the back of the MAR immediately after each medication.
7. Ensure that your signature or initials are on each MAR after each child.

TOPICAL MEDICATIONS

1. Compare the medication package with the MAR again to double check the seven rights.
2. Wash hands.
3. Apply amount prescribed to specific area of skin as directed with tongue blade or gloves
4. Close container and dispose of tongue blade or gloves appropriately.
5. Document dose appropriately on MAR.

EAR DROPS

1. Compare the medication package with the MAR again to double check the seven rights.
2. Wash hands.
3. Obtain container and warm ear drops to near body temperature.
4. Shake the bottle for 10 seconds if drops are a cloudy suspension, then check dropper tip if dirty, chipped or cracked.
5. Draw medication into dropper and tilt affected ear(s) up and place correct number of drops in each ear(s) while tugging on outer ear to allow drops to run in.
6. Keep ear tilted several minutes or insert soft cotton plug as directed.
7. Replace cap and tighten immediately.
8. Wash hands to remove any medication and document dose.

EYE DROPS

1. Compare the medication package with the MAR again to double check the seven rights.
2. Wash hands.
3. Obtain container and check dropper to assure it is not dirty, chipped or cracked.
4. Tilt head back or have child look at the ceiling.
5. Pull down lower lid of correct eye with index finger to form a pocket.
6. Dispense correct number of drops without touching dropper to eye while holding hand against forehead to steady it.
7. Instruct child to close eye for 2-3 minutes.
8. Child or staff may wipe any spill from cheeks.
9. Replace cap and tighten immediately.
10. Wash hands to remove any medication and document dose.

INHALER USE

1. Shake inhaler 5 seconds if directed to do so.
2. Attach spacer to inhaler if directed.
3. Hold inhaler between index finger and thumb and remove cap.
4. Insert inhaler mouthpiece or spacer into mouth and close lips around it.
5. Exhale normally with head tilted back slightly.
6. Press down inhaler to release spray and inhale deeply and slowly one time over 3 to 5 seconds.
7. Hold breath for 10 seconds then exhale.
8. Wait 2-3 minutes and repeat aforementioned steps if directed.
9. Child may rinse mouth with water after using the inhaler to remove the medication taste.
10. Replace cap and document.

AUTO-INJECTOR (EPINEPHRINE) FOR ALLERGIC EMERGENCIES

1. At first appearance of symptoms and signs of impending serious allergy reaction (facial swelling, hives, difficulty breathing) or as directed, be prepared to use epinephrine (adrenalin) by injection.
2. While preparing to use an injection, have someone call emergency number (usually 911) for immediate transportation to nearest health care facility or hospital emergency room.
3. Pull off safety cap if present.
4. Place tip of Epi-pen® or needle at right angle to front of and just to the outside of the leg in the fleshiest part of the front of the thigh.
5. Press into thigh hard (Epi-pen ®)or push plunger (Anakit®)to release medication and hold for a few seconds before removing the needle.
6. Massage area for ten seconds.
7. Dispose of sharps appropriately
8. Document/report following all appropriate policies.

PRN Medications

As-needed (PRN) medications are often used to provide short term relief of mild to moderate symptoms. Many times these are medications that are available OTC (non-prescription) for people outside a facility to use without a specific diagnosis. Other PRN medications by prescription are used to relieve the symptoms of a known condition. For instance, someone who has had recent surgery or an injury will take pain medication as needed while they recover. Another example: Someone who suffers panic attacks might use an anti-anxiety medication to relieve the rapid heart rate, chest pain and overwhelming sense of fear that accompany acute attacks of panic as they get involved with other types of therapy that reduce the number and severity of attacks. Pennsylvania regulations for child residential settings do not allow medications to be prescribed for PRN use as chemical restraints, but this last example is a setting where a psychotropic medication to be used as needed is permitted.

Using PRN medications to relieve symptoms is also an example where it is not always possible to administer medication to children in an agency setting exactly like one would at home. Inside a facility, it is always wise to have the oversight of a licensed health care professional–even for OTC meds-- whenever as-needed medications are administered to a child. Many agencies have a list of medications that may be used to relieve common symptoms providing certain guidelines are followed. These guidelines always require that each use be documented, since this is a regulation: §3800.184. Also, policies for as-needed medications should require staff who administer medications to report prolonged episodes or symptoms that persist, recur frequently, are not explained by known conditions or are otherwise concerning to them.

The list of medications that may be used on an as-needed basis commonly appears in what is called called a <u>*standing order*</u>. Many agencies have such a list which is reviewed and approved by the licensed health care professional. The list is then signed by the doctor or other health professional and becomes orders for medication just like a prescription medication is ordered. Or, the doctor or other health care professional is asked what may be used for common symptoms such a headache or a cough when the child is given an admission physical exam. Again, these orders are signed even for OTC medications just like a prescription. The Seven Rights of Medication Administration always apply, and the questions for any new medication (see Exhibit 7, *Resources* p. 13) should also be answered. Incidentally, standing orders may not always be for medication, as many OTC medications may not be considered that effective, a health care professional feels that the risk of a medication might outweigh its benefit, or there are other instructions such as "Call nurse if no improvement in an hour." For example, a cool wash clothe to the forehead and a quiet room to lie down for a bit can be just as effective for some headaches as Tylenol. Likewise, a glass of warm milk or cup of herbal tea has less likelihood of unwanted effects than a prescription sleeping pill for insomnia.

Your trainer should review any as-needed medications that you might encounter since the actual list in an agency depends upon the population of children, especially their ages. You should always follow agency policy and procedure, and you should consult your agency health care authority for any questions or before using any medication if you are not sure. Remember that §3800.184b requires that all medications, including over the counter medications used as needed, must be recorded in a medication log or medication administration record (MAR).

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October 14, 2002

Teleta Nevius, Director

Department of Public Welfare

Room 316 Health & Welfare Building
P. O. Box 2675
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Dear Teleta Nevius,

This will be the first of several memos you will receive from the Northern Area Personal Care Home Administrators Association. We will also be presenting a final form document from our Association by October 31, 2002. I would like to deal with just one issue today. It is an issue that you and I have had much discussion over. It is an issue that has received great debate in over 6 meetings that both you and I were in attendance at over this past year. It is a vital issue to residents and personal care homes across Pennsylvania.

NAPCHAA would like to discuss **2600.53 Staff titles and qualifications for administrators.** We do not agree with what is listed. Please take time to read why we don't agree and what we would suggest as a solution to this issue. Proposed 2600.53 reads:

(a) The administrator shall have one of the following qualifications:

(1) A valid license as a registered nurse, from this commonwealth.

(2) An associate's degree or 60 credit hours from an accredited college or university.

(3) A valid license as a licensed practical nurse, from this commonwealth and one year of work related experience in a related field.

(4) A valid license as a nursing home administrator from this commonwealth.

Why does NAPCHAA oppose this ? Let us be clear, concise and to the point:

(A) Many personal care homes are FAMILY HOMES that have been passed on from one generation to the next. This is a fact that OLRM/DPW can not ignore. Homes could not be passed on in future generations if a member who has grown up in the business and lived the business does not meet one of the 4 criteria above. This is unacceptable. It is discriminatory against family businesses that have served as the back bone of America from the beginning. It is also discriminatory against small businesses.

(B) Personal care homes under your proposed 2600 regulations have strict guidelines for residents who may or may not reside in a personal care home. Residents who exceed the standard must be placed in a higher level of care. Therefore, personal care homes are not a **nursing home** and are not a **hospital**. So it is clear that the needs are much less in a personal care home. Why such a medical background?

(C) NAPCHAA has supported 2600.57 Administrator training and orientation from the beginning. It is a great improvement over current 2620.72.

Current 2620	Proposed 2600	We support because:
40 Clock Hours	60 Clock Hours	+20 additional hours to educate on changing Industry.
No Competency Based testing in 40 Hour Class	Competency based testing in 60 hour class that requires successful completion.	Testing in place.
No Internship	80 Clock hour Internship in Department approved home.	+80 Hours on the job training.
No Internship/No Competency based testing	Competency based testing in Internship that requires successful completion.	Testing in place.

(D) Does this increased training with much more time, better topics, testing and Internship with testing improve the health safety and welfare for residents of personal care homes. Yes, of course it certainly does.

Therefore, NAPCHAA suggests that the increased training negates the new qualifications. You have done your job to "raise the standard". You have done your job to ensure the health safety and welfare of all residents of personal care homes.

We would respectfully recommend the following changes to 2600.53 Staff titles and qualifications for *administrators:*

(1) The administrator shall have the following qualifications:

(a) Prior to initial employment at a home, an administrator shall complete at least the minimum training required by the department. (2600.57)

(b) The Administrator shall be 21 years of age or older.

(c) The administrator shall be responsible for the administration and management of the home, including the safety and protection of the residents, implementation of policies and procedures, and compliance with this chapter.

(d) The administrator shall have the ability to provide personal care services, or to supervise or direct the work of others to provide personal care services.

(e) The administrator shall have knowledge of this chapter.

(f) The administrator shall have the ability to conform to applicable statutes, rules and regulations, including this chapter.

(g) The administrator shall have the ability to maintain or supervise the maintenance of financial and other records.

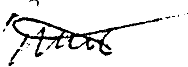
(h) The administrator shall be of good morale character.

(i) The administrator shall be free from a medical condition, including drug or alcohol addiction that would limit the administrator from performing duties with reasonable skill and safety.

Again, the Northern Area Personal Care Home Administrators Association solidly supports a higher training level for administrators. To increase the qualifications to **licensed** personnel will take away the family business, raise the cost for administrators to be hired in the future and then in turn pass the cost onto the residents. This is a vital and important issue. Please don't ignore this. Please consider our input. Please don't discriminate against our profession.

I look forward to your written response. I'll see you in Harrisburg soon. Thank you for your time.

Sincerely yours,



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October 17, 2002

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

Dear Teleta Nevius,

This is part of a series of memos from the Northern Area Personal Care Home Administrators Association. We will also be presenting a final form document from our Association by October 31, 2002. I would like to deal with one issue that effects several parts of the proposed 2600 proposed regulations. It is an issue that has had great debate. On your visit to Western Pennsylvania, we believed that these areas were going to be changed by comments that you made at the meeting. In fact two meetings, one at Cordia Commons and one at St. Barnabas on June 17 & 18, 2002.

NAPCHAA would like to discuss **2600.58 staff training and orientation 14 (e) Direct care staff shall have at least 24 hours of annual training relating to their job duties. Staff orientation shall be included in the 24 hours of training for the first year of employment. On the job training for direct care staff may count for 12 out of 24 training hours required annually.**

NAPCHAA would like to recommend the following: <u>Direct care home staff shall have at least 12 hours of annual training relating to their job duties. Staff orientation shall be included in the 12 hours of training for the first year of employment. On the job training for direct care staff may account for 6 out of 12 training hours required annually.</u>

The Northern Area Personal Care Home Administrators Association stands firmly with OLRM in the fact that training hours must be increased. Continuing education create success for any profession. As PROVIDERS, we thought we had meet the consumer advocates ½ way on this issue and as a group that we were in total agreement on <u>12 hours</u>. The proposed 24 hours is excessive. It will raise the monthly fee for residents dramatically. It is double the requirement for certified nursing assistants in nursing homes which is 12. And the proposed hours are higher than the required hours for care giver's in hospitals, which is currently 10.

NAPCHAA would also like to discuss topics **required for annual training for direct care staff:**
(f) Training topics for the required annual training for direct care staff shall include the following.
NAPCHAA would recommend the following:
<u>(f) Training topics for the required annual training for direct care staff may include the following:</u>
Why may ? Many Personal Care Homes in Pennsylvania deal with other populations than just elderly. We have mental health, mental retardation, spine injury, brain injury, sexual disfunctioning, young, middle age and old. Many are not pertinent to these special populations, and these homes would be in violation of the regulations and face fines and penalties for not following through. Please take this into consideration.

(3) Understanding, locating and implementing preadmission screening tools, initial assessments, annual assessments and support plans.
NAPCHAA would recommend the following:
<u>(3) Understanding, locating and implementing assessments and support plans.</u>
NAPCHAA believes that these are clearly the Administrators job. You are mixing certified nursing assistants from nursing homes into Personal Care Homes. The four tools mentioned above will be managed differently at each location.

2600.58 Continued

(4) Care for persons with dementia and cognitive impairments.
NAPCHAA would recommend the following:
(4) Care for persons with dementia and cognitive impairments if applicable.
Again, this does not apply to all populations served in all Personal Care Homes. If applicable is common sense.

(7) Safe management technique training, which shall include positive interventions such as:
NAPCHAA would recommend:
(7) If the population is served in the home, safe management technique training, which shall include the following interventions such as:
NAPCHAA must be very clear about this area. Again, this is specifically for mental health residents. Not all Personal Care Homes serve mental health residents. The cost to bring in a "Trainer" to complete all of this is over $1200.00 each time you need to complete this. Also the high cost of wages for such an extensive course. Many hours, many dollars all wasted when the Personal Care Home does not take care of mental health residents. Sure, the entire section of safe management techniques looks great on paper but, in reality, a real safe management technique class in mental health is complex, needs a lot of classroom time and costs a lot of money. Money that **private pay residents are being mandated to pay for this when it may not apply to them.**

NAPCHAA would also like to discuss **2600.59 Staff training plan and 2600.60 Individual staff-training plan.** As PROVIDERS, these sections take us away from the residents we serve to complete wasted paperwork. Do you want us to become nursing home administrators and sit in offices and spend countless, useless hours completing paperwork? Do you want us to become like nursing home administrators and spend all of our time in the office? These two sections do just that. Our residents **PAY us to take care of them, not complete useless paperwork.** NAPCHAA is committed to quality care and training and would recommend the following:
2600.59 The administrator shall ensure that a staff training plan is developed and conducted annually for the development and improvement of the home's staff. The staff training plan shall include the personal care home's policies and procedures for developing and conducting the staff training plan, indicating who is responsible. The plan shall be reviewed and updated annually with staff present. Strike #1,#2,#3,#4.

NAPCHAA would strike 2600.60 completely. This is duplication of the work we are already completing. It is called an employee evaluation. We have included one from Windsor Place as an attachment. It is clear that education is important. Page 2 /#3. Recommendations for professional development.(seminars, schooling, training, etc.

In closing, we have tried to give you **solutions to keep a higher standard** and not hold homes accountable for populations they do not serve. We have tried to give the Office of Licensing and Regulatory Management **ways to decrease the high cost** of these regulations and **still raise the standard**. These are vital and important issues. Please do not ignore our input. Please consider our input.

I look forward to your written response. I'll see you in Harrisburg soon. Thank you for your time.

Sincerely yours,

Matthew C. Harvey
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October 16, 2002

Teleta Nevius, Director
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Dear Teleta Nevius,

This is the third in a series of memos that you will be receiving from the Northern Area Personal Care Home Administrator Association. We will be presenting a final form document from our Association by October 31, 2002. I would like to deal with two issues today. It is an issue that we have had much discussion over. As NAPCHAA travels the 15 counties of Western Pennsylvania this topic comes up at every meeting. It is a vital issue to the residents of Personal Care Homes in Pennsylvania.

NAPCHAA would like to discuss **2600.58 training and orientation. (a)** Prior to working with residents, all staff including temporary staff, part-time staff and **volunteers** shall have an orientation that includes the following. Volunteers are in short supply. Volunteers give freely of their time. In asking volunteers to review this new regulation, they were insulted. They did not view themselves as coming in to complete jobs as an employee. Which this says they are. They pictured themselves of coming for an hour to brighten the day of the residents. No do an employees job. We would recommend: **eliminate volunteer.**

NAPCHAA would like to discuss **2600.58 Staff Training and Orientation. (5) General operation of the Personal Care Home. © Training of the direct care staff hired after the effective date of the adoption of these regulations. Shall include a demonstration of job duties, followed by guided practice, then proven competency before newly hired direct care staff may provide unsupervised direct care in any particular area. Prior to direct care contact with residents, all direct care staff shall successfully complete and pass the following competency based training including the following specific duties and responsibilities:**

#1 We salute and agree with the Department on the addition of competency based training. This practice already exist in the majority of Personal Care Homes in Pennsylvania. We also salute the intent of the Department to ensure that a new employee is thoroughly trained before they may provide unsupervised care to residents.

#2 We would recommend to the Department that they add under #5 © **followed by guided practice, the new employee be required to complete 16 hours of on the job training shadowing and working with a trainer. At this point their orientation and training be tested and evaluated before working independently**. This would eliminate prior to contact with the residents.

On the job training is done right now through out Personal Care Homes in Pennsylvania. Why is on the job training important ?

a) Many people take a job caring for residents and have never performed the job before. Therefore, you can sit in a classroom for hour on hour but, not until you do it with a trainer do you see and experience what it actually entails. Studies show that currently two out of every five new hires decide on that first day that they cannot handle or do the job. By taking away our right to have classroom session followed up by on the job training you will **dramatically increase the cost to residents.** Instead of a new hire

being able to make the decision in 8 hours, which they are paid for, it would now take as far as we can project 56 hours of training to find out that they cannot handle it or perform the job. Cost comparison is $72.00 to decide that they cannot do the job to $504.00. Let common sense prevail for the residents we serve.

b) On the job training is covered by how you complete a task before you do it with the resident. Also, what tools do you need to complete the task. Example would be in making a bed-we do it in the following manner. Tucked corners, off the floor etc. You will need the following tools to complete the task: pillow case, fitted sheet, sheet, blanket and a bed spread. They are stored in the linen room. Now, let's go to then linen room and make all of the necessary beds together today. Tomorrow, you will do it and I will observe.

c) At the completion of the second day, competency-based testing takes place on making beds. Common sense, classroom time, practice and testing to back it up. This ensures care. This is what makes a successful operation. Not, 56 hours before you ever see a resident.

In closing, we would appreciate your attention to these two areas. These are vital and important to the residents that Personal Care Homes serve. You will raise the monthly fee unnecessarily and run off many volunteers. Please consider our point of view.

I look forward to your written response. I'll see you in Harrisburg soon. Thank you for your time.

Sincerely yours,

Matthew C. Harvey, President
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October 24, 2002

Teleta Nevius, Director
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P.O. Box 2675
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Dear Teleta Nevius,

The Northern Area Personal Care Home Administrators Association would like to deal with an issue that has had tremendous debate across the Commonwealth of Pennsylvania. As PROVIDERS, we would like to suggest workable solutions to you in this area. Please take time to consider our input.

The following input was agreed to by all State Stakeholders PROVIDER Associations on October 23, 2002 in Somerset Pennsylvania. Today we would like to discuss **2600.54 Staff titles and qualifications for direct care staff. Direct care staff shall have the following qualifications:**

(1) Be 18 years of age or older.
(2) Have a high school diploma or GED.
(3) Be of good morale character.
(4) Be free from a medical condition, including drug or alcohol addiction that would limit the direct care staff from providing necessary personal care services with reasonable skill and safety.

NAPCHAA would recommend the following:

(1) Same
(2) Have a high school diploma or GED, or commensurate life experience.
(3) Same
(4) Same
(5) Personal Care Homes may employee 16 and 17 year old employees as direct care staff. They may not perform tasks related to medication management.

NAPCHAA would like to be clear on changes proposed with **"commensurate life experience."** Care giving is from the heart. Many current employees do not have a high school diploma or GED. We will discuss the grandfathering of current employees later. Many people left school to take care of family matters. Grandparents, death of parent to raise siblings, aunts and uncles, etc. In previous generations it was a calling and duty. Now, we want to penalize people for that calling?

The labor pool is very tight. We don't want to use that as an excuse but, **PROVIDERS have agreed to an increase in training hours, training subject's and yearly continuing education credits.** Is that not a great increase of raising the bar to ensure better health, safety and welfare of residents in Personal Care Homes? Is not that a standard increased? Yes, NAPCHAA believes it sure is. We ask you to give this serous consideration.

NAPCHAA would like to be clear on adding **#5 Personal Care Homes may employee 16 and 17 year old employees as direct care staff. They may not perform tasks related to medication management.** NAPCHAA moved this from **2600.55 Exceptions for staff qualifications.** In rural Pennsylvania and even in some urban homes this is a great concern. Right now, 16 and 17 year olds are performing direct care staff duties all across the Commonwealth. 16 and 17 year olds have a great impact on the residents they serve. They give the residents life and love! They deliver hugs, kisses and warmth. The residents live through the prom's, dances and dating of the 16 and 17 year olds.

The 16 and 17 year olds are currently performing duties related to incontinence care and bathing of persons of the opposite sex. Why would that be restricted in 2600. **Is the issue really about training of 16 and 17 year olds? Is the issue about supervising 16 and 17 year olds?** Be honest, and let us discuss it and come to successful conclusions.

On the afternoon shift across the Commonwealth the 16 and 17 year old are on a shift supervised by a supervisor 21 years of age or older. Do you realize that in many areas that is the only employment pool available at this time. Mothers are at home preparing dinner, checking homework and car pooling kids everywhere. That pool has dried up. Therefore you take and limit the employment pool AGAIN. **NAPCHAA would agree that 16 and 17 year olds should not perform tasks related to medication administration. No exceptions or excuses. Please consider these two aspects.** Please consider rural Pennsylvania and Urban Pennsylvania. The impact is negative for the resident and the employee. It is a tremendous mistake.

2600.55 Exceptions for staff qualifications. (b) A staff person who transfers to another licensed home, with no more than a 1 year break in service, may work in the same capacity as long as the staff person meets the qualifications outlined in subsection (a).

NAPCHAA believes that this is discriminatory towards people who have worked in Personal Care without a high school diploma or GED. No were else in health care is this listed as an exception. If you leave employment for 366 days as a direct care giver and you don't have a high school diploma or GED you can't come back???????? Why? Yes, we have raised the standard through training. Yes, they must complete training again on reemployment. Why "black ball" them.

NAPCHAA would recommend the following as a solution:

(b) A staff person who transfers to another licensed home, with a break in service, may work in the same capacity as long as they have completed 12 hours of continuing education hours annually. Please consider this input.

2600.56 Staffing © The administrator shall be present in the personal care home an average of at least 20 hours per week, or in the alternative, a designee shall meet all of the qualifications and training for an administrator under 2600.53.

This specific regulation comes from DPW not enforcing the current 2620 regulations on Penalties and violations. **This one regulation will close several hundred small personal care homes.** Many small family homes have several small homes that have a resident manager or resident couple that live on site. The residents are high functioning and need very little care. Maybe only one ADL for assistance. The owner serves as the Administrator of all their homes and rotates time between them. Why put all of these people out of homes needlessly. If it is an **enforcement** issue of homes not operating correctly than cite and fine that home and hold them accountable. Don't create needless regulation that punish good homes doing their job. Again, put the cards on the table, be honest about the goal and let us work to come to a better compromise. Why force the closure of homes and moving people that are happy where they are.

NAPCHAA would recommend: **eliminate the 20 hours per week.**

Let common sense prevail in all of the areas we have discussed in this memo. Why punish people doing a good job.? Why punish people by age? Please do not ignore this. Please consider our input. I look forward to your written response. I'll see you in Harrisburg soon. Thank you for your time.

Sincerely yours,

Matthew C. Harvey
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October 22, 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 issue with you today. It is an issue that has had great discussion around the Commonwealth of Pennsylvania. It is also one that we have had many discussions with you about as well. NAPCHAA believed that we had come to a compromise in this area from comments you had made on June 17 & 18, 2002 at Cordia Commons and St. Barnabas in Western Pennsylvania.

Today we would like to discuss **2600.57 Administrator training and orientation#6 (e) An administrator shall have at least 24 hours of annual training relating to the job duties, which may include the following:**

NAPCHAA as a provider agrees with the Office of Licensing and Regulatory Management that continuing education credits hours must increase. Yes, education is the key to success. Education is the key to improving the health, safety and welfare for the residents in Personal Care Homes in Pennsylvania.

Therefore, NAPCHAA must also be honest in that the requirement is **FOUR TIMES GREATER** than the current 2620 regulation. It is also equal to a nursing home administrator whom must do 48 hours every two years. It is also equal to a hospital administrator that must do 24 hours per year. Both facilities serve a much more frail and suffering many more chronic illnesses than a Personal Care Home.

NAPCHAA would recommend the following: #6 (e) An administrator shall have at least 12 hours of annual training relating to the job duties which include the following:
DOUBLE the requirement. Raise the standard and hold administrators accountable to the new standard .

We appreciate you taking time to review our comments. Please take them into consideration. I look forward to your written response. I will see you in Harrisburg soon.

Sincerely yours,

Matthew C. Harvey
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October 21, 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 issue with you today. This issue is much different than other issues that we have discussed to date. This is one issue that is of great concern because of **lack of enforcement.** If enforcement had been enforced in **2600.26 Resident funds.**

What is NAPCHAA's concern here? Many "Personal Care Homes that assume the responsibility of maintaining residents financial resources" will STOP if this section is enacted. The Pennsylvania Health Law Project has showed NAPCHAA, Personal Care Homes that have had consistent trouble in managing a residents funds. One home for 13 straight years. **Still no citing and no fining and no enforcement from the Department of Public Welfare.** This entire section penalizes all of the Personal Care Homes that are doing the job correctly. 95% of homes will be penalized for the 5% that have not been held accountable to the current regulations.

To meet all of the new requirements of this section, homes that provide financial management project they will have to spend 12 additional hours a week on this. That is 12 hours away from resident care. That is 12 hours at $29.70 per hour (Avg. administrators hourly rate) or $356.40 a week. $1,425.60 a month and $17,107.20 per year. Most Personal Care Homes that manage resident funds do it because they are on the Social Security Supplement or they are the Representative Payee. Therefore, this cost cannot be passed on to them. Which means a home must pass this cost onto PRIVATE PAY residents.

NAPCHAA would recommend the following: 2600.20 Resident Funds. That the entire section be eliminated and the current section from 2620.35 Financial Management be put into the proposed regulations.

If you will not consider this, then NAPCHAA is opposed to **#4 The resident shall be given funds requested within 24 hours if available, and immediately if the request is for $10.00 or less. This service shall be offered on a daily basis.** Through out the regulations we talk about the health, safety and welfare of the resident. Well, how about the safety of the Personal Care Home and the security of the residents funds. Let's be realistic, you can't leave money "laying around" 24 hours a day. Safety and security are the issue.

NAPCHAA would recommend: #4 the resident shall be given funds within 24 hours. This service shall be made available on a daily basis.

Lastly, **#12 is of concern to refund money immediately.** This is already outlined in the contract through out Pennsylvania. Immediately is not consistent with any other profession. Immediately does not apply in any other health care facility. So, why a Personal Care Home? Why again are PCH singled out? A 30 day refund is consistent with the contract and across Pennsylvania. Again, homes that violated their contracts and DPW's lack of enforcement are the true issue here. Cite, fine and enforce regulations that are current.

We appreciate you taking time to look at this area. It is costly, excessive, overdone and way over the line. Please do not ignore this. I look forward to your written response. I'll see you in Harrisburg soon.

Sincerely yours,

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October 27, 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 very important issue with you today. This is definitely one that applies to the health, safety and welfare of the residents in Personal Care Homes in Pennsylvania.

As PROVIDERS, we realize that raising the standard in **FIRE SAFETY** is always necessary. One of the main reasons is you learn from what has happened. So what has happened? The top two reasons for fires in Personal Care Homes since 1983 are smoking in bed and lint in dryer vents in Personal Care Homes in Pennsylvania. This is according to Patsy Taylor Moore. It is reflected in the proposed 2600 regulations. Smoking is now in designated areas only and dryer vents are to be cleaned daily.

NAPCHAA would like to discuss one area out of the entire section with you today. **2600.132 Fire drills (d) Residents shall be able to evacuate the entire building into a public thoroughfare, or to a fire safe area designated in writing within the past year by a fire safety expert, within 2 ½ minutes or within the period of time specified in writing within the past year by a fire safety expert. The safety expert may not be an employee of the home.**

In discussing this in the past with the Office Of Licensing and Regulatory Management, we were told that the 2 ½ minute evacuation time would be the new standard from the Department of Labor and Industry. We have reviewed the proposed Labor and Industry regulations before the Independent Regulatory Review Commission. The 2 ½ minute evacuation time was not in the new regulations.

Therefore, let us discuss this issue. **Currently the evacuation time in 2620 is 5 minutes**. This now truly becomes a SAFETY issue for the residents of Personal Care Homes. Will DPW and OLRM come and observe this new safety danger. We are going to rush elderly and disabled people to double the pace to get out of the building. SLIPS, FALLS, DANGER. Liability is incredible. We realize that a fire drill is an educational issue. Educate for successful fire drills in case of a real fire. Not double the pace, hurry, run, move it to satisfy 2 ½ minutes.

Also, the resident must be evacuated from the entire building. This is not even a requirement in a nursing home or a hospital. In both facilities they simulate the drill. Personal Care Homes will do their fire drills monthly. But, why evacuate the entire building? **Rain, Cold, Snow, Extreme Heat.**

NAPCHAA would recommend the following: <u>evacuation be at 5 minutes. And, evacuation out of the entire building except during inclement weather.</u>

Thank you for considering 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
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