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## MEDICATION SAFETY TOOLKIT



*A Licensed Nurse's Guide to Medication Safety in  
North Dakota Assisted Living/Basic Care Facilities*

# MEDICATION SAFETY TOOLKIT – TABLE OF CONTENTS

■ INTRODUCTION.....	1
■ MEDICATION ASSISTANT I TRAINING AND COMPETENCY.....	3
Agency Reference for Medication Assistance Questions.....	4
Medication Assistant I Hiring, Training, Competency.....	5
■ NURSING DELEGATION.....	9
Making Decisions on Delegating Medication Administration Tasks.....	10
Medication Administration Involving Specific Delegation.....	16
Specific Delegation Training Template.....	18
■ ADMINISTRATORS.....	19
■ MEDICATION SAFETY RESOURCES.....	21
Medication Safety.....	22
Resident and Family Engagement.....	36
■ SAMPLE POLICIES.....	37
Medication Administration Policy Template.....	38
PRN Medication Administration Policy Template.....	41
■ APPENDICES	
Screening Tool of Older Person’s Potentially Inappropriate Prescriptions (STOPP) – Attachment A	
The Many Rights of Medication Administration – Attachment B	
Common Abbreviations Used in Medication Administration – Attachment C	
Tips to Reduce Medication Errors – Attachment D	
Identifying Possible Drug Diversion – Attachment E	

## MEDICATION SAFETY TOOLKIT - INTRODUCTION

Assistance with medication administration is one of the most common services utilized by residents of assisted living and basic care (ALF/BC) facilities. It is a complex issue involving many moving pieces both within and outside the facility. Rules and regulations pertaining to medication administration fall under the jurisdiction of multiple departments of the state government. Knowledge regarding effective staff training, policies and procedures, and applicable rules and regulations is necessary to ensure resident safety and minimize the risk of medication-related errors and adverse events.

Quality Health Associates of North Dakota (QHA) has collaborated with stakeholders from across the state to identify and address key aspects related to the provision of medication safety in ALF/BC facilities. This toolkit is the result of those efforts. Its primary intended audience is ALF/BC facility directors of nursing and nursing staff. In addition, facility administrators and pharmacists will also find value in certain areas and materials in the toolkit.

*NOTE: This toolkit is designed for use by licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

The toolkit provides valuable information related to medication safety through the review of state rules and regulations as they pertain to medication administration, training, and nursing delegation to medication assistants, policy and procedure guidance, and resources available from national and state organizations. It was developed through a review of state regulations, literature review, expert opinions, and consensus. While this toolkit provides reference to many state regulations, it is not regulatory in and of itself. The licensed nurse and ALF/BC administrators have responsibility to know, understand, and comply with all the regulatory laws and requirements. (See *Disclaimers* below.)

The objectives of the toolkit include:

- Overview of nursing delegation of medication administration duties
- Review of licensed nurse responsibilities related to the role of medication assistants and their training
- Provision of resources intended for licensed nurses and facility administration pertaining to multiple aspects of medication safety

*NOTE: Please consider how the licensed nursing professionals in your facility can best utilize this toolkit. Does your facility have computer/internet access that allows the toolkit to be easily accessed online? If so, the toolkit can be bookmarked for easy access. If not, consider creating a binder or some sort of paper reference where copies can be kept. If using paper copies, you will also need to consider the importance of making sure the most recent updates are included.*

Please contact QHA with any questions regarding this toolkit. We can be reached at:

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# MEDICATION SAFETY TOOLKIT - INTRODUCTION

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## ■ ACKNOWLEDGEMENTS

This toolkit was made possible through the efforts of many individuals and organizations. QHA acknowledges and sincerely appreciates the collaboration and contribution of our many stakeholders to this toolkit.

## ■ DISCLAIMERS

This toolkit is offered to assisted living and basic care facilities for information and educational purposes only. It is not intended to be an all-inclusive resource, and there is no liability implied or assumed by QHA with this toolkit. While of assistance, it should not be used as a substitute for the need to review state statutes and regulations and the development and implementation of facility-specific policies and procedures or training. The licensed nurse and the ALF/BC administrators have responsibility to know, understand, and comply with all applicable regulatory laws and requirements.

The information contained in this document is current as of September 2014. You must be aware of any changes to state rules and regulations after this date.

While reviewing this toolkit and the resources it contains, you will find links to other websites containing relevant information. QHA is not directly associated with any of these other sites or their owners. While it is the intention of QHA that you find these other sites valuable and that the information is provided from reputable national and state organizations, QHA has no responsibility or liability of any nature whatsoever for these other sites or any information contained in them.



This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11S0W-GPQIN-ND-C3-07/0115

## MEDICATION ASSISTANT TRAINING AND COMPETENCY

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Medication Assistant I (MA I) programs differ from facility to facility, but all programs in North Dakota have some components in common. The North Dakota Department of Health (NDDoH) requires that any facility desiring to hire and train MA I staff to submit their program components to them for approval.

This section of the toolkit contains references, guidelines, and tips to help facilities provide quality training for their MA I. Below is a list of these tools:

### ■ AGENCY REFERENCE FOR MEDICATION ASSISTANT QUESTIONS

Refers the proper state office or organization for specific issues related to MA I training.

### ■ MEDICATION ASSISTANT I HIRING, TRAINING, AND COMPETENCY

A summary of NDDoH requirements for MA I training programs.

## AGENCY REFERENCE FOR MEDICATION ASSISTANT QUESTIONS

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Medication Assistant I (MA I) programs differ from facility to facility, but all programs in North Dakota have some components in common. The North Dakota Department of Health (NDDoH) requires that any facility desiring to hire and train MA I staff to submit their program components to them for approval.

When facilities have questions about their medication assistant program, they can utilize the following list of contacts for answers to their topic-related questions:

### ■ NORTH DAKOTA DEPARTMENT OF HEALTH

[North Dakota Department of Health Nurse Aide Registry](#)

Phone #: 701.328.2353 (request to speak to Bruce Pritschet) or e-mail [naregistry@nd.gov](mailto:naregistry@nd.gov)

1. Clarification of items in ND Century Code and ND Administrative Code specific to the facility's medication assistant training program
2. Clarification related to background checks prior to participating in a training program, reporting concerns to the department, and eligibility of an individual to participate in a training program
3. Roles and responsibilities of MA I
4. Requirements for certification and recertification of the individual
5. Elements of skills competency evaluation
6. Nurse aide/medication assistant registry
7. Clarification on reporting of findings to the department and disciplinary actions

### ■ NORTH DAKOTA BOARD OF NURSING

[North Dakota Board of Nursing](#)

Phone #: 701.328.9777 or e-mail [contactus@NDBON.org](mailto:contactus@NDBON.org)

1. Clarifications of items in ND Century Code and ND Administrative Code specific to delegation by the licensed nurse
2. Roles and responsibilities of the licensed nurse in oversight of medication assistants

### ■ MINOT STATE UNIVERSITY, NORTH DAKOTA CENTER FOR PERSONS WITH DISABILITIES

[North Dakota Center for Persons with Disabilities](#)

Phone #: 701.858.3580 or toll free 800.233.1737 (request to speak to Mary Mercer or someone about questions about the *LTC Medication Assistant Curriculum*\*)

1. Clarification of elements of the Minot State University curriculum agreement
2. Instructional text "Minot State University (MSU) LTC Medication Assistant I Curriculum"

### ■ QUALITY HEALTH ASSOCIATES OF NORTH DAKOTA (QHA)

[Great Plains Quality Innovation Network](#)

Phone #: 701.852.4231 (ask to speak to someone about the *Medication Safety Toolkit*) or e-mail [jayme.steig@area-A.hcqis.org](mailto:jayme.steig@area-A.hcqis.org)

1. Clarification about the *Medication Safety Toolkit*
2. Request for training

\*A facility may choose to use a different curriculum than the Minot State University LTC Medication Assistant Curriculum, but this must be submitted to NDDoH for approval, along with all medication administration policies, prior to implementation. Thereafter, any questions, specific to that curriculum, should be addressed to the provider of that curriculum.

## MEDICATION ASSISTANT I HIRING, TRAINING, AND COMPETENCY

There are a variety of scenarios which can occur when hiring a Medication Assistant I (MA I). The information below can assist Assisted Living and Basic Care (ALF/BC) facilities in the hiring and/or training of an MA I.

*NOTE: Medication Assistants need to understand their scope of practice and that they must be working under the supervision of a licensed nurse. They can never consider themselves independent practitioners.*

### ■ NEW HIRE THAT IS ALREADY CERTIFIED AS A MEDICATION ASSISTANT I

1. Verify certified nurse aide (CNA)/Nurse Aide (NA) AND Medication Assistant I (MA I) is active and in good standing for the state of North Dakota through the [ND Department of Health Nurse Aide Inquiry System](#). [NDAC 33-43-01-20](#)
2. Background checks, criminal history, drug testing, or other screenings as required by the facility to mitigate, to the extent possible, any risk to the vulnerable population served. [North Dakota court records](#) can be accessed online. [NDAC 33-43-01-03](#)
3. Evaluate the new hire's clinical skills for medication administration for all routes and methods delegated to MA I staff in the facility prior to allowing the individual to administer medications. This should be done by a licensed nurse, one to one, utilizing the Minot State University (MSU) clinical skills checklist (or other NDDoH-approved MA I skills competency checklist). [NDAC 33-43-01-12](#)
  - A. If the facility currently has any resident with a stable predictable condition that requires regular administration of medication via gastrostomy, jejunostomy, or subcutaneous injection or a resident has a prescription for a premeasured injectable medication for allergic reactions, a licensed nurse will need to provide education to the MA I specific to that route for that specific resident as well as verify competency for the administration of medications via that route for that individual resident. Consider maintaining a copy of this verification in the specific resident's file and in the MA I employee file. A documentation template is available in the "Specific Delegation" section. [NDAC 33-43-01-16](#)
  - B. Maintain documentation of these competencies in employee file and in record of MA I program for a period of at least seven years. [NDAC 33-43-01-14.9](#)

*NOTE: The training process for a new hire that is already certified as a Medication Assistant needs to include competency evaluations and education regarding the facility's policies and procedures. The new MA hire may not have been delegated tasks at their previous position that your facility is delegating to them and need to demonstrate competency and understanding of your facility's processes. Also consider reviewing with the new hire the [Medication Assistant I Scope of Delegated Medication Administration](#) from the North Dakota Department of Health.*

### ■ NEW HIRE FOR MA I POSITION (OR CURRENT EMPLOYEE MOVING INTO MA I POSITION) WHO WILL COMPLETE MEDICATION ASSISTANT I TRAINING PROGRAM

MA I training programs differ from facility to facility. The North Dakota Department of Health (NDDoH) requires that any facility desiring to hire and train MA I staff submit their program components to them for approval. Some facilities use the Minot State University (MSU) curriculum and others may develop their own programs.

## MEDICATION ASSISTANT I HIRING, TRAINING, AND COMPETENCY

*NOTE: The Long Term Care Medication Assistant I curriculum provided by Minot State University Center for Persons with Disabilities is an important part of a facility's MA I training program; however, it is not a training program in and of itself. The facility needs to further develop its training program specific to its facility to address the facility's culture and policies and procedures.*

1. Facility verifies Certified Nurse Assistant (CNA)/Nurse Aide (NA) is active and in good standing for the state of North Dakota through the [ND Department of Health nurse aide inquiry system](#). [NDAC 33-43-01-20](#)
2. Background checks, criminal history, drug testing, and/or other screenings as required by the facility to mitigate, to the extent possible, any risk to the vulnerable population served. This screening is to be completed prior to an individual entering the program. Information regarding background checks on potential students identified as a potential risk to the vulnerable population to be served must be submitted to the Department of Health prior to acceptance of the individual into the program. [North Dakota court records](#) can be accessed online. [NDAC 33-43-01-03](#)
3. Provide for MA I theory and clinical skills education as developed by the facility and approved by NDDoH. [NDAC 33-43-01-14](#) Refer to MSU curriculum (or other NDDoH-approved MA I curriculum).
  - A. Prospective MA I must pass theory test with 85% or better. [NDAC 33-43-01-14.5](#)
  - B. Prospective MA I must demonstrate at least 90% performance standard on all clinical skills check lists. [NDAC 33-43-01-14.7.b](#)
  - C. Consider requiring prospective MA I to demonstrate competence in all routes of medication administration in a lab-type setting prior to working with residents. Maintain a copy of this competency evaluation in employee file. If the facility does not have medical mannequins for a lab, inquiries can be made with other community health partners such as EMS to borrow or share resources.
  - D. Once this competency is assured, supervised medication administration to residents is allowed during the clinical portion of the MA I training with the nurse present. A prospective MA I may sign the Medication Administration Record (MAR) with the designation of Medication Assistant Student (MAS) or Student Medication Assistant (SMA), or similar designation as defined in facility policies. The licensed nurse who is present and observing medication administration to residents should co-sign all procedures observed. Maintain documentation of these competencies in employee file and in records of the facility's MA I program for a period of at least seven years. [NDAC 33-43-01-14.9](#)

*NOTE: Medication Assistant students must complete **BOTH** the didactic (theory) and the over the shoulder (clinical competency) portions of the MA I training program before documentation is sent to the Department of Health for the students to become certified Medication Assistants.*

4. Complete [Initial Medication Assistant I and II Application](#) form with applicant.
  - The applicant will need to complete page 1 to verify suitability to work with the facility's vulnerable population.
  - The RN instructor/program supervisor will complete page 2, indicating dates of enrollment and completion of the training (dates when all components of the program are completed as required). Confirm the applicant was active on the registry as a nurse aide or certified nurse aide before being enrolled in the Medication Assistant training program.



## MEDICATION ASSISTANT I HIRING, TRAINING, AND COMPETENCY

- Mail this application form with copy of applicant's Certification of Completion and/or a Class Roster or letter demonstrating successful completion of the approved program to NDDoH. Include required fee from applicant or employer (as per facility policy—ND Century Code does not have same requirements for charges to an MA I as to a CNA). [NDAC 33-43-01-14](#)
5. A maximum six-month period is allowed for a student that has enrolled in the program to finish the course and become active on the Nurse Aide Registry. [NDAC 33-43-01-14.4](#)
  6. If the facility has any resident with a stable predictable condition, as determined by a Registered Nurse, that requires regular administration of medication via gastrostomy, jejunostomy, or subcutaneous injection or a resident has a prescription for a premeasured injectable medication for allergic reactions, a licensed nurse will need to provide education specific to that route for that resident and verify competency for the administration of medications via that route for that individual resident. Maintain a copy of this verification in the specific resident's file as a means to verify that specific delegation as well as in the Medication Assistant's employee file. A sample document is provided in the *Nursing Delegation* section of this toolkit titled "Specific Delegation." [NDAC 33-43-01-16](#)
  7. These competency verifications do not need to be sent to NDDoH.
  8. Once the applicant receives a certification card, use that registry number to verify Certified Nurse Aide (CNA)/Nurse Aide (NA) AND Medication Assistant I (MA I) is active and in good standing for the state of North Dakota through the [ND Department of Health nurse aide inquiry system](#). Then print a copy of this information and put it in the employee's file.

### CONTINUED COMPETENCY EVALUATION FOR MEDICATION ASSISTANT I

1. Medication administration delegation requires assuring that the MA I has the necessary skills and competence to accomplish medication administration safely. The facility must continue to evaluate the competency of its Medication Assistants. Facility policies and procedures should address direct and indirect supervision, frequency of competency evaluations, and continued use of competency evaluation documents from MSU modules, etc.

*NOTE: The licensed nurse should consider completing, at least annually, a one-on-one over the shoulder skills competency evaluation med pass as well as in a lab-type setting within one month of employee's initial certificate date or hire date. Document completion of competencies with skills competency checklists and place in employee's file. This is also a good time to review with the employee the [Medication Assistant I Scope of Delegated Medication Administration](#) from the North Dakota Department of Health.*

2. Ensure that the MA I is on the NDDoH registry. See [NDAC 33-43-01-20](#) for initial registration and renewal requirements. The renewal process for MA I includes competency evaluation by a licensed nurse within the last 12 months prior to renewal. [NDAC 33-43-01-20](#)

Every 2 years, direct caregiving staff are required to renew their certification, whether NA, or CNA, NA + MA I, or CNA + MA I.

- A. Renewal for NA and NA + MA I is always September 30 of the year due.

## MEDICATION ASSISTANT I HIRING, TRAINING, AND COMPETENCY

- B. Renewal for CNA and CNA + MA I is a flexible expiration date based on the CNA's last day worked.
- C. [Renewal flow chart from NDDoH](#)
- D. NDDoH sends out renewal reminders one time, and if the individual has moved without sending notice of change of address, the individual may not receive a notice. It is the responsibility of the individual to ensure their certification(s) or registration(s) is current; however, the facility also needs to ensure that these certificates are maintained and may, therefore, want a staff member to do a monthly audit to identify that staff are aware of their expiring certificate and are working on the renewal process.
- E. Renewal forms can be found on the NDDoH website:
  - a. [Nurse Aide \(NA\) renewal form](#)
  - b. [Certified Nurse Aide \(CNA\) renewal form](#)
  - c. [NA and Medication Assistant I \(MA I\) renewal form](#)
  - d. [CNA and Medication Assistant I \(MA I\) renewal form](#)

*NOTE: Concerns with certified Medication Assistant competency and action within scope of practice should be reported to the ND Department of Health.*

## NURSING DELEGATION OF MEDICATION ADMINISTRATION TASKS

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Delegation is an essential nursing skill involving a process for a licensed nurse to direct another person to perform nursing tasks and activities. Licensed nurses remain ultimately accountable for safe medication administration by assuring the Medication Assistant is competent by having the required knowledge, skills, and ability to perform delegated medication administration interventions safely, accurately, and according to standard procedures. To accomplish safe delegation, the licensed nurse must understand their scope of practice in North Dakota and understand the role of Medication Assistants.

This section of the medication safety toolkit provides an overview of nurse delegation of medication administration to Medication Assistants. Below is a list of these tools:

### ■ **MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS**

An overview of process involved for licensed nurses to delegate medication administration tasks.

### ■ **MEDICATION ADMINISTRATION INVOLVING SPECIFIC DELEGATION**

Additional information on training and documentation needed for certain dosage routes requiring specific delegation to a Medication Assistant for a specific client, drug, and dose.

## MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS

Delegation is an essential nursing skill involving a process for a licensed nurse to direct another person to perform nursing tasks and activities. Licensed nurses remain ultimately accountable for safe medication administration by assuring the Medication Assistant is competent by having the required knowledge, skills, and ability to perform delegated medication administration interventions safely, accurately, and according to standard procedures. To accomplish safe delegation, the licensed nurse must understand their scope of practice in North Dakota and understand the role of Medication Assistants. When delegating to a Medication Assistant, licensed nurses must consider the following questions. The links provided reflect North Dakota rules and regulations.

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>Does North Dakota have rules and regulations that support delegation?</b></p>	<p>The North Dakota <a href="#">Nurse Practices Act</a> is the state law that governs the practice of nursing. A license to practice nursing is a right and responsibility granted by the state to protect those who need nursing care. All licensed nurses have a duty to understand the Nurse Practices Act.</p>
<p><b>Do North Dakota and my facility permit me to delegate this activity?</b></p>	<p>ND Standards of Practice for licensed nurses provides standards related to a licensed nurse’s responsibility for delegation.</p> <p><a href="#">Scope of Practice for RN</a>  <a href="#">Scope of Practice for LPN</a></p> <p>Medication Assistants may administer medications by the following routes to individuals or groups of individuals with stable, predictable conditions according to their organization’s policy:</p> <ol style="list-style-type: none"> <li>a. Oral, sublingual, and buccal medications;</li> <li>b. Eye medications;</li> <li>c. Ear medications;</li> <li>d. Nasal medications;</li> <li>e. Rectal medications and enemas;</li> <li>f. Vaginal medications;</li> <li>g. Skins ointments, topical medications, including patches and transdermal medications;</li> <li>h. Metered hand-held inhalants; and</li> <li>i. Unit dose nebulizers.</li> </ol> <p>Medication Assistants may administer medications by the following routes only when specifically delegated (<i>see “Specific Delegation” document in this toolkit</i>) by a licensed nurse to a specific Medication Assistant for a specific client with stable, predictable conditions:</p> <ol style="list-style-type: none"> <li>a. Gastrostomy;</li> <li>b. Jejunostomy;</li> <li>c. Subcutaneous; and</li> <li>d. Premeasured injectable medication for allergic reactions.</li> </ol> <p style="text-align: right;"><i>(Continued on next page)</i></p>

## MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>Do North Dakota and my facility permit me to delegate this activity?</b> <i>(Continued from previous page)</i></p>	<p style="text-align: right;"><i>(Continued from previous page)</i></p> <p>Medication Assistants may NOT administer medications by the following routes:</p> <ol style="list-style-type: none"> <li>Central lines</li> <li>Colostomy</li> <li>Intramuscular injection (except premeasured injectable medication for allergic reactions via specific delegation)</li> <li>Intravenous and intravenous lock</li> <li>Intrathecal</li> <li>Nasogastric tube</li> <li>Nonmetered inhaler</li> <li>Intradermal</li> <li>Nonunit dose aerosol or nebulizer</li> <li>Urethral catheter</li> </ol> <p>Medication Assistants may NOT administer the following kinds of medications:</p> <ol style="list-style-type: none"> <li>Barium and other diagnostic contrast media</li> <li>Chemotherapeutic agents except oral maintenance chemotherapy</li> <li>Through any medication pumps, or assume responsibility for medication pumps, including client-controlled analgesia</li> </ol> <p>See <a href="#">NDAC 33-43-01 Nurse Aide Training, Competency Evaluation, and Registry</a>.</p> <p>Medication Assistants cannot be delegated interventions that require:</p> <ol style="list-style-type: none"> <li>Conversion or calculation to medication dosage;</li> <li>Assessment of resident need for response to medications; and</li> <li>Nursing judgment regarding the administration of pro re nata medications.</li> </ol> <p>See also <a href="#">NDAC 33-43-01-19 Medication interventions that may not be delegated</a>.</p>

*NOTE: Licensed nurses must understand their scope of practice and the scopes of practice of the individuals they are supervising in order to delegate any task to them. The licensed nurse must follow his/her scope of practice and the Nurse Practice Act at all times. In situations where facility policy and procedure differs from state regulations, the stricter of the two should be followed.*

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>Have I assessed the resident and evaluated current needs?</b></p>	<p>Medication Assistants may administer routine, regularly scheduled medications to residents with stable, predictable conditions. <a href="#">NDAC 54-05-02-07</a> and <a href="#">NDAC 54-05-01-09</a>.</p> <p>Delegation of medication administration to residents with unstable or changing nursing care needs is not allowed. <a href="#">NDAC 33-43-01-13. 4</a>.</p>

## MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS

*NOTE: "Routine, regularly scheduled medication" means the components of an identified medication regimen for an individual or groups of individuals with stable conditions which are administered on a routine basis and do not require determination of need, drug calculation, or dosage conversion. ([NDAC 33-43-01-01](#), (29) Definitions)*  
*"Stable" means a situation in which the patient's or client's clinical and behavioral status and nursing care needs are determined by the registered nurse or licensed practitioner to be predictable, nonfluctuating, and consistent or in which the fluctuations are expected and the interventions are planned. ([NDAC 33-43-01-01](#), (31) Definitions)*

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>Have I assessed the Medication Assistant's abilities?</b></p>	<p>Delegate to another only those nursing interventions for which the Medication Assistant has the necessary skills and competence to accomplish safely. See <a href="#">NDAC 54-05-02-07</a> and <a href="#">NDAC 54-05-01-09</a>.</p> <p>For specific delegation (i.e., delegating to administer insulin), additional requirements need to be considered. Specific delegation is required for administering medications by the following routes: gastrostomy, jejunostomy, subcutaneous, and premeasured injectable medication for allergic reactions. Licensed nurses delegating specific medications shall:</p> <ol style="list-style-type: none"> <li>1. Supply organization procedural guidelines for the Medication Assistant.</li> <li>2. Teach the Medication Assistant for each specific resident's medication administration which includes verbal and written instructions on: drug name, purpose, signs and symptoms of common side effects, route of administration, and instructions under which circumstances to contact the licensed nurse.</li> <li>3. Observe the Medication Assistant administering the medication until competency is demonstrated.</li> <li>4. Verify the Medication Assistant's competency.</li> <li>5. Document the training provided. (See "Specific Delegation" template.)</li> <li>6. Evaluate the resident when medication orders change and determine if further instructions for the Medication Assistant is necessary. See <a href="#">NDAC 54-07-08-01</a> and <a href="#">NDAC 33-43-01-16</a>.</li> </ol> <p>Medication Assistants Scope of Practice:  <a href="#">ND Department of Health Medication Assistant I: Scope of Delegated Medication Administration Statement</a>  <a href="#">ND Department of Health Medication Assistant II: Scope of Delegated Medication Administration Statement</a></p>

*NOTE: The licensed nurse must know that the MA is competent and capable of performing the intervention prior to delegating any task. Licensed nurses should know where to find completed competencies for Medication Assistants. It is the responsibility of the facility/organization to supply a readily accessible resource for the nurse to aid in your decision as to whether the person you are delegating to has been properly trained and competent (ANA Principles for Delegation, 2012).*

## MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS

*NOTE: The medical record must indicate that the resident has been assessed by a licensed nurse and determined stable with reasonably predictable results of the intervention before medication administration can be delegated. MAR/TAR must indicate if the MA is required to contact the licensed nurse for assessment prior to medication administration.*

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<b>Is adequate RN supervision available?</b>	In assisted living and basic care facilities, the Medication Assistant may perform the delegated medication administration only if the licensed nurse has established in writing the process for providing the supervision in order to provide safeguards for the resident receiving the medication. See <a href="#">NDAC 33-43-01-13</a> .

*NOTE: In any healthcare environment in ND, the LPN is required to have oversight by an RN who is licensed in ND or licensed in one of the [compact states](#). Per correspondence from ND BON, "An LPN may not work independently without supervision in any setting. The licensed practical nurse practices nursing dependently under the direction/supervision of the registered nurse, advanced practice registered nurse, or licensed practitioner. The LPN assists in implementing the nursing process. In order to satisfy these requirements, the LPN must have a formal relationship established and maintained with an authorized supervising person at all times while providing nursing services. Such a relationship requires the supervising RN to be available to go to the practice setting and proximity would be determined in that formal relationship. The supervising nurse is required to be licensed in ND or hold a compact license to provide supervision."*

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<b>Would a prudent nurse delegate the task in this situation?</b>	It is within the licensed nurses' professional judgment and scope of practice to determine whether the task to be delegated may or may not be delegated to a Medication Assistant.
<b>Have I communicated clearly to the Medication Assistant?</b>	Provide clear directions and guidelines regarding the delegated medication administration intervention for stable residents. See <a href="#">NDAC 54-05-02-07</a> and <a href="#">NDAC 54-05-01-09</a> .

*NOTE: If the licensed nurse has any concerns about the competency of the MA or the stability of the resident, the task should not be delegated.*

*NOTE: For PRN medications, written parameters specific to an individual resident's care must be written by the licensed nurse for use by the MA when an onsite assessment is not required prior to administration of a PRN medication. (See "PRN Policy Sample" in this toolkit.)*

# MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS

## SPECIAL CONSIDERATIONS

### Insulin

Insulin is considered to be a specific delegation and whether the resident's insulin is from a Flex Pen, or is drawn up from a vial of insulin, the Medication Assistant will be required to be properly educated according to your facility's policy on insulin administration. Follow ND BON rules for specific delegation for each resident. The training provided to each MA must be specific to the resident, the medication, and the dose. This would include re-education of the MA and additional documentation of that education if the resident's insulin dose is changed. (See "Specific Delegation" document in this toolkit for more information.)

### Sliding Scale

The Medication Assistant cannot be delegated any task that would require a "conversion or calculation of a medication dosage," and "assessment of client need for or response to a medication." [NDAC 33-43-01-19](#) Therefore, Medication Assistants are **NOT** allowed to administer insulin to a resident who would need sliding scales for insulin administration.

*NOTE: The administration of insulin per sliding scale dosing dependent on the individual's blood sugar is not a recommended practice. This practice requires assessment skills that can only be practiced by a licensed nurse. Additionally, an individual requiring sliding scale insulin administration would not be considered stable and therefore, not appropriate for care in a residential care setting.*

### PRN (Pro Re Nata) Medications

Facility policies and procedures must address PRN medication administration and specific criteria for delegation of PRN administration. See "PRN Policy Sample" and [NDAC 33-43-01-18](#) for more guidance.

### Oxygen

Per correspondence from ND BON on July 1, 2014, "MAs can refill O<sub>2</sub> tanks according to facility policy." The licensed nurse must be sure the MA is trained in the proper procedure on how to do this.

Oxygen administration can be delegated to MAs. Be sure the facility policy is current and reviewed and the MA is checked off as competent to complete this task. If the oxygen is considered a PRN treatment, the facility policy should follow the regulations according to [NDAC 33-43-01-18](#).

### Preparing Medications for Residents on Leave

[Procedures for Residents/Patients Going on Pass from Long-Term Care Including Basic Care and Assisted Living Facilities](#) - Developed by the North Dakota Board of Pharmacy in conjunction with the North Dakota Board of Nursing and the North Dakota Department of Health. This guidance is intended for instances where a proper pharmacy labeled container **cannot** be provided because the resident's family or others have arrived at the long-term care facility wanting to take the resident out on pass and there is not time or feasibility to provide a pharmacy labeled container for their medications.

The NDDoH also has guidance on "Options for Medication Management when a Resident Unexpectedly Goes out of a Facility on a Short Pass (Four hours or Less)" provided as a separate document in this toolkit.



## MAKING DECISIONS ON DELEGATING MEDICATION ADMINISTRATION TASKS

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See also [Administrative Guidelines for Repackaging of Prescriptions](#).

### ■ TRAINING AND EDUCATIONAL OPPORTUNITIES

According to [Chapter 54-05-02](#) of the ND Administrative Code, Standards of Practice for Registered Nurses, “It is not the setting or the position title that determines a nursing practice role, but rather the application of nursing knowledge.” It is very important for licensed nurses to stay abreast with current standards, regulations, and rules for their professional license. Below are links to training and educational opportunities for licensed nurses to increase and/or maintain their nursing knowledge. Some may charge a fee.

- [Navigating the Complex World of Delegation](#) (this is a web-based webinar for 1 continuing education credit through the American Nurses Association)
- [Medication Errors: Don't Let them Happen to You](#) (This is a web-based webinar for 1.6 CEUs through American Nurses Association)
- [Pharmacology Review: Drugs that Alter Blood Coagulation](#) (This is a web-based webinar for 1.4 CEUs through American Nurses Association)
- [Adult Gerontology Clinical Nurse Specialist](#) (Online course to obtain a special certificate from the American Nurse Credentialing Center)
- [Conflict Competence Combined Module](#) (Online course to understand how to deal with conflict in the workplace from American Nurses Association worth 3.8 CEUs)

### ■ ADDITIONAL RESOURCES

- [Joint Statement on Delegation American Nurses Association \(ANA\) and the National Council of State Boards of Nursing \(NCSBN\)](#) – The American Nurses Association and the National Council of State Boards of Nursing adopted papers on nursing delegation. This joint statement was developed to support the practicing nurse in using delegation safely and effectively.
- [Code of Ethics for Nurses with Interpretive Statements](#) – This document provides a framework for nurses in establishing ethical standards for nursing.

## MEDICATION ADMINISTRATION INVOLVING SPECIFIC DELEGATION

Delegation is an essential nursing skill involving a process for a licensed nurse to direct another person to perform nursing tasks and activities. Licensed nurses remain ultimately accountable for safe medication administration by assuring the Medication Assistant (MA) is competent by having the required knowledge, skills, and ability to perform delegated medication administration interventions safely, accurately, and according to standard procedures. To accomplish safe delegation, the licensed nurse must understand his/her scope of practice in North Dakota and understand the role of Medication Assistants. Delegating medication administration to a Medication Assistant for certain routes of administration requires specific delegation to the MA that is individualized to the resident, medication, and dose.

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>What routes of administration require specific delegation?</b></p>	<p>Medication Assistants may administer medications by the following routes only when specifically delegated by a licensed nurse to a specific Medication Assistant for a specific client with stable, predictable conditions according to the organization policy:</p> <ol style="list-style-type: none"> <li>Gastrostomy;</li> <li>Jejunostomy;</li> <li>Subcutaneous; and</li> <li>Premeasured injectable medication for allergic reactions. See <a href="#">NDAC 33-43-01-17.3</a>.</li> </ol>

*NOTE: Subcutaneous administration is the most common route requiring specific delegation. This includes insulin and other diabetic medications delivered via subcutaneous injection.*

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>Have I assessed the resident and evaluated current needs?</b></p>	<p>Medication Assistants may administer routine, regularly scheduled medications to residents with stable, predictable conditions. <a href="#">NDAC 54-05-02-07</a> and <a href="#">NDAC 54-05-01-09</a>.</p> <p>Delegation of medication administration to residents with unstable or changing nursing care needs is not allowed. <a href="#">NDAC 33-43-01-13. 4</a>.</p>
<p><b>What steps are required for specific delegation?</b></p>	<p>For specific delegation, additional requirements need to be considered. Licensed nurses delegating specific medications shall:</p> <ol style="list-style-type: none"> <li>Supply organization procedural guidelines for the Medication Assistant to follow in administration of medication by specific delegation.</li> <li>Teach the Medication Assistant for each specific resident's medication administration which includes verbal and written instructions on: drug name, purpose, signs and symptoms of common side effects, route of administration, and instructions under which circumstances to contact the licensed nurse.</li> <li>Observe the Medication Assistant administering the medication until competency is demonstrated.</li> <li>Verify the Medication Assistant's competency through a variety of methods, including oral quizzes, written tests, and observation.</li> </ol> <p style="text-align: right;"><i>(Continued on following page)</i></p>

## MEDICATION ADMINISTRATION INVOLVING SPECIFIC DELEGATION

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>What steps are required for specific delegation?</b> <i>(Continued from previous page)</i></p>	<p style="text-align: right;"><i>(Continued from previous page)</i></p> <ol style="list-style-type: none"> <li>5. Observe the Medication Assistant administering the medication until competency is demonstrated.</li> <li>6. Verify the Medication Assistant’s competency through a variety of methods, including oral quizzes, written tests, and observation.</li> <li>7. Document the training provided. Consider using “Specific Delegation Training Template” provided in this toolkit.</li> <li>8. Evaluate the resident when medication orders change and determine if further instructions for the Medication Assistant is necessary. See <a href="#">NDAC 54-07-08-01</a> and <a href="#">NDAC 33-43-01-16</a>.</li> </ol>

*NOTE: The delegation is specific to the Medication Assistant, resident, drug, and dose. If changes are made then the MA training and specific delegation needs occur again to address the change.*

QUESTION	SUPPORTING REGULATIONS/DOCUMENTATION
<p><b>What competency needs to be verified?</b></p>	<p>Verify the Medication Assistant’s competency through a variety of methods, including oral quizzes, written tests, and observation. The nurse verifies the MA:</p> <ol style="list-style-type: none"> <li>a. Knows the six rights of each medication for the specific resident (right resident, right medication, right dosage, right route, right time, and right documentation)</li> <li>b. Knows the name of the medication and common dosage</li> <li>c. Knows the signs and symptoms of side effects for each medication</li> <li>d. Knows when to contact the licensed nurse</li> <li>e. Can administer the medication properly to the client</li> <li>f. Documents medication administration according to facility policy.</li> </ol> <p>See <a href="#">NDAC 54-07-08-01</a> and <a href="#">NDAC 33-43-01-16</a>.</p>
<p><b>Is adequate RN supervision available?</b></p>	<p>In assisted living and basic care facilities, the Medication Assistant may perform the delegated medication administration only if the licensed nurse has established in writing the process for providing the supervision in order to provide safeguards for the resident receiving the medication. See <a href="#">NDAC 33-43-01-13</a>.</p>

*NOTE: If the licensed nurse has any concerns about the competency of the MA or the stability of the resident, the task should not be delegated.*

### **SPECIFIC DOCUMENTATION TRAINING TEMPLATE**

Use the “Specific Delegation Training Template” to document specific delegation to MA for a specific resident, drug, and dose. A copy of the training should be kept in resident’s chart and in the employee’s file.

## SPECIFIC DELEGATION TRAINING TEMPLATE

Use this template to document specific delegation to MA for a specific resident, drug, and dose. Keep a copy of this document in the resident's chart and in the employee's file.

The Medication Assistant below has received training specific to the resident, drug, and dose for the below medication and is delegated to administer this medication to this resident. Any changes to the medication order will require additional training.

<b>Resident Name:</b>			
<b>Medication Assistant (MA) Name:</b>			
<b>Medication Name (Trade and Generic):</b>			
<b>Purpose of the medication:</b>			
<b>Dose of medication:</b>			
<b>Route and frequency of administration:</b>			
<b>Signs and symptoms of common side effects, warnings, and precautions:</b>			
<b>Circumstances to contact the licensed nurse:</b>			
<b>Verify the following:</b> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Direct observation of competency of MA administering the medication to the above resident  <input type="checkbox"/> MA knows the six rights for each medication for the above resident  <input type="checkbox"/> MA knows the name of the medication and common dosage                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> MA knows the signs and symptoms of side effects for the medication  <input type="checkbox"/> MA knows when to contact the licensed nurse  <input type="checkbox"/> MA can administer the medication properly to the resident  <input type="checkbox"/> MA can correctly document medication administration according to facility policy                 </td> </tr> </table>		<input type="checkbox"/> Direct observation of competency of MA administering the medication to the above resident <input type="checkbox"/> MA knows the six rights for each medication for the above resident <input type="checkbox"/> MA knows the name of the medication and common dosage	<input type="checkbox"/> MA knows the signs and symptoms of side effects for the medication <input type="checkbox"/> MA knows when to contact the licensed nurse <input type="checkbox"/> MA can administer the medication properly to the resident <input type="checkbox"/> MA can correctly document medication administration according to facility policy
<input type="checkbox"/> Direct observation of competency of MA administering the medication to the above resident <input type="checkbox"/> MA knows the six rights for each medication for the above resident <input type="checkbox"/> MA knows the name of the medication and common dosage	<input type="checkbox"/> MA knows the signs and symptoms of side effects for the medication <input type="checkbox"/> MA knows when to contact the licensed nurse <input type="checkbox"/> MA can administer the medication properly to the resident <input type="checkbox"/> MA can correctly document medication administration according to facility policy		
MA Signature:	Date:		
Nurse Signature:	Date:		

See [NDAC 54-07-08-01](#) and [NDAC 33-43-01-16](#).

## RESOURCES FOR FACILITY ADMINISTRATORS

Assistance with medication administration is one of the main reasons for individuals to move into Assisted Living and Basic Care (ALF/BC) facilities. A sound medication administration program involving properly trained staff, adequate oversight, and policies and procedures is an asset to your facility. Medication adherence is shown to improve patient outcomes and proper assistance with medication administration has been shown to improve adherence. Improper medication administration can lead to medication errors, adverse drug events, and increased liability risk.

This section of the toolkit will provide resources of interest to facility administrators. Some of the resources are within other sections of this toolkit while others are from external sources. Topics will include nursing delegation, medication assistant training, and quality improvement efforts within the assisted living market.

*NOTE: Internal staff key to medication administration are licensed nurses and Medication Assistants. An external partner that can be of value to your medication assistance services are pharmacies in your community that offer services to ALF/BC facilities. Have staff compile a list of pharmacies that offer ALF/BC services. Inquire about those services. Do they include: delivery, after hours services, unit dose packaging, MARs, label changes, assistance with drug destruction, Medication Therapy Management (MTM), assistance in policy and procedure development, repackaging of mail order medications, and their fee for doing so, etc. The American Society of Consultant Pharmacists has guidelines for providing pharmacy services to ALF/BC residents.*

### RELEVANT REGULATIONS

The [North Dakota Long Term Care Association](#) (NDLTCA) has compilations of North Dakota requirements available for both assisted living and basic care facilities. Regulations specific to medication administration are below. Contact [NDLTCA](#) for the complete listing.

#### ND Requirements for Assisted Living and Basic Care

- [NDCC Chapter 23-44](#) – Nurse Aid Registry
- [NDAC Chapter 33-43](#) – Nurse Aid Training, Competency Evaluation, and Registry
- [NDCC Chapter 43-12.1](#) – Nurse Practices Act
- [NDAC Chapter 54-05-01](#) – Standards of Practice for Licensed Practical Nurses
- [NDAC Chapter 54-05-02](#) – Standards of Practice for Registered Nurses
- [NDAC Chapter 54-07-08](#) – Specific Delegation of Medication Administration

#### ND Requirements Specific for Assisted Living

- [NDCC Chapter 50-32](#) – Assisted Living Facilities

#### ND Requirements Specific for Basic Care

- [NDAC Chapter 61-03-02](#) – Consulting Pharmacist Regulations for Long-Term Care Facilities (including Basic Care)
- [NDAC 33-03-24.1-09.2c](#) – Governing Body
- [NDAC 33-03-24.1-15](#) – Pharmacy and Medication Administration Services
- [North Dakota Department of Health Basic Care Facilities](#)

#### Other State Guidance/Resources

- [Medication Assistant Training Program Application for Approval](#)
- [Medication Procedures for Residents/Tenants Going on Pass from a Basic Care or Assisted Living Facility](#)
- [ND Department of Health Medication Assistant I Scope of Delegated Medication Administration Statement](#)
- [ND Department of Health Medication Assistant II Scope of Delegated Medication Administration Statement](#)
- [ND Department of Health Basic Care Survey Process Questions & Answers](#)
- [ND Department of Health Options for Medication Management when a Resident Unexpectedly Goes Out of a Facility on a Short Pass \(Four Hours or Less\)](#)

## RESOURCES FOR FACILITY ADMINISTRATORS

### ■ ADDITIONAL RESOURCES

These sections of the toolkit address the staffing and training aspects of medication administration. Following these guidelines will help with the development of staff that are properly trained and knowledgeable of their scopes of practice, which could aid in staff retention.

- Medication Assistant I Training and Competency
- Nursing Delegation

### [National Center for Assisted Living \(NCAL\) Resources and Tools](#)

NCAL is a national professional and advocacy organization in support of assisted living facilities. NDLTCA is ND's affiliate of NCAL. NCAL has a variety of tools and resources available. Some require membership login to access but many are available publically. If your facility is a member of NDLTCA, then your facility is also a member of NCAL and will have access to all tools and resources on this site. If you do not know if your facility is a member or do not know your username and password, contact NDLTCA at 701-222-0660. Resources of note include:

- [Guiding Principles for Quality in Assisted Living](#) – Provides an overview of quality improvement efforts including person-centered care, benchmarking, and workforce.
- [The Quality Initiative](#) – Identifies four main quality improvement efforts encouraged by NCAL. It identifies areas where the entire industry is looking for improvement.
- [Staff Stability](#) – One of NCAL's quality initiatives involves staff stability. A more stable staff contributes to better outcomes. Resources include documents on staff stability as well as a staff turnover calculator for seeing the true financial burden of staff turnover.

### [NDLTCA Resources](#)

NDLTCA also has resources that can be accessed by ND providers, available in the [Resources Links](#) section of the NDLTCA. This website contains recorded video and audio of training and conference calls as well as links to valuable information specific to North Dakota.

### [Medication Management Programs: A Safe Investment](#)

This article from Assisted Living Consult provides an excellent overview of issues involving medication administration, recommended policies, and training and competency for assistive personnel.

### **Institute for Healthcare Improvement (IHI)**

IHI is a national leader on quality improvement. They have many resources related to error reporting and creating a culture of safety.

[Create a reporting system](#) – Discusses the need for a non-punitive error reporting system so staff are not fearful of reporting errors. The focus of error reporting should be on identification of system factors that led to the error or near miss rather than individual factors.

*NOTE: It is important to report patterns of findings that have the potential for causing a negative impact or harm to the resident and medication errors that result in actual resident harm as a result of unsafe actions by a MA to the North Dakota Nurse Aide Registry. The North Dakota Department of Health licenses Medication Assistants and should be informed when a medication assistant makes a significant error resulting in resident harm.*

[Develop a culture of safety](#) – Make everyone in the facility take responsibility for resident safety. Leadership should be visibly committed to a culture of safety.

## MEDICATION SAFETY AND RESIDENT AND FAMILY ENGAGEMENT



Medication safety and resident engagement are essential when providing medication administration in your facility. Other sections of this toolkit have addressed successfully training Medication Assistants, licensed nurse responsibilities when delegating nursing interventions, and guidance regarding medication administration policies and procedures. The following sections in this toolkit provide valuable, reliable resources to address medication safety and resident and family engagement.

*NOTE: This section is designed for use by Assisted Living and Basic care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### ■ MEDICATION SAFETY

This section provides a variety of resources from nationally-recognized, reputable sources to guide you in assuring medication safety is practiced in your facility. Topics include:

- Introduction to Medication Safety
- High Alert Medications
- Medication Administration
- Medication Reconciliation
- Medication Disposal
- Medication Errors and Adverse Drug Events
- Other Resources

### ■ RESIDENT AND FAMILY ENGAGEMENT

This section provides resources for you to share with your residents to help them become more actively engaged in their care.

## MEDICATION SAFETY RESOURCES - INTRODUCTION



This section provides reliable sources of information related to medication safety. These resources are nationally-recognized, reputable, and frequently updated as medication knowledge changes. They are all available online.

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

Another great resource, in addition to the resources listed in this section, are the pharmacies that provide medications to ALF/BC residents. Utilize them with questions involving medications. They can provide additional resources and information.

*NOTE: Compile a master list of all pharmacies in the community that offer services to ALF/BC facilities. Inquire about their services. Do they include: delivery, after hours services, unit dose packaging, Medication Administration Records (MARs), label changes, assistance with drug destruction, Medication Therapy Management (MTM), assistance in policy and procedure development, repackaging of mail order medications and their fee for doing so, are they agreeable to accepting questions from your staff, etc.? The American Society of Consultant Pharmacists has [guidelines](#) for providing pharmacy services to ALF/BC residents.*

### MEDICATION SAFETY TOPICS

- Introduction to Medication Safety
- High Alert Medications
- Medication Administration
- Medication Reconciliation
- Medication Disposal
- Medication Errors and Adverse Drug Events
- Other Resources



## MEDICATION SAFETY RESOURCES – HIGH ALERT MEDICATIONS

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### ■ HIGH ALERT MEDICATION RESOURCES

Most medication errors and adverse drug events can be attributed to certain high risk medications. It is important to be aware of these high alert medications, the reasons why they are more likely to cause errors or adverse drug events, and how to minimize the risk. The resources below can assist licensed nurses in addressing high alert medications.

#### [Institute for Safe Medication Practices \(ISMP\)](#)

The ISMP is the nation's leading organization regarding safe medication use and medication error prevention. They have a variety of resources beneficial for ALF/BC facilities on high risk medications, high risk error situations, and more, including:

- [High-Alert Medications in Community/Ambulatory Healthcare](#) – A list of drug classes and medications with significant risk for harm when involved in an error.

*NOTE: Facilities can use this resource to identify “red flag” medications where additional precautions should be involved. Those most commonly seen in the ALF/BC setting include anticoagulants (warfarin), hypoglycemic agents (insulin and oral agents), antipsychotics, and opioids.*

- [Confused Drug Name List](#) – A list of look-alike or sound-alike medications where medication errors have occurred.

*NOTE: While the list is lengthy, licensed nurses should consider using it to highlight some of the commonly used medications in their facility on the confused name list, such as Aciphex vs. Aricept, alprazolam vs. lorazepam, glyburide vs. glipizide, Humalog vs. Humulin, etc. Another area to note in facility policies and procedures is that many of the names on the list involve the same medication available in immediate release and extended release forms (e.g., Seroquel vs. Seroquel XR).*

- [Tall Man Lettering](#) – This tool is a good companion to the Confused Drug Name List as it provides one practice to avoid confusion. Tall man lettering can help distinguish between two similar names. It is something that should be considered on pharmacy labeling, storage areas, and MARs.
- [Error-Prone Abbreviations, Symbols, and Dose Designations](#) – This is a great list of medical short-hand that increases risk for error on prescription labels, MARs, and verbal discussion.

## MEDICATION SAFETY RESOURCES – HIGH ALERT MEDICATIONS

*NOTE: This is very valuable in showing how terminology can be misinterpreted as well as corrected language to help avoid medication errors. Facilities should consider using in implementing medication administration policies.*

- [Do Not Crush List](#) – This list of oral dosage forms that should not be crushed is valuable in that it also explains the reasons why it cannot be crushed. Facilities may consider using it in their policies to highlight dosage forms in many instances that should not be crushed, such as extended release forms and enteric-coated or film-coated forms.

*NOTE: Many medications that cannot be crushed also cannot be split. Licensed nurses should consider using the Do Not Crush list to also identify medications that should not be split. However, there are exceptions to this rule such as metoprolol succinate, which is an extended release tablet that can be split but not crushed. Always contact the pharmacy for clarification if there is doubt whether or not a medication can be split or crushed.*

*If your facility uses unit-dose packaging, often referred to as “blister packs” or “bingo cards,” then the standard of practice for splitting tablets is that the pharmacy should perform this function.*

- [Long-Term Care Advise-ERR Newsletter](#) – This is an ISMP newsletter designed specifically to address medication safety for those working in long-term care facilities. Many of the newsletter topics are applicable to the ALF/BC setting. A subscription is needed.

### [ConsumerMedSafety.org](#)

[ConsumerMedSafety.org](#) is an ISMP site with additional high risk medication safety tools and resources. These resources are designed for patients, and therefore, may be a tool for facilities to use as an adjunct to education for staff, residents, and family members. Some of their valuable resources include:

- [High-Alert Medication Learning Guides](#) – This is a companion webpage to the ISMP High-Alert Medications list. This page has links to patient learning guides for [warfarin](#), multiple types of insulin, certain opioids, and [methotrexate](#).
- [Insulin Safety Center](#) – The insulin safety center has a variety of resources on insulin treatment. There is an overview of insulin basics as well as information regarding insulin errors.

*NOTE: Licensed nurses can use this resource to identify “red flag” medications where additional precautions should be involved. Those most commonly seen in the ALF/BC setting include anticoagulants (warfarin), hypoglycemic agents (insulin and oral agents), antipsychotics, and opioids.*

## MEDICATION SAFETY RESOURCES – HIGH ALERT MEDICATIONS

### [Beers Criteria for Potentially Inappropriate Medication Use in Older Adults](#)

This resource is from the American Geriatrics Society (AGS), the organization responsible for updating the Beers Criteria. The website contains medications that are potentially inappropriate in older adults due to increased risk of adverse effects. A table of the recommendations is [here](#). There are also patient and family education resources. When reviewing the list, it is important to remember that medications on this list are “potentially” inappropriate—meaning they can still be used in the elderly if benefits of the medication are determined to outweigh the risks with proper monitoring.

### **STOPP Criteria**

The Screening Tool of Older People’s potentially inappropriate Prescriptions (STOPP) criteria is a tool that is becoming more favored with geriatric health care providers. The STOPP criteria are more focused than the Beers Criteria and include drugs most likely to have risks that outweigh the benefits. Licensed nurses should consider using this resource to identify potentially inappropriate medications. (*Provided in this toolkit.*)

### [FDA Medication Guides](#)

Medication guides are required by the FDA for certain medications that have higher risk of adverse events or where adherence may be an issue. These guides often have supplemental information and directions for use that can be used to minimize the risk for adverse drug events. Medications with safety guides include: Advair, Coumadin (warfarin), Oxycontin, and many others.

### [Additional Resources for Specific High Alert Medication Classes](#)

In addition to the above resources, below are resources specifically targeting some of the most prevalent high alert medications in residents of ALF/BC facilities which may be of value:

- Anticoagulants
  - [Coumadin.com](#) – This website contains more detailed documents related to warfarin safety, including: [foods with vitamin K](#), [drug interactions](#), and [understanding warfarin](#).
  - [Warfarin - Introduction for New Users](#) – Tool available at National Library of Medicine that provides interactive, narrated education on understanding the benefits and risks of warfarin and how to properly administer.
- Insulin
  - [Insulin Safety Center](#) – The insulin safety center from ConsumerMedSafety.org previously listed includes an overview of [insulin basics](#), [types of insulin](#), [insulin administration](#), as well as information regarding [insulin errors](#). Consider using this resource to augment one on one training provided by licensed nurses to MA for specific delegation of subcutaneous insulin administration.
  - Pen Delivery Devices – While utilization of pens for insulin and other diabetic drugs has advantages regarding ease of use, there are still [safe practices](#) that need to be followed. In addition, the pens from each manufacturer differ slightly.
    - [Lantus SoloSTAR](#) – Similar directions for [Apidra](#)
    - [NovoLog FlexPen](#) – Similar directions for Novolin, [Levemir](#) and [Victoza](#) pens
    - [Humalog KwikPen](#) – Similar directions for Humulin pens
    - [Byetta Pen](#)

*NOTE: Licensed nurses should be aware of the differences between insulin pens and address these issues when providing one-on-one training for specific delegation to a Medication Assistant.*

## MEDICATION SAFETY RESOURCES – HIGH ALERT MEDICATIONS

- Antipsychotics
  - [Improving Antipsychotic Appropriateness in Dementia Patient](#) (IA-ADAPT) – This website contains resources to help [licensed nurses](#) increase their understanding of how to effectively manage behaviors in residents with dementia with the goal to avoid inappropriate use of antipsychotics. The site does require registration, but there is no subscription fee or e-mail list serve associated with registration. Some of their tools include:
    - [Evaluation of Problem Behaviors Pocket Guide](#)
    - [Antipsychotics for Dementia Prescribing Guide](#)
    - [Antipsychotic Guide for Care Providers](#)
    - [Non-Drug Management of Problem Behaviors in Dementia](#)
- Opioids
  - [How to Use Transdermal Patches](#) – This guideline from SafeMedication.com outlines proper application of transdermal patches.
  - [AMDA Clinical Practice Guideline: Pain Management in ALFs](#) – This guideline from the American Medical Directors Association provides broad information specifically for assisted living facilities.
  - [ER/LA Opioid Analgesics REMS \(risk evaluation and mitigation strategy\)](#) – This site contains continuing education, patient education, and medication guides for extended-release and long-acting opioid analgesics. It provides information on the risks involving opioid analgesics.

*NOTE: Most medication errors and adverse drug events (ADE) can be attributed to a small number of high risk medication classes. Awareness of these medications helps facilities implement medication administration polices to minimize the risk for errors and ADEs.*

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### **MEDICATION ADMINISTRATION RESOURCES**

Improper medication administration is a major contributor to medication errors and adverse drug events. As medication technology increases, so do complex drug delivery devices and directions. The resources below can assist licensed nurses in developing education and policies to improve medication administration.

#### **The Rights of Medication Administration**

What started as the “5 Rights” of medication administration (person, medication, dose, time, and route) has had additional rights added to increase medication safety. Many resources and references now refer to the “6 Rights” (original “5 Rights” + documentation). This reference lists medication administration rights and reminders to achieve the rights. *(This document is included in this toolkit.)*

#### **[Do Not Crush List](#)**

This ISMP resource, also listed in the High Alert Medications section, includes a list of oral dosage forms that should not be crushed and is valuable in that it also explains the reasons why it cannot be crushed.

*NOTE: Facilities may consider using this in their policies to highlight dosage forms in many instances that should not be crushed, such as extended-release forms and enteric-coated or film-coated forms.*

#### **[ConsumerMedSafety.org Medication Administration Guidelines](#)**

This website has a section with guidelines for administration of many non-solid oral dosage forms. They provide some basic illustrations as well.

*NOTE: Eye and ear medication packaging has become more similar to each other. Facilities should develop methods to identify each to avoid a medication error where an ear drop is administered into the eye.*

#### **[SafeMedication.com](#)**

SafeMedication.com also has a section with guidelines for medication administration. It has some different dosage forms, such as transdermal patches, that are not listed on the ConsumerMedSafety.org website. Both sites should be reviewed to identify preferred guidelines.

#### **Common Abbreviations Used in Medication Administration**

This resource is provided as part of this toolkit and lists common abbreviations used in medication administration. Abbreviations identified as error-prone by ISMP are highlighted. It is a good companion document to the [ISMP list of error-prone abbreviations](#) referenced earlier in this section.

*NOTE: Facilities should consider using this information to develop a policy on appropriate abbreviation use.*

## MEDICATION SAFETY RESOURCES – MEDICATION ADMINISTRATION

### [Potentially Hazardous Drugs for Pregnant Healthcare Staff](#)

There are many drugs that can be potentially hazardous to female staff that are pregnant, attempting to become pregnant, or are breastfeeding. These drugs could have teratogenic effects (an effect that may halt a pregnancy or produce a birth defect in a developing embryo or fetus) or easily pass through to breast milk which may then cause adverse effects in a nursing child. Crushing or splitting tablets in many cases increases this risk. This table is a composite from multiple resources regarding medications to avoid. Some medications of note are: azathioprine, carbamazepine, dutasteride (Avodart), finasteride, methotrexate, raloxifene (Evista), tamoxifen, and topical testosterone (Androgel, Testoderm, others).

### [Medication Management Programs: A Safe Investment](#)

This article from Assisted Living Consult provides an excellent overview of issues involving medication administration, recommended policies, and training and competency for assistive personnel.

### [Pill Identifier](#)

This resource from Drugs.com licensed nurses can use to help confirm the identity of an unknown medication. While it is recommended that a pharmacist be consulted on any unknown medication, this tool can complement the pharmacist's identification of the pill.

*NOTE: Facilities should consider use of this tool when investigating potential drug diversion, where an individual may replace one medication with another.*

### **Other Medication Administration Resources**

In addition to the guidelines referenced above, the number of “unique” drug delivery systems continues to increase. This is especially true for insulin dry powder inhaled medications and newer metered dose inhalers. For these medications, in addition to directions included in their packaging, their websites often have detailed written directions and how-to videos that can be useful to learn proper technique. Some of these include:

- [Spiriva](#)
- [Combivent Respimat](#)
- [Advair Diskus](#) (also works for Serevent Diskus)
- [Pulmicort Flexhaler](#)
- [Asmanex Twisthaler](#)

*NOTE: Coordination and correct administration of dry powder inhalers can be a difficult task as it varies from traditional metered dose inhalers. Facilities should perform staff competency evaluations for each type of inhaler, not just metered dose inhalers. Staff may consider contacting the drug manufacturer and request to have demonstration inhalers sent to your facility.*

### [Tools to Assess Self Administration of Medication](#)

The University of Maryland has developed a resource that lists a variety of tools that can be used at facilities to assess resident self-administration skills.

*NOTE: It is important that medication administration policies follow the six rights of medication administration.*

## MEDICATION SAFETY RESOURCES – MEDICATION RECONCILIATION

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### **MEDICATION RECONCILIATION RESOURCES**

Medication reconciliation is the process of recording and updating a complete list of the resident's active medications (prescription, over-the-counter, vitamins, herbal supplements, etc.). Medication reconciliation is needed with every new medication order, change or discontinuation. It is needed whenever a transition of care occurs such as a hospital admission or discharge or a new resident moves into a facility. Everyone involved in the coordination of the resident's care needs to be involved in medication reconciliation. The medication orders at the facility should match the medication list maintained by the resident's primary care provider, specialists, pharmacy, and other health care providers. Below are some resources to aid facilities and licensed nurses in their role in medication reconciliation.

#### **[ND Board of Nursing Guidance on Medication Reconciliation](#)** (third question in list)

This resource clarifies the role of the licensed nurse in medication reconciliation. While medication reconciliation is the ultimate responsibility of the provider, everyone involved in the resident's care coordination needs to have open communication to avoid potential discrepancies. This is a task that cannot be delegated to a Medication Assistant.

*NOTE: Facilities should review their policies regarding medication reconciliation. Are medication lists or copies of MARs sent with the resident each time they visit a health care provider? Are updated lists requested when the resident returns? Does the nursing staff effectively communicate with the resident, their pharmacy, and their prescribers to clarify discrepancies during medication reconciliation?*

#### **[Medication Reconciliation Worksheet](#)**

This worksheet from INTERACT can assist with medication reconciliation and identifying orders needing clarification upon a transition of care.

#### **[Medications at Transitions and Clinical Handoffs \(MATCH\) Toolkit for Medication Reconciliation](#)**

This toolkit from the Agency for Healthcare Research and Quality (AHRQ), while designed more specifically for hospitals, outlines valuable practices in medication reconciliation, including: conducting patient interviews, performing medication reconciliation, and special considerations such as health literacy.

#### **[IHI How-to Guide: Prevent Adverse Drug Events \(Medication Reconciliation\)](#)**

This toolkit from the Institute for Healthcare Improvement (IHI) addresses medication reconciliation at many levels of patient care. While designed more for hospitals, it provides information that can be applicable to most levels of care.

## MEDICATION SAFETY RESOURCES – MEDICATION DISPOSAL

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### **MEDICATION DISPOSAL**

Disposal of expired or discontinued medications can result in unwanted situations if not done properly. Medication errors can occur if discontinued or expired medications are administered to a resident because they are not stored in a separate area from current prescriptions. In addition, these medications need to be disposed of in an appropriate manner to avoid diversion and illicit drug use.

There are state and federal requirements involving medication disposal. [North Dakota Administrative Code 33-03-24.1-09.2.c.2](#) requires basic care facilities to have provisions for medication disposal developed in consultation with a pharmacist. The Drug Enforcement Administration ([DEA](#)), through the federal Controlled Substance Act, does not allow controlled substances to be returned to pharmacies for disposal.

As discussed in the resources below, there are multiple options for medication disposal. Local pharmacy providers may accept discontinued medications (not controlled substances) from their pharmacy and others for destruction. They also may be able to assist with controlled substance destruction on-site at the facility. Local law enforcement agencies may accept controlled substances for destruction. Consider contacting medical waste contractors regarding medication disposal. Finally, there are options available to dispose of the medications through the trash.

*NOTE: ALF/BC facilities should develop effective policies and procedures to address medication disposal. The policy should include: how checks are done to identify expired medications (prescription and over-the-counter), where discontinued/expired medications are stored to isolate them from current medications, the process used to destroy discontinued and expired medications, and how the amount of medication disposed is documented. It is recommended that all medication disposal and documentation involve two individuals to provide confirmation of medication disposal. Work with a local pharmacist to develop this policy.*

### **[North Dakota Board of Pharmacy General Guidelines for Drug Disposal](#)**

The ND Board of Pharmacy addresses options available to the public for drug disposal. The TakeAway program (local pharmacies) and the Drug Take Back Program (Attorney General program for controlled substances) are state programs that allow for safe disposal of medications.

### **[North Dakota Board of Pharmacy Drug Disposal Log](#)**

This log is designed for controlled substance destruction by the consultant pharmacist at skilled and basic care facilities. It could also be used by assisted living facilities to aid in documentation of medication destruction.



### [FDA Disposal of Unused Medicines: What You Should Know](#)

This resource from the US Food and Drug Administration (FDA) provides a good overview of medication disposal options: take-back programs, how to dispose in trash, and medications that should be flushed down sink or toilet.

### [North Dakota Administrative Code for Consultant Pharmacists for Basic Care](#)

The Administrative Code for consultant pharmacists in long term care (including basic care) outlines key requirements for drug storage and disposal in basic care facilities: [61-03-02-03.4.b](#) discusses medication storage; [61-03-02-04.4b](#) discusses discontinued medications; and [61-03-02-04.7](#) discusses controlled drug accountability.

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### MEDICATION ERRORS AND ADVERSE DRUG EVENTS

This entire toolkit has been designed to help improve medication safety with the ultimate goal of reducing medication errors and adverse drug events. While implementing many of the guidelines and utilizing the resources provided will help minimize the risk of errors and adverse drugs events, it is unavoidable that at some point in time an error or adverse drug event will occur. What is important is how staff responds to an error and how the facility analyzes the cause and makes improvements to reduce the risk of future occurrence.

#### Medication Error Reporting and Analysis

Facilities should encourage staff to report all medication errors as well as near misses. How these errors are addressed with staff will affect how they report future errors and near misses. Below are resources to help facilities develop open communications with staff regarding medication errors.

- Institute for Healthcare Improvement (IHI) – IHI is a national leader on quality improvement. They have many resources related to error reporting.
  - [Create a reporting system](#) – Discusses the need for non-punitive error reporting system; therefore staff are not so fearful of reporting errors. The focus of error reporting should be on identification of system factors that led to the error or near miss rather than individual factors.
  - [Develop a culture of safety](#) – Make sure everyone in the facility takes responsibility for resident safety. Leadership should be visibly committed to a culture of safety.
  - [Decision Tree for Unsafe Acts Culpability](#) – Used in analyzing errors to determine human and system factors that contribute to the error.

*NOTE: Facilities need to report patterns of findings that have the potential for causing a negative impact or harm to the resident and medication errors that result in actual resident harm as a result of unsafe actions by a MA to the North Dakota Nurse Aide Registry. The North Dakota Department of Health licenses Medication Assistants and should be informed when a medication assistant makes a significant error resulting in resident harm.*

- [Failure Modes and Effects Analysis Tool](#) – A toolkit for performing root cause analysis to determine system factors contributing to errors.
- [Error Reporting and Disclosure](#) – This chapter from the book, Patient Safety and Quality: An Evidence-Based Handbook for Nurses, provides an excellent overview of error reporting, including IHI and Institute of Medicine (IOM) principles.
- [ISMP National Medication Errors Reporting Program \(ISMP MERP\)](#) – This is a confidential national reporting system that assists ISMP in identifying system factors contributing to errors and ways to prevent them.

## MEDICATION SAFETY RESOURCES – MEDICATION ERRORS AND ADVERSE DRUG EVENTS

### Medication Error Risk Reduction

Root cause analysis of medication errors and near misses can identify system factors that contributed to the error. Knowing these factors can lead to improvement efforts in your system that will impact all residents. Below are resources to help reduce errors.

- [IHI Improve Core Process for Administering Medications](#) – Provides ideas for addressing system failures with a variety of suggestions that can be applied to the assisted living environment.
- [AHRQ Patient Safety Primer on Medication Errors](#) – This resource provides a broad overview of where medication errors occur and safety strategies.
- [Continuous Quality Improvement \(CQI\) Readiness Assessment Process and Tool](#) – This document from NCAL provides survey and information on advancing your quality improvement efforts.
- **Tips to Reduce Medication Errors** – Suggested practices to consider using to identify situations where errors may occur to minimize the risk. (*Document is included as part of this toolkit.*)

*NOTE: While looking at system issues and training all staff on error reduction strategies, individual training and monitoring of Medication Assistants should be provided if a pattern of individual errors are identified.*

- **Identifying Possible Drug Diversion** – Lists behaviors and situations that indicate possible drug diversion. (*Document is included as part of this toolkit.*)

*NOTE: Facilities should consider adding information related to drug diversion to policies and procedures to ensure all staff report any issues they may notice regarding possible drug diversion. Any identified drug diversion or illegal drug use by a Nurse Aide, Certified Nurse Aide, or Medication Assistant should be reported to the ND Department of Health and other appropriate authorities for investigation.*

### Adverse Drug Events

An adverse effect is any effect from a medication other than its intended effect. Adverse effects can be caused by the drug itself or by the interaction of that drug with other drugs, diseases, or food. Many of the more serious adverse effects were addressed in the high alert medication portion of this section. Below are some additional resources to assist licensed nurses in reporting (internal and external) and identifying possible adverse drug events.

- [Drugs.com](#) – A variety of useful drug-related references.
  - [Drug Interaction Checker](#) – Resource that allows for cross referencing for drug interactions between prescription medications, OTCs, and herbal supplements.
  - [Drug Information](#) – Provides access to the drug information sheets on prescription medications, including adverse effects.
- [Interventions to Reduce Acute Care Transfers \(INTERACT\) Tools](#)
  - [Stop and Watch Early Warning Tool](#) – This tool, while designed to detect any type of change in a resident's condition, can also be used to report possible adverse drug events.

## MEDICATION SAFETY RESOURCES – MEDICATION ERRORS AND ADVERSE DRUG EVENTS

[SBAR \(Situation, Background, Assessment, Request\) Communication Form](#) – A useful template for licensed nurses needing to communicate with resident’s Physician/NP/PA.

- [FDA MedWatch](#) – Voluntary reporting site from the FDA for observed adverse drug effects. The FDA uses the information reported here to identify adverse drug effects not previously discovered through the research and development process.

*NOTE: Facilities should have policies and procedures in place for medication error reporting that promote a culture of safety that focuses on system issues rather than individual issues while also meeting regulatory requirements.*

## MEDICATION SAFETY RESOURCES – OTHER RESOURCES

*NOTE: This section is designed for use by Assisted Living and Basic Care (ALF/BC) facilities and licensed nurses to develop and implement facility policies, procedures, and training to address medication safety and administration.*

### RESOURCES FROM OTHER ENTITIES AVAILABLE FOR PURCHASE

While these materials have not been directly reviewed and evaluated for this toolkit, they do come from reputable national organizations. They may be of value if additional resources are deemed necessary.

#### National Center for Assisted Living (NCAL) Resources

NCAL is the national association for assisted living facilities. They offer a variety of tools for purchase by both members and non-members.

- [Assisted Living Medication Training Kit](#) – A toolkit for training staff and assessing competency.
- [Assisted Living Policy and Procedure Manual](#) – Policies and procedures for many areas including medication management.
- [Assisted Living Nursing: A Manual for Management and Practice](#) – A book with both management activities and clinical competencies for assisted living nurses.

#### Med-Pass Assisted Living Resources

Med-Pass produces many template documents and publications for use in long term care settings. These documents are identified by Med-Pass as relating directly to assisted living facilities.

- [Medication Management in Assisted Living](#) – This handbook for pharmacists was developed by the American Society of Consultant Pharmacists (ASCP) and is distributed by Med-Pass.
- [ASCP Pharmacy Policy and Procedure Manual for Assisted Living](#) – A more comprehensive resource designed for pharmacies providing services to assisted living facilities.

## RESIDENT AND FAMILY ENGAGEMENT

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Person-centered care is one of the main focuses for quality improvement throughout the health care system. It is one of National Center for Assisted Living (NCAL)'s five [Guiding Principles for Quality in Assisted Living](#). Delivering care that is person-centered helps residents and their families be more engaged in their health care. Many of the resources provided throughout this Medication Safety Resources section such as the resources for specific high-alert medications, pill identifiers, and drug interaction checker can help residents become more involved in their health care. Below are additional resources Assisted Living and Basic Care facilities and their licensed nurses can make available to residents and their loved ones as a way to encourage active patient engagement.

### [How to Organize and Direct an Effective Resident Council](#)

Resident councils are an excellent way to engage residents and allow them to maintain autonomy in their health care decisions. This technical assistance manual from the Missouri Long-Term Care Ombudsman program provides guidance on establishing resident councils or how to improve your current resident council.

NCAL also has a [resource](#) for successful resident and family councils. Member login is required to view this NCAL resource.

### [Medicare Part D Medication Therapy Management Program](#)

Most residents of assisted living facilities receive prescription drug coverage through Medicare Part D. Medicare has a program for Part D beneficiaries with complex health needs taking multiple medications for multiple chronic conditions with high combined costs. The program is called Medication Therapy Management (MTM). MTM programs have some variation depending upon the company that provided the Part D prescription drug benefit. CMS has a [Physician's Guide to MTM Programs](#) that can be used to educate staff on the program so they are more aware of the program and can encourage residents that qualify for MTM to take full advantage of the program.

### [Four Medication Safety Tips for Older Adults](#)

This US Food and Drug Administration (FDA) consumer update provides general information on being knowledgeable about your medications.

### [NIH Senior Health](#)

This resource from the National Institutes for Health (NIH) has health information specific for older adults. It also includes training tools to help adults better search for health information online.

### [A Consumer's Guide to Choosing an Assisted Living Residence](#)

This resource from NCAL provides residents with an overview of assisted living facilities with a focus on person-centered care.

*NOTE: Information, both verbal and written, provided by facilities to residents and families regarding medication administration services should include descriptions of staff involved and their duties. Residents and families need to understand that Medication Assistants are performing the technical administration of medication and cannot provide any assessment regarding the resident's condition. Residents and families should understand questions and inquiries regarding the status of the resident should be made to a licensed nurse.*

## ORGANIZATIONAL POLICIES RELATED TO MEDICATION ADMINISTRATION

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Sample policies for medication administration and PRN medications are included in this toolkit. These templates are not intended to meet all the policies related to medication administration required by the NDDoH.

According to correspondence from the North Dakota Department of Health (NDDoH) for instructions with the use of the Minot State Medication Assistant I Curriculum (memo from NDDoH, updated 2/7/2013), facilities need to make sure they have policies and procedures for medication administration practices.

### ■ REQUIRED POLICIES

Organizational policies related to medication include:

1. Scope of duties of the Medication Assistant I, including:
  - A. Additional instruction on those categories of medications and routes of administration relevant to the health care setting where the Medication Assistant is employed
  - B. Specific delegation including routes that may be used only with specific delegation from the Licensed Nurse
  - C. Routes, medications, and medication interventions that may not be used (See [Medication Assistant I Scope of Delegated Medication Administration](#))
2. Licensed Nurse responsibilities in relationship to the Medication Assistant I
3. Prevention, causes, reporting, and documentation of medication errors
4. Organizational procedural guidelines to follow in medication administration by specific delegation from the Licensed Nurse
5. Medication scheduling at regular times, administration, and documentation (use of Medication Administration Record)
6. New medication orders (or change in dosage) and administration of the initial dose of a medication that has not previously been administered to a resident
7. Medication storage
8. Procedure for medical emergencies (anaphylactic shock)
9. Administration of pro re nata (PRN) medications
10. Use of standing orders
11. Self-administration of medications
12. Dropped medication, medication storage, disposal of medication, and documentation
13. Medication information sheets, nursing care plans, and referral forms
14. Medication management when a resident is away from the facility
15. Refusal of medications
16. When to notify the licensed nurse

# MEDICATION ADMINISTRATION POLICY TEMPLATE

## **POLICY: MEDICATIONS TO BE ADMINISTERED IN A SAFE AND TIMELY MANNER AS PRESCRIBED**

Residents who chose not to or cannot self-administer their medications will have their medications administered by a person who:

1. Is licensed or permitted by North Dakota to prepare, administer, and document the administration of medications.

*NOTE: Medication administration is the responsibility of licensed nurses and requires the knowledge, skills, and abilities of the licensed nurse to ensure public safety and accountability. Licensed nurses in Assisted Living and Basic Care (ALF/BC) facilities may delegate medication administration to Medication Assistant I and IIs in accordance with North Dakota Nurse Practice Act and North Dakota Century Code.*

### DEFINITIONS:

- a. “Licensed Nurse” means a person licensed pursuant to North Dakota Century Code [Chapter 43-12.1](#) and North Dakota Administrative Code title 54. [NDAC title 54-01-03](#)
  - a. “Licensed Practical Nurse” means an individual who holds a current license to practice in this state as a Licensed Practical Nurse and who practices dependently under the supervision of a Registered Nurse, Specialty Practice Registered Nurse, Advanced Practice Registered Nurse, or Licensed Practitioner. [NDAC Chapter 43](#)
  - b. “Registered Nurse” means an individual who holds a current license to practice in this state as a Registered Nurse and who practices nursing independently and interdependently through the application of the nursing process. [NDAC Chapter 43](#)
- b. “Medication Assistant” means an individual who is registered on the nurse aide registry as a Certified Nurse Aide or Nurse Aide who has successfully completed the requirements of a North Dakota Department of Health (NDDoH)-approved Medication Assistant program for a specific employment setting. Upon successful completion of a Medication Assistant program, the Certified Nurse Aid or Nurse Aide is eligible to be registered on the NDDoH’s nurse aide registry as a Medication Assistant I or a Medication Assistant II. [NDAC 33-43-01-01](#)
- c. Medication Assistant I (MA I) is a Certified Nurse Aid or Nurse Aide who has completed all the requirements for a NDDoH-approved Medication Assistant I program. A Medication Assistant I is limited to employment in a setting in which a Licensed Nurse is not regularly scheduled. [NDAC 33-43-01-01](#)
- d. Medication Assistant II (MA II) is a Certified Nurse Aide who has completed all the requirements for a NDDoH-approved Medication Assistant II program. A Medication Assistant II may be employed both in a setting in which a Licensed Nurse is regularly scheduled and a setting in which Licensed Nurse is not regularly scheduled. [NDAC 33-43-01-01](#)

## **PRACTICE**

1. All medications will be observed and placed on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) by a Licensed Nurse, prior to being administered.
  - A. This includes all medications that are ordered via telephone order, standing order, and written order to be given in a consistent scheduled manner, as well as any medications ordered to be



## MEDICATION ADMINISTRATION POLICY TEMPLATE

given pro re nata (PRN) or “as needed.” Only Licensed Nurses are authorized to take physician orders (verbal, telephone, or written).

- B. The Licensed Nurse will use discretion to determine the necessity of onsite assessment and/or telephone consultation with the Licensed Nurse for any medication to be given, at the time the order is transcribed to the MAR/TAR and indicate this on the MAR/TAR entry, by \_\_\_\_\_ (method by which the MA will know that the Licensed Nurse must do an onsite assessment and/or telephone consultation with the Licensed Nurse prior to this medication administration.) See PRN policy provided in this toolkit for additional guidance specific to PRN medications.
2. The individual administering the medication will check the label with the MAR to verify the right medication, right dosage, right time, and right route of administration before giving the medication. The expiration date on the medication label must be checked prior to administering.
3. Medications will be administered in accordance with the orders, including any required time frame.
4. Administration of the initial dose of a medication that has not been previously administered to a resident must be administered \_\_\_\_\_. (Your policy must indicate how the administration of initial dose of a medication that has not been previously administered to a resident will be administered.)

*NOTE: Consider if initial dose of a medication needs to be administered by a licensed nurse. [NDCC 33-43-01-17](#)*

5. The individual administering medications will verify the resident’s identity before giving the resident his/her medications by \_\_\_\_\_ (include in your policy what methods will be used to identify residents).

*NOTE: Methods to identify the resident may include: Checking photograph attached to medical record; requesting the resident to state their name and date of birth, facial recognition, or verifying resident identification with other facility personnel.*

5. Any unusual reactions to medications or treatments will be reported by the Licensed Nurse to the resident’s physician and responsible party.
6. As required or indicated for a medication, the individual administering the medication will document in the MAR/TAR:
  - A. The date and time the medication was administered;
  - B. The dosage;
  - C. The route of administration;
  - D. The injection site (if applicable);
  - E. Any complaints or symptoms for which the drug was administered;
  - F. Any results achieved and when those results were observed; and
  - G. The signature and title of the person administering the medication.
  - H. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall explain reason and document. Medications that are being withheld shall be documented \_\_\_\_\_. (Indicate

## MEDICATION ADMINISTRATION POLICY TEMPLATE

how withheld medications will be documented.) Refused medications shall be documented \_\_\_\_\_ (indicate how refused medications will be documented.)

7. Medications will be stored in a locked area, according to the manufacturer's instructions for light, humidity, temperature, or other storage instructions.
  - A. External medications will be stored separately from other medications.
  - B. Only authorized personnel will have access to locked medication storage areas.
  - C. Controlled substances will be kept in a separate container or compartment with a lock or other safeguard system which is permanently attached in the medication room.

*NOTE: Storage and management of controlled substances requires additional security. Effective procedures need to be in place to assure that adequate records are maintained regarding use and accountability to prevent diversion of controlled substances. This may include implementing a procedure to keep controlled substances in a double locked area and to be counted concurrently by two (2) authorized personnel at least every shift with corresponding documentation. Also include in your policy what to do if there is any discrepancy with these narcotic counts. This recommendation is based on Administrative Code for Long Term Care: [61-03-02-03.4.b](#); [61-03-02-04.4.b](#); [61-03-02-04.7](#)*

8. Medications belonging to one resident may not be administered to another resident.

### ■ RELEVANT REGULATIONS

[NDCC 33-43](#): Nurse Aide Training, Competency Evaluation and Registry

### ■ ADDITIONAL RESOURCES

[ND Department of Health Medication Assistant I: Scope of Delegated Medication Administration Statement](#)  
[ND Department of Health Medication Assistant II: Scope of Delegated Medication Administration Statement](#)

# PRN MEDICATION ADMINISTRATION POLICY TEMPLATE

## POLICY: PRO RE NATA (PRN) AND MEDICATION ADMINISTRATION BY MEDICATION ASSISTANT

### PROCEDURE

1. All medications must be observed and placed by a licensed nurse on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) by a licensed nurse, prior to being administered to a resident of \_\_\_\_\_ (ALF/BC).
  - A. This includes all medications that are ordered via telephone order, and written order to be given in a consistent scheduled manner, as well as any medications ordered to be given pro re nata (PRN) or “as needed.”
  - B. The licensed nurse must determine the necessity of onsite assessment, using his/her clinical knowledge and knowledge of the resident, or any medication to be given, at the time the order is transcribed to the MAR/TAR and indicate this on the MAR/TAR entry, by \_\_\_\_\_ (method by which the MA I will know that the licensed nurse must do an onsite assessment prior to this medication administration, e.g., red box outlining that MAR entry, or notation, “call nurse before administration”)

*NOTE: Some facilities require that a licensed nurse be consulted before ANY PRN medication is administered and have clear documentation of what communication transpires between the MA and the nurse in the determination of administering the PRN medication. If this is the policy of your facility, your policy must indicate the method by which the MA will know that the licensed nurse must be consulted prior to administration.*

- C. Written parameters specific to an individual patient’s care must be written in the MAR/TAR by the licensed nurse for use by the Medication Assistant when an onsite assessment is not required prior to administration of a medication. The written parameters:
  - a. Supplement the physician’s PRN order; and
  - b. Provide the Medication Assistant with guidelines that are specific regarding the PRN medication, e.g., give acetaminophen 325 mg (1 tablet) every 4 hours as needed for back pain at a level indicated by resident report to be “mild to moderate” or 1 to 4 on the 0-10 or FACES scale; if after 60 minutes, resident self-reports no relief may give additional acetaminophen 325 mg (1 tablet). If after 60 minutes, resident continues to self-report no relief, contact licensed nurse.
- D. Prescribers must provide an objective description of the condition or behavior that medication is intended to treat. Prescribers must also provide clarification of any order that may require any nursing judgment. No range orders will be accepted (e.g., “give 1-2 tablets every 4-6 hours as needed”).

*NOTE: Some facilities have established guidelines for writing MAR/TAR administration parameters in policy.*

2. All staff administering PRN medications must document the reason/symptom(s) for administering the medication, and this reason must align with the specific parameters of the written MAR/TAR entry.
  - A. If resident requests a PRN medication, but indicates a symptom other than those specified in the written MAR/TAR entry, Medication Assistant must consult licensed nurse to receive further guidance and document that guidance.
  - B. All staff administering PRN medications will follow-up on effectiveness of that administration within no more than 60 minutes. Medication Assistant should ask resident to self-assess effectiveness of PRN medication.

# PRN MEDICATION ADMINISTRATION POLICY TEMPLATE

- C. All staff administering medications will document the effectiveness of the PRN medication on the MAR/TAR by noting resident's self-assessment of PRN medication efficacy and the Medication Assistant's factual observations.

*NOTE: Medication Assistants cannot use their own judgment to determine if a PRN medication is needed or if it was effective. They must rely on resident self-assessment and their observations in relation to the written parameters specific to that resident and that PRN medication.*

- D. If alleviation of symptoms has not been achieved, Medication Assistant will follow written or verbal guidance of licensed nurse regarding further steps.
- E. Medication Assistant staff will document any and all communication between the Medication Assistant administering the medication and the licensed nurse.
3. Medication errors of any medication administration will be reported to \_\_\_\_\_ (indicate appropriate person in chain of command) immediately upon recognition of error. The resident's physician and family will be notified by \_\_\_\_\_ (indicate appropriate person in chain of command) in a timely manner.

## ■ RELEVANT REGULATION

[NDCC 33-43](#): Nurse Aide Training, Competency Evaluation and Registry

## ■ ADDITIONAL RESOURCE

[ND Department of Health Medication Assistant I: Scope of Delegated Medication Administration Statement](#)

## ■ ADDITIONAL CONSIDERATIONS

Once the licensed nurse has determined that onsite assessment by the licensed nurse will not be required for the administration of a specific medication to a specific individual by the Medication Assistant, the Medication Assistant must have and follow specific, written parameters as part of the MAR/TAR entry.

1. These written parameters must include the exact symptoms that this individual resident is known to exhibit indicating a need for this medication. Knowing these exact symptoms will allow the Medication Assistant to observe the effect of the PRN administration, i.e., if those exact symptoms are now improved or gone. The written parameters can in no way allow for any judgment on the part of the Medication Assistant when this medication is indicated, how it must be administered, and determination of efficacy.
2. The written parameters should indicate the number of pills/tablets/drops/puffs/etc. that will equal the dose prescribed.
3. Written parameters should specify when the effectiveness of a medication should be checked. This time frame should never exceed 60 minutes after administration of the PRN medication but can be appropriate to check sooner. Effectiveness should be checked by asking resident to self-assess PRN medication efficacy and by having Medication Assistant document factually what she/he is observing.
4. Written parameters should indicate a dose limit of any PRNs within a specified time frame (e.g., "acetaminophen dose should not exceed 3000mg in 24 hours").

## PRN MEDICATION ADMINISTRATION POLICY TEMPLATE

5. Written parameters must specify number of pills to be given and the time frame when transcribed to the MAR/TAR by the licensed nurse. Consider policy avoiding range orders by requiring clarification of any prescriber's order written requiring any nursing judgment (e.g., "give 1-2 tablets every 4-6 hours as needed").
6. Certain classes of medication will require even more specific guidance:
  - A. Pain medications
    - a. Should specify for which types of pain, which location and level of pain (i.e., using the 0-10 or FACES scale) this medication is indicated.
    - b. If a resident has an order for more than one pain medication, when/how often can they be given? Can/should they be given in combination with each other?
    - c. Specify what the next step is if pain is not alleviated (e.g., "Nitroquick every 5 minutes up to 2 doses as needed for chest pain. If no relief, call 911.")
    - d. Consider including non-pharmacological interventions to alleviate pain be added to MAR/TAR.
  - B. Psychotropic medications
    - a. Antipsychotic medications should rarely be prescribed for PRN administration. Any class of psychotropic medication that is ordered in the case of a documented emergency or when necessary to protect the resident from injury to self or others, may be considered a chemical restraint. In such cases, the restraint must be authorized and documented by a physician for a limited period of time and must be administered by a licensed nurse or physician. [NDCC 50-10.2](#)
    - b. For any other PRN administration of psychotropic medications, the MAR must indicate the individual, resident-specific symptoms indicating the medication should be given (e.g., order transcription should NEVER just say, "Ativan for anxiety"). What specific symptoms are displayed by this individual resident that indicate a need for this medication, e.g., pacing, refusal of care, repeating spouse's name, awake after midnight, repeatedly opening and closing drawers, weeping.
    - c. Include individualized, non-pharmacological interventions to attempt with resident to address and de-escalate behavioral concerns before any psychotropic medication is given. These resident-specific interventions should be identified through discussion with resident and former care partners. Consider including these interventions be added to MAR/TAR.

*NOTE: Consider requiring a licensed nurse be contacted via phone or for onsite assessment before any PRN psychotropic medication is administered.*

- C. Bowel protocols
  - a. Bowel protocols should be individualized to each resident upon admission or as soon as possible. Discuss with the resident, family and former care partners, the individual's history of bowel habits and concerns, as well as interventions that have worked in the past and request orders from the primary care provider to follow prior regimen when indicated.
  - b. Indicate the individual, resident-specific symptoms that signify an intervention may be indicated. Be especially mindful to collect relevant behavioral indicators for those residents who are not able to verbally express their needs (e.g., increased agitation, confusion, signs of pain/discomfort.)
  - c. Include individualized non-pharmacological interventions. Consider including this information on the MAR/TAR.

## SCREENING TOOL OF OLDER PERSON'S POTENTIALLY INAPPROPRIATE PRESCRIPTIONS (STOPP)

The tool contains medications that are potentially inappropriate in older adults due to increased risk of adverse effects. It can be used to become more familiar with potentially inappropriate medications. When reviewing the list, it is important to remember that medications on this list are “potentially” inappropriate—meaning they can still be used in the elderly if benefits of the medication are determined to outweigh the risks with proper monitoring.

### CARDIOVASCULAR SYSTEM

- Digoxin at a long-term dose > 125µg/day with impaired renal function\* (*increased risk of toxicity*)
- Loop diuretic for dependent ankle edema only, i.e., no clinical signs of heart failure (*no evidence of efficacy, compression hosiery usually more appropriate*)
- Loop diuretic as first-line monotherapy for hypertension (*safer, more effective alternatives available*)
- Thiazide diuretic with a history of gout (*may exacerbate gout*)
- Non-cardioselective beta-blocker with Chronic Obstructive Pulmonary Disease (COPD) (*risk of bronchospasm*)
  1. Beta-blocker in combination with verapamil (*risk of symptomatic heart block*)
  2. Use of diltiazem or verapamil with NYHA Class III or IV heart failure (*may worsen heart failure*)
  3. Calcium channel blockers with chronic constipation (*may exacerbate constipation*)
  4. Use of aspirin and warfarin in combination without histamine H2 receptor antagonist (except cimetidine because of interaction with warfarin) or proton pump inhibitor (*high risk of gastrointestinal bleeding*)
  5. Dipyridamole as monotherapy for cardiovascular secondary prevention (*no evidence for efficacy*)
  6. Aspirin with a past history of peptic ulcer disease without histamine H2 receptor antagonist or Proton Pump Inhibitor (*risk of bleeding*)
  7. Aspirin at dose > 150 mg day (*increased bleeding risk, no evidence for increased efficacy*)
  8. Aspirin with no history of coronary, cerebral, or peripheral vascular symptoms or occlusive arterial event (*not indicated*)
  9. Aspirin to treat dizziness not clearly attributable to cerebrovascular disease (*not indicated*)
  10. Warfarin for first, uncomplicated deep venous thrombosis for longer than 6 months duration (*no proven added benefit*)
  11. Warfarin for first uncomplicated pulmonary embolus for longer than 12 months duration (*no proven benefit*)
  12. Aspirin, clopidogrel, dipyridamole, or warfarin with concurrent bleeding disorder (*high risk of bleeding*)

### CENTRAL NERVOUS SYSTEM AND PSYCHOTROPIC DRUGS

1. Tricyclic antidepressants (TCAs) with dementia (*risk of worsening cognitive impairment*)
2. TCAs with glaucoma (*likely to exacerbate glaucoma*)
3. TCAs with cardiac conductive abnormalities (*pro-arrhythmic effects*)
4. TCAs with constipation (*likely to worsen constipation*)
5. TCAs with an opiate or calcium channel blocker (*risk of severe constipation*)
6. TCAs with prostatism or prior history of urinary retention (*risk of urinary retention*)
7. Long-term (i.e., > 1 month), long-acting benzodiazepines, e.g., chlorthalidone, flurazepam, nitrazepam, chlorazepate, and benzodiazepines with long-acting metabolites, e.g., diazepam (*risk of prolonged sedation, confusion, impaired balance, falls*)
8. Long-term (i.e., > 1 month) neuroleptics as long-term hypnotics (*risk of confusion, hypotension, extra-pyramidal side effects, falls*)
9. Long-term neuroleptics (> 1 month) in those with parkinsonism (*likely to worsen extra-pyramidal symptoms*)

## SCREENING TOOL OF OLDER PERSON'S POTENTIALLY INAPPROPRIATE PRESCRIPTIONS (STOPP)

10. Phenothiazines in patients with epilepsy (*may lower seizure threshold*)
11. Anticholinergics to treat extra-pyramidal side-effects of neuroleptic medications (*risk of anticholinergic toxicity*)
12. Selective serotonin re-uptake inhibitors (SSRIs) with a history of clinically significant hyponatraemia (*non-iatrogenic hyponatraemia < 130 mmol/l within the previous 2 months*)
13. Prolonged use (> 1 week) of first generation antihistamines, i.e., diphenhydramine, chlorpheniramine, cyclizine, promethazine (*risk of sedation and anti-cholinergic side effects*)

### ■ RESPIRATORY SYSTEM

1. Diphenoxylate, loperamide, or codeine phosphate for treatment of diarrhea of unknown cause (*risk of delayed diagnosis, may exacerbate constipation with overflow diarrhea, may precipitate toxic megacolon in inflammatory bowel disease, may delay recovery in unrecognized gastroenteritis*)
2. Diphenoxylate, loperamide, or codeine phosphate for treatment of severe infective gastroenteritis, i.e., bloody diarrhea, high fever or severe systemic toxicity (*risk of exacerbation or protraction of infection*)
3. Prochlorperazine (Stemetil) or metoclopramide with Parkinsonism (*risk of exacerbating Parkinsonism*)
4. PPI for peptic ulcer disease at full therapeutic dosage for > 8 weeks (*earlier discontinuation or dose reduction for maintenance/prophylactic treatment of peptic ulcer disease, esophagitis, or GORD indicated*)
5. Anticholinergic antispasmodic drugs with chronic constipation (*risk of exacerbation of constipation*)

### ■ GASTROINTESTINAL SYSTEM

1. Theophylline as monotherapy for COPD (*safer, more effective alternative; risk of adverse effects due to narrow therapeutic index*)
2. Systemic corticosteroids instead of inhaled corticosteroids for maintenance therapy in moderate-severe COPD (*unnecessary exposure to long-term side-effects of systemic steroids*)
3. Nebulized ipratropium with glaucoma (*may exacerbate glaucoma*)

### ■ MUSCULOSKELETAL SYSTEM

1. Non-steroidal anti-inflammatory drug (NSAID) with history of peptic ulcer disease or gastrointestinal bleeding, unless with concurrent histamine H2 receptor antagonist, PPI, or misoprostol (*risk of peptic ulcer relapse*)
2. NSAID with moderate-severe hypertension (moderate: 160/100 mmHg – 179/109 mmHg; severe:  $\geq$ 180/110 mmHg) (*risk of exacerbation of hypertension*)
3. NSAID with heart failure (*risk of exacerbation of heart failure*)
4. Long-term use of NSAID (>3 months) for relief of mild joint pain in osteoarthritis (*simple analgesics preferable and usually as effective for pain relief*)
5. Warfarin and NSAID together (*risk of gastrointestinal bleeding*)
6. NSAID with chronic renal failure\* (*risk of deterioration in renal function*)
7. Long-term corticosteroids (>3 months) as monotherapy for rheumatoid arthritis or osteoarthritis (*risk of major systemic corticosteroid side-effects*)
8. Long-term NSAID or colchicine for chronic treatment of gout where there is no contraindication to allopurinol (*allopurinol first choice prophylactic drug in gout*)

### ■ UROGENITAL SYSTEM

1. Bladder antimuscarinic drugs with dementia (*risk of increased confusion, agitation*)
2. Bladder antimuscarinic drugs with chronic glaucoma (*risk of acute exacerbation of glaucoma*)
3. Bladder antimuscarinic drugs with chronic constipation (*risk of exacerbation of constipation*)
4. Bladder antimuscarinic drugs with chronic prostatism (*risk of urinary retention*)

## SCREENING TOOL OF OLDER PERSON'S POTENTIALLY INAPPROPRIATE PRESCRIPTIONS (STOPP)

5. Alpha-blockers in males with frequent incontinence, i.e., one or more episodes of incontinence daily (*risk of urinary frequency and worsening of incontinence*)
6. Alpha-blockers with long-term urinary catheter *in situ*, i.e., more than 2 months (*drug not indicated*)

### ■ ENDOCRINE SYSTEM

1. Glibenclamide or chlorpropamide with type 2 diabetes mellitus (*risk of prolonged hypoglycemia*)
2. Beta-blockers in those with diabetes mellitus and frequent hypoglycemic episodes, i.e.,  $\geq 1$  episode per month (*risk of masking hypoglycemic symptoms*)
3. Estrogens with a history of breast cancer or venous thromboembolism (*increased risk of recurrence*)
4. Estrogens without progestogen in patients with intact uterus (*risk of endometrial cancer*)

### ■ DRUGS THAT ADVERSELY AFFECT THOSE PRONE TO FALLS (>1 FALL IN PAST 3 MONTHS)

1. Benzodiazepines (*sedative, may cause reduced sensorium, impair balance*)
2. Neuroleptic drugs (*may cause gait dyspraxia, Parkinsonism*)
3. First generation antihistamines (*sedative, may impair sensorium*)
4. Vasodilator drugs known to cause hypotension in those with persistent postural hypotension, i.e., recurrent  $> 20\text{mmHg}$  drop in systolic blood pressure (*risk of syncope, falls*)
5. Long-term opiates in those with recurrent falls (*risk of drowsiness, postural hypotension, vertigo*)

### ■ ANALGESIC DRUGS

1. Use of long-term powerful opiates, e.g., morphine or fentanyl as first line therapy for mild-moderate pain (*WHO analgesic ladder not observed*)
2. Regular opiates for more than 2 weeks in those with chronic constipation without concurrent use of laxatives (*risk of severe constipation*)
3. Long-term opiates in those with dementia unless indicated for palliative care or management of moderate/severe chronic pain syndrome (*risk of exacerbation of cognitive impairment*)

### ■ DUPLICATE DRUG CLASSES

Any duplicate drug class prescription, e.g., two concurrent opiates, NSAIDs, SSRIs, loop diuretics, ACE inhibitors (*optimization of monotherapy within a single drug class should be observed prior to considering a new class of drug*); excluding duplicate prescribing of inhaled beta2 agonists (long and short acting) for asthma or COPD

\*Estimated GFR  $< 50$  ml/min

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Hamilton HJ, Gallagher PF, O'Mahony D. Inappropriate prescribing and adverse drug events in older people. *BMC Geriatrics* 2009; 9:5.



# THE MANY RIGHTS OF MEDICATION ADMINISTRATION

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What started as the “5 Rights” of medication administration (person, medication, dose, time, and route) has had additional rights added to increase medication safety. Many resources and references now refer to the “6 Rights” (original “5 Rights” + documentation) while some list even more. Below are some of these rights along with tips to meet them.

## RIGHT . . .

### RESIDENT

- Make sure you know the resident
- Identify RESIDENT every time and confirm by name, date of birth, picture on Medication Administration Record (MAR), and other means of accurate identification
- NEVER give medication to more than one resident at a time
- Check the name on the label and the MAR
- Use at least two identifiers
- Ask the resident to identify himself/herself
- Use technology, when possible, such as bar codes

### MEDICATION

- Check MEDICATION label and compare it to the order on the MAR entry **three** times
- **Check MAR, Check LABEL, then Check MAR with LABEL**
- Read the label to the resident and verify the resident understands the drug dosage and reason for use

### DOSAGE

- Check the DOSAGE (AMOUNT); triple check the label with the MAR
- Use caution with dosages that involve split tablets—verify tablet strength and order strength
- Check the DAY OF THE WEEK with medications that have different doses on different days (warfarin)
- Use the metric measuring system for all liquid medications
- Only use standardized measuring devices designed for medication use when measuring liquid medications. Do NOT use cooking utensils or other devices.
- LEARN your facility’s policies on STANDARD times when medications are given multiple times a day (twice a day, three times a day, etc.)

### TIME

- Check the TIME; medications must be given at the TIME prescribed
- Standard practice is that medications are given within 30-60 minutes (depending upon facility policy) before or after the TIME noted on the MAR or medication label
- It is considered a medication error if outside the time range
- Best practice would be TIME exactly as indicated on MAR or prescription label
- OR, consider implementing a Personalized Medication Administration Policy

### ROUTE

- Check the ROUTE—Confirm that the patient can take or receive the medication by this route: oral by mouth, topical creams, ointments, or patches on skin; ophthalmic drops or ointments in eye; otic drops in ear; nasal drops or sprays in nose; and inhalers or diskus inhaled through mouth
- Medication Assistants may administer medication only by the routes for which they have been trained and demonstrated competence

# THE MANY RIGHTS OF MEDICATION ADMINISTRATION

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## ■ DOCUMENTATION

- Properly document each dose offered on the MAR
- Document administration AFTER giving the ordered medication
- Document the time, route, and any other specific information as necessary
- NEVER document in pencil or use white out
- Document refusal of medication per your facility's policy

## ■ RESPONSE

- Make sure that the drug led to the desired effect—If Tylenol was given for backache, was the pain relieved? Does the patient verbalize improvement in depression while on an antidepressant?
- Be sure to document your observation of the resident and report to nursing
- Observe for adverse drug effects—Document any observed changes in the resident's condition and report to nursing
- Pay especially close attention when new medications are started, medications are discontinued or when resident is experiencing an acute health change, such as an infection. Ensure the Medication Assistant is aware of order changes and have documented competency to administer the new medication.

## ■ REASON

- Revisit the reasons for medication use—If you are unsure of the reason for use, ASK!
- Ask the nurse, doctor, or pharmacist

## ■ REFUSE

- A resident has the right to refuse a medication
- A resident may not be compelled (forced) to take a medication
- Check the frequency of the ordered medication—Double-check that you are giving the ordered dose at the correct time—Confirm when the last dose was given
- Use effective approaches such as the “sandwich technique” or “Premack Principle” to get resident to agree to take the medication – additional information on these techniques is in the Minot State MA I training curriculum.
- Document refusal according to facility policy and notify nurse—Share any observations on why resident may be refusing medication

### **Adapted From:**

Florida Department of Elder Affairs. [Assistance with Self-Administration of Medication: Study Guide for Assisted Living Facility \(ALF\) Staff](#). July 2012 (revised June 2013). Last accessed June 23, 2014.  
Mercer, M (2012). Medications Training (Rev. Ed) Minot, ND: North Dakota Center for Persons with Disabilities a University Affiliated Program at Minot State University.

## COMMON ABBREVIATIONS USED IN MEDICATION ADMINISTRATION

Abbreviation	Definition	Abbreviation	Definition
AAA	Apply to Affected Area	mg/ml	Milligrams per milliliter
AC	Before meals	ML	Milliliter
AD	Right ear	OD	Right eye
AM	Morning	OS	Left eye
amp	Ampule	OU	Both eyes
AL, AS	Left ear	oph	Ophthalmic, eye
AU	Both ears	otic	Ear
BID	Twice a day	oz	Ounce
buc, bucc	Buccal; inside cheek	PC	After meals
cap	Capsule	PM	Evening
c̄	With	PO	By mouth
cc	Cubic centimeter (milliliter)	PRN	As needed
crm	Cream	q	Every
D	Days	qAM	Every morning
DAW	Dispense as written (brand name only)	QD	Everyday
D/C, dc	Discontinue or discharge	qPM	Every evening
elix.	Elixir	q#h	Every # hours (i.e., q4h=every 4hours)
g	Gram	QOD	Every other day
gr	Grain	̄	Without
gtt(s)	Drop(s)	SC, SQ, SubQ	Subcutaneous
h, hr	Hour	SL	Sublingual
HS, QHS	At bedtime	sol	Solution
ID	Intradermal	supp	Suppository
inj	Injection	susp	Suspension
IM	Intramuscular	syr	Syrup
IU	International unit	tab	Tablet
IV	Intravenous	tbsp	Tablespoon
kg	Kilogram	tsp	Teaspoon
LCD	Coal tar solution	TID	Three times a day
liq	Solution	TIW	Three times a week
lot	Lotion	U	Unit
mcg	Microgram	UD	As directed
mEq	Milliequivalent	ung	Ointment
mg	Milligram	vag	Vaginally
μg	Microgram		

Abbreviations highlighted in **RED** are listed in [ISMP's List of Error-Prone Abbreviations](#) and are recommended NEVER to be used.

Reference: Institute for Safe Medication Practices. [ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations](#). 2013. Accessed July 3, 2014.

## TIPS TO REDUCE MEDICATION ERRORS

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A [medication error](#) refers to an error (of commission or omission) at any step along the pathway that begins when a clinician prescribes a medication and ends when the patient actually receives the medication. Research has led to the development of recommendations and tools to assist you, as the supervising nurse, Assisted Living and Basic Care facilities and their licensed nurses in ways to minimize the risk of MA IMedication Assistant staff making some common medication errors:

- **Minimize Interruptions** — Make every effort to minimize interruptions for the staff administering medications. Educate other staff, families, and residents of the seriousness of medication administration and encourage them to direct questions and comments, unrelated to the immediate medication administration for the current resident, to be directed to other staff or defer until a later time. Additionally, supervisory staff needs to model this behavior by restraining themselves from interrupting the Medication Assistant staff as well.
- **Scheduled Audits** – A systematic review and evaluation of records and other data to determine the quality of the services or products provided in a given situation.
  - Monthly MAR/TAR sign-off and documentation review – At the end of each month, collect all MARs and TARs and
    - Audit for a signature to match each set of initials used within the form
    - Audit for initials (or other notation) in every box indicating medication given or treatment done and/or appropriate notation of medications held, refused, or not given for any reason (per facility policy), including documentation of reason and follow-up actions (as required by facility policy)
    - Audit for all elements of your PRN documentation, as required by facility policy, including evaluation of resident’s response to effectiveness of the intervention
  - Monthly review of the narcotic counting documentation and verification of two authorized signatures
- **Spot checks** — A quick random examination/check to monitor competency
  - Narcotic counts
  - Locking of med carts
  - Ask MA IMedication Assistants “What are the 6 rights of medication administration?”
  - Observe med administration even though it may not be the scheduled and expected time for an annual competency evaluation
  - Trends/patterns - Use any data that you can collect to look for trends and patterns in incidents, identify gaps in appropriate care, and then make adjustments in procedures to try to eliminate those types of issues from your system
    - Consider tracking medication administration errors to identify patterns, such as what external factors may be impacting med administration, is there a consistent time of day or day of the week when errors are more prevalent, is there a certain resident or area of the facility that has more errors, who is making errors, is there a licensed nurse that has more transcribing errors, etc.
    - When patterns are identified, use this opportunity to delve into the root causes of increased errors to make systems-level improvements, rather than immediately instituting disciplinary action.

## IDENTIFYING POSSIBLE DRUG DIVERSION

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Illicit use of prescription medication is the fastest growing type of drug abuse. Drug diversion puts resident safety at risk as they may not receive the medications they were prescribed. Be aware of the sign of possible drug diversion:

1. Reports of poor pain relief by residents
2. Medications in bubble pack appear different from each other without notice from pharmacy
3. Poor handwriting
4. Significant increases in medication refills
5. Discrepancy in narcotic count sheets and actual number of meds
6. Discrepancy between narcotic count sheets and MAR
7. Patterns of wasted meds and dropped meds by same individual
8. Medication assistants exhibiting symptoms of drug use/abuse (confusion, memory loss, difficulty remembering details, change in appearance, change in attitude, wears long sleeves when inappropriate, professional and personal isolation, tremors, sweating, stomach ache, and nausea complaints) Losben, N.L. (2013). [Detection of Drug Diversion in a Long Term Care Facility: A Multi-Victim Crime. \[PPT\]](#) *Presentation at American Society of Consultant Pharmacists (ASCP) Annual Meeting and Exhibition.* Seattle, WA.
  - Medication assistants exhibiting behaviors that may indicate diversion
    - a. Tardiness, unscheduled absences, and an excessive number of sick days used
    - b. Frequent disappearances from the work site and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept
    - c. Volunteers for overtime and is at work when not scheduled to be there
    - d. Arrives at work early and stays late
    - e. Pattern of removal of controlled substances near or at end of shift
    - f. Work performance alternates between periods of high and low productivity, may suffer from mistakes, poor judgment and bad decisions
    - g. Interpersonal relations with colleagues, staff, and patients suffer; rarely admits errors or accepts blame for errors or oversights (denial)
    - h. Insistence on personal administration of narcotics to patients
    - i. Heavy or no "wastage" of drugs
    - j. Pattern of holding waste until oncoming shift
9. Problems in personal life – Personal situations involving depression, financial difficulties, or ill family members are risk factors for drug abuse. If an individual you are working with has a personal situation, be aware and monitor for any of the above behaviors
10. Don't attempt to confront the suspected individual alone. Do not share your suspicions with anyone except your supervisor or administrator.