

Florida's Agency for Health Care Administration 2014 Joint Training for Assisted Living Facilities



Wednesday, February 5, 2014 – Orlando
Friday, February 7, 2014 – Tampa
Tuesday, February 25, 2014 – Davie/Ft. Lauderdale
Friday, February 28, 2014 – Tallahassee

Approved for 6 hours of continuing education – FHCA Provider Number 50-720:

Florida Board of Nursing Home Administrators

Florida Board of Nursing

Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

Florida Board of Occupational Therapy

Florida Board of Speech-Language Pathology & Audiology

FHCA does not have NAB approval for this program

Event Overview

The 2014 Joint Training for Assisted Living Facilities will provide interpretations of regulatory compliance by leaders from the Agency for Health Care Administration and the Department of Elder Affairs. Clinical and legal professional leaders will also highlight best practice guidelines and professional guidance. The training offers the opportunity for providers and surveyors to hear the same interpretations of compliance requirements and standards of practice for Assisted Living in Florida.

Schedule of Events

7:30 a.m.	Registration
8:30 a.m.	Welcome and Introductions
8:45 to 9:45 a.m.	Medicaid Managed Care LTC Program Update for Assisted Living Facilities <i>Beth Kidder, AHCA and Cheryl Young, DOEA</i> AHCA and DOEA representatives will provide an update on implementation of the Statewide Medicaid Managed Care Long-term Care program and will discuss how Florida will ensure the system will provide quality services to ALFs.
9:45 to 10:00 a.m.	Break
10:00 a.m. to 12:00 p.m.	Top 10 Deficiencies and Major Regulatory Concerns – Including Tuberculosis Requirements, Background Screening and Bed Bugs <i>Polly Weaver and Anne Avery, AHCA</i> Florida's Survey Director will discuss the major areas of deficiencies in addition to the questions most frequently raised. Key concerns from a variety of enforcement areas will be discussed.
12:00 to 1:15 p.m.	Lunch
1:15 to 2:15 p.m.	Successful Practice Guidelines: Assisted Living Facilities' Quality Outcomes <i>Deborah Afasano, Avante Group, Inc.</i> Successful care practices will be highlighted within the framework of a facility's license, including more clinical care in ALFs with an ECC license and assistance with medication in facilities without a specialty license.
2:15 to 3:15 p.m.	Rights of Assisted Living Facility Providers and Assisted Living Facility Residents: Contracts and Negotiations with Managed Care Organizations <i>James Barclay, Hayward, Grant & Rumph P.A.</i> Questions continue to arise about contract negotiations between Assisted Living Facilities and individual residents. This session will address both the concerns within managed care contracting as well as private pay contractual situations.
3:15 to 3:30 p.m.	Break
3:30 to 4:30 p.m.	Directed Plans of Correction, Quality Reviews and Adverse Incident Reporting <i>Kimberly Smoak and Catherine Anne Avery, AHCA</i> Florida ALF providers have experienced an increase in the Agency's Directed Plans of Correction and questions have been raised. The Agency's enforcement spokesperson will answer questions regarding incident reporting and explain the process for providers requesting a "Quality Review."

*6 total contact hours can be earned

Target Audience

Assisted Living Facility executive directors, administrators, nurse leaders, charge nurses, social workers, therapists, activity directors, consultants, education trainers, dietary staff and state surveyors.

Faculty:

Polly Weaver has over 25 years of regulatory experience and has served as the Chief of Field Operations for the Division of Health Quality Assurance, Agency for Health Care Administration (Agency) since 1995. Her responsibilities include management of the eight field offices located throughout Florida, which are responsible for the certification, survey functions and enforcement activities of the health care facilities licensed by the Agency.

Deborah Afasano, BSN, CDONA, HCRM, ELNEC is Vice President of Clinical Services for Avante Group, Inc. She is an end-of-life trainer through ELNEC, MDS 3.0 resident assessment coordinator through AANAC and a licensed health care risk manager. Her diverse nursing background spans 30-plus years in acute and long term care settings. Ms. Afasano also serves as Chair of the FHCA Quality Foundation Senior Clinicians Council.

Catherine Anne Avery earned her Registered Nursing degree in 1990, with specific clinical focus on critical care. In 1999, she began work for AHCA doing on-site inspections of Florida health care facilities and functioned as the nursing supervisor for the 18 Panhandle counties. Ms. Avery joined the Office of the Attorney General's Medicaid Fraud Control Unit as a Medical Investigator in April 2005. In 2008, Ms. Avery became a certified Legal Nurse Consultant and has provided expert testimony in both administrative and criminal proceedings. In 2010, she returned to AHCA and currently oversees the Statewide ALF Enforcement Team.

James M. "Chet" Barclay, JD, practices administrative and governmental law in Tallahassee, Florida, with Hayward Grant & Rumph, P.A. He represents a wide variety of health care clients, including Assisted Living Facilities, in connection with matters such as licensure, certification and sanction proceedings in administrative hearings, before Circuit Courts and on appeal. His recent activities include advising and counseling clients about strategic and tactical approaches to managed care contracting and private pay contractual situations.

Beth Kidder is the Assistant Deputy Secretary for Medicaid Operations at the Agency for Health Care Administration. She oversees Medicaid policy development and quality initiatives. She has 15 years of experience working for state Medicaid programs, beginning in North Carolina, and including 11 years with Florida Medicaid. Ms. Kidder holds a Bachelor's Degree from the University of Florida and a Master of Public Policy Degree from Duke University.

Kimberly Smoak, QDDP, MSH has been with the Agency for Health Care Administration (Agency) for over 18 years. Currently, she is the Manager of the Survey & Certification Support Branch located in the Division of Health Quality Assurance (Division). As the Manager of the Survey & Certification Support Branch, she is responsible for monitoring quality improvement/quality assurance indicators for the Division, training of survey staff and other Division staff, data management and support functions. She provides technical assistance regarding programmatic issues and assists in interpreting rules, policies and standards.

Cheryl Young has worked with each of Florida's Medicaid home and community-based waiver programs in capacities with both the Agency for Health Care Administration and the Department of Elder Affairs (Department) since 2003. In 2008, Cheryl became the Department's Program Administrator for the Long-Term Care Community Diversion Program and was appointed Bureau Chief over Medicaid for the fee-for-service and managed care waiver programs and long-term care policy in 2011. Cheryl is the Department's lead representative to collaborate with the Agency regarding the implementation of Statewide Medicaid Managed Care.

February 5, 2014

**Radisson Resort
Orlando-Celebration**
2900 Parkway Boulevard
Kissimmee, FL 34747
(407) 396-7000

Room rate: \$99
Cut-off: January 15

Parking is complimentary

February 7, 2014

**Embassy Suites Hotel
USF/Busch Gardens**
3705 Spectrum Boulevard
Tampa, FL 33612
(813) 977-7066

Room rate: \$129 single
\$139 double

Cut-off: January 17

Parking is complimentary

February 25, 2014

Signature Grand
6900 State Road 84
Davie, FL 33317
(954) 424-4000 (directions
only)

Parking is complimentary

*Hotel reservations can be
made at the Holiday Inn
located at 2540 Davie
Road, Davie, FL 33317 by
calling (954) 585-7071.*

*Room Rate: 15% Discount
on published room rates
when you mention
Signature Grand Event*

February 28, 2014

**Tallahassee Automobile
Museum**
6800 Mahan Drive
Tallahassee, FL 32308
(850) 942-0137 (directions
only)

Parking is complimentary

*If you need suggestions
on hotel accommodations,
contact FHCA at
(850) 224-3907.*

Florida's Agency for Health Care Administration

2014 Joint Training for Assisted Living Facilities

Program Objectives:

After completion of this program, the attendee will be able to:

- describe the most up-to-date Medicaid Managed Care implementation processes;
- recognize the methods through which Florida's Medicaid Program will ensure quality services to individuals in Assisted Living Facilities;
- identify the major areas of deficiencies, including TB requirements, background screening and bed bugs, and methods for compliance;
- outline successful care practice strategies within Assisted Living Facility licenses;
- describe the unique issues that arise in contract negotiations between Assisted Living Facilities and Managed Care Organizations and the impact of resident rights; and
- summarize methods for successful regulatory compliance, requesting a quality review and adverse incident reporting.

Presenter Bios:

Beth Kidder is the Assistant Deputy Secretary for Medicaid Operations at the Agency for Health Care Administration. She oversees Medicaid policy development and quality initiatives. She has 15 years of experience working for state Medicaid programs, beginning in North Carolina and including 12 years with Florida Medicaid. Beth holds a Bachelor's Degree from the University of Florida and a Master of Public Policy Degree from Duke University.

Catherine Anne Avery, RN, LNC, earned her registered nursing degree in 1990, with specific clinical focus on critical care. Anne began her career as a registered nurse and case manager with Tallahassee Community Hospital. She was recruited by the Agency for Health Care Administration in 1999 and served as the nursing supervisor for the Panhandle. Anne joined the Office of the Attorney General's Medicaid Fraud Control Unit as a Medical Investigator in 2005 where she was involved with the Patient Abuse, Neglect, and Exploitation (PANE) program as well as assisting with Operation Spot Check. She served on the National Association of Medicaid Fraud Control Committee for "Best Practices in Investigation Patient Abuse and Neglect." In 2008, she became a certified Legal Nurse Consultant and has provided expert testimony in both Administrative and Criminal proceedings. In 2010, Anne returned to AHCA as a Registered Nurse Specialist for Health Quality Assurance and currently oversees the Statewide ALF Enforcement Team.

Cheryl Young has worked with each of Florida's Medicaid home and community-based waiver programs in capacities with both the Agency for Health Care Administration and the Department of Elder Affairs (Department) since 2003. In 2008, Cheryl became the Department's Program Administrator for the Long-Term Care Community Diversion Program and was appointed Bureau Chief over Medicaid for the fee-for-service and managed care waiver programs and long term care policy in 2011. Cheryl is the Department's lead representative to collaborate with the Agency regarding the implementation of Statewide Medicaid Managed Care.

Deborah Afasano, BSN, RNC, CDONA, HCRM, is a certified Director of Nurses, a certified end-of-life ELNEC trainer and a health care risk manager on faculty for the USF Health Care Risk Management Program. Her diverse nursing background spans over 30 years in acute and LTC settings. Debbie is currently the VP of Clinical Services for the Avante Group with skilled nursing and assisted living facilities in three states. She is a former governor appointee to the Florida Center for Nursing, and the founding and current chair of the FHCA Senior Clinicians' Council. Debbie is the 2011 recipient of the NADONA Spirit of Nursing Presidents Award and an inductee into the Sigma Theta Tau National Honor Society.

James M. "Chet" Barclay practices administrative and governmental law in Tallahassee, Florida, with Hayward Grant & Rumph, P.A., representing a wide variety of health care clients, including Assisted Living Facilities, with licensure, certification and sanction proceedings in administrative hearings. Recent activities include advising clients about strategic approaches to managed care contracting and private pay contractual situations. His practice includes a special emphasis on medical record privacy, security and breach notification under HIPAA. He speaks frequently to professional audiences about legal aspects of health care. An AV® rated attorney with more than 20 reported appellate Court opinions, Chet served as Chief Certificate of Need attorney for the State of Florida, general counsel of the Florida Hospital Cost Containment Board, general counsel to The Florida Patient Safety Corporation and as counsel to numerous corporate and individual healthcare clients and statewide healthcare associations. He is past chair of the Health Law Section of The Florida Bar and past president of the Florida Academy of Healthcare Attorneys.

Kimberly Smoak has been with the Agency for Health Care Administration for over 18 years. Currently, she is the Manager of the Survey & Certification Support Branch located in the Division of Health Quality Assurance. She is responsible for monitoring quality improvement/quality assurance indicators for the Division, training of survey staff and other Division staff, data management and support functions. She develops and implements strategies to improve consistency among the field offices and the program units as those functions relate to the Survey and Certification functions of the Agency under contract with the Federal Centers for Medicare and Medicaid Services (CMS), in addition to monitoring state requirements and timeframes. She provides technical assistance regarding programmatic issues and assists in interpreting rules, policies and standards.

Polly Weaver has over 25 years of regulatory experience and, since 1995, has served as the Chief of Field Operations for the Division of Health Quality Assurance, Agency for Health Care Administration. Her responsibilities include management of the eight Agency for Health Care Administration field offices located throughout Florida, overseeing the staff training and quality assurance program, as well as complaint administration activities.

Shevaun Harris is the Bureau Chief for Medicaid Services at the Agency for Health Care Administration. She has over 10 years of experience in the health and human services field, working with children and adults with HIV/AIDS, chronic conditions and behavioral health issues. She has worked at the Agency for Health Care Administration since 2005 and has held several progressively responsible positions. In her current role with the Agency, Shevaun is responsible for managing a staff of over 65 employees and responsible for the development, coordination and implementation of Medicaid program policies and procedures (with the exception of pharmacy services) and is responsible for the administration of the program's medical authorization functions. She received her Bachelor's degree in Psychology and a Master's degree in Social Work from Florida State University and most recently earned another Master's degree in Business Administration from Quinnipiac University.

Presentations and Descriptions:

8:45 to 9:45 a.m.	Medicaid Managed Care LTC Program Update for Assisted Living Facilities <i>Cheryl Young, DOEA; and Beth Kidder, AHCA (Orlando and Tallahassee) or Shevaun Harris (Tampa and Davie)</i>
Description:	AHCA and DOEA representatives will provide an update on implementation of the Statewide Medicaid Managed Care Long-term Care program and will discuss how Florida will ensure the system will provide quality services to ALFs.
10:00 a.m. to 12:00 p.m.	Top 10 Deficiencies and Major Regulatory Concerns – Including Tuberculosis Requirements, Background Screening and Bed Bugs <i>Polly Weaver and Catherine Anne Avery, AHCA</i>
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Description:	Successful care practices will be highlighted within the framework of a facility’s license, including more clinical care in ALFs with an ECC license and assistance with medication in facilities without a specialty license.
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Description:	Florida ALF providers have experienced an increase in the Agency’s Directed Plans of Correction and questions have been raised. The Agency’s enforcement spokesperson will answer



questions regarding incident reporting and explain the process for providers requesting a "Quality Review."

The Statewide Medicaid Managed Care Program & Assisted Living Facilities

Presented at the 2014 Joint Training for Nursing Facilities and Assisted Living Facilities

Beth Kidder/ Shevaun Harris
Agency for Health Care Administration

Cheryl Young
Department of Elder Affairs

Presentation Objectives

- Provide a refresher on Statewide Medicaid Managed Care Long-term Care program
- Discuss home and community-based characteristics requirements
- Provide updates on quality measures, statutory or contract provisions impacting assisted living facilities
- Introduce Statewide Medicaid Managed Care Managed Medical Assistance
- Ensure all attendees know how to get more information on the program

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Why are changes being made to Florida's Medicaid program?

- Because of the Statewide Medicaid Managed Care (SMMC) program, the Agency is changing how a majority of individuals receive most health care services from Florida Medicaid.

Statewide Medicaid Managed Care program

Long-term Care program
(implementation Aug. 2013 – March 2014)

Managed Medical Assistance program
(implementation May 2014 – August 2014)

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The SMMC program does not/is not:

- The program ***does not*** limit medically necessary services.
- The program ***is not*** linked to changes in the Medicare program and does not change Medicare benefits or choices.
- The program ***is not*** linked to National Health Care Reform, or the Affordable Care Act passed by the U.S. Congress.
 - It does not contain mandates for individuals to purchase insurance.
 - It does not contain mandates for employers to purchase insurance.
 - It does not expand Medicaid coverage or cost the state or federal government any additional money.

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Refresher on the Statewide Medicaid Managed Long-term Care (LTC) Program

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Who is Required to Participate?

Individuals who fit into one of the following categories may be eligible for the LTC program:

- 65 years of age or older ***AND*** need nursing facility level of care (LOC)*

OR

- 18 years of age or older ***AND*** are eligible for Medicaid by reason of a disability ***AND*** need nursing facility level of care.*

* Nursing facility level of care means that someone meets the medical eligibility criteria for Institutional Care Programs (ICP), as defined in Florida Statute.

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What Services are Covered?	
Adult companion care	Hospice
Adult day health care	Intermittent and skilled nursing
Assisted living services	Medical equipment and supplies
Assistive care services	Medication administration
Attendant care	Medication management
Behavioral management	Nursing facility
Care coordination/Case management	Nutritional assessment/Risk reduction
Caregiver training	Personal care
Home accessibility adaptation	Personal emergency response system (PERS)
Home-delivered meals	Respite care
Homemaker	Therapies, occupational, physical, respiratory, and speech
Transportation, non-emergency	

Each recipient will not receive all services listed. Recipients will work with a case manager to determine the services they need based on their condition.

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Selecting Long-term Care Plans

- AHCA selected Long-term Care plans through a competitive bid process.
- The state is divided into 11 regions that coincide with the existing Medicaid areas and the Department of Elder Affairs Planning and Service Areas.
- Plans will provide services by region:
 - Five year contracting period for LTC plans.
 - Penalties for plan withdrawals.

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Enrollment by Plan As of January 2014	
American Eldercare, Inc.	5,229
Amerigroup Florida, Inc.	4,921
Coventry Health Plan	3,503
Humana Medical Plan, Inc.	2,937
Molina Healthcare of Florida, Inc.	2,775
Sunshine State Health Plan	14,682
United Healthcare of Florida, Inc.	11,807
Total	49,384

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LTC Program Eligibility and Enrollment

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How Does Enrollment Begin?

There are two categories of recipients:

1. Recipients actively receiving Medicaid nursing facility (NF) services or Medicaid home and community based services (HCBS).
 - Active recipients will be transitioned into the LTC program.
2. New individuals seeking NF or HCBS.
 - Individuals seeking NF follow the same process as they do currently. There is no waitlist for NF services.

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Enrollment Process for Individuals Currently on the HCBS Waitlist

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- Individuals on the waitlist for A/DA, AL, or NHD waivers are being moved to a consolidated LTC program waitlist
- Once the LTC program starts in a region, AHCA will mail plan selection materials to individuals who have met the medical level of care criteria and who have filed an application for Medicaid financial eligibility.
 - This can only occur after being released from the HCBS waitlist managed by DOE.

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Enrollment of Individuals
Newly Seeking HCBS

- Individuals seeking home and community based services must contact the Aging and Disability Resource Center (ADRC)
- ADRC staff will conduct intake and screening:
 - Use screening form 701S
 - Place on waitlist
- When additional funding is available, new individuals may complete eligibility and enroll in the LTC program.

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Enrollment Process Following Release
from the Waitlist

- ADRC staff help the individual file Medicaid application with DCF for financial eligibility and obtain the physician-completed 3008 form.
- ADRC staff refer the case to CARES.
- CARES completes 701B assessment and authorizes level of care.
- DOEA sends daily list of approved individuals to AHCA to start LTC program enrollment.

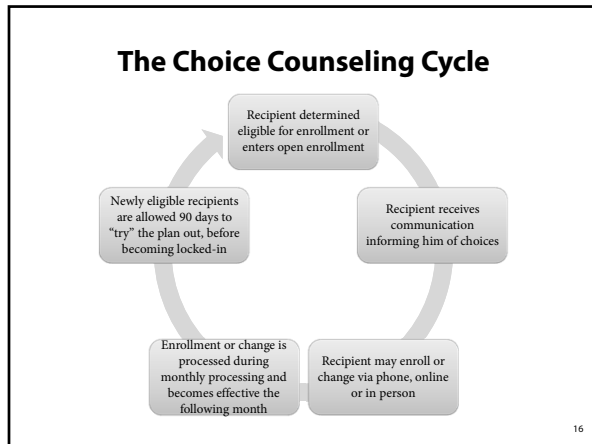
14

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Choice Counseling

- Choice counseling is a service offered by the Agency, through a contracted enrollment broker, to assist recipients in understanding:
 - managed care
 - available plan choices
 - plan differences
 - the enrollment and plan change process.
- Counseling is unbiased and objective.

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A Closer Look at the Choice Counseling Cycle

Individuals may enroll or change their plans using one of the following methods:

- Online at: www.flmedicaidmanagedcare.com
- By contacting the call center at **1-877-711-3662** and speaking with a counselor to complete enrollment or to request a face-to-face meeting.

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Helping your Residents Make Choices

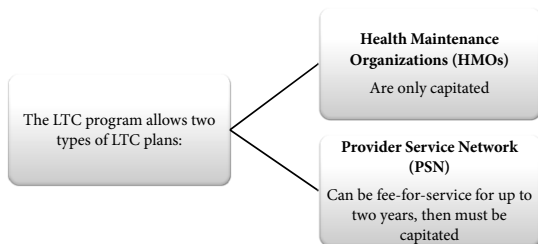
- When individuals call to make a managed care choice or change they must first be able to verify information about themselves to confirm their identity.
- If you are calling on behalf of your residents you must:
 - Have this identity information
 - Explain how you are authorized to make a choice or change on their behalf
 - Submit -proof of authorization after the choice is made.
 - An optional form is at <http://ahca.myflorida.com/smmc>
 - Select LTC tab, then Recipients tab

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Contracting with a Long-term Care Plan

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Two Types of Long-term Care Plans



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Differences in Types of LTC Plans

- Payment:
 - If the LTC plan is capitated, then network providers will be paid by the plan.
 - If the LTC plan is fee-for-service, then providers will be paid by the Agency after claims are submitted to the LTC plan for authorization.
- Network providers for a fee-for-service provider service network must be fully enrolled in Medicaid.

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Enrollment vs. Registration

- ALF providers that contract with the Provider Service Network (PSN) must be *fully enrolled* in Florida Medicaid.
- ALF providers that contract with HMOs must *register* with Medicaid.
- ALF providers currently enrolled in Medicaid simply share their Medicaid ID with the PSN or LTC plan.
- ALF providers not enrolled in Medicaid must submit a Florida Medicaid Provider Enrollment Application or registration.

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When Should I Have a Contract with a LTC or MMA Plan?

Assisted living facilities should contract **now** with the long-term care plans in their region.
ALFs may also need new or amended contracts to provide assistive care services for MMA.

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When Should I Have A Contract? (Continued)

- Recipients begin choosing LTC and MMA plans **two months before their region “go live” date**.
- Choice counselors use a list of contracted providers to help recipients choose a plan.
- To be on the list, ALFs must have an executed contract, and the contract must be verified by an automated system (PNV).
- Each plan’s provider contracting contacts are listed at <http://ahca.myflorida.com/SMMC>

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Other Important Information about the LTC Program

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Assistive Care Services

Medicaid Long-term Care Program Enrollees*

Funding: Medicaid Long-term Care Plan
Provided in-

- Adult Family Care Homes
- Assisted Living Facilities**

**Level of Care & enrollment required
**Assistive Care Services are rolled into Assisted Living Services and are no longer separate under the LTC program.*

Medicaid Recipients not in an LTC Plan

Funding: Medicaid State Plan or Managed Medical Assistance Plan
Provided in-

- Assisted Living Facilities
- Adult Family Care Homes
- Residential Treatment Facilities

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LTC Plan Case Managers

- Every person enrolled in LTC program has a case manager.
- Case manager contact requirements include:
 - At least monthly telephone contact with the resident to verify satisfaction and receipt of services
 - At least every 90 days, the case manager must meet with the recipient face-to-face:
 - Update the plan of care, if needed
 - Evaluate and document the home and community based characteristics for assisted living facility and adult family care home residents
 - Annual face-to-face visit with the enrollee to complete the annual reassessment and determine the enrollee's functional status, satisfaction with services, changes in service needs and develop a new plan of care.

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ALF Training

LTC plans must provide training to ALF staff that includes:

- Signs and symptoms of mental illness;
- Behavior management strategies;
- Identification of suicide risk and management;
- Verbal de-escalation strategies for aggressive behavior;
- Trauma informed care;
- Documentation and reporting of behavioral health concerns;
- Abuse, neglect, exploitation and adverse incident reporting

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Incentives to Shift to Community-Based Services & Recipient Safeguards

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Incentives Shift to Home & Community Based Care Services

- The law requires that managed care plan rates be adjusted annually to provide an incentive to shift services from nursing facilities to community based care.
- Payment incentives will be in place until no more than 35% of the plan's enrollees are in nursing facilities.

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Recipient Safeguards

- Recipients residing in a nursing facility can choose to remain in that facility, as long as they meet nursing facility level of care.
- Recipients residing in the community can choose to remain in the community, even if the LTC plan recommends a different placement.
- Recipients may choose any plan in their region.
- Recipients may choose any provider in their plan's network.

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Recipient Safeguards

- LTC plans will assess their enrollees in nursing facilities about the choice to transition to an assisted living facility, adult family care home, or other community living arrangement.
- Like the former Medicaid Nursing Home Transition Program, transition cannot occur prior to a continuous 60 day stay in the nursing facility.
- LTC plans will coordinate and track these transitions with the enrollees and the assisted living facilities in the LTC plan network. The LTC Plan will notify DCF of the date of nursing facility/ALF admission/discharge prior to the respective admission/discharge date.

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Successes & Issues

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Program Implementation

The overarching goals for the Long-term Care program implementation are:

1. Ensuring that enrollees have no break in services, and
 2. Ensuring skilled nursing facility and assisted living facility residents do not have to move to another facility.
- Both of these goals continue to be met for the implementation to date.
 - Transitioned waiver recipients are receiving services as outlined on their pre-transition care plans until the LTC plans complete the person-centered planning process, and residents of assisted living facilities and skilled nursing facilities have not had to move to another facility since the transition.

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Recipient's Address & Enrollment

- The basis of Medicaid recipient enrollment is the recipient's Residence County in the Florida Medicaid Management Information System (FMMIS).
- If the recipient's address is incorrect in the Medicaid system, the recipient must contact the agency that determined their eligibility.
- This would be either the Department of Children and Families (DCF) or the Social Security Administration (SSA).
 - The recipient will need to request both an address and county change.

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Recipient's Address & Enrollment

<http://ahca.myflorida.com/smmc>



If the recipient's address is correct in the Medicaid system, but his *county* is incorrect:

- Report it online at: <http://ahca.myflorida.com/smmc>
- Select the blue "Report a Complaint" button.
- AHCA will work with DCF or SSA to resolve the issue and correct the person's enrollment.

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Quality Measures for Assisted Living Facilities

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Quality Measures for Assisted Living Facilities

- *Each managed care plan shall monitor the quality and performance of each participating provider using measures adopted by and collected by the agency and any additional measures mutually agreed upon by the provider and the plan.*

-s. 409.982(3), Florida Statutes

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Quality Measures for Assisted Living Facilities

- LTC plans must offer a contract to any ALF that was billing for Medicaid Waiver services as of July 2012.
- After the first year of contract, LTC plans can exclude ALFs for not meeting credentials, price, quality or performance standards.

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Home & Community-Based Characteristics and ALFs

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Centers for Medicare and Medicaid Services Final Rule

- Requires providers (ALFs and AFCHs) that serve Medicaid recipients in the community maintain home and community-based characteristics, which includes person-centered services and a home-like environment
- Final rule announced January 10, 2014:
 “The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living.”
- The rule is available at: <http://www.medicaid.gov/HCBS>.

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Programs Affected

- All Medicaid waiver programs providing services in Assisted Living Facilities and Adult Family Care Homes are expected to provide a home-like environment and community integration to the fullest extent possible:
 - Long-term Care program
 - Program of All-inclusive Care for the Elderly (PACE)
 - Nursing Home Diversion Waiver (ends 2/28/14)
 - Assisted Living Waiver (ends 2/28/14)
 - Aged/Disabled Adult Waiver (Facility-based Respite) (ends 2/28/14)
 - Any other Medicaid waiver program that offers services in ALFs or AFCHs.

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Characteristics of a Home-Like Environment

- Each resident must be assured privacy in sleeping and personal living areas:
 - Entrance doors must have locks, with appropriate staff having keys to the doors
 - Freedom to furnish and/or decorate sleeping or personal living areas
 - Choice of private or semi-private rooms
 - Choice of roommate for semi-private rooms
 - Access to telephone service as well as length of use
 - Freedom to engage in private communications at any time

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Characteristics of a Home-Like Environment (continued)

- Freedom to control daily schedule and activities (physical and mental conditions permitting)
- Visitation options of the resident's choosing
- Access to food and preparation areas in the facility at any time (physical and mental conditions permitting)
- Personal sleeping schedule
- Participation in facility and community activities of the resident's choice
- Ensuring that residents are allowed to participate in unscheduled activities of their choosing

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Community Integration

- Access to the greater community is facilitated by the ALF or AFCH based on the resident's abilities, needs and preferences
- The ALF or AFCH setting must offer meaningful community participation opportunities for their residents at times, frequencies and with persons of their choosing
 - **Example:** The resident wishes to visit the senior center to participate in social activities
 - **Barrier:** The resident does not have access to transportation
 - **Intervention:** The case manager works with the ALF or AFCH to ensure that transportation, such as Dial-a-Ride, is available to transport the resident to and from the senior center and to ensure that the resident is dressed and ready to depart

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Person-Centered Care Planning

- Creation of a individualized and inclusive person-centered plan of care that addresses services, supports, and goals based on the resident's preferences
- The person-centered plan of care is based on a comprehensive assessment that includes the resident and participation by any other individuals chosen by the resident
- The plan of care must support the resident's needs in the most integrated community setting possible
- The waiver recipient's plan of care must include personal preferences, choices, and goals to achieve personal outcomes

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Personal Goals

- Examples of personal goals a resident may choose:
 - Deciding where and with whom to live
 - Making decisions regarding supports and services
 - Choosing which activities are important
 - Maintaining relationships with family and friends
 - Deciding how to spend each day

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Promoting a Home-Like Environment

- All ALFs/AFCHs participating in SMMC LTC must meet these requirements before the first date of enrollment in region.
- LTC plans must verify during the credentialing and re-credentialing process that home-like environment and community integration exist in all facilities under contract.
- DOEA staff completed on-site reviews in 2013 of a sample of ALFs by region to ensure a home-like environment.

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Remediation

- If a LTC plan discovers that an ALF/AFCH is not maintaining a home-like environment or supporting full community integration, it must:
 - Report that finding to the State immediately
 - Propose a remediation plan within three business days of discovery
- AHCA and DOEA will ensure the LTC plans contract only with ALFs/AFCHs providing and supporting a home-like environment and community integration.

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HCB Characteristics – Ongoing Monitoring

- The LTC plans will conduct re-credentialing activities and on-going on-site verification to ensure that home and community based characteristics exist in their contracted facilities.
- DOEA compliance staff will:
 - Conduct annual reviews of the LTC plans' credentialing files.
 - Review a representative sample, organized by region, of current enrollee files of each LTC plan.
 - Conduct on-site visits with enrollees in ALFs and AFCHs.
- If DOEA staff determine that an enrollee is residing in an environment that meets HCB characteristics, the State will follow up with the LTC plan within 24 hours.
 - LTC plans will remediate the deficiencies and submit a corrective action plan to the State within 15 business days.

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Disenrollment Reason

- ALFs or AFCHs that do not and will not conform to HCB characteristics, must be disenrolled from the LTC plan's network.
- Enrollees may choose to move to another ALF or AFCH in the plan's network.
- Enrollees who choose to stay in an ALF/AFCH that does not meet HCB characteristics will be disenrolled from the LTC program.

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Introduction to Managed Medical Assistance (MMA) Program

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Who MAY participate?

- The following individuals may choose to enroll in program:
 - Individuals who have other creditable health care coverage, excluding Medicare;
 - Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;
 - Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID); and
 - Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients.

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Who is Excluded from participating?

- Women who are eligible only for family planning services
- Women who are eligible only for breast and cervical cancer services
- Persons who are eligible for emergency Medicaid for aliens
- Children receiving services in a prescribed pediatric extended care center

54

Managed Medical Assistance Services

Minimum Required Covered Services: Managed Medical Assistance Plans	
Advanced registered nurse practitioner services	Laboratory and imaging services
Ambulatory surgical treatment center services	Medical supplies, equipment, prostheses and orthoses
Assistive care services	Mental health services
Birthright center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Physician services, including physician assistant services
Family planning services and supplies (some exception)	Podiatric services
Healthy Start Services (some exception)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services

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Where will recipients receive services?

- Several types of health plans will offer services through the MMA program:
 - Standard Health Plan
 - Health Maintenance Organizations (HMOs)
 - Provider Service Networks (PSNs)
 - Specialty Plans
 - Comprehensive Plans
 - Children's Medical Services Network
- Health plans were selected through a competitive bid for each of 11 regions of the state.

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Non-standard Health Plans

- Specialty Plan
 - A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.
- Comprehensive Plan
 - Comprehensive plans are managed care plans that offer both Long-term Care and Acute Care services.
- Children's Medical Services Network
 - Children's Medical Services is the statewide managed care plan for children with special healthcare needs.

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Managed Medical Assistance Program Implementation

- The Agency has selected 14 companies to serve as general, non-specialty MMA plans.
- Five different companies were selected to provide specialty plans that will serve populations with a distinct diagnosis or chronic condition; these plans are tailored to meet the specific needs of the specialty population.
- The selected health plans are contracted with the Agency to provide services for 5 years.

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Managed Medical Assistance Program Roll Out Schedule

Implementation Schedule	
Regions	Enrollment Date
2, 3 and 4	May 1, 2014
5, 6 and 8	June 1, 2014
10 and 11	July 1, 2014
1, 7 and 9	August 1, 2014

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What providers will be included in the MMA plans?

- Plans must have a sufficient provider network to serve the needs of their plan enrollees, as determined by the State.
- Managed Medical Assistance plans may limit the providers in their networks based on credentials, quality indicators, and price.

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Assistive Care Services under the MMA Program

- Under MMA , plans must provide assistive care services as detailed in the Medicaid Assistive Care Services Coverage and Limitations Handbook.
- Unlike in the LTC program, MMA plans pay for an enrollee's assistive care services separately from any payments made to the assisted living facility. (Note: In the LTC program, assistive care services payments may only be made for recipients in an adult family care home.)
- If an enrollee is only enrolled in the MMA program and receives assistive care services, the MMA plan covers and pays for the service.
- If an enrollee is enrolled in a Comprehensive LTC plan and is receiving both LTC and MMA services and receives assistive care services, the Comprehensive LTC plan covers and pays for the assistive care services.
- If an enrollee is enrolled in non-comprehensive plan and is receiving services from a LTC plan and an MMA plan, the LTC plan covers and pays for the assistive care services.

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Resources

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Keep up to date on information by signing up to receive program updates by visiting the SMMC website at:
<http://ahca.myflorida.com/smmc>

Florida Medicaid



Would you like to receive email updates about this program?

Sign up by entering your information below.

• Email

First Name

Last Name

- = Required Field

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Stay Informed



- Participate in webinars regarding implementation activities.
- The direct link to the webinars is:
<http://ahca.myflorida.com/LTCwebinars>

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Review the SMMC
Frequently Asked
Questions document
which is posted at:

<http://ahca.myflorida.com/smmc>

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Updates about the SMMC program and upcoming events
and news can be found on the SMMC website at:
<http://ahca.myflorida.com/smmc>

Florida Medicaid



Home News and Events Long-term Care Managed Medical Assistance Federal Authorities

Statewide Medicaid Managed Care Program

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance program and the Long-term Care program.

Choose a tab above to view guidance statements and specific information regarding the Long-term Care and Managed Medical Assistance programs.

Program Updates

Report a Complaint

Frequently Asked Questions

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Use "Report A Complaint" to submit issues. These can be requests for help from local AHCA staff or anonymous complaints.

Florida Medicaid

Home News and Events Long-term Care Managed Medical Assistance Federal Authorities

Statewide Medicaid Managed Care Program

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance program and the Long-term Care program.

Choose a tab above to view guidance statements and specific information regarding the Long-term Care and Managed Medical Assistance programs.

Program Updates

Report a Complaint

Frequently Asked Questions

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Search/ Create <http://ahca.myflorida.com/smmc>

Florida Statewide Medicaid Managed Care Program Complaint Reporting

If you have a complaint about Medicaid Managed Care services, please complete the information below.

Required Info:
For each complaint, please provide:
Your name:
Your email:
Your phone number:
Your address:

Who is the complaint about?
Name of officer/contractor:
Last name, first, or middle initial:
County:

What type of Medicaid Managed Care Program is the complaint about?
What is the name of the Managed Care Plan?
What should best describe the issue?
(Please describe)
Is assistance requested?

Under Florida law, a child who is a public benefit. If you do not want your child's name to appear in a public records report, do not send electronic mail to this entity. Instead, contact the local law enforcement agency or the state attorney in writing. If you need assistance completing this form or wish to report your issue, please contact your local Area Office. Please number of form 1000-0000

Report a Complaint

- If you have a complaint, or issue about Medicaid Managed Care services, please complete the online form found at: <http://ahca.myflorida.com/smmc>
- Click on the "Report a Complaint" blue button.
- If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office.
- Find contact information for the Medicaid area offices at: <http://www.mymedicaid-florida.com/>

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Stay Connected



[Youtube.com/AHCAFlorida](https://www.youtube.com/AHCAFlorida)



[Facebook.com/AHCAFlorida](https://www.facebook.com/AHCAFlorida)



[Twitter.com/AHCA_FL](https://twitter.com/AHCA_FL)




[SlideShare.net/AHCAFlorida](https://www.slideshare.net/AHCAFlorida)

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Agency for Health Care Administration **Joint Training** **Assisted Living Facility** **2014**


Catherine Anne Avery, RN LNC
 Bureau of Field Operations
 Survey & Certification Support Branch



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Objectives


- Review Top 10 ALF deficiencies during calendar year 2013
- Review of Directed Plans of Correction
- Discuss major regulatory concerns- Tuberculosis requirements
- Review background screening
- Discuss bed bugs infestations in ALFs



2


Top 10 ALF Deficiencies As of January 3, 2014

Rank	Tag	Count	Description
1	A0030	581	Resident Care - Rights & Facility Procedures (58A-5.0182(6) F.A.C.; 429.28 F.S.)
2	A0078	435	Staffing Standards - Staff (58A-5.019(2) F.A.C.)
3	A0052	367	Medication - Assistance With Self-Admin (58A-5.0185(3) F.A.C.)
4	A0025	336	Resident Care - Supervision (58A-5.0182(1) F.A.C.)
5	A0081	329	Training - Staff In-Service (58A-5.0191(2) F.A.C.)
6	A0093	308	Food Service - Dietary Standards (58A-5.020(2) F.A.C.)
7	A0008	292	Admissions - Health Assessment (58A-5.0181(2) F.A.C.)
8	A0055	282	Medication - Storage And Disposal (58A-5.0185(6) F.A.C.)
9	A0152	273	Physical Plant - Safe Living Environ/Other (58A-5.023(3) F.A.C.)
10	A0054	266	Medication - Records (58A-5.0185(5) F.A.C.)



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Top Class 1 Deficiencies				
As of January 16, 2014				
Rank	Tag	Deficiency Count	Facility Count	Description
1	A0030	13	13	Resident Care - Rights & Facility Procedures (58A-5.0182(6) FAC; 429.28 FS)
2	A0025	8	8	Resident Care - Supervision (58A-5.0182(1) FAC)
3	A0077	5	5	Staffing Standards - Administrators (58A-5.019(1) FAC)
4	A0152	4	4	Physical Plant - Safe Living Environ/Other (58A-5.023(3) FAC)
5	A0053	2	2	Medication - Administration (58A-5.0185(4) FAC)
6	A0079	2	2	Staffing Standards - Levels (58A-5.019(4) FAC)
7	A0010	1	1	Admissions - Continued Residency (58A-5.0181(4) FAC)
8	A0032	1	1	Resident Care - Elopement Standards (58A-5.0182(8) FAC)



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Directed Plans of Correction


- Used to address Class I and Class II deficiencies which require immediate action to alleviate ongoing deficient practice
- Help improve services and assist providers in attaining compliance



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Directed Plans of Correction

- Not intended as a sole intervention by a provider
- Intended to impose directed interventions to address immediate concerns with identified deficient practice
- Provider must still complete and implement a plan of correction



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Directed Plans of Correction Process

Top 10 Recited Deficiencies

Top 10 Complaint Citations				
As of January 16, 2014				
Rank	Tag	Deficiency Count	Facility Count	Description
1	A0030	449	229	Resident Care - Rights & Facility Procedures (58A-5.0182(6) FAC; 429.28 FS)
2	A0025	385	204	Resident Care - Supervision (58A-5.0182(1) FAC)
3	A0152	205	104	Physical Plant - Safe Living Environ/Other (58A-5.023(3) FAC)
4	A0052	186	103	Medication - Assistance With Self-Admin (58A-5.0185(3) FAC)
5	A0054	177	93	Medication - Records (58A-5.0185(5) FAC)
6	A0165	168	92	Risk Mgmt & Qa; Adverse Incident Report (429.23 FS; 58A-5.0241 FAC)
7	A0078	159	82	Staffing Standards - Staff (58A-5.019(2) FAC)
8	A2815	155	84	Background Screening; Prohibited Offenses (408.809, 435.02(2), 435.06, FS)
9	A0008	150	89	Admissions - Health Assessment (58A-5.0181(2) FAC)
10	A0079	147	87	Staffing Standards - Levels (58A-5.019(4) FAC)



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Complaint Investigation Process

- Complaint allegations are received by the Complaint Administration Unit (CAU)
- Reviewed for jurisdiction and prioritized
- CAU forwards complaint to the Field Office and is assigned to a qualified surveyor(s) for investigation



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Complaint Investigation Process

- Surveyor(s) follow a prescribed complaint investigational process as outlined the in AHCA Complaint Manual
- Develop a investigational plan
- Conduct the complaint survey and determine if substantiated or not, and if any deficient practices
- May utilize photographic evidence protocol
- Refer to other agencies or entities with jurisdiction as necessary (i.e. DCF, DOH, LE, Building Code, Fire Dept., Medicaid)



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Tuberculosis Requirements

Resident Requirements

- Be free from signs and symptoms of any communicable disease
 - This is accomplished by the face to face examination by the Health Care Provider
 - 60 days prior to admission or up to 30 days after admission
- Documented on the Health Assessment (AHCA form 1823)



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Tuberculosis Requirements

- Health Assessment (AHCA 1823) must be conducted every 3 years after initial assessment or after a significant change
- Significant change is defined as: A sudden or major shift in behavior or mood, or a deterioration in health status such as unplanned weight change, stroke, heart condition, or stage 2, 3, or 4 pressure sore



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Tuberculosis Requirements

Staff Requirements

- Newly hired staff have 30 days to submit a statement from a health care provider, based on an examination conducted within the last 6 months
- The statement should reflect the person does not have any signs or symptoms of a communicable disease including tuberculosis



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Tuberculosis Requirements

- Freedom from tuberculosis must be documented on an annual basis
 - The regulation does not specify a particular method for making this determination
 - The practitioner making this determination must operate within their scope of practice
- A person with positive tuberculosis test must submit a health care provider's statement that the person does not constitute a risk of communicating tuberculosis



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Tuberculosis Requirements

- If any staff member is later found to have or is suspected of having a communicable disease, he/she shall be removed from duties until the administrator determines that such condition no longer exists
- Personnel records should contain verification of freedom from communicable disease including tuberculosis



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Background Screening Care Provider Background Screening Clearinghouse

- Provides a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and disabled individuals.
- Allows the results of criminal history checks to be shared among specified agencies when a person has applied to volunteer, be employed, be licensed, or enter into a contract that requires a state and national fingerprint-based criminal history check.



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Background Screening Clearinghouse

Seven state agencies will participate in the Clearinghouse

- Agency for Health Care Administration (AHCA)
- Department of Health (DOH)
- Department of Children and Families (DCF)
- Department of Juvenile Justice (DJJ)
- Department of Elder affairs (DOEA)
- Agency for Persons with Disabilities (APD)
- Vocational Rehabilitation (DOE-VR)

- To be entered into the Clearinghouse a person screened must:
 - Undergo Level 2 screening and have finger prints retained by FDLE, and
 - Have a photograph taken at the time of screening, and
 - Sign a privacy policy



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Benefits of the Clearinghouse

- Allows the results of criminal history checks to be shared among specified state agencies, thereby reducing duplicative screenings for individuals requiring screening across multiple state agencies.
- Applicants will now have their fingerprints retained for five years
 - The retention of fingerprints enables a provider to be notified of an arrest of their employee as soon as the information is reported to the Agency by FDLE.
 - The retention of fingerprints will also provide a cost savings for those employees that are in the Clearinghouse but have had a lapse in employment greater than 90 days. After a 90 day lapse in employment, these applicants would only be required to pay for a new national criminal history check (currently \$16.50).



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Employee Roster

According to section 435.12(2)(c), F.S., an employer of persons subject to screening by a specified agency must register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.

- You must add an employee to your employee roster to receive arrest and criminal registration notifications. Please remember, per section 435.06(2)(b), F.S., if an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any vulnerable person that places the employee in a role that requires background screening.
- Even though the requirement is only for employees/contractors with a Clearinghouse screening, it is highly recommended that ALL employees/contractors are added to the employee roster. By doing so the provider will receive email notifications of employment status changes for all employees.



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How do I, as a provider, ensure I am receiving all of the benefits of the Clearinghouse

Initiating screenings through the website is now required per section 59A-35.090(2)(a), Florida Administrative Code (F.A.C.).

- During the initiation process, you will be seamlessly connected with approved *Livescan* service providers, so that you may enter applicant information, as well as schedule and pay for appointments through one system.

By initiating the screening through our website you will:

- Enter applicant demographic information once (no need to use both the Clearinghouse and a service provider website)
- Reduce duplicative/unnecessary screenings costs
 - The first step to initiate a screening requires you to search the database for an existing screening. By checking for an existing screening first, you will be able to use the existing screening, thereby reducing your screening costs.



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Initiating Screenings Through The Website Continued

- Receive a Florida criminal history report
 - Initiating providers will receive a public record of the applicant's Florida criminal history report.
- Be able to track a screening through the entire screening process and receive email notifications
 - You will be able to see a status at each stage of the screening process, including Fingerprints Submitted, Fingerprints Received from FDLE, Fingerprints Rejected, Fingerprints Rejected 2nd – NCO requested, etc.
 - Each time an applicant's status is updated, you will receive an email notification, reducing the time needed to search the system for updates.
- Screenings in process and screening results will be displayed on their own page, reducing the need to search the entire database.



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Clearinghouse Statistics

- From January 1, 2013 to December 31, 2013:
 - 2,154 individuals arrested AFTER they were screened (rap backs)
 - 660 individuals went from Eligible to Not Eligible for offenses including:
 - Grand Theft
 - Battery and Assault
 - Sex Offenses
 - Exploitation of the Elderly



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Bed Bug in Residential Settings

- In recognition of the growing problem of bed bugs in Florida residential settings, a workgroup was developed to study the issue and make recommendations
- The group was comprised of staff from Dept. of Health, Dept. of Agriculture, University of Florida, and the AHCA
- June 2013 Best Practices for ALFs was released



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Bed Bug Infestations

WHAT ARE BED BUGS?

The common bed bugs (*Cimex Lectorious*) are nocturnal small insects that feed on both animal and human blood that have been long known to be a public health pest. Bed bug bites cause itchy bites and are generally irritating to their human hosts. Bed bugs have been living among humans for hundreds of years however they were eradicated back in the 1950's.



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Bed Bug Infestations

WHAT ARE BED BUGS?

Bed Bugs showed resistance to some pesticides widely used in the past and that are no longer available. In the 1990's bed bugs began to re-merge worldwide due to an increase in international travel and commerce, lack of knowledge about preventing infestation, increase resistance to pesticides, and ineffective pest control practices.



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Bed Bug Life Cycle

Bed Bugs have a Cryptic lifestyle (meaning they spend the majority of their time hiding together in cracks and crevices where they will not be seen or disturbed). Bed bugs are attracted to CO₂ and body. Usually they aggregate near their host (i.e. beds, bed frames, head boards, and in clutter under beds).

Bed Bug Identification


- The first and most cost effective method of inspection is training any and all ALFs staff members to be able to recognize Bed Bugs activity.
- Encourage ALFs staff to be aware each time they are in a room of these signs.
- If ALFs staff identify Bed Bugs presence they should immediately notify Management for further instructions

Bed Bugs Signs and Symptoms

- Bites on residents or guests.
- Blood spots and smears on linens and mattresses.
- Blood spots and smears on walls and ceilings.
- Brown fecal stains on linens, walls, corners and ceilings.
- Cast/shed skins
- Look for Bed Bugs infestations at the following possible Bed Bugs harborage locations.
- Mattress, box Spring, bed frame and headboard.
- Baseboards around bedding and nightstands
- Couches, chairs
- Corner walls, ceilings
- Durable medical equipment (wheelchairs and blood pressure equipment)

Bed Bug Treatment

- Limit room access and anything removed should be sealed in plastic
- Contact a Licensed Pest Control company who can perform an thorough inspection and explain the treatment options
- The actual treatment scheduling date and due date and time for preparations to be completed
- A request to make arrangement for people and any living things (i.e. plants and pets) to be off the ALF during the bed bug treatment. There should be an Intake plan in place if you are moving people from one facility to another facility

Better Health Care for All Floridians
AHCA.org/Florida.com

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Bed Bug Treatment continued

- Laundering instructions- Wash and dry all clothes in dresser drawers and closets, curtains linens, pillow cases, comforters, and towels for 30 minutes minimum. Placing all clean clothing in trash bags, air tight containers or garment protectors and leave in center of room or in bathtub.
- Vacuuming instructions- Inspect and vacuum all items thoroughly- Vacuum mattresses, box springs, floors, sofas, cushions, etc.


Better Health Care for All Floridians
AHCA.org/Florida.com

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Contact Information

ahca.myflorida.com (“contact us”)

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Better Health Care for All Floridians
AHCA.org/Florida.com

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*Mobilizing Operational and Clinical
Excellence*

**The ALF Leaders Role In
Quality...
No Place Like Home?**



*Debbie Ayasano
VP of Clinical Services
Aurora Group*

Objectives

- Identify strategies to incorporate quality assurance and performance improvement
- Discuss the Leaders Role in Quality, Quality Assurance and Improvement, Mobilizing Operational and Clinical Excellence and creating quality in the resident's home
- Review possible Performance Improvement Plan (PIP) opportunities and related tools and resources

**Be- Aware of Residents Facing Loss...
In The Tornado of Their Life**



- The resident who fell in her garden and broke a hip, rehabbed at the SNF and now needs more assistance
- The recently widowed grandfather who has limited vision, cannot drive, and now needs AL placement
- The former teacher with early dementia who wandered from her home and needs more supervision
- The new Resident in Room 302 has a story and The need to find a New HOME

Quality = Different Things



Use Your Heart



- To address transitional loss
- To explore systems of care
- To put the care in Caring for others

Have Courage

- To be the voice
- The advocate
- The hope



We Have Brains to Ask

Ask: Are We Survey Ready?

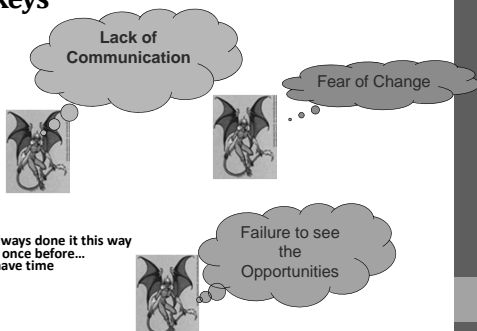
- Individually based care decisions
- Person Centered Systems
- Nothing is forever attitude
- Abreast of new standards, staff/resident needs, and/or new requirements –
- Vested in quality



And to Know There's No Place Like The Homes We Create



Quality Thinking Attacks The Flying Monkeys



The Messages

- *Instill an attitude that places elders and caregivers at the heart of all decisions, and at the heart of the home*



Quality Requires

**Employee and
Customer
Involvement**



Resident Well Being

- Understand the nature of the client condition
- Know capabilities, performance patterns and problems
- Listen...How does the team observe, talk with, and discuss the needs of each client?
- Tour with new eyes:
 - Appearance
 - Comfort
 - Affect/Behavior
 - Staff Interactions
 - Responsiveness?
 - Appropriate level of assistance?



•

Acknowledge Universal Themes

- Privacy
- Comfort
- Personalization of goals
- Part of community
- Being needed
- Being seen and heard



Know Your Staff

- Staffing strengths and weaknesses
- Identify staff training needs
- (Dignity, resident communication, effective care planning)
- QAPI to identify opportunities



Quality Requires



**Buy In
And Leadership**

Quality Begins Before the Admission

Promote Safe Transitions

- Resident Health Assessment 1823 new update on website
- Living arrangement before admission
- Identifying and planning for the trigger(s) for the move in
- Director of Marketing has to know and respect capabilities of the ALF

Physical, Mental, Social needs is a QUALITY focus



What Makes a Good or Bad Admission?

Prior Level of Function

Goals of Care



Third Party Contacts

Admission Preparedness

- Describe how and to what extent the facility offers or arranges to offer the following:
- Nursing services
- Personal care services
- Pharmacy services
- Medication administration or assistance
- Primary care clinician services
- Diagnostic testing
- Social and psychology services
- Therapies

Admission Vulnerabilities

- The first 72 hours
- The person who is a repeat faller or declining without changes to the plan
- The elopement risk
- The med error, missing med, wrong med
- The person in pain
- The facility acquired pressure ulcer
- The unhappy family or client
- The employee that does not know or follow policy
- Failure to sustain survey oversight and corrections
- Failure to sustain processes and systems

How will you know?

Engaging Partners

- Safe Transitions require two or more partners
- How do you get the right information?
- Verify contact information; Make contact!
- Suggest periodic reviews with partners
- What (Handoffs, missing information, medication reconciliation, pain management, advanced directives and care planning at transfer?)

Quality Elements From QAPI

- Establish a climate of open communication and respect : Make quality a priority across the continuum
- Have an open-door policy to communicate and knock on partners doors!
- Emphasize communication across shifts and between department heads and with external partners.
- Create an environment (s) where people feel free to bring quality concerns forward without fear of reprisal

Element 2: Governance and Leadership

- The administration of the assisted living facility develops a culture that involves leadership
- Seeks input from facility staff, clients/residents, and families and/or representatives. (Who, what, when, where, how?)
- Ensures staff time, equipment, and technical training as needed
- Quality improvement is a priority and ensures staff accountability
- Accountability sustains the gains and keeps it going!

What Do We Do? Assisted Living Capabilities

1. Assistance with
 - a) Medications
 - b) Bathing
 - c) Dressing
 - d) Bathroom needs
 - e) Transferring
 - f) Eating
2. Dementia care (or other specialty)
3. 24 hour care (not nursing) and supervision
4. Social services
5. Recreational activities
6. Meals and snacks
7. Transportation
8. Housekeeping and Laundry

Transitional Care and Comfort

How do procedures and staffing training affect the experience?

Planned transfer

- Comfort level
- Records
- Medications
- Communication with stakeholders
- Unplanned transfer
 - Comfort level; staff control
 - Records, including DNRO preferences
 - Medications
 - Communication with stakeholders

Advance information will promote readiness, and help alleviate patient/family anxiety about the transfer.

Improving the Patient, Resident and Family Experience

MISSION PROCESS

1. All new residents will receive a warm welcome. A member of the management team meets the resident at the front door and escorts the resident to their new room
2. Members of the care staff introduce themselves to the new resident
3. All members of the management team meet the new resident within the first 72 hours of admission
4. Have a family meeting within 72 hours of admission to discuss progress and concerns. This provides the family and the resident a time to talk about their goals or outcome of their stay.
5. Administrator calls family members the next business day after admission
6. Resident handbook or welcome note with pictures of management team, with contact information to include cell phone and email address
7. Ensure resident room is set up correctly with correct equipment two hours prior to admission
8. Encourage family members to bring things from home to comfort the resident
9. Be realistic in goal setting with the resident
10. At the time of admission and at each care plan there is discussion regarding the resident's goal for returning to home or other non-institutional living.
11. Advance directives and advance care planning is discussed with the resident/family/guardian

Element 3: Feedback, Data Systems and Monitoring

- Systems to monitor care and services, knowing where to get the data you want to figure out if you're meeting your goal
- Feedback systems – what's this?
- Performance Indicators – start small
- Benchmarks
- Tracking, investigating, and monitoring
- Action plans implemented

Quality is Rooted in Knowledge



Continual
Learning

Care Planning

Suggested actions:

- Meet new resident/family ASAP post admission
- Verify decision making, update face sheets as part of care planning
- Reinforce: The advance care planning process is an integral aspect of the facility's comprehensive care planning process.

Assure re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition.

Daily Quality Information

Indicator Sources

- Rounds
- Incidents
- Business Office
- HR
- Maintenance
- Dining Services
- Activities
- SS
- Clinical
- Change in condition or changes in independence in ADLs
- Therapy
- Medication Management



EARLY WARNING TOOL Assisted Living "Stop and Watch"

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the nurse/supervisor before the end of your shift.

Name of Resident _____

Seems different than usual
Talks or communicates less than usual
Overall needs more help than usual
Participated in activities less than usual

Ate less than usual (Not because of dislike of food)
N
Drank less than usual

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Staff _____
Reported to _____

Date ____/____/____ Time _____

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Resources: Advancing Excellence



Change Ideas Board: Consistent Assignment

Page 1 of 4

Integration- Element 3



Describe how your staff will become and remain proficient with process improvement tools and techniques related to their level of proficiency regarding SAFE TRANSITIONS OF CARE?

- Example: Establish monthly staff meetings at set times for all shifts.
 - Include Quality time on each meeting agenda, involve direct staff in care updates
- Stop and Watch Medication Oversight

Element 4: Performance Improvement Projects (PIPs)

- A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide



Start Small to Get the Quality Picture

- Satisfaction of meals
- Cleanliness of rooms
- Activities



QAPI Facilitates PIP's (Performance Improvement Plans) FOCUS

- Find a process to improve
- Organize a team that knows the process
- Clarify the current knowledge of the process
- Understand causes of process variation
- Select the process improvement: Your PIP!



What keeps you up at night?

Medication errors in assisted living facilities (ALFs) in one study: More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).

Medication errors alone, occurring either in or out of the hospital, are estimated to account for 7,000 deaths annually.

Adverse drug events cause more than 770,000 injuries and deaths each year and cost up to \$5.6 million per hospital.

Wrong time (71.3 percent)
Omission of dose (12.2 percent)
Unauthorized dose (1.4 percent)
Wrong dose (11.3 percent)
Wrong drug (0.2 percent)

Recognize Bad Orders

- Recognize the need to obtain clarification of “as needed” prescription order;
- Recognize a medication order which requires judgment or discretion, and to advise the resident, resident’s health care provider or facility employer of inability to assist in the administration of such orders;
-

Stop and Watch For Changes

- “If facility staff note deviations which could reasonably be attributed to the improper self- administration of medication, staff shall consult with the resident concerning any problems the resident may be experiencing with the medications; and the need to permit the facility to aid the resident through the use of a pill organizer, provide assistance with self-administration of medications, or administer medications if such services are offered by the facility.”
- How do you comply and ensure this occurs?
- The facility shall contact the resident’s health care provider when observable health care changes occur that may be attributed to the resident’s medications. The facility shall document such contacts in the resident’s records.

Stop and Watch Early Warning Tool

INTERACT
Version 3.0.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

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H**

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less
Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Name of Resident _____

Your Name _____

Reported to _____

Date and Time (am/pm) _____

Nurse Response _____

Date and Time (am/pm) _____

Nurse's Name _____

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Medication and Self Administration A PIP?

- Supervision or assistance with self-administration of medications is a key element of the personal services provided by assisted living facilities (ALFs).
- In Florida, a Standard, Extended Congregate Care (ECC), Limited Nursing Services (LNS), or Limited Mental Health (LMH) license allows a facility to provide this service.
- How do you monitor for compliance or changing needs?

Competency: a PIP?

- Training shall include demonstrations of proper techniques
When does this occur? How are trends evaluated?
- Hands on learning through practice exercises.
- Training by a registered nurse or licensed pharmacist (Address problematic observations timely)
- Read and understand a prescription label; (Cart to card checks?)
 - Assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms;(Technique)
 - Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;

Competency

- Complete a medication observation record; (How are they audited)
- Retrieve and store medication; (Proper storage, who checks) and
- Recognize the general signs of adverse reactions to medications and report such reactions.
- Unlicensed persons, as defined in Section 429.256(1) (b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility which must also be provided by a licensed registered nurse or a licensed pharmacist.

PIP Around Quality Expectations?

- Retrieve, store, and dispose of medication properly;
- Recognize a medication order which requires judgment and advise the resident, resident's health care provider, or facility employer of the unlicensed caregiver's inability to assist in the administration of such orders;
- Recognize the general side effects of medications and classes of drugs and the need to report adverse drug events (ADEs);
- Develop and understand the types of questions to ask a health care provider (HCP) regarding a resident's medications;
- Promote medication error reduction, reporting, and safety in ALFs; and
- Promote timely adverse drug event (ADE) reporting in ALFs;

Element 5: Systematic Analysis and Systemic Action

- Systematic approach when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change.




Risk and Quality =

- Keep your eyes on the environment
- Mobilize your senses, mobilize the IDT
- Know what your customers are experiencing
- Know your policies, if they work, if your staff know them
- Know your staffing patterns, staff strengths and weakness and address it
- Know your indicators of quality
- Know and Mobilize Your Quality Team

Safe Practice

- DO assist resident in taking each medication exactly as it has been prescribed. (Competency observations)
- DO make sure that all your residents' doctors and HCPs know about all your residents' medications. (Bridge external consultants)
- DO let your residents' doctors know about any other over-the-counter medications, vitamins/supplements, or herbs that they are taking. (Safe admissions) Reconcile meds
- DO try to use the same pharmacy
- DO use the triple check system when checking medications.
- DO read medication labels and follow instructions carefully.
- DO make sure all medication orders are written and signed.
- DO make sure all medication orders are on the right resident chart.
- DO identify the resident every time you give medications.
- DO LOOK AT CHANGES IN CONDITION AND REVIEW MEDS

<p>Alzheimer's Association Campaign for Quality Residential Care</p> <p>Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes</p>	<p>Resources Include</p> <p>CMS Launches Partnership to Improve Dementia Care in Nursing Homes www.advancingexcellence.org</p>
	
<p>Building consensus on quality care for people living with dementia</p> <p>alzheimer's association</p>	

Somewhere Over at the ALF

- Somewhere Over at the ALF
- There am I
- There's a calling I listened to,
- Once when I was knee high
- Somewhere over at the ALF
- Staff believe in what they do
- And the people whose lives we touch
- Know they love them too





- So I will do my best to lead
- Reach out and touch someone in need
- I'll be there!
- I'll make sure staff arrive on time
- I'll keep it safe for folks of mine
- That's where you'll find me



- Somewhere over AT THE ALF
- Time sure flies
- Golden years swirl around us
- We cry when a resident dies...
- And if I can I'll make hearts fly
- I'll create rainbows
- Watch how hard I'll try!



Quality Partnerships

- Establish Collaborative Partnerships
 - Physicians and health care providers
 - Third party services
 - Hospitals
- Identify mutual goals of care
- Facilitate Advanced Care Planning

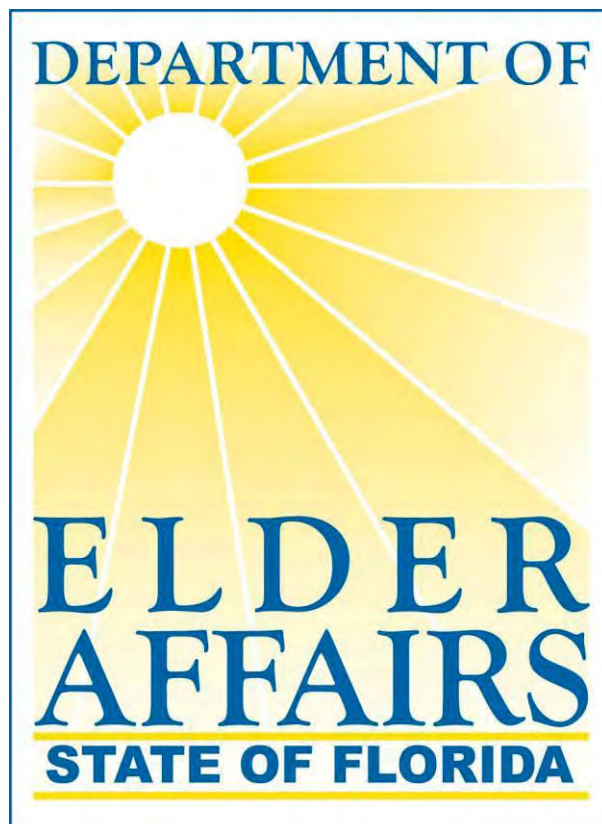
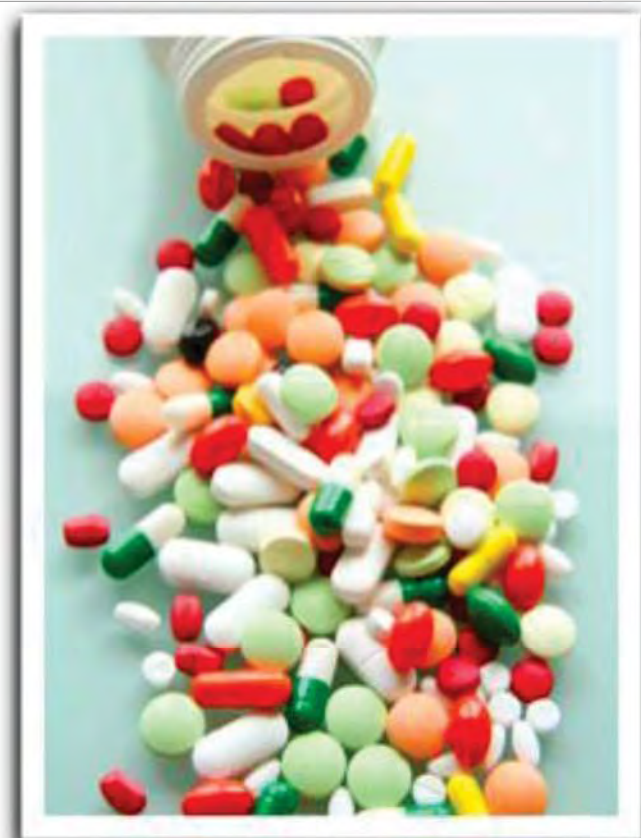
HOW TO ASSIST WITH EAR MEDICATION (Otic Preparations)

Staff Member:

Date:

Observer:

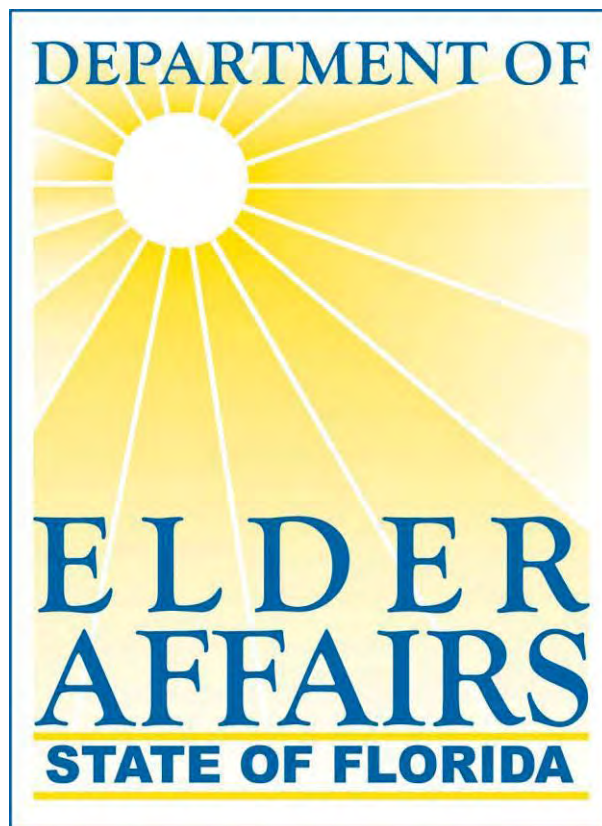
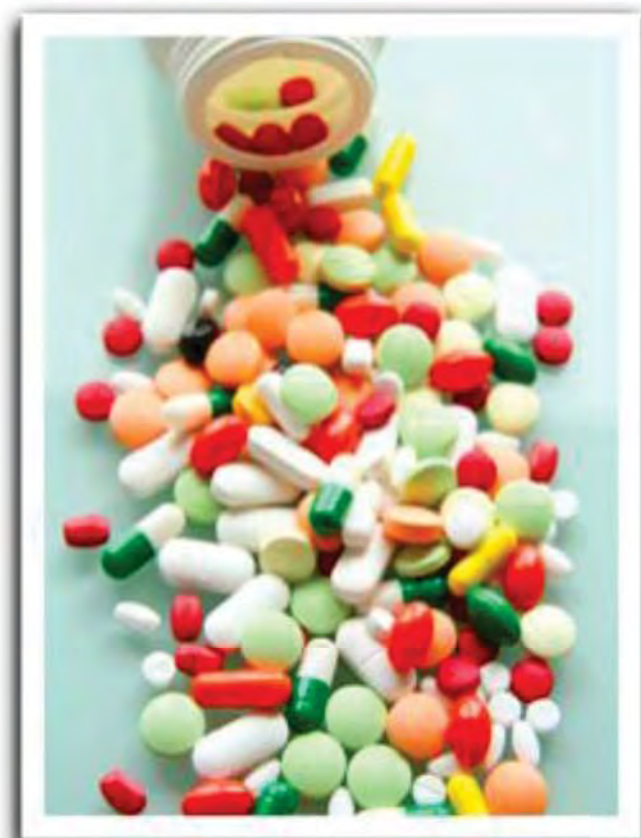
	Yes	No
1. If EAR medication requires REFRIGERATION , is it stored in locked REFRIGERATOR and monitored for temperature with a daily log.		
2. Does the person observed: Wash hands and obtain necessary items (ear medication with label, MOR, gloves, cotton balls, tissues, barrier as disposable tray, etc.). Check expiration date of medication when retrieving medication?		
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident?		
4. Follow facility policy for identifying resident. Address resident by name.		
5. Identify which ear (right, left, or both) to receive medication.		
6. Explain procedure. Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If drops are suspension, then “SHAKE WELL.”		
7. Assist the resident to a comfortable position and turn resident’s head so that the affected ear is facing up.		
8. If bottle serves as dropper, does the person observed remove cap and place it upright on barrier or on a clean, dry surface?		
9. Does the person: Straighten ear canal by gently pulling earlobe up and back.		
10. IF DROPS, does the person observed: instill prescribed number of drops into ear canal. Is the person careful not to let tip of dropper touch the ear or any other surface? Do they recap container?		
11. Is the person observed: Instructing the resident to remain in same position about five minutes with affected ear upwards. Gently place a cotton ball in the external ear canal or canal to prevent leakage.		
12. Do they: Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator if required).		
13. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.		
14. Remove and dispose of gloves. Discard barrier.		
15. Wash hands thoroughly.		
16. Monitor for side effects or adverse effects.		



ASSISTANCE WITH SELF- ADMINISTRATION OF MEDICATION

STUDY GUIDE FOR ASSISTED LIVING FACILITY (ALF) STAFF

JULY 2012 (revised June 2013)



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Introduction

Supervision or assistance with self-administration of medications is a key element of the personal services provided by assisted living facilities (ALFs). In Florida, a Standard, Extended Congregate Care (ECC), Limited Nursing Services (LNS), or Limited Mental Health (LMH) license allows a facility to provide this service.

This guide provides valuable training information regarding all aspects of the 2011 Florida Laws for “assistance with self-administration of medication” as required by 429.256 and 429.52 F.S., and medication practices as required by Rules 58A-5.0185 and 58A-5.0191, F.A.C. Facilities should train their staff on facility-specific policies and procedures. Medication safety is top priority.

After successful completion of this initial four (4) hour training, completion of a post-test, and demonstration of tasks and exercises associated with assistance with self-administration of medication in ALFs, the unlicensed person will receive a training certificate provided by a licensed registered nurse or pharmacist, to be maintained in his or her personnel file. In addition, unlicensed persons must obtain, annually, a minimum of two (2) hours of continuing education (CE) training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The two hours of continuing education training shall only be provided by a licensed registered nurse or pharmacist.

This is the third printing of this edition of the guide. Special thanks to Ron Hoover, M.S., C.Ph., R.Ph., Donna Essaf Cimabue, R.N., Donna Crivaro, BS, RN, CRNI, Norma Jean Rumberger, and Guy Wagner, Pharm.D., R.Ph., for their hard work and contributions in enhancing this teaching and training manual.

Disclaimer: This book is strictly a study guide and is not intended to be an all-inclusive resource, and there is no liability implied or assumed by either the State of Florida or the authors of this training manual.

Purpose

Information resource and best practice systems intend to do the following:

1. Provide guidelines for the training of unlicensed personnel regarding safe medication practices in assisted living facilities (ALFs) in Florida;
2. Improve the quality of care and well being of adults living in Florida ALFs;
3. Outline safety guidelines for prescribing, dispensing, delivering, storing, administering, monitoring, and properly disposing of medications in ALFs that provide assistance with self-administration of medication;
4. Reduce medication errors and improve reporting of adverse drug events; and
5. Reduce facility risk and professional liability in ALFs in Florida.

Objectives

Upon completion of the training program, caregivers should be able to demonstrate the ability to do the following:

- Read and **understand a prescription label**;
- **Provide** assistance with oral medication;
- **Measure** liquid solutions and suspensions (shake well), **break** scored tablets, and **crush** tablets as directed by prescription order;
- **Provide assistance with topical forms of medication for the skin, eye, ear, and nose**, including creams, lotions, ointments, patches, ophthalmic drops and ointments, otic solutions, and nasal drops, sprays, inhalers, and diskus forms.
- **Complete** a Medication Observation Record (**MOR**);
- **Retrieve, store, and dispose** of medication properly;
- **Recognize a medication order which requires judgment and advise** the resident, resident's health care provider, or facility employer of the unlicensed caregiver's **inability to assist** in the administration of such orders;
- **Recognize** the general **side effects** of medications and classes of drugs and the need to **report adverse drug events (ADEs)**;
- Develop and understand the **types of questions to ask** a health care provider (HCP) regarding a resident's medications;
- **Promote medication error reduction, reporting, and safety in ALFs**; and
- **Promote timely adverse drug event (ADE) reporting in ALFs**;

Chapter 1. Florida Law 429 and Medication Practices 58A

Section 429.255, F.S., Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, **may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician,** observe residents, document observations on the appropriate resident's record, report observations to the resident's physician, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician.

Section 429.256(1)(a), F.S., provides that **"assistance with self-administration of medication"** by an **unlicensed** person requires, **"informed consent"** which means advising the resident, or resident's surrogate, guardian, or attorney in fact, that an assisted living facility is **not required to have a licensed nurse on staff**, that the resident may be receiving assistance with self-administration of medication from an **unlicensed person**, and that such assistance, if provided by an unlicensed person, **will or will not be overseen by a licensed nurse**.

See example of an **Informed Consent Form - Appendix 1.**

Section 429.256(1)(b), F.S., **"assistance with self-administration of medication"** defines **"unlicensed person"** as an individual not currently licensed to practice nursing or medicine who is employed by or under contract to an assisted living facility and who has received training with respect to assisting with the self-administration of medication in an ALF as provided under s. 429.52 **prior to providing** such assistance as described in this section. Section 429.256(2) F.S., Residents **who are capable** of self-administering their own medications without assistance shall be **encouraged and allowed** to do so.

See example of **Resident Assessment Form - Appendix 2.**

Section 429.256(2) F.S., defines **"self-administered medications"** as both legend (Rx) and over-the-counter (OTC) oral dosage forms, topical dosage forms, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

Section 429.256(3), F.S., **"assistance with the self-administration of medications"** by an **unlicensed** person **includes or shall be allowed for:**

- A. Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.
- B. In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
- C. Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.
- D. Applying topical medications to skin, eye, ear, or nose including solutions, suspensions, sprays, and inhalers.
- E. Returning the medication container to proper storage.
- F. Keeping a record of when a resident receives assistance with self-administration of medication using a Medication Observation Record (MOR).

Section 429.256(4), F.S., “**assistance with the self administration of medication**” by an **unlicensed** person **does NOT include or shall NOT be allowed for:**

- A. **Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.**
- B. **The preparation of syringes for injection or the administration of medications by any injectable route.**
- C. **Administration of medications through intermittent positive pressure breathing machines or a nebulizer.**
- D. **Administration of medications by way of a tube inserted in a cavity of the body.**
- E. **Administration of parenteral preparations.**
- F. **Irrigations or debriding agents used in the treatment of a skin condition.**
- G. **Rectal, urethral, or vaginal preparations.**
- H. **Medications ordered by the physician or health care professional with prescriptive authority to be given “as needed,” unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.**
- I. **Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.**

Section 429.256(5), F.S., provides that “**assistance with the self- administration of medication**” by an **unlicensed** person as described in this statute **shall NOT be** considered **administration of medication** as defined in § 465.003, F.S. Nurse Practice Act.

Section 429.41, F.S., Rules Establishing Standards - The management of medication;
(k) The use of physical or chemical restraints. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident’s physician and must be consistent with the resident’s diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by physician at least annually to assess:

- 1. The continued need for the medication.
- 2. The level of the medication in the resident’s blood.
- 3. The need for adjustments in the prescription.

Section 429.42, FS, Pharmacy services.

(1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

(2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.

(3) The agency shall employ at least two pharmacists licensed pursuant to chapter 465 among its personnel who biennially inspect assisted living facilities licensed under this part, to participate in biennial inspections or consult with the agency regarding deficiencies relating to medicinal drugs or over-the-counter preparations.

Section 429.52, FS, requires **unlicensed personnel** involved in assisting with the self-administration of medications to complete a minimum of four (4) hours of training pursuant to a curriculum developed by DOEA and provided by a registered nurse, licensed pharmacist, or DOEA staff prior to assisting with medications. Rule 58A-5.0191(c) mandates they must obtain, annually, a minimum of two (2) hours of CE training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The two (2) hours of CE training shall only be provided by a licensed registered nurse or a licensed pharmacist.

58A-5.0181 ADMISSION PROCEDURES, APPROPRIATENESS OF PLACEMENT AND CONTINUED RESIDENCY CRITERIA.

(1) ADMISSION CRITERIA. An individual must meet the minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license:

(e) Be capable of taking own medication with assistance from staff if necessary.

1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's **written informed consent to provide such assistance** as required under Section 429.256, F.S.

2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident.

Rule 58A-5.0185, FAC, MEDICATION PRACTICES.

Pursuant to Sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule.

(1) SELF-ADMINISTERED MEDICATIONS.

(a) Residents who are capable of self-administering their medications without assistance shall be encouraged and allowed to do so.

(b) If facility staff note deviations which could reasonably be attributed to the improper self-administration of medication, staff shall consult with the resident concerning any problems the resident may be experiencing with the medications; the need to permit the facility to aid the resident through the use of a pill organizer, provide assistance with self-administration of medications, or administer medications if such services are offered by the facility. The facility shall contact the resident's health care provider when observable health care changes occur that may be attributed to the resident's medications. The facility shall document such contacts in the resident's records.

(2) PILL ORGANIZERS.

(a) A “pill organizer” means a container which is designed to hold solid doses of medication and is according to day and time increments.

(b) A resident who self-administers medications may use a pill organizer.

(c) A nurse may manage a pill organizer to be used only by residents who self-administer medications. The nurse is responsible for instructing the resident in the proper use of the pill organizer. The nurse shall manage the pill organizer in the following manner:

1. Obtain the labeled medication container from the storage area or the resident;
2. Transfer the medication from the original container into a pill organizer, labeled with the resident’s name, according to the day and time increments as prescribed;
3. Return the medication container to the storage area or resident; and
4. Document the date and time the pill organizer was filled in the resident’s record.

(d) If there is a determination that the resident is not taking medications as prescribed after the medicinal benefits are explained, it shall be noted in the resident’s record and the facility shall consult with the resident concerning providing assistance with self-administration or the administration of medications if such services are offered by the facility. The facility shall contact the resident’s health care provider regarding questions, concerns, or observations relating to the resident’s medications. Such communication shall be documented in the resident’s record.

(3) ASSISTANCE WITH SELF-ADMINISTRATION.

(a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least 18 years old, trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.

(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.

(c) Staff shall observe the resident take the medication. Any concerns about the resident’s reaction to the medication shall be reported to the resident’s health care provider and documented in the resident’s record.

(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:

1. The health care provider may prescribe a medication schedule which coincides with the resident’s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident’s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident’s medication record; or

4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;

(e) Pursuant to Section 429.256(4)(h), F.S., the term “competent resident” means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.

Pursuant to Section 429.256(4)(i), F.S., the terms “judgment” and “discretion” mean interpreting vital signs and evaluating or assessing a resident’s condition.

(4) MEDICATION ADMINISTRATION.

(a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider’s order or prescription label.

(b) Unusual reactions or a significant change in the resident’s health or behavior shall be documented in the resident’s record and reported immediately to the resident’s health care provider. The contact with the health care provider shall also be documented in the resident’s record.

(c) Medication administration includes the conducting of any examination or testing such as blood glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff.

(d) A facility which performs clinical laboratory tests for residents, including blood glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents’ own equipment.

(5) MEDICATION RECORDS.

(a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider’s name, the resident’s name, the date dispensed, the name and strength of the drug, and the directions for use.

(b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known allergies the resident may have; the name of the resident’s health care provider, the health care provider’s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.

For medications which serve as chemical restraints, the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician’s annual evaluation of the use of the medication.

(6) MEDICATION STORAGE AND DISPOSAL.

(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their rooms or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the rooms or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:

1. The facility administers the medication;
2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or
6. The facility's rules and regulations require central storage of medication and that policy was provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.

(b) Centrally stored medications must always be:

1. Kept in a locked cabinet, cart, or other locked storage receptacle, room, or area.
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and kept separately from the medications of other residents and properly closed or sealed.

(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident's request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked "discontinued medication." Such medication may be reused if re-prescribed by the resident's health care provider.

(d) When a resident's stay in the facility has ended, the administrator shall return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications shall be considered abandoned and may be disposed of in accordance with paragraph (e).

(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.

(f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

(7) MEDICATION LABELING AND ORDERS.

(a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S. and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for the resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:

1. The resident's name; and
2. Identification of each medicinal drug product in the container.

(b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another.

(c) If the directions for use are "as needed" or "as directed", the health care provider shall be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.

(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.

(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable.

(f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.

(g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which shall also include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they shall be kept in a container that bears a label containing the following:

1. Practitioner's name;
2. Resident's name;
3. Date dispensed;
4. Name and strength of the drug;
5. Directions for use; and
6. Expiration date.

(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider shall provide the resident with a written prescription, or a fax copy of such order.

OVER THE COUNTER (OTC) PRODUCTS.

For purposes of this subsection, the term OTC includes, but is not limited to, OTC medications, vitamins, nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription.

(a) A stock supply of OTC products for multiple resident use is not permitted in any facility.

(b) OT products, including those prescribed by a licensed health care provider, must be labeled with the resident's name and the manufacturer's label with directions for use, or the licensed health care provider's directions for use. No other labeling requirements are necessary nor should be required.

(c) Residents or their representatives may purchase OTC products from an establishment of their choice.

A facility cannot require a licensed health care provider's order for all OTC products when a resident self-administers his or her own medications, or when staff provides assistance with self-administration of medications pursuant to Section 429.526, F.S. A licensed health care provider's order is required when a licensed nurse provides assistance with self-administration or administration of medications, which includes OTC products. When such an order for an OTC product exists, only the requirements of paragraphs (b) and (c) of this subsection are required.

Rule 58A-5.0191(5), F.A.C., TRAINING: ASSISTANCE WITH SELF-ADMINISTERED MEDICATION and MEDICATION MANAGEMENT.

Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.018, F.A.C., must receive a minimum of four (4) hours of training prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria:

(a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal.

Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises.

(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to:

1. Read and understand a prescription label;
2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C. including:
 - a. Assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms;
 - b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
 - c. Recognize the need to obtain clarification of an "as needed" prescription order;
 - d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;

- e. Complete a medication observation record;
 - f. Retrieve and store medication; and
 - g. Recognize the general signs of adverse reactions to medications and report such reactions.
- (c) Unlicensed persons, as defined in Section 429.256(1) (b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility which must also be provided by a licensed registered nurse or a licensed pharmacist.

Rule 58A-5.0191(12), F.A.C., TRAINING DOCUMENTATION AND MONITORING

(a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following:

1. The title of the training program;
2. The subject matter of the training program;
3. The training program agenda;
4. The number of hours of the training program;
5. The trainee's name, dates of participation, and location of the training program;
6. The training provider's name, dated signature and credentials, and professional license number, if applicable.

(b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule.

(c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements.

See example of **Training Certificate – Appendix 3**.

Rule 58A-5.033(4), F.A.C., EMPLOYMENT OF A CONSULTANT.

(a) Medication Deficiencies.

If a Class I, Class II or uncorrected Class III deficiency directly relating to a facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by agency personnel pursuant to an inspection of the facility, the agency shall notify the facility in writing that the facility must employ, on staff or by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse, as determined by the agency. The initial onsite consultant visit shall take place within 7 working days of the identification of a Class I or class II deficiency and with 14 working days of the identification of an uncorrected Class III deficiency. The facility shall have available for review by the agency a copy of the pharmacist's or registered nurse's license and a signed and dated recommended corrective action plan no later than 10 working days subsequent to the initial onsite consultant visit.

The facility shall provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency shall provide the facility with written notification of such determination.

Medication Management

The management of medication and use of chemical restraints is limited to prescribed dosages of medication authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medication that can serve as chemical restraints must be **evaluated by their physician at least annually** to assess:

1. The continued need for the medication.
2. The level of the medication in the resident's blood.
3. The need for adjustments in the prescription.

EXAMPLES of common chemical restraints include lorazepam (ATIVAN), diazepam (VALIUM), etc.

Supervision and Assistance With Medication by Unlicensed Staff

Assistance with or supervision of self-administered medications includes reminding residents to properly take self-administered medications and, when appropriate or necessary, to observe or provide verbal instructions to residents while they perform this task.

Supervision of a resident's medication includes and is limited to:

- Reminders to take medications at the prescribed time.
- Opening containers or packages and replacing lids.
- Pouring liquid dosages and crushing or breaking scored tablets as prescribed.
- Applying topical medications including eye, ear, nose, and skin application.
- Returning medications to the proper locked areas.
- Obtaining medications from a pharmacy.
- Listing the medication on a resident's Medication Observation Record.
- A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, **changes in the method of medication administration**, or other changes which resulted in the provision of additional services. The owner, administrator, doctor, pharmacist, nurse, CAN, health care provider (HCP), and/or unlicensed personnel may be responsible for medication therapy and must provide written records as required by law.

Assistance With Self-Administration of Medication

One of the most important services an ALF may provide is assisting a resident with medications. For caregivers in ALFs, this is often a crucial component of caring for residents. Unlicensed staff who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, FAC, must meet the training requirements pursuant to Section 429.52(5), FS, prior to assuming this responsibility. Most people move to an ALF because of a need for assistance with personal care, **including assistance with medications**, and other activities of daily living. As a caregiver, you may need to assist a resident with medications. You may be required to pick up medications at the pharmacy, check them when they are delivered, and make sure that they are taken as prescribed.

This guide describes the process for assisting residents with safely taking their medications; provides an overview of the law and rule requirements with respect to assistance; and describes procedures relating to the management and supervision of medications in the assisted living setting.

Administration of Medication

Administration of medication as defined by 464.003 FS is forbidden by **unlicensed personnel**. Nurses and others may administer medications because they are licensed to do so.

Definition of Drug or Medication

A pharmaceutical drug, also referred to as medicine, medication, or medicament, can be loosely defined as any chemical substance intended for use in the medical diagnosis, cure, treatment, or prevention of disease.

Definition of Controlled Substance Schedules

The drugs and other substances that are considered controlled substances under the CSA are divided into five (5) schedules. A listing of the substances and their schedules is found in the DEA regulations, 21 C.F.R. Sections 1308.11 through 1308.15. A controlled substance is placed in its schedule based on whether it has a currently accepted medical use in treatment in the United States, its relative abuse potential, and its likelihood of causing dependence. Some examples of controlled substances in each schedule are outlined below. NOTE: Drugs listed in schedule I have no currently accepted medical use in treatment in the United States and, therefore, may not be prescribed, administered, or dispensed for medical use. In contrast, drugs listed in schedules II-V have some accepted medical use and may be prescribed, administered, or dispensed for medical use.

SCHEDULE I CONTROLLED SUBSTANCES

Substances in this schedule have a high potential for abuse, have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of these drugs or other substances under medical supervision. Some substances listed in schedule I are: heroin, lysergic acid diethyl-amide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("ecstasy").

SCHEDULE II CONTROLLED SUBSTANCES

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence. Examples of single entity schedule II narcotics include morphine and opium. Other schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®), and fentanyl (Sublimaze® or Duragesic®). Examples of schedule II stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®). Other schedule II substances include: cocaine, amobarbital, glutethimide, and pentobarbital.

SCHEDULE III CONTROLLED SUBSTANCES

Substances in this schedule have a potential for abuse less than substances in schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence. Examples of schedule III narcotics include combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin®) and products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with codeine®). Also included are buprenorphine products (Suboxone® and Subutex®) used to treat opioid addiction. Examples of schedule III non-narcotics include benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as oxandrolone (Oxandrin®).

SCHEDULE IV CONTROLLED SUBSTANCES

These substances have a low potential for abuse relative to substances in schedule III. Examples of schedule IV controlled substances include: alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

SCHEDULE V CONTROLLED SUBSTANCES

Substances in this schedule have a low potential for abuse relative to substances listed in schedule IV and consist primarily of preparations containing limited quantities of certain narcotics. These are generally used for antitussive, antidiarrheal, and analgesic purposes. Examples include cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (ROBITUSSIN AC and PHENERGAN with CODEINE).

DEA Regulation of Controlled Substances in Nursing Homes, Hospices, and Assisted Living Facilities (ALFs)

Issue: The regulations implementing the Controlled Substances Act (CSA) require that all prescriptions for Schedule II-V controlled substances be written, signed by the prescriber, and presented to a pharmacy for fulfillment. In nursing homes, hospices and assisted living facilities, where a resident's physician usually is not physically on-site, nurses for years have played a key role in communicating information on residents' conditions to physicians and other practitioners. This communication usually takes place by telephone, with a nurse acting as the physician's "agent" by recording the physician's verbal order of the needed medications in the resident's clinical record, creating a "chart order," and ensuring that the physician's orders are carried out. Nurses in hospitals operate similarly. Through this process, nurses ensure that medications are acquired timely to meet residents' changing and emergent medical needs.

Under an interpretation adopted in the past several years by the U.S. Drug Enforcement Administration (DEA), which has oversight authority for the CSA, a nurse in a long-term care (LTC) setting (nursing home, assisted living facility, and hospice) is prohibited from serving as an "agent" of a practitioner prescribing a Schedule II-V medication for a LTC resident. Under this prohibition, practitioners cannot rely on LTC nurses to document their prescription orders and transmit them to the pharmacy; instead, the DEA requires the pharmacist to locate and communicate with the prescribing physician in person and obtain a separate, signed "hard copy" prescription order from the prescriber before the pharmacist/pharmacy can dispense the needed controlled substance. The DEA also has ruled that a chart order in a resident's medical record is not considered a valid prescription.

It is important to note that there is ALWAYS ONLY ONE generic name for a drug such as the generic ampicillin, but there may be two or more BRAND NAMES (OMNIPEN, POLYPEN, PRIMAPEN) for the same single generic name.

This guide will generally present generic names in lower case, hydromorphone, and BRAND NAMES in UPPER CASE as (DILAUDID), and will NOT use a trademark symbol as (Dilaudid®), due to some medication safety concerns with symbols such as ®.

Occasionally, the generic name will be printed in TALL MAN lettering as cloNIDine (CATAPRESS), glyBURIDE (DIABETA), glipiZIDE (GLUCOTROL).

Chapter 2. Medication Administration and Safety

Medication Administration is helping a person with the ingestion, application, or inhalation of medications as prescribed by a doctor or other authorized health care provider (HCP).

Understanding the routes of administration is important in understanding the limitations of an unlicensed person and the responsibility of licensed health care professionals.

Routes of Administration allowed by trained unlicensed persons

Oral	by mouth
Sublingual	under the tongue
Ophthalmic	into eye
Otic	into ear
Nasal	into nose
Inhalant	into lungs through mouth
Topical	on to skin
Transdermal	through skin by patch



Medication routes only given by nurses or licensed personnel

Rectal	into the rectum
Vaginal	into the vagina
Subcutaneous (Sub-q)	injection-under the skin
Intramuscular (IM) injection	injection into muscle
Intravenous (IV) injection	injection into vein
Naso-Gastric	into the NG tube



UNLICENSED STAFF MAY NOT ADMINISTER MEDICATION, THEY ARE ONLY ALLOWED TO ASSIST WITH SELF-ADMINISTRATION OF MEDICATION.

MEDICATION ADMINISTRATION

Facilities that provide medication administration must have available a staff member who is licensed to administer medications according to a doctor's order or prescription label.

Unusual reactions or a significant change in the resident's health or behavior shall be documented in the resident's record and reported immediately to the resident's HCP. Any contact with the health care provider shall also be documented in the resident's record.

Medication administration includes the conducting of **any examination or testing** such as **blood glucose testing** or other procedure necessary, **including vital signs (temperature, blood pressure, heart rate, and/or respirations)** for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff.

Medication administration is forbidden by unlicensed personnel in Florida.

Providing safe assistance with medications for many residents on multiple medications is complicated and requires concentration and attention to detail.

Licensed Staff ONLY

Medication administration is for licensed staff only and is forbidden for unlicensed personnel due to problems related to medication administration and safety. Medication safety is a major concern in hospitals, nursing homes, assisted living facilities, as well as with the general public. It is a global problem. It is extremely important to take medications properly to achieve maximum health benefits. The importance and benefits of taking medications as prescribed is the foundation of rational drug therapy. The first rule in medicine is “**Do No Harm.**” **The health benefits of taking a drug should always be weighed against the risks, side effects, and consequences of taking that drug.**

Persons under contract to the facility, facility staff, or volunteers, who are **licensed according to Section 464.003, such as nurses, may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication**, document observations on the appropriate resident's record, and report observations to the resident's doctor/physician. **Certified Nursing Assistants (CNAs) certified pursuant to chapter 464 may take residents' vital signs as directed by a licensed nurse or doctor/physician. Unlicensed staff may NOT take vital signs.**

MEDICATION SAFETY

Medication safety is the responsibility of everyone who handles medications. The original five rights of medication administration (RIGHT resident, medication, dosage, time, and route) have developed into the nine rights of medication administration, adding the right documentation, right to refuse, right reason, and right response.

HELP STOP MEDICATION ERRORS!
CHECK "EYE" and "EAR" MEDICATIONS CAREFULLY.
"EAR" DROPS IN THE "EYE" COULD BE DANGEROUS.

NINE (9) RIGHTS of Medication Administration in ALFs

Assisting with self-administered medications includes knowing that the Right RESIDENT takes the Right MEDICATION at the Right DOSAGE at the Right TIME by the Right ROUTE for the Right REASON, has the Right RESPONSE, has the Right to REFUSE, and is followed by the Right DOCUMENTATION on the Medication Observation Record (MOR).

Right RESIDENT Make sure you know the resident. Identify RESIDENT every time and confirm by name, date of birth, picture on MOR (with permission), and/or other means of accurate identification. Check the name on the order and the patient. Use at least two identifiers. Ask the patient to identify themselves. Use technology when possible such as bar codes. Use picture or picture ID.

Right MEDICATION – Check MEDICATION label and order **three** times. **Check** MOR, **Check** LABEL, then **Check** MOR with LABEL. Read the label to the resident and verify the resident understands the drug dosage and reason for use, if known.

Right DOSAGE – Check the DOSAGE (AMOUNT). Triple check the label with the MOR.

Right TIME – Check the TIME. Medications must be given at the TIME prescribed. Standard practice is that medications are given within one hour before or one hour after the TIME noted on the MOR or medication label. It is considered a medication error if outside the one hour range. Best practice would be TIME exactly as indicated on MOR or prescription label.

Right 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. **UNLICENSED STAFF ARE NOT ALLOWED TO ASSIST with INJECTABLE, URETHRAL, VAGINAL, or RECTAL MEDICATIONS.**

Right DOCUMENTATION – properly document each dose offered on the Medication Observation Record (MOR). Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary, including refusal of medication.

Right RESPONSE – Make sure that the drug led to the desired effect. If an antacid was given for heartburn, was the heartburn relieved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your observation of the resident and report to HCP.

Right REASON – Confirm the rationale for the ordered medication. What is the resident's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use. If you are unsure of the reason for use, ask! Ask your pharmacist, doctor, or nurse.

Right to REFUSE – A resident has the right to refuse a medication by Florida law. A resident may not be compelled (forced) to take a medication, nor may you hide medication in their food or drink. 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.

BEST Practice Recommendations for Medication Safety.

If you are not sure about a medication issue (i.e., drug to be given, dose, time, route, reason for taking medication), then ASK HCP, NURSE, or PHARMACIST. Medications, both prescription and over-the-counter, can help to improve and maintain health if taken and/or administered safely and appropriately.



This section provides valuable information and recommendations regarding medication safety in the care of the aging in ALFs.

MEDICATION ERRORS ARE A GLOBAL PROBLEM!

Hospitals, emergency rooms, nursing homes, assisted living facilities (ALFs), and community residents all make medication errors. To err is human! However, we must strive to minimize and continually reduce medication errors through medication safety practices.

Common Types of Errors

**Wrong time
Omission of dose
Wrong dose
Extra dose
Unauthorized dose
Wrong drug
Wrong resident**

Common Medications

**Involved in Errors
Insulin - all types
Warfarin - Coumadin
Furosemide - Lasix
Opiates - Fentanyl
Opiates - Morphine
Lorazepam - Ativan**

Medication errors in assisted living facilities (ALFs) in one study:

Wrong time (71.3 percent) Omission of dose (12.2 percent) Wrong dose (11.3 percent)
Extra dose (3.7percent) Unauthorized dose (1.4 percent) Wrong drug (0.2 percent)

More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).

Medication errors alone, occurring either in or out of the hospital, are estimated to account for 7,000 deaths annually.

Adverse drug events cause more than 770,000 injuries and deaths each year and cost up to \$5.6 million per hospital.

Rule # 1. "DO NO HARM"

HOW TO PREVENT MEDICATION ERRORS

Always TRIPLE Check Medications.

DOs and DON'Ts can help you make sure that your residents' medication works safely to improve their health and well being.



Medication DOs...

1. DO assist resident in taking each medication exactly as it has been prescribed.
2. DO make sure that all your residents' doctors and HCPs know about all your residents' medications.
3. DO let your residents' doctors know about any other over-the-counter medications, vitamins and supplements, or herbs that they are taking.
4. DO try to use the same pharmacy to fill all your residents' prescriptions, so that the pharmacist can help you keep track of everything your residents are taking.
5. DO keep medications out of the reach of children when they visit the facility.
6. DO use the triple check system when checking medications.
7. DO read medication labels and follow instructions carefully.
8. DO make sure all medication orders are written and signed.
9. DO make sure all medication orders are on the right resident chart.
10. DO identify the resident every time you give medications.

Medication DON'Ts...

1. DON'T change your residents' medication dose or schedule without talking with their doctor or health care provider.
2. DON'T share or use medication prescribed for any other resident or person.
3. DON'T crush or break pills unless the resident's doctor instructs you to do so.
4. DON'T use any medication that has passed its expiration date.
5. DON'T use abbreviations.
6. DON'T assist with a medication poured by someone else. You cannot be sure what it is.
7. DON'T touch the medication with your hand.
8. DON'T hide medications in food. Medications cannot be "hidden" in foods or drinks. A resident may knowingly take a medication with food if it is easier.
9. DON'T use contaminated medications or medications dropped on the floor.

How to Prevent Wrong-RESIDENT Errors

Take steps to reduce wrong resident errors.

Make sure orders are written and placed on the correct chart.

Make sure orders are transcribed correctly onto the correct chart/MOR.

Check medications from the pharmacy and confirm for the correct resident name, ID, etc.

Make sure systems used can identify residents correctly, especially by new or temporary workers (picture ID or MOR). Use two (2) forms of resident's identification, including:

- a) Asking, "What is your name?"
- b) Checking ID bracelet;
- c) Checking photo (update photo annually);
- d) Following "like names alert" policy to avoid similar residents' name errors.

Note: Do not use room or bed number.



How to Prevent Wrong-DRUG Errors

Take steps to reduce wrong-drug errors.

Use systems that triple check medications prior to assistance with self-administration.

Print generic name using **TALL MAN** lettering as cloNIDine.

**HELP STOP
MEDICATION ERRORS!**

How to Prevent Wrong-TIME Errors

The standard acceptable time is within one hour before or after the scheduled administration time or it is considered a medication error.



How to Prevent OVERDOSES

OVERDOSE: Take steps to reduce overdose errors.

Put systems in place for triple checking dosages.

Make sure medication is recorded, so that a second dose is not given inadvertently.

HIGH ALERT MEDICATIONS!

Anticoagulants (warfarin - COUMADIN), Anti-platelets (clopidogrel - PLAVIX, aspirin)

Insulin and other antidiabetic agents,

Opiates (Hydrocodone, Oxycodone, morphine, codeine, hydromorphone, etc.)

SOME BEST MEDICATION SAFETY PRACTICES

1. ALWAYS FOLLOW THE NINE RIGHTS.
2. ALWAYS TRIPLE CHECK YOURSELF.
3. IDENTIFY RESIDENT WITH AT LEAST TWO FORMS OF ID.
4. READ LABELS CAREFULLY AND FOLLOW DIRECTIONS.
5. BE SURE ALL MEDICATION ORDERS ARE SIGNED.
6. DOCUMENT ASSISTANCE IMMEDIATELY EACH TIME.
7. PAY ATTENTION TO DETAIL; SAFETY IS NUMBER ONE!

LISTEN FOR SOUND-ALIKE DRUGS!

WATCH FOR LOOK-ALIKE DRUGS!

Chapter 3. Self-Administered Medication Use & Storage

Residents who are capable of self-administration without assistance shall be encouraged and allowed to do so.

SELF-ADMINISTRATION OF MEDICATION AND RISK REDUCTION

1. Assess resident's ability to safely store and self-administer medication.
 - a) **Reassess** resident capacity to self-administer at least **quarterly**.
2. Educate resident regarding the following:
 - a) **Indications** for use and expected **benefits**,
 - b) **Method** of administration, and
 - c) **Side effects** and adverse consequences.
3. Provide for proper **storage**.
4. Staff will **monitor and record** indications of therapeutic benefits, side effects, and adverse events, and will keep prescriber informed at all times.

A resident may not be compelled to take medication, but may be counseled according to Florida law.

If facility staff note deviations which could reasonably be attributed to the improper self-administration of medication, staff shall consult with the resident concerning any problems the resident may have with medication.

Staff shall consult the resident on the need to permit the facility to aid the resident through the use of a pill organizer. **See Chapter 4.**

Staff shall consult the resident on the ability of the facility staff to provide assistance with self-administration of medication.

Staff may also consult the resident on the administration of medication if such services are offered by the facility.

The facility shall contact the resident's health care provider (HCP) when observable health care changes occur that may be attributed to the resident's medication. The facility shall document such contacts in the resident's record.

Locked medications should be stored free of dampness and temperature change, except for medications that require refrigeration.

MEDICATION STORAGE

Storage in Resident's Room

In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription (Rx) and over-the-counter (OTC), in their possession both on or off the facility premises, or in their rooms or apartments. Medications must be kept locked when residents are absent, unless the medication is in a secure place within the room or apartment or in another secure place out of sight of other residents.

Residents who are capable may store both prescription (Rx) and over-the-counter (OTC) medications in their room. Medications must be kept locked when resident is absent.

Central Storage in Facility

Both Rx and OTC medications for residents shall be centrally stored under the following conditions:

1. The facility administers the medication;
2. **The resident requests central storage, in which case the facility shall maintain a list of all medications being stored pursuant to such a request;**
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents.
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.

When resident possession is considered a safety hazard, both Rx and OTC medications must be kept locked in CENTRAL STORAGE by the facility.

Centrally stored medications must be maintained as follows:

1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated; refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area locked in which the refrigerator is located;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication, and such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.

**Centrally stored medication must be locked
in a box, cabinet, cart, room,
or other locked storage receptacle at all times.**

Discontinued Medication

Medication which has been discontinued but which has not expired shall be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident's request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked "**discontinued medication.**" Such medication may be reused if re-prescribed by the resident's health care provider.

**Discontinued medication
must be stored separately
from medication in current use
and marked "Discontinued Medication."**

Chapter 4. Pill Organizers

Nurses licensed under 464.003, FS, may manage individual weekly pill organizers for residents who self-administer medication.

“Nurse” means a licensed practical nurse (LPN), registered nurse (RN), or advanced registered nurse practitioner (ARNP) licensed under Sec 464, F.S.

PILL ORGANIZER

A “pill organizer” means a container that is designed to hold solid doses of medication and is divided according to day and time increments.



A resident who self-administers medications may use a pill organizer.

A nurse may manage a pill organizer to be used only by residents who self-administer medications. The nurse is responsible for instructing the resident in the proper use of the pill organizer. The nurse shall manage the pill organizer in the following manner:

Obtain the labeled medication container from the storage area or the resident.

Transfer the medication from the original container into a pill organizer, labeled with the resident’s name, according to the day and time increments as prescribed.

Return the medication container to the storage area or resident.

Document the date and time the pill organizer was filled in the resident’s record.

If there is a determination that the resident is not taking medications as prescribed after the medicinal benefits are explained, it shall be noted in the resident’s record and the facility shall consult with the resident concerning providing assistance with self-administration or the administration of medications if such services are offered by the facility. The facility shall contact the resident’s health care provider regarding questions, concerns, or observations relating to the resident’s medications. Such communication shall be documented in the resident’s record.

Unlicensed personnel are forbidden from using pill organizers.

Assistance with self-administration does not include pill organizers.

Only a family member or friend may assist residents with pill organizers, except for pharmacists, physicians, and nurses (ARNP, RN, LPN) licensed under 464.003,FS.

**Unlicensed personnel are forbidden from using
“pill organizers.”**

Chapter 5. Assistance With Self-Administration

One of the most important services an ALF may provide is assisting a person with medication. This may require picking up medications at the pharmacy, checking them when delivered, and making sure they are taken as prescribed.

Medication assistance with self-administration is helping a person with the oral ingestion, topical application, and/or oral or nasal inhalation of medications as prescribed by a doctor/physician or other authorized health care provider (HCP).

Medications are an important part of caring for residents.

The term “competent resident” means that the resident is cognizant regarding when a medication is required and understands the purpose for taking the medication.

**Admission Criteria:
Competent and Capable**

Residents must be capable of taking their own medication with assistance from staff if necessary.

If the individual needs assistance with self-administration, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident's written informed consent.

**Resident Assessment Form -
Facility must evaluate residents
ability to safely self-administer
medication. See Appendix 2.**

**Informed consent means advising the resident
whether a licensed nurse will or will not
supervise unlicensed ALF staff.
ALFs are not required to have a licensed nurse on staff.**

The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident contracts with a licensed third party to provide this service.

Facilities that provide assistance with self-administered medication must have either a nurse or an unlicensed staff member, who is at least age 18, trained to assist with self-administered medication and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, and must be available to assist residents with self-administered medications in accordance with Florida Statute 429 and Rule 58A.

Unlicensed staff must successfully complete a four hour training program provided by a licensed registered nurse, pharmacist, or qualified DOEA staff.

“Unlicensed person” means an individual not currently licensed to practice nursing or medicine who is employed by or under contract to an assisted living facility and who has received training in assisting with the self-administration of medication in an assisted living facility as provided under 429.52, FS prior to providing such assistance.

Courses provided in fulfillment of this requirement must meet these criteria:

Training must cover state law and rule requirements regarding the following:

1. **Supervision, assistance, administration, and safe management of medications in assisted living facilities (ALFs);**
2. **Procedures and techniques for safely assisting the resident with self-administration of medication including how to read a prescription label;**
3. **Providing the right medication to the right resident;**
4. **Common medications;**
5. **The importance of taking medication as prescribed;**
6. **Recognition of side effects and adverse reactions as well as procedures to follow when residents appear to be experiencing side effects and/or adverse drug reactions (ADRs);**
7. **Documentation and record keeping; and**
8. **Medication retrieval, storage, and disposal.**



Each year unlicensed staff must successfully complete a two-hour annual update training program provided by a licensed registered nurse or pharmacist.

Only a registered nurse (RN), a licensed pharmacist, or Department of Elder Affairs’ staff person may provide the training. A certificate of completion for assistance with self-administration of medication training must be documented (copy of original) in your personnel file. In addition, a two-hour update course is required annually.

Unlicensed persons may, consistent with a dispensed prescription’s label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered.

Self-administered medications include both legend and over-the-counter oral dosage forms; topical dosage forms; and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, inhalers, and diskus.

In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, spoons, tongue blades, etc.

Assistance with self-administration means verbally prompting a resident to take medication as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), FS, below:

SELF-ADMINISTERED MEDICATIONS include both prescription (Rx) and over-the-counter (OTC) medications.

Assistance with self-administration of medication includes the following:

- A. Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident;
- B. In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container;
- C. Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth;
- D. Applying topical medications;
- E. Returning the medication container to proper storage; and
- F. Keeping a record on a MOR when a resident receives assistance with self-administration each time a medication is offered.

Unlicensed staff may assist with Oral and Topical Dosage Forms including skin, ophthalmic (eye), otic (ear), and nasal (nose).

Medications that appear to have been contaminated shall not be returned to the container (for example, dropped on the floor, etc.).

Staff shall observe the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record.

Assistance with self-administration does not include the following:



- A. Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed;
- B. The preparation of syringes for injection or the administration of medications by any injectable route;
- C. Administration of medications through intermittent positive-pressure breathing machines or a nebulizer;
- D. Administration of medications by way of a tube inserted in a cavity of the body;
- E. Administration of parenteral preparations;
- F. Irrigations or debriding agents used in the treatment of a skin condition;
- G. Rectal, urethral, or vaginal preparations;
- H. Medications ordered by the physician or health care professional with prescriptive authority to be given “as needed,” unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident; and
- I. Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

Unlicensed staff are not allowed to prepare syringes for injection (i.e., insulin) or administer medication by any injectable route.

Please note the role of unlicensed personnel in assisting with PRN medication orders or prescription labels. If a licensed nurse inappropriately delegates responsibility to an unlicensed person to assist with self-administration of medication that requires the judgment of a licensed health care professional, the nurse could jeopardize his/her license. To avoid such a problem, **PRN orders should include “specific parameters that preclude independent judgment on the part of the unlicensed person.”**

The terms “judgment” and “discretion” mean interpreting vital signs and evaluating or assessing a residents condition.

Either a nurse or trained unlicensed staff must be in the facility at all times when residents need assistance with any medications.

WHEN RESIDENT IS AWAY FROM FACILITY

When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:

The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility.

The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident's medication record.

The medication may be transferred to a **pill organizer** pursuant to Florida law (i.e., if filled by a nurse or pharmacist) and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record.



Medications may be separately prescribed and dispensed in an easier-to-use form, such as **unit dose packaging**:



Chapter 6. Medication Orders and Prescription Labels

Prescriptions require a doctor's order. Orders should be written in simple clear terms. Assistance provided to residents with prescription medication can only occur as a result of a health care provider's (HCP's) order such as a doctor's. A prescription (Rx) is a written order to a pharmacist listing the name and quantities of drugs or ingredients to be mixed and/or dispensed to a specific person or resident including directions for use. The green table below contains some Latin abbreviations that are commonly used on prescriptions or medical orders. The red table contains a few abbreviations that should **not** be used because their use frequently results in medication errors.

COMMON MEDICAL and PRESCRIPTION (Rx) ABBREVIATIONS

Refer to a pharmacy or medical reference book for a more complete guide to abbreviations, or go online to ISMP - Institute for Safe Medication Practices at www.ISMP.org/

Common Rx Abbreviations

bid - two times daily
tid - three times daily
qid - four times daily
ac - before each meal
pc - after each meal
HS - at bedtime (hour of sleep)
PRN - as needed
D/C - Discontinue
q am - every morning
q3h - every 3 hours
q4h - every 4 hours
q6h - every 6 hours
q8h - every 8 hours
q pm - every evening
OD - right eye
OS - left eye
OU - both eyes
ad - right ear
as - left ear
au - both ears
gtt - drop
PO - by mouth
SL - sublingual
tab - tablet
cap - capsule
tsp - teaspoonful = 5 mL

**If You Assist,
You Must Be Able to
Read and Understand
Medication Orders
and Prescription Labels**

Do Not Use the Following Abbreviations:

<u>DO NOT USE</u>		<u>USE INSTEAD</u>
q.d.	-	daily
.5 mg	-	0.5 mg
1.0 mg	-	1 mg
U	-	unit
q.o.d.	-	every other day

**Recommended by the
Joint Commission**

PRESCRIPTION LABELS

No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is **properly labeled** and dispensed according to Chapters 465 and 499, FS, and Rule 64B16-28.108, FAC. See sample Rx label below:

(1) Ned

Halftab

(2) Atenolol (generic for TENORMIN)

(3) 50 mg

(4) #45

(5) Take one-half (1/2) tablet twice daily

(6) for Hypertension (high blood pressure).

(7) Fill Date: January 21, 2012 3 Refills before 01/21/2013

(8) Dr. Pill Splitter, MD. (10) Rx # 772001

(9) ALF PHARMACY (11) Discard after 01/21/2013
2300 Flagler Avenue
Flagler Beach, FL 32136
386-555-1212

Prescription drug labels should be written according to the doctor's order and should include at least:

- (1)) Resident's name
- (2) Name of the drug
- (3) Strength of drug
- (4) Quantity of drug
- (5) Time medication should be taken
- (6) Any directions for use or special precautions (i.e., SHAKE WELL)
- (7) Prescription date and number of refills
- (8) Prescriber's name (i.e., doctor/physician)
- (9) Pharmacy name, address, and phone number
- (10) Prescription (Rx) number for pharmacy filing
- (11) Expiration date/discard date/do not use by date

**Nurses, CNAs, and
unlicensed staff
cannot change
a prescription label,
only a pharmacist can.**

**Examples of
AUXILIARY LABELS:
Take With Food
Shake Well Before Using
May Cause Drowsiness
Take With Plenty of Water
Do Not Drink Alcohol
Take Before or After Meals**

Auxiliary Labels

Auxiliary labels are additional labels (usually colored) added by the pharmacist.



Example:

If a customized patient medication package is prepared for a resident and separated into individual drug containers, then the following information must be recorded on each individual container:

The resident's name and Identification of each drug product in the container.

Except for pill organizers filled by nurses, no person other than a pharmacist may transfer medications from one storage container to another.

Customized pre-packaged unit dose packages must be labeled with resident and medication names.

Except for the use of pill organizers filled by nurses, only a pharmacist may transfer medications from one storage container to another.



SAMPLE MEDICATIONS

Sample or complimentary prescription drugs that are dispensed by a health care provider must be kept in their original manufacturer's packaging, which shall also include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed.

If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they shall be kept in a container that bears a label containing the following information:

1. Practitioner's name
2. Name and strength of the drug
3. Resident's name
4. Directions for use
5. Date dispensed
6. Expiration date

Note: Before dispensing any sample or complimentary prescription drug, the resident's health care provider shall provide the resident with a written prescription, or a fax copy of such order.

Sample medications must have a written prescription or fax copy of such order.

OVER THE COUNTER (OTC) PRODUCTS

The term OTC includes, but is not limited to, OTC medications, vitamins, nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription.

A stock supply of OTC products for multiple resident use is not permitted in any facility. OTC products, including those prescribed by a licensed health care provider, must be

labeled with the resident's name and the manufacturer's label with directions for use, or the licensed health care provider's directions for use. No other labeling requirements are necessary nor should be required. Residents or their representatives may purchase OTC products from an establishment of their choice.

A stock of OTC medications for multiple resident use is prohibited in any facility.

CLARIFYING PRN MEDICATION ORDERS AND Rx LABELS

If the directions for use are "as needed" or "as directed," the health care provider shall be contacted and requested to provide revised instructions.

For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations shall be specified; for example, Take one tablet every four hours, **"as needed for pain, not to exceed four tablets per day."**

The written or fax copy of revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.

Recognize the need to clarify "as needed" prescription orders.

Unlicensed staff may assist with PRN "as needed" orders only at the request of the resident.

Unlicensed staff may assist residents to take medications only as directed on a prescription label or written medication order. The instructions must be clear and not require Judgment.

It may be necessary to clarify unclear, vague, or non-specific orders or labels as needed.

The directions should include the following:

1. **Condition for which the medication should be given (for pain),**
2. **Dosage of medication to give (1-2 tablets),**
3. **Hours it should be given (every six hours), and**
4. **Upper limit of dosages (do not exceed six (6) tablets in 24 hours).**

This is an example of a **clear**, concise prescription label.

(1) Vera Clear
 (2) Hydrocodone /Acetaminophen (APAP)
 (3) 5 mg - 500 mg
 (4) #60 (sixty)
 (5) Take 1-2 tablets every six (6) hours
 (6) as needed for pain.
 Do not exceed six (6) tablets in 24 hours.

(7) Fill Date: February 2, 2012 3 Refills before 07/2/2012

(8) Dr. Noah Clarify, MD. (10) Rx # 772002

(9) ALF PHARMACY (11) Discard after 02/02/2013
 2300 Flagler Avenue
 Flagler Beach, FL 32136
 386-555-1212

This is an example of an **unclear** label that does not provide clear directions.

(1) Unna Clear
 (2) Zolpidem (generic for AMBIEN)
 (3)) 5 mg
 (4) #30 (thirty)
 (5) Take as needed
 (6)

(7) Fill Date: March 21, 2012 3 Refills before 08/21/2012

(8) Dr. Anita Clarify, MD. (10) Rx # 772003

(9) ALF PHARMACY (11) Discard after 03/21/2013
 2300 Flagler Avenue
 Flagler Beach, FL 32136
 386-555-1212

The prescription label directions above should include the following:

- (5) Take one tablet at bedtime as needed for sleep, and
- (6) May repeat x1 if needed 1 hour later.

When a medication label is without all the necessary information, the health care provider (HCP) should be contacted and requested to provide revised directions.

With ALL PRN "as needed" medication orders, you MUST KNOW and the label MUST SAY: as needed FOR WHAT? and any LIMITS to taking the medication.

As required, the **revised directions** should be **noted on the Medication Observation Record (MOR) or in** the medication record with the date and time they were provided by the health care provider and the signature of the person receiving the order.

If an **unlicensed** person obtains such clarification from the health care provider the **order must be written**; a fax copy is sufficient.

A revised medication label may be obtained only from a pharmacist.

How to Clarify Medication Orders

Determine the information you need: for example, the dosage amount, time schedule, or the upper dosage limits for the medication. Call the health care provider's office and explain that you are not a nurse, you are unlicensed, but are assisting a resident with medication as allowed in assisted living facilities. Ask the HCP's office to fax a copy of the order. This will decrease the likelihood of a medication error as a result of a hearing, interpretation, or transcription error. Ask another staff member who is trained to assist residents with medications, or a nurse, to double check this information on the medication record. Ask the pharmacist to review the medication record including the revised directions.

MEDICATION ORDERS INVOLVING JUDGMENT OR DISCRETION

Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.

Recognize a medication order that requires judgment or discretion and advise the resident, resident's health care provider, or facility employer that by law you are not allowed to assist with such orders. As an unlicensed person, you are prohibited by law from assisting with medication orders or prescription labels which require judgment or discretion. A medication label or order must be specific regarding:

1. Strength of medication
2. Amount of each dose of medication (dosage)
3. Route of administration (oral, sublingual, topical, etc.)
4. Time of administration
5. Reason for use of medication

Example of label with directions that unlicensed persons are **not allowed to assist with**:

- (1) Asah Needed

(2) Furosemide (generic for LASIX)

(3) 20 mg

(4) #60 (sixty)

(5) Take one tablet daily as needed

(6) **for fluid retention**

(7) Fill Date: January 12, 2012 3 Refills before 01/21/2013

(8) Dr. Will Clarify, MD. **(10)** Rx # 772004

(9) ALF PHARMACY **(11)** Discard after 01/21/2013
2300 Flagler Avenue
Flagler Beach, FL 32136
386-555-1212

Unlicensed persons may not assist with directions that require judgment, such as:

“Furosemide 20 mg take one tablet as needed for fluid retention.”

Unlicensed persons cannot assist with this type of medication order because they are not trained to assess “fluid retention.”

“Acetaminophen 500 mg take one tablet every six (6) hours as needed for fever > 100 degrees.” Unlicensed staff are not trained to assess vital signs such as “temperature.”

Orders like this should be discussed with the resident's health care provider to clarify directions for when the resident needs the medication so that judgment is not required.

How to advise the resident and your employer that you are not allowed to assist with certain medication orders:

When medication orders or prescriptions are first received, check to make sure the directions do not require “judgment” or “discretion.”

If the directions are not clear, or if they require a decision by the unlicensed person to determine when or how to give a medication, contact your supervisor or employer.

Describe the exact reasons why you are not allowed to assist the resident with this medication.

Advise the resident that the medication directions require judgment, and you must call the health care provider to request clear directions regarding this medication so that you may assist with this medication. Inform the resident that you will let them know the results of your discussion with the health care provider. **Advise the HCP that you are not a nurse.** Inform the health care provider that you are prohibited by law from assisting a resident with medication directions that require judgment or discretion.

Advise HCP that you would like to discuss the best option for the resident.

Note: Sometimes HCPs don't realize what an assisted living facility is, or assume that all ALFs have nurses on staff who can take care of doctor's medication orders.

MEDICATION ORDER CHANGES

Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container, which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.

Telephone Orders

A nurse or pharmacist may take a medication order by telephone. Such orders must be promptly documented in the resident's medication record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable.

**The facility may place
an "alert" label
on the medication container
alerting staff
of revised directions
on the MOR.**

**Examples of
"ALERT" LABELS:
Note: Dosage/Strength
Change in order, see MOR**

**A nurse or pharmacist may take
a medication order by telephone.
The facility must obtain a written order
in 10 working days.**

Prescription Refills

The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled and refilled in a timely manner. Mail order medications may require two-three weeks to arrive. On demand reorder/refills usually arrive same day or next day. Medications that require prior authorization may take five-10 business days. This requires the physician to sign off on a form. If the client does not have refills, allow 72 hours for the physician to respond to a refill request. RTS-refill too soon means that if we send the medication that the insurance will not pay for it and the resident will have to pay the cash price. ANY TIME YOU ARE OUT OF MEDICATIONS, THIS IS URGENT, PLEASE LET THE PHARMACY KNOW!

**Prescriptions should always
be filled and refilled
in a timely manner.**

PRACTICE EXERCISE

As related to assistance with self-administration of medication, there are five problems on the label below. Can you find all five?

Judge (1) Ned
(2) Digoxin (generic for LANOXIN)
(3) .125 mg
(4)
(5) Take as needed
(6) Hold for heart rate less than 60

(7) Fill Date: April 1, 2012 3 Refills before 07/1/2013

(8) Dr. Will Clarify, MD. (10) Rx # 772005

(9) ALF PHARMACY (11) Discard after 04/1/2013
2300 Flagler Avenue
Flagler Beach, FL 32136 386-555-
1212

ANSWERS:

Chapter 7. Medication Documentation and Records

HOW LONG ARE PRESCRIPTIONS VALID IN FLORIDA?

Rx's or prescriptions for non-controlled substances are valid for one year or the number of refills noted on the prescription are all filled, whichever is first. Controlled substances in Schedule II (CII) are valid for that original prescription only. Never refills. Schedules III-V are valid for six months or until the total number of refills noted on the prescription are filled. Facilities must maintain a written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, **changes in the method of medication administration**, or other changes which resulted in the provision of additional services.

Always record any changes in method of medication administration

PILL ORGANIZERS

For residents who use a pill organizer as described in Chapter 4, the facility shall keep either the original labeled medication container; or a medication listing with the following:

1. Prescription number;
2. Name and address of the issuing pharmacy;
3. Health care provider's name;
4. Resident's name and the date dispensed;
5. Name and strength of the drug, and
6. Directions for use.



MEDICATIONS DOCUMENTED ON AHCA FORM 1823

The AHCA form 1823 is required to verify the resident's current list of medications and must be signed by the admitting doctor/physician or authorized health care provider (HCP). See the current page 4 of the AHCA form 1823 medication form as **Appendix 4**. The complete AHCA form 1823 can also be obtained from www.ahca.myflorida.com/assistedlivingunit.

HCP must complete an annual review for use and continued need for any chemical restraint.

CHEMICAL RESTRAINTS

For medications that serve as chemical restraints, the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use and continued need for the medication.

Always record medication immediately after it is offered.

DOCUMENTATION AND GUIDELINES FOR MEDICATION OBSERVATION RECORDS (MOR)

The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration or medication administration.

The MOR must include the following:

1. **Name** of resident and all **known drug allergies** or note NKDA (no known drug allergies);
2. The **name** and **phone number** of **doctor, physician, or health care provider (HCP)**;
3. The **name** of each medication, **dose, route, time**, and **specific directions for use**;
4. The **signature** and **initials** of **each staff person who will be assisting with self-administered medications or administering** any medication for a resident;
5. **Record of each time the medication was offered and taken** as prescribed; and
6. **Record of any missed dosages, refusals to take medication as prescribed, medication errors, or side effects.**

Guidelines:

An order written on the MOR must exactly match the prescription label.

Document on the MOR **IMMEDIATELY** after assisting the resident with his/her medication.

DO NOT begin to assist the **next** resident until the MOR is completed on the resident you are currently assisting and all medications have been properly returned to the storage area.

When an order is changed, the original entry on the MOR should **not** be altered. Instead, the original entry should be marked “Discontinued,” and then write the new order in a new space as a new entry.

NEVER USE WHITEOUT. If you make a mistake on the MOR, draw one line through the mistake and initial it.

Abbreviations should NOT be used on the MOR.

Always document on the MOR the assistance with PRN “as needed” medication orders that have **clear specific directions** for use and that **DO NOT** require judgment or discretion by the unlicensed staff.

Always check for allergies to drugs or latex.

How to Use the Medication Observation Record

The MOR is your record of all the medications a resident is receiving assistance with self-administration and the verification that you have assisted a resident to take his/her medication. When you provide assistance to a resident, record it on the MOR immediately after providing assistance. If a resident refuses to take a medication, record the refusal code on the MOR and explain why the resident refused the medication on the back of the MOR. Contact with the resident's physician should also be noted on the MOR or charted in the medical record. When a resident is hospitalized or out of the facility and does not receive assistance with medication, indicate this on the MOR. For example, write "H" in the box you would typically initial if the resident is hospitalized or "O" if the resident is out of the facility. **Many**

facilities use different codes. The table here shows some examples of codes. On the back of the MOR, keep a record of when the resident takes his/her medications out of the facility so this matches the chart. Circled initials or X in box means dose was not given. Record the reasons for missed dosages and medication errors on the back of the MOR. Any resulting actions should also be noted, (i.e., contacting the health care provider and/or instructions given by HCP). When an order is changed, the original entry on the MOR should not be altered. Instead, the original entry should be marked "discontinued" and the new order written

in a new space. The order written on the MOR must match the prescription label exactly. If the label says "Alprazolam 0.25 mg - take one tablet twice daily as needed for anxiety," the MOR cannot read differently.

MORs should contain the signature and initials of each staff person who will be using the MOR. Abbreviations should not be used on the MOR.

DO NOT begin to assist the **next** resident until the MOR is completed on the resident you are currently assisting and all medications have been properly returned to the storage area.

How to Use MORs

Put INITIALS in appropriate box when MEDICATION given.

Circle INITIALS when medication is REFUSED or NOT GIVEN.

State REASON for refusal on medication NOTES on MOR.

"As needed" PRN: REASON should be NOTED on MOR

Charting Codes for MORs

Circle initials or mark with X if dose was not given.

Other codes may include:

- H** - In Hospital / Rehab.
- O** - Out of facility
- E** - Charted in ERROR
- U** - Drug unavailable
- R** - Resident REFUSED
- D/C** - Discontinued by HCP
- V** - Vomited or spit out
- MED**
- X** - Drug held by HCP

EXAMPLE of BLANK MOR (FRONT)



Name:	DOB: ____/____/____	AGE ____yrs	Month / Yr ____/____
Allergies:	Height ____' ____"	Weight ____ lbs	MEDICATION OBSERVATION RECORD MOR
DIAGNOSIS:			
LABS / NOTES:			

MEDICATIONS	DOSE	DIRECTIONS for USE	TIMES	INDICATION	ALERTS

Physician Name	Phone	Practice	Pharmacy Name	Address	Phone

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

EXAMPLE of BLANK MOR (BACK)

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

INITIALS	Print Name	Signature	INITIALS	Print Name	Signature

Blood Pressure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Systolic																															
Diastolic																															
Heart Rate																															
Temperature																															
Blood Sugar - 8 am																															
Initials																															

CHARTING INSTRUCTIONS

1. Put INITIALS in appropriate box when MED given.
2. Circle INITIALS when medication REFUSED or NOT GIVEN
3. State REASON for refusal on medication NOTES below.
4. As needed MED: REASON should be NOTED below.

CHARTING CODES

- A. Charted in ERROR
- B. Drug temporarily unavailable
- C. Resident REFUSED
- D. Discontinued by Health Care Provider

CHARTING CODES

- E. Resident vomited or spit out MED
- F. Drug Held by Medical Order
- G. Drug Holiday
- H. Home / Pass / Out of Facility

DATE	HOUR	MEDICATION / DOSE	CODE	REASON	RESULTS / RESPONSE	TIME NOTED	SIGNATURE



Name:

DOB: ____ / ____ / ____ AGE ____ yrs

Month / Yr ____ / ____

Allergies:

Height ____' ____" Weight ____ lbs

MEDICATION OBSERVATION RECORD
MOR

EXAMPLE of COMPLETED Medication Observation Record (MOR)

Ron Sample MOR (FRONT)



Ron Sample **DOB: 1/21/1955** **AGE: 57 yrs** **JUNE 1-30, 2012**
Allergies: Codeine, PCN **Height: 5'11"** **Weight: 201 lbs** **MEDICATION OBSERVATION RECORD MOR**
DIAGNOSIS: High Cholesterol, Hypertension, Stroke Prevention, Acid reflux, Diabetes Mellitus Type 2, Depression, Back Pain, Nasal Infection,
LABS / NOTES: Check LFT's, HR, BP, Blood sugar, Cholesterol, and temperature.

MEDICATIONS	DOSE	DIRECTIONS for USE	TIMES	INDICATION	ALERTS
Lipitor 10 mg	10 mg	Take one tablet daily.	8 am	Cholesterol	Muscular pain
Lisinopril 20 mg	20 mg	Take one tablet daily.	8 am	Hypertension	Headache, dizziness, fatigue
Plavix 75 mg	75 mg	Take one tablet daily.	8 am	Antiplatelet drug	Bleeding, bruising
Nexium 20 mg	20 mg	Take one tablet daily.	8 am	Acid reflux	Headache
Metoprolol 50 mg	50 mg	Take one tablet two (2) times daily.	8 am, 8 pm	Hypertension	Hypotension, dizziness
Metformin 500 mg	500 mg	Take one tablet two (2) times daily.	8 am, 8 pm	Diabetes Mellitus Type 2	Diarrhea, nausea, vomiting
Amoxicillin Suspension 250 mg / 5 ml	500 mg	Take two (2) teaspoonfuls (10 ml) three (3) times daily.	8 am, 4 pm, 12 am	Infection	"Shake Well" Diarrhea, GI Upset
Sertraline 25 mg	25 mg	Take one tablet at bedtime.	9 pm	Depression	Suicidal thinking
Hydrocodone/ APAP 5-500 mg	5-500 mg	Take one tablet every six (6) hours as needed for pain.	8 am, 2 pm, 8 pm, 2 am	PRN as needed for Pain	Constipation, drowsiness

Physician Name	Phone	Practice	Pharmacy Name	Address	Phone
Dr. Hope U. Feelgood	386-555-7777	Family	ALF Pharmacy	2300 S Flagler Ave. Flagler Beach, FL 32177	386-555-1212

Lipitor 10 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	8 am																															
Lisinopril 20 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	8 am																															
Plavix 75 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	8 am																															
Nexium 20 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one capsule	8 am																															
Metoprolol 50 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	8 am																															
Take one tablet	8 pm																															
Metformin 500 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	8 am																															
Take one tablet	8 pm																															

Ron Sample MOR (BACK)

Amoxicillin 500 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take 10 mls	8 am																															
Take 10 mls	4 pm																															
Take 10 mls	12 am																															

Sertraline 25 mg	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	9 pm																															

Hydrocodone / APAP 5-500mg as needed for Pain.	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Take one tablet	8 am																															
Take one tablet	2 pm																															
Take one tablet	8 pm																															
Take one tablet	2 am																															


	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

INITIALS	Print Name	Signature	INITIALS	Print Name	Signature

Blood Pressure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Systolic																															
Diastolic																															
Heart Rate																															
Temperature																															
Blood Sugar - 8 am																															
Initials																															

CHARTING INSTRUCTIONS	CHARTING CODES	CHARTING CODES
1. Put INITIALS in appropriate box when MED given.	A. Charted in ERROR	E. Resident vomited or spit out MED
2. Circle INITIALS when medication REFUSED or NOT GIVEN	B. Drug temporarily unavailable	F. Drug Held by Medical Order
3. State REASON for refusal on medication NOTES below.	C. Resident REFUSED	G. Drug Holiday
4. As needed MED: REASON should be NOTED below.	D. Discontinued by Health Care Provider	H. Home / Pass / Out of Facility

DATE	TIME	MEDICATION / DOSE	CODE	REASON	RESULTS / RESPONSE	TIME NOTED	SIGNATURE

	Ron Sample	DOB: 1/21/1955	AGE: 57 yrs	JUNE 1-30, 2012
	Allergies: Codeine, PCN	Height: 5'11"	Weight: 201 lbs	MEDICATION OBSERVATION RECORD MOR

Completing a Medication Observation Record

When completing an MOR, you must record on the MOR the directions exactly from the prescription label. The MOR must exactly match the medication label.

Prescription and MOR SAMPLE Exercise 1.

- (1) **Ron Sample**
- (2) Amoxicillin Suspension
- (3) 250 mg / 5 ml
- (4) Dispense 120 ml
- (5) Take two (2) teaspoonfuls (10 ml) three (3) times daily.
- (6) for infection. FINISH ALL MEDICATION.
SHAKE WELL before USE. REFRIGERATE.
- (7) Fill Date: June 1, 2012 No Refills
- (8) Dr. Hope. U. Feelgood, MD
- (9) ALF PHARMACY (10) Rx # 772012
2300 Flagler Avenue. (11) Discard after 06/14/2012
Flagler Beach, FL 32136
386-555-1212

Ron Sample has a penicillin allergy and a prescription for Amoxicillin, which is a penicillin derivative that commonly causes a cross sensitivity allergic reaction like penicillin. Alert the doctor or other HCP. Amoxicillin is an antibiotic so it is important to finish all medication as prescribed. Note that amoxicillin is a suspension, so you should always SHAKE IT WELL. Also, once amoxicillin is mixed, it should be stored in refrigerator and discarded after 14 days or as noted on medication container. Always check for expiration dates on medication.

- (1) **Ron Sample**
- (2) Hydrocodone / Acetaminophen (APAP)
- (3) 5 mg - 500 mg
- (4) #60 (sixty)
- (5) Take one tablet every six (6) hours
- (6) as needed for pain.
- (7) Fill Date: June 1, 2012 1 Refill before 12/1/2012
- (8) Dr. Hope U. Feelgood, MD.
- (9) ALF PHARMACY. (10) Rx # 772013
2300 Flagler Avenue. (11) Discard after 06/1/2013
Flagler Beach, FL 32136
386-555-1212

Ron Sample also has a codeine allergy and a prescription for Hydrocodone/APAP. Hydrocodone is an opiate that may cause an allergic reaction in people allergic to codeine. Hydrocodone may not always cause a cross sensitivity reaction. Some people who are allergic to codeine are not always allergic to Hydrocodone, morphine, meperidine, and/or other opiates. Alert the doctor or HCP. Allergies depend on an individual's response, which may or may not be different. Always contact the HCP when in doubt.

Prescription and MOR SAMPLE Exercise 2.

Mary Sample MOR (FRONT)



Mary Sample	DOB: 11-21-1926	AGE 86	JUNE 1-30, 2012
Allergies: NKDA	Height 5' 7"	Weight 157 lbs	MEDICATION OBSERVATION RECORD MOR
DIAGNOSIS: Alzheimer's, Hypertension, Hypothyroidism			
LABS / NOTES:			

MEDICATIONS	DOSE	DIRECTIONS for USE	TIMES	INDICATION	ALERTS
Levothyroxine 175 mcg	175 mcg	Take one tablet daily.	8 AM	Hypothyroidism	
Metoprolol ER 50 mg	50 mg	Take one tablet daily.	8 AM	Hypertension	
Synthroid 125 mcg	125 mcg	Take one tablet daily.	8 AM	Hypothyroidism	
Lorazepam 1 mg	1 mg	Take one tablet two (2) times daily.	8 AM, 5 PM	Anxiety	May cause drowsiness
Namenda 10 mg	10 mg	Take one tablet two (2) times daily.	8 AM, 8 PM	Alzheimer's	
Aricept 10 mg	10 mg	Take one tablet daily at bedtime	8 PM	Alzheimer's	
Nitroglycerin 0.4 mg sublingual tablet	0.4 mg	Place one tablet under tongue as needed for chest pain.	PRN As needed	For Chest Pain	May cause headache

Physician Name	Phone	Type of Practice	Pharmacy Name	Address	Phone
Ned A. Brain, MD	386-555-1875	Neurology	ALF Pharmacy	2300 S. Flagler Avenue	386-555-1212
Hope U. Feelgood, MD	386-555-2043	Family		Flagler Beach, FL 32136	

Levothyroxine 175 mcg	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One tab - 8 AM																																
Metoprolol ER 50 mg	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One tab - 8 AM																																
Synthroid 125 mcg	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One tab - 8 AM																																
Lorazepam 1 mg	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One tab - 8 AM																																
One tab - 6 PM																																
Namenda 10 mg	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One tab - 8 AM																																
One tab - 8 PM																																
Aricept 10 mg	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
One tab - 8 PM																																

Mary Sample MOR (BACK)

Nitroglycerin 0.4 mg sublingual tablet	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
One tab - time																															
Initial																															

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

INITIALS	Print Name	Signature	INITIALS	Print Name	Signature

Blood Pressure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Systolic																															
Diastolic																															
Heart Rate																															
Temperature																															
Blood Sugar																															
Initials																															

CHARTING INSTRUCTIONS	CHARTING CODES	CHARTING CODES
1. Put INITIALS In appropriate box when MED given.	A. Charted in ERROR	E. Resident vomited or spit out MED
2. Circle INITIALS when medication REFUSED or NOT GIVEN	B. Drug temporarily unavailable	F. Drug Held by Medical Order
3. State REASON for refusal on medication NOTES below.	C. Resident REFUSED	O. Out of Facility
4. As needed MED: REASON should be NOTED below.	D. Discontinued by Health Care Provider	H. In Hospital

DATE	HOUR	MEDICATION / DOSE	CODE	REASON	RESULTS / RESPONSE	TIME NOTED	SIGNATURE



Mary Sample	DOB: 11-21-1926	AGE 86	JUNE 1-30, 2012
Allergies: NKDA	Height 5' 7"	Weight 157 lbs	MEDICATION OBSERVATION RECORD MOR

Mary Sample has a prescription for levothyroxine 175 mcg and SYNTHROID 150 mcg. Levothyroxine is the generic for SYNTHROID, so this would be duplication therapy. Contact the health care provider (HCP). Some residents may be confused between brand and generic names. Always check drug names very carefully. Some look alike and sound alike.

(1) **Mary Sample**
(2) Levothyroxine
(3) 175 mcg
(4) #30 (thirty)
(5) Take one tablet daily.
(6) for Hypothyroidism.
(7) Fill Date: June 1, 2012 11 Refills before 06/1/2013
(8) Dr. Ned A. Brain, MD.
(9) ALF PHARMACY. (10) Rx # 772021
 2300 Flagler Avenue. (11) Discard after 06/1/2013
 Flagler Beach, FL 32136
 386-555-1212

(1) **Mary Sample**
(2) Synthroid
(3) 150 mcg
(4) #30 (thirty)
(5) Take one tablet daily.
(6) for Hypothyroidism..
(7) Fill Date: June 1, 2012 11 Refills before 06/01/2013
(8) Dr. I. M. Brand, MD. (10) Rx # 772054
(9) ALF PHARMACY. (11) Discard after 06/01/2013
 2300 Flagler Avenue
 Flagler Beach, FL 32136 386-555-
 1212

Prescription and MOR PRACTICE Exercise 1

PRACTICE MOR (FRONT)



Name:	DOB: ____/____/____	AGE ____ yrs	Month / Yr ____ / ____
Allergies:	Height ____' ____"	Weight ____ lbs	MEDICATION OBSERVATION RECORD MOR
DIAGNOSIS:			
LABS / NOTES:			

MEDICATIONS	DOSE	DIRECTIONS for USE	TIMES	INDICATION	ALERTS

Physician Name	Phone	Practice	Pharmacy Name	Address	Phone

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PRACTICE MOR (BACK)

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

INITIALS	Print Name	Signature	INITIALS	Print Name	Signature

Blood Pressure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Systolic																															
Diastolic																															
Heart Rate																															
Temperature																															
Blood Sugar - 8 am																															
Initials																															

CHARTING INSTRUCTIONS	CHARTING CODES	CHARTING CODES
1. Put INITIALS In appropriate box when MED given.	A. Charted in ERROR	E. Resident vomited or spit out MED
2. Circle INITIALS when medication REFUSED or NOT GIVEN	B. Drug temporarily unavailable	F. Drug Held by Medical Order
3. State REASON for refusal on medication NOTES below.	C. Resident REFUSED	G. Drug Holiday
4. As needed MED: REASON should be NOTED below.	D. Discontinued by Health Care Provider	H. Home / Pass / Out of Facility

DATE	HOUR	MEDICATION / DOSE	CODE	REASON	RESULTS / RESPONSE	TIME NOTED	SIGNATURE



Name:	DOB: ____ / ____ / ____	AGE ____ yrs	Month / Yr ____ / ____
Allergies:	Height ____ ' ____ "	Weight ____ lbs	MEDICATION OBSERVATION RECORD MOR

(1) **George Sample**
 (2) Hydrocodone / Acetaminophen (APAP)
 (3) 10 mg - 500 mg
 (4) #100 (one hundred)
 (5) Take two(2) tablets every six (6) hours
 (6) as needed for Pain. DO NOT exceed six (6) in 24 hrs.
 (7) Fill Date: July 1, 2012 0 Refills require authorization
 (8) Dr. Over A. Dose, MD.
 (9) ALF PHARMACY. (10) Rx # 772099
 2300 Flagler Avenue. (11) Discard after 07/01/2013
 Flagler Beach, FL 32136
 386-555-1212

(1) **George Sample**
 (2) Lisinopril / HCTZ
 (3) 20 mg / 25 mg
 (4) #30
 (5) Take one tablet every day in the morning.
 (6) for Hypertension
 (7) Fill Date: August 1, 2012 11 Refills before 08/1/2013
 (8) Dr. High U. Pressure, MD.
 (9) ALF PHARMACY. (10) Rx # 772101
 2300 Flagler Avenue. (11) Discard after 06/1/2014
 Flagler Beach, FL 32136
 386-555-1212

Complete MOR for Practice EXAMPLE above 1.

PRACTICE EXERCISE QUESTIONS for example 1.

1. What is the resident's name?
2. What is the drug or medication name? Is it a generic or brand name?
3. What is the dose of the drug or medication? How many tabs, caps, tsp, mLs, drops, inhalations, etc., for this dose?
4. How many pills in the medication container?
5. What are the proper directions for taking the drug or medication, including special directions?
6. For what is the medication used in this case?
7. When was the prescription filled? How many refills remain?
8. What is the HCP's or doctor's name?
9. What is the pharmacy's name, address, and phone number?
10. What is the pharmacy Rx number?
11. What is the discard, expiration date, or do-not-use-after date?

EXAMPLE of Standard Administration Time Schedule

Some facilities may choose to use a standard administration time schedule.

Standard Administration Time Schedule

Abbreviation	Means	Administration Times
ac am	before breakfast	7 am
q am	every morning	8 am
QD (do not use)	Daily	8 am
qd (do not use)	Daily	9 am
bid	two times daily	8 am, 6 pm
tid	three times daily	8 am, 4 pm, 8 pm
tidac	before each meal	7 am, 11 am, 5 pm
tidpc	after each meal	9 am, 1 pm, 7 pm
qid	four times daily	8 am, 12 pm, 4 pm, 8 pm
q4h	every 4 hours	8 am, 12 pm, 4 pm, 8 pm, 12 am, 4 am
q6h	every 6 hours	6 am, 12 pm, 6 pm, 12 am
q8h	every 8 hours	8 am, 4 pm, 12 am
q pm	every evening	9 pm
HS	at bedtime (hour of sleep)	9 pm

Chapter 8. Medication Retrieval, Storage, and Disposal

This chapter covers the following requirements, related to the retrieval, storage, and disposal of medication, for assisted living facility unlicensed personnel:

- A. Residents' right to privacy
- B. How to retrieve medication using safety practices (see also Chapter 2)
- C. Storage for residents who self-administer
- D. Centrally stored medications
- E. Storing over-the-counter medications
- F. Storage of discontinued medications and reuse
- G. Disposal of discontinued, abandoned, or expired medications
- H. Best practice for proper disposal of medication

All residents have the right to privacy and rights regarding medication decisions.

A resident has the right to the following:

1. Be treated with respect and dignity;
2. Be treated as capable of making decisions;
3. Receive prompt and appropriate medical treatment;
4. Choose his/her own healthcare provider, and or physician;
5. Receive only medication prescribed for him/her;
6. Be given privacy including the administration of medications and treatments;
7. Be free from neglect and abuse;
8. Be free of restraints including chemical restraints;
9. Expect medication caregivers to know about and promote medication safety;
10. Refuse to participate in experimental research;
11. Complain without fear of being reprimanded or punished; and
12. Choose and refuse treatment prescribed, including medications.

A. RESIDENTS' RIGHT TO PRIVACY

Assisted living facilities have been increasing in number due to consumer (resident) desire to live in a more homelike environment that encourages personal autonomy allowing residents to be independent and make their own decisions. Assisted living staff have the responsibility of protecting resident privacy and supporting personal dignity and individuality, while at the same time providing supervision and assistance with daily living activities including medication management. This is not always an easy task, especially when it comes to working with residents and their families to safely manage the resident's medications. Residents' rooms are their private spaces. Staff should not violate this by searching through their drawers or cabinets without residents' permission. However, you must be aware of the conditions in the room. Are there any pills on the floor? Are there excessive amounts of over-the-counter medications in the room? When you are assisting the resident to put away clean clothes in drawers, you may observe for any medications that may be hidden. Ask the resident's permission to review the expiration dates on containers. If you do observe any pills on the floor or any other irregularity, discuss it with the resident and report it to the health care provider.

B. HOW TO RETRIEVE MEDICATIONS (TRIPLE CHECK)

1. Take the medication, in its previously dispensed, properly labeled container, from where it is stored, **check it**, and bring it to the resident.
2. In the presence of the resident, **check it again**, read the label, open the container, remove the correct prescribed amount of medication from the container, and close the container.
3. **Check it again**, then place an oral dosage in the resident's hand or place the dosage in another container and help (if necessary) the resident by lifting the container to his or her mouth.
4. Apply topical medications to skin, eye, ear, nose, or mouth as prescribed.
5. Return the medication container to proper storage. (**Best practice is to check it again when you return medication, to finally confirm all was done properly**).
6. Keep a record on a MOR when a resident receives assistance with self-administration each time a medication is offered. Record immediately after medication is given and observed that it was swallowed or administered properly.



C. STORAGE FOR RESIDENTS WHO SELF-ADMINISTER

Assisted living facilities are like residents' homes. Residents who are capable of self-administration and managing their own medications are allowed to do so. Residents are encouraged and allowed to remain as independent as possible. Therefore, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises, or in their rooms or apartments. Medications **must be kept locked** when residents are absent, unless the medication is in a secure place within the room or apartment or in some other secure place which is out of sight of other residents.

ONLY self-administered medications may be kept in resident's room, if stored safely and securely.



Prescription and over-the-counter medications for residents shall be centrally stored when the following conditions apply:

1. The facility administers the medication;
2. The resident requests that the facility store his/her medications (the facility shall maintain a list of all medications being stored pursuant to such a request);
3. A health care provider documents that it would be hazardous to the resident to keep the medication in his/her personal possession;
4. The resident does not keep it in a secure place or keep his/her room locked when absent or the resident fails to maintain the medication in a safe manner;
5. The facility determines that because of physical arrangements and the conditions or habits of residents that the resident keeping his/her medication poses a safety hazard to other residents; and

6. Facility policy requires all residents to centrally store their medications.

Note: An ALF may require all residents to “centrally store” their medications, but if an ALF has such a policy, the facility must provide this information to all residents prior to admission.

D. CENTRALLY STORED MEDICATIONS

All medications that are centrally stored are subject to the following restrictions:

1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and at normal temperature unless the medication is required to be refrigerated;
3. If required to be refrigerated, kept in locked container in the refrigerator, or the refrigerator must be locked, or the room or area where the refrigerator is located must be locked;
4. Kept in their legally dispensed, labeled package, and kept separately from the medication of other residents (**weekly pill organizers cannot be centrally stored without a proper label**); and
5. Staff trained to assist with or licensed to administer medications must have access to keys to the medication storage area or container at all times.



levels,



Medication Storage Tips:

Medication containers must be properly closed or sealed so that medications do not become loose and get mixed together.

The medication storage area should be well organized to reduce the risk of errors and to help save time when assisting with medications.

Place medications in a systematic order, for example, in alphabetical order by resident name or by room number.

Always store medications in their labeled containers. If, for example, a tube of medication arrives in a box labeled by the pharmacy, the medication must be stored in the labeled box.

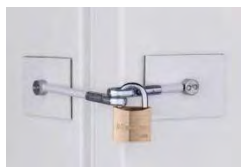
Store medications for the eye, ear, nose, and throat separately, for example, in different drawers of a medication cart, by using drawer dividers, separate plastic bags or boxes.

Ask your pharmacist or nurse for suggestions on how to set up and organize your storage areas.



REFRIGERATED MEDICATIONS MUST BE KEPT LOCKED

Always check medications for proper storage requirements.



- Once opened, most insulin should be stored in a REFRIGERATOR.
- Once mixed, most antibiotics should be REFRIGERATED.
- Medications shall be properly stored and safeguarded to prevent access by unauthorized persons.
- Expired or discontinued medications shall not be stored with current medications.
- Storage areas shall be locked, and of sufficient size for clean and orderly storage.
- Storage areas shall not be located near sources of heat, humidity, or other hazards that may negatively affect medication effectiveness or shelf life.
- Medications requiring refrigeration shall be stored in a refrigerator at the temperature established by the U.S. Pharmacopeia (36 - 46 degrees F.). If a multi-use refrigerator is used to store medications outside the secured medication storage area, a separate locked box shall be used to store medications, provided the refrigerator is near the medication storage area. Accurate thermometers (within ± 3 degrees) shall be provided in all refrigerators storing medications.

Do not expose medications to extremes in temperature or moisture unless medications are supposed to be refrigerated.

E. STORAGE OF OVER-THE-COUNTER (OTC) MEDICATIONS

An ALF cannot have a “stock supply” of over-the-counter (OTC) medications. Bottles of ibuprofen, aspirin, Maalox, Tums, creams, ointments, etc., may not be kept for use by multiple residents. However, individual residents may have their own OTC medications.

Residents may be allowed to keep over-the-counter medication in their rooms if they self-administer their medications, with or without assistance. If the resident requires medication to be administered, they should not store OTC medications in their room.

An ALF may centrally store OTC medications for residents. An ALF may store OTC medications for residents that have not been prescribed by a health care provider. OTC medications must be labeled with the resident’s name and the manufacturer’s instructions for use and kept with the medication at all times. When an OTC medication is prescribed by a health care provider, the medication must be stored in the same manner as a prescription and managed just like a prescribed medication.

A stock supply of any OTC Medication may not be stored for use by multiple residents in any ALF.

F. STORAGE OF “DISCONTINUED” MEDICATION

Store “**discontinued**” medications separately from medications being used currently. This will prevent you from continuing to give a medication that is no longer prescribed.

When a resident’s medication has been discontinued but has not expired, the medication should be returned to the resident (if safe) or the resident’s representative, OR the facility may centrally store the medication for future use for the same resident.

When centrally storing discontinued medications for residents, remember that only medications that have not expired may be kept. These medications must be stored separately from medications in current use, for example, in a separate drawer. The medication must be kept in a separate area that is marked “Discontinued Medication.”

NOTE: Do not alter or write on the medication label when a medication is discontinued.

Store "Discontinued Medications" separately from medications in current use.

When storing discontinued medications, **write the date the medication was discontinued** and the **name of the health care provider** who gave the order to discontinue **on the MOR**, and **keep a copy with the discontinued medication**. Store each resident’s discontinued medication together, for example, in a plastic bag, with the resident’s name clearly marked on the bag, in the area marked “Discontinued Medications.” If a medication, which was previously discontinued but has not yet expired, is re-prescribed, it may be used instead of having a new prescription filled. ALF staff must be sure that they are using the right medication and strength by checking with a pharmacist or HCP.

The ALF is responsible for storing, managing, and disposing of medications properly.

Do not alter or write on the medication label when a medication is "Discontinued."

Medication which has been discontinued but which has not expired shall be returned to the resident or the resident’s representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident’s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked “**DISCONTINUED MEDICATION.**”

G. DISPOSAL OF “DISCONTINUED” MEDICATION

If “discontinued” medications are “expired” or “abandoned,” they must be disposed of properly as described below. Otherwise, they may be stored.

DISPOSAL OF “ABANDONED” OR “EXPIRED” MEDICATION

When a resident’s stay in the ALF has ended, the medications must be returned to the resident, or the resident’s representative, unless otherwise prohibited by law. You must notify the resident, or his/her representative, that the medication needs to be removed. The resident or representative may take the medications or request that you dispose of the medication. If you do not hear from the resident or resident’s representative within 15 days of notification, the medications may be considered “abandoned,” and the ALF needs to dispose of them.

Medications which have been “abandoned” or which have “expired” must be disposed of within 30 days of expiration or abandonment. Documentation that the medications have been disposed of must be made in the resident’s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.

When medications have expired, disposing of them properly will protect you and others in your

Medications which have been “abandoned” or “expired” must be disposed of within 30 days.

home from consuming a medication that may have become ineffective or even toxic. Disposing of medications properly will help protect the environment as well as pets, children, and anyone who might find medicines in your trash.

While experts used to recommend flushing old medication down the toilet, today the Environmental Protection Agency (EPA) recommends against this because sewage plants may not be able to adequately remove drug ingredients from the water.

Medication must be disposed of properly.

There are two ways to dispose of discontinued, abandoned, or expired medications:

1. The medication may be taken to a pharmacist or other waste management agent for disposal; or
2. The medication may be destroyed by the administrator, or person(s) designated by the administrator, and one witness.

SOME DRUGS YOU CAN FLUSH

The FDA recommends flushing only if the drug label or accompanying information has instructions to do so. The FDA recommends that the following controlled substances (*) and other drugs should be flushed down the toilet instead of any other disposal method.

atazanavir sulfate capsules (REYATAZ)
entecavir tablets (BARACLUDE)
*fentanyl buccal tablets (FENTOR)
*fentanyl citrate (ACTIQ)
*fentanyl transdermal system (DURAGESIC) - cut it up.
gatifloxacin tablets (TEQUIN)
*meperidine HCL tablets (DEMEROL)
*methylphenidate transdermal patch (DAYTRANA)
*morphine sulfate capsules (AVINZA)
*oxycodone and acetaminophen (PERCOCET)
*oxycodone tablets (OXYCONTIN)
sodium oxybate (XYREM)
stavudine (ZERIT for oral solution)



IMPROPER DISPOSAL: To destroy medications in a facility, it is no longer appropriate to flush them down the toilet, except for those that are approved for flushing (see list above).

**Most medications should NOT
be flushed down the toilet.**



Always refer to printed material accompanying these medications for proper disposal.

HOW TO PROPERLY DISPOSE OF MEDICATION WASTE

Medication waste is generally in one of three regulatory categories: hazardous waste, infectious waste (also called biohazardous waste), and solid waste. All waste generators that are businesses and institutions, including assisted living facilities (ALFs), must separate their wastes into the correct regulatory category and ensure proper disposal.

You may return medications to the resident or his/her family for disposal. If the assisted living facility assumes responsibility for disposing of medications, solid, and hazardous waste, then all regulations DO apply to the waste. DO NOT always flush medications. Destroying medications by placing them in the sink or toilet and flushing them into the waste water is highly discouraged, because waste water treatment plants do not remove medications. Drugs can harm plants and animals that live downstream. It may be illegal to flush certain hazardous medications.

**Do not put medications
in infectious waste containers.**

DO NOT put medications in infectious waste containers. It is not appropriate (nor is it cost-effective) to put medications, empty medication bottles, or empty insulin or vaccine vials in sharps containers or biohazard waste bags. Mixing non-infectious waste with infectious waste is prohibited in Florida. It is no longer true that most infectious waste is incinerated; typically these wastes are disinfected and put in a landfill instead. Medications that are hazardous waste are regulated both by state and federal regulations. Hazardous waste includes items that are listed by name in the regulations, or exhibit characteristics of hazardous waste. Common hazardous waste medications include Epinephrine, Coumadin, vaccines preserved with Thimerosal, and even certain shampoos and vitamins/minerals.

An estimated 5-15 percent of medication waste may be hazardous waste. A reputable hazardous waste hauler can help you separate these wastes.

Health care products that are infectious waste include sharps such as syringes and intravenous delivery devices that can cut or puncture the skin. Please refer to other sources to help you in handling infectious waste.

Medications that are neither infectious nor hazardous are classified as solid waste. Medications that are considered solid waste can generally be handled like other garbage. A potential problem with disposal in general garbage is that medications can pose safety risks to individuals who inappropriately access the garbage and expose themselves to the medications.

PROPER DISPOSAL OF SOME MEDICATION

Take your medications out of their original containers.

Using gloves, mix drugs with a little water to make a slurry, then mix with an undesirable substance, such as plaster of paris, cat litter, or used coffee grounds.

Put mixture into a disposable container with a lid, such as a empty coffee can, margarine tub, or into a sealable bag.

Conceal or remove any personal information, including Rx number from the empty medication containers by covering it with black permanent marker or duct tape, or by scratching it off.

Place the sealed container with the mixture and the empty medication containers in trash.

BEST PRACTICE FOR PROPER DISPOSAL

The preferred practice is to have a waste hauler take medications to a medical waste or hazardous waste incinerator. The solid waste hauler may have appropriate containers and specific procedures for disposing of medications in your local area.

If the hauler method of disposal isn't available, place the medications in a container that can be sealed, such as a coffee container. Add a small amount of water to the medication to make a slurry. Add cat litter, plaster of paris, or some other absorbent material to the slurry to make it unusable. Finally, seal the container, such as an empty coffee container, and place the container in the garbage. Remove or obliterate any labels identifying the container as containing medications. This is a potential risk if someone handles the trash.

Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medications to the dispensing pharmacy pursuant to Rule 64B16-28.870, FAC. The Special-ALF permit is an optional facility license for those assisted living facilities providing a drug delivery system utilizing medicinal drugs provided in unit dose packaging. All medicinal drugs must be maintained in individual prescription containers for the individual patient. Medicinal drugs may not be dispensed on the premises. Medicinal drugs dispensed to patients of Special-ALF permits may be returned to the dispensing pharmacy's stock under the provisions of Rule 64B16-28.118, F.A.C. Dispensed controlled substances that have been discontinued shall be disposed of under the provisions of Rule 64B16-28.301, F.A.C. Medicinal drugs dispensed to the residents of a Special-ALF permit shall meet the labeling requirements of Rule 64B16-28.502 and paragraph 64B16-28.402(1) (h), F.A.C. Each facility holding a Special-ALF permit shall designate a consultant pharmacist of record to ensure compliance with the laws and rules governing the permit. The Board office shall be notified in writing within 10 days of any change in the consultant pharmacist of record. The consultant pharmacist of record shall be responsible for the preparation of the Policy and Procedure Manual required by subsection 64B16-28.800(2), F.A.C. Policy and Procedure Manuals must provide for the appropriate storage conditions and security of the medicinal drugs stored at the facility. The consultant pharmacist of record shall inspect the facility and prepare a written report to be filed at the permitted facility at least monthly.

Rulemaking Authority 465.022 FS. Law Implemented 465.0196 FS. History—New 2-23-98.

Chapter 9. How to Assist With Self-Administration of Medication

Unlicensed persons may, consistent with a dispensed prescription label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered.

ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION FOR UNLICENSED ALF STAFF INCLUDES the following: Oral and Topical Dosage Forms including skin, ophthalmic (eye), otic (ear), and nasal (nose) forms.

Assistance with self-administration of medication includes the following:

- Preparing and making available such items as water, juice, cups, spoons, tongue blades, tissues, etc.
- Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.
- In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
- Observing the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record.
- Returning unused doses to the medication container.
- Documenting assistance with self-administered medications on the MOR immediately.
- Self-administered medications include both legend and over-the-counter oral dosage forms; topical dosage forms; and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, inhalers, and diskus.

Understand what “assistance” with medication includes and does not include.

**ASSISTANCE DOES NOT INCLUDE the following:
Injectables by any route, parenterals,
IPPB machines or nebulizers, irrigations for wound care,
PRN “as needed” orders that require
“judgment” or “discretion.”**

Routes of administration for trained unlicensed personnel.

Oral	tablets, capsules, or liquids swallowed by mouth
Buccal	tablet dissolved in the cheek of mouth
Sublingual	tablet dissolved under the tongue
Topical	creams, ointments or sprays applied to the skin
Transdermal	patch absorbed through the skin
Ophthalmic	drops instilled or ointments applied into the eye
Otic	drops or suspensions placed into the ear
Nasal	drops or sprays placed into the nose or nostril
Inhalant	inhaler or diskus inhaled into lungs through the mouth



Routes of administration only for nurses or licensed personnel.

Rectal	into the rectum
Vaginal	into the vagina
Subcutaneous (Sub-q)	injection-under the skin
Intramuscular (IM) injection	injection into muscle
Intravenous (IV) injection	injection into vein
Naso-Gastric	into the NG tube



Universal Precautions

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infection for HIV, HVB, and other blood-borne pathogens.

Review the common aseptic practices that should be followed in all settings to prevent the spread of infections.

HAND WASHING

- Always wash hands after urination, bowel movements, and changing of sanitary products.
- Wash hands when there is any contact with a body fluid or substance (i.e., blood, urine, feces, vomit, saliva, respiratory secretions, any other body fluid or drainage).
- Wash hands before preparing or eating food.
- Wash hands after covering the mouth and nose when coughing or sneezing.

One of the easiest and most important ways to prevent infection is hand washing.

Hands are one of the most common transmitters of pathogens from one person or item to either yourself or another person.

Hands should be washed BEFORE and AFTER providing any type of care.

Hand Washing Procedure

1. Make sure that soap, paper towels, and a wastebasket are available.
2. Move watch and sleeves (if applicable) up arms approximately five inches.
3. Turn the faucet on using a paper towel and adjust water temperature.
4. Toss paper towel into wastebasket.
5. Wet the wrists and hands thoroughly, keeping them below elbow level to keep microorganisms from moving up your arms.
6. Dispense soap.
7. Lather hands and wrists by rubbing palms together for at least 20 seconds.
8. Wash each hand and wrist and between the fingers for one to two minutes. Underneath the fingernails can be cleaned by rubbing the fingertips against the palm of the other hand.



9. Dry hands with clean paper towel and use paper towel to turn off faucet. Dispose of paper towel in wastebasket.
10. The fingernails should be cleaned with the first hand washing of the day and if they are contaminated or soiled in any way.

Always wash hands before and after handling medications.

HOW TO ASSIST WITH ORAL SOLID AND LIQUID MEDICATIONS

ORAL SOLID MEDICATIONS

- First, the unlicensed person must ensure that the patient is alert and able to swallow the medication without difficulty. If patients have a difficult time swallowing the pills, instruct them to first drink some water or juice and then attempt to swallow the medication again. If a resident seems to be having difficulty swallowing medications, talk to the health care provider regarding the need for a more convenient dosage form such as a liquid or capsule.
- Obtain needed supplies (water, juice, cups, spoon, pill splitter, etc.) before assisting with the administration of medications to a resident.
- It is usually best to take medications with a full glass of water (check MOR for directions).
- Breaking, cutting, splitting, or crushing any oral solid tablet or capsule requires judgment or discretion and must be decided by a licensed health care provider or pharmacist.
- Only break, cut, or split SCORED TABLETS or crush oral solid tablets or capsules as prescribed or authorized by licensed health care provider.
- Long-acting forms of medication (i.e., extended-ER or sustained release-SR) should not be broken, crushed, or chewed before swallowing.
- Medication that appears to have been contaminated (dropped on floor, etc.), shall not be returned to the container.
- Assist with medication only when you are sure the “nine rights” are being carried out and the resident does not have any drug or latex allergies: Right resident, drug, dose, route, time, reason, response, right to refuse, and record/document.
- Compare medication label with the MOR three times to ensure accuracy.
- Verify the medication label with the MOR before retrieving medication.
- Check to ensure proper medication was taken from storage with the MOR.
- Check pharmacy label and MOR for any change in directions or dose change.



- If the medication is a tablet or capsule in special or unit dose packaging, the medication is removed from the individually wrapped package and placed into a cup. Hand the cup to the resident along with a fresh glass of water. The unlicensed person must observe the patient put the medication into his/her mouth and swallow the medication completely without difficulty. The medication cup is then disposed of properly.

Always observe the resident swallow the medication.

- Have resident place tablets, capsules, etc., in middle of the tongue, and if sublingual under the tongue or buccal in the cheek, if applicable. Removing dentures helps with swallowing if edentulous (without teeth). Follow with at least a half (1/2) cup water, preferably a full 8 ounce glass of water.

**ALWAYS CHECK EXPIRATION DATES
when retrieving medication from locked storage area.**

How to Assist With Oral SOLID Medications:

1. Wash hands and obtain necessary items (medication container with label, MOR, water, juice, etc.). Check expiration date of medication.
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the alert resident and confirm understanding.
5. Open container in front of the resident and place medication in resident's hand or cup or other suitable device or container.
6. Assist the resident in taking the medication. (Do not put in mouth.)
7. Observe the resident swallowing the medication.
8. Return medication to proper storage area.
9. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
10. Always document the administration of a PRN "as needed" medication and the resident's response.
11. Wash hands properly.

Do not SPLIT or CRUSH medication WITHOUT a health care provider ORDER or Rx LABEL.



Breaking, cutting, or splitting scored tablets

- Only scored tablets can be broken by unlicensed personnel or staff. A medication label may state “take half a tablet”; **however**, you may **only** break tablets and caplets that are “scored.”
- A scored tablet has been imbedded for easier and even breakage; it assures the correct amount is divided.
- You may use a pill cutter or other devices to break a scored medication.
- You must wear gloves if you handle the pill to break it with your thumbs.



How to BREAK tablets

1. Wash hands and gather necessary items (medication container with label, MOR, cups, facility’s designated pill cutting device).
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
5. Open container in front of the resident, split scored medication using pill splitter or cutting device and place medication in resident’s hand or cup or other suitable container.
6. Assist the resident in taking medication. (Do not put in mouth.)
7. Observe the resident swallowing the medication.
8. Return medication to proper storage area.
9. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
10. Always document the administration of a PRN “as needed” medication and the resident’s response.
11. Wash hands properly.

Crushing Tablets

Can the medication be crushed?

You may crush a medication only when the medication label specifically directs you to do so. Some medications are not meant to be crushed. In general, medications that are “sustained-release,” “controlled release,” “extended release,” or which have an “enteric coating” may not be crushed.



Can the capsule be opened and mixed with food?

- Most crushed tablets or emptied capsules may be mixed with certain foods including applesauce, pudding, or jelly immediately prior to administration.
- Medications cannot be “hidden” in foods for residents who are refusing them.
- Residents may only **knowingly** take a medication with food if it is easier for them.
- Remember that you are assisting residents to take medications, not administering medications.
- Pay close attention to the instructions on the label. It’s a good idea to check with the pharmacist to **be certain** a particular medication can be broken or crushed.
- Request specific directions for crushing medication. Could the medication be given in liquid form? Is there another medication which may be easier for the resident to swallow?

How to CRUSH a Medication, Using a Pill Crusher

1. Wash hands and obtain necessary items.
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying a resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
5. Open container in front of the resident, **crush medication (see below)**, and place medication in resident’s hand or cup or other suitable device.
6. **Crushing medication: Place medication in paper cup and cover with another paper cup, and use pill crusher or firm instrument on top of cup to crush the medication.**
7. Assist the resident in taking medication with food. (Do not put in mouth.) Place all of the crushed medication onto a spoon with food.
8. Observe the resident swallowing the medication.
9. Return medication and supplies to proper storage area.
10. Record assistance with medication on MOR.
11. Wash hands properly.



DO NOT CRUSH:
Buccal (cheeks or mouth cavity), enteric coated, sustained-release, or sublingual (under the tongue) tablets.

Medications that should not be crushed or chewed

Many solid dosage forms should not be crushed or chewed for a variety of reasons. If a resident's condition does not allow for oral solid dosage forms (tablets, capsules, etc.), check with the HCP to see if it is acceptable to crush the medication in question. If crushing is not allowed, consult with the pharmacist or HCP to prescribe the medication in a liquid or other suitable form. A reference should be checked, or HCP, or a pharmacist should be consulted before crushing any medication.

Buccal tablets (cheeks or oral cavity) and sublingual tablets (under the tongue) are designed to dissolve in the oral fluids of the mouth for more rapid and complete absorption than in the stomach or GI tract.

Enteric Coated tablets are designed to pass through the stomach and then dissolve in the gastrointestinal (GI) tract to prevent destruction of the medication by stomach acid, to prevent medication from irritating the stomach lining, or to achieve a prolonged action from the medication.

Sustained or Time Release CAPSULES are designed to release medication over a prolonged or sustained period, usually 8-24 hours. The beads or pellets within the capsule are designed to dissolve at different rates to either reduce stomach irritation or prolong the action of the medication. **If prescribed**, it is acceptable to open the capsules and administer the contents in food so long as the beads or pellets are not crushed or chewed. A reference should be checked, or HCP, or a pharmacist consulted before assisting with medication in this manner.

Sustained or Time Release TABLETS are designed to release medication over a prolonged or sustained period, usually 8-24 hours. The tablets are designed to dissolve at different rates to either reduce stomach irritation or prolong the action of the medication.

Some specific time release tablets include formulations with a slow release core, mixed release granules, multilayer tablets, or porous inert carriers.

Do not crush or chew these products. A reference should be checked, or HCP, or pharmacist consulted before assisting with medication in this manner.

ORAL LIQUID MEDICATIONS

- These are medications that are poured, measured, and swallowed.
- If the medication is a liquid suspension, it is necessary to shake thoroughly prior to offering it to the resident. A rotating wrist movement will ensure a more thorough mixture.
- After “SHAKING WELL,” always measure out the required exact amount in milliliters (mLs) into a measurable container or cup, measured at EYE level.
- Take care not to pour more than is needed.
- Be sure not to touch the rim or inside of the cup with your dirty or contaminated hands.
- Clean the lip of the bottle, if necessary, with a clean moist paper towel before recapping.



- **Do not use silverware spoons for giving medication. They are not all the same size. A silverware teaspoon could be as small as a half teaspoon or as large as two teaspoons.**
- Measuring spoons used for cooking are accurate, but they spill easily.
- Oral syringes have some advantages for giving liquid medications. They are accurate and easy to use.
- Dosing cups are also a handy way to give liquid medications. However, dosing errors have occurred with them. Always check to make sure the units (teaspoon, tablespoon, or mL) on the cup or syringe matches the units of the dose you want to give.
- Liquid medications often don't taste good, but many flavors are now available and can be added to any liquid medication. Ask your pharmacist.
- If medication requires REFRIGERATION, store in REFRIGERATOR and monitor temperature daily.
- Liquid medications will be given in their unit dose container if provided. If liquid medication is not in unit dose form, follow proper procedure for pouring. Use only specially marked measuring devices to measure doses. Liquid medications should be measured at eye level.



**Liquid medications
should be measured at eye level.**



- When giving both tablets and syrups, remember to always offer the syrups last. Always be aware that most elixirs and spirits have alcohol, and the medication must be monitored for patient abuse.

How to Measure and Pour Oral LIQUID Medication:

1. If LIQUID medication requires **REFRIGERATION**, store in **locked REFRIGERATOR** and monitor temperature with daily log.
2. Wash hands and obtain necessary items (medication with label, MOR, cups, **accurate measuring container or device**, etc.).
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
4. Follow facility policy for identifying a resident. Address resident by name.
5. If LIQUID medication is a **suspension**, **“SHAKE WELL.”**
6. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
7. Measure and pour liquids using a container with measurements on it (oral syringes, unit dose cups, cooking spoons, etc.). Remove the cap and place it with the open side up. Hold the bottle with the label toward the palm of the hand to avoid soiling the label. Locate the marking on the container for the amount to be poured in a container at eye level.
8. Measure with container at eye level and pour medication using thumb to identify the correct level (dose) and then close container properly.
9. Assist the resident in taking the right medication. (Do not place in mouth.) Pour right amount of medication in cup or other suitable container and place in the resident’s hand.
10. Observe the resident swallowing the medication.
11. Check to see that the cap of the bottle is on securely. Return medication container to proper storage area (i.e., LOCKED refrigerator).
12. Record that assistance was provided on the MOR.
13. Wash hands properly.



Unit conversions

- 1 mL = 1 mL (Do not use cc)
- 2.5 mL = 1/2 teaspoonful
- 5 mL = 1 teaspoonful
- 15 mL = 1 tablespoonful = 3 teaspoonfuls
- 3 teaspoonfuls (15 mL) = 1 tablespoonful (15 mL).

- Many liquid medications are pre-measured and come individually wrapped.
- When dispensing from a bottle the health care provider must measure the liquid carefully. Locate the desired ml mark on the cup and put your thumbnail on the mark. At eye level, pour the liquid up to the exact mark. Place measuring cup on level surface. Pour the medication on the side away from the label to keep the label clean. Wipe off excess from the bottle.
- The suspension may be drawn up into a syringe for ease of delivery; remember to have the patient upright and push slowly so as not to eject the fluid into the patient’s mouth.
- If resident has trouble swallowing a medication, check with the health care provider (HCP) for other available forms of the medication or ask your pharmacist for advice.

Unit Conversions
1mL = 1mL (Do not use cc)
2.5 mL = 1/2 teaspoonful
5 mL = 1 teaspoonful
15 mL = 1 tablespoonful
3 teaspoons (15 mL) =
1 tablespoonful (15 mL)

HOW TO ASSIST WITH TOPICAL MEDICATIONS FOR THE SKIN (creams, lotions, ointments, patches, and sprays)

- Medications should be applied as directed by HCP. Examine the skin site to observe the condition both before and after applying the topical medication.
- It is best to use latex gloves during the application process to prevent any unwanted reactions from the medication, and always wash your hands after removing gloves as per OSHA standards.
- Be gentle when applying medication as the area may be sensitive or painful.
- **YOU ARE NOT ALLOWED TO ASSIST WITH CREMES OR OINTMENTS THAT REQUIRE A DRESSING (i.e., wound care).**



How to Assist With TOPICAL Creams, Lotions, Ointments, and Sprays

1. Wash hands, identify right resident, **provide for privacy**, and obtain necessary items (medication container with label, MOR, tongue blades, clean gauze pads, etc.).
2. TRIPLE CHECK. Verify the medication label with the MOR. Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable position, and read the medication label to the resident and confirm understanding.
5. Use gloves or an applicator, such as a wooden tongue depressor, clean Q-tip, or gauze pad, so that your hands don't come into contact with medication or affected skin. Using gloved hand, apply thin film of cream, ointment, lotion, or spray to affected area. **Do not cover with a bandage unless directed by the HCP.** Replace container top promptly.
6. Spread onto affected area as prescribed by a physician until absorbed, unless the directions say to leave a film. Avoid rubbing the skin.
7. Dispose of tongue depressor, gauze pads, and gloves, and wash hands immediately.
8. Return medication to proper storage area (i.e., LOCKED area).
9. Record that assistance was provided on the MOR.
10. Always document the administration of a PRN "as needed" medication and the resident's response.

How to Assist With the Application of Transdermal PATCHES

1. Wash hands, identify right resident, **provide for privacy**, and obtain necessary items (medication patch with label, MOR, etc.).
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR again before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
5. Open the package and remove the patch. Date and initial the patch (and time, if appropriate).
6. Remove the backing from the patch, using care not to touch medication with hands.
7. Apply the patch to a dry, hairless part of the body, according to package instructions. Watch for old patches that should be removed or absence of a patch that should be present. Alternate the application sites to avoid skin irritation. Notify the health care provider of irritation.
8. Dispose of supplies and wash hands immediately to avoid absorbing the medication yourself.



9. Return medication to proper storage area (i.e., LOCKED area).
10. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
11. Always document the administration of a PRN “as needed” medication and the resident’s response.
12. Wash hands properly.

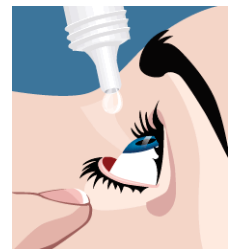
ALWAYS CHECK EXPIRATION DATES when retrieving medication.

**When dispensing medications for the eyes, ears, and through the nose,
it is always best to check with the registered nurse
to assure the delivery procedure is performed correctly.
When assisting the patient with self-administration of these types of medications,
it is best to observe the procedure first before attempting to assist on your own.**

HOW TO ASSIST WITH TOPICAL EYE MEDICATIONS (Ophthalmics)

Proper Use of EYE DROPS and EYE OINTMENT

1. If EYE medication requires **REFRIGERATION**, store in locked **REFRIGERATOR** and monitor temperature with daily log.
2. Wash hands and obtain necessary items (**eye** medication with label, MOR, warm cloth, gauze, tissues, barrier as disposable tray, etc.).
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
4. Follow facility policy for identifying resident. Address resident by name.
5. Identify which eye (right, left, or both) to receive medication.
6. Ask the resident to sit or lie down and clean the eye with warm water if needed to remove any discharge from the eye. If crusting or discharge is present, the eye should be cleaned with a clean, warm washcloth. Use a clean area of the cloth for each eye. When cleaning the eye, wipe from the inner eye to the outer eye (from closest to the nose, to away from the nose). Wash hands again. Put on examination gloves. If drops are a suspension, then “SHAKE WELL.”
7. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
8. Remove cap and place it upright on barrier or on a clean dry surface.



9. Explain procedure. Tilt resident's head slightly back and with gloved finger assist resident to pull down gently on the lower eyelid to form a "pouch," while instructing the resident to look up. Place other hand against resident's forehead to steady. Hold inverted medication container between the thumb and index finger, and press gently to instill prescribed amount into "pouch" near outer corner of eye.
10. **IF DROPS, place drops in "pouch" in the lower eye lid. Do NOT let tip of dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration. Recap container.**
11. **IF OINTMENT, run a strip of ointment in "pouch" in the lower eye lid. Recap container.** With other hand, place dropper or dispensing bottle as close to eye as possible without touching it.
12. Instruct resident to close eyes gently to allow for even distribution over surface of eye. Resident should not blink or squeeze eyes shut.
13. Wipe off tears or excess from the eye with a clean gauze, cotton ball, or tissue.
14. Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator).
15. If administering medication to BOTH eyes, use a different gloved finger to apply pressure to other eye tear duct.
16. If additional drops of the same or different medication are required in the same eye, wait 3-10 minutes (check package insert) and repeat procedures above.
17. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
18. Always document the administration of a PRN "as needed" medication and the resident's response.
19. Remove and dispose of gloves. Discard barrier.
20. Wash hands thoroughly.
21. Monitor for side effects or adverse effects.
22. When two or more eye medications are being administered, they should be scheduled at least 10 minutes apart. Check package insert.
23. Special Note: If more than one eye medication is to be administered at same time as ointment, consult physician or pharmacist for direction.
24. Some medications require longer waiting periods. Always refer to the individual package insert or other reliable reference for complete administration information of eye medications.
25. **Resident's vision may be blurred after application. Instruct resident to remain seated until vision clears up to reduce chance of falling.**



When more than one eye medication is being administered, they should be at least 10 minutes apart.

HOW TO ASSIST WITH EAR MEDICATION (Otic Preparations)

1. If EAR medication requires **REFRIGERATION**, store in **locked REFRIGERATOR** and monitor temperature with daily log.
2. Wash hands and obtain necessary items (**ear** medication with label, MOR, gloves, cotton balls, tissues, barrier as disposable tray, etc.). Check expiration date of medication when retrieving medication.
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
4. Follow facility policy for identifying resident. Address resident by name.
5. Identify which ear (right, left, or both) to receive medication.
6. **Explain procedure.** Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If drops are suspension, then **“SHAKE WELL.”**
7. Assist the resident to a comfortable position and turn resident’s head so that the affected **ear** is facing up.
8. If bottle serves as dropper, remove cap and place it upright on barrier or on a clean, dry surface.
9. Straighten **ear** canal by gently pulling earlobe up and back.
10. **IF DROPS, instill prescribed number of drops into ear canal. Do NOT let tip of dropper touch the ear or any other surface. Recap container.**
11. Instruct resident to remain in same position about five minutes with affected ear upwards. Gently place a cotton ball in the external ear canal or canal to prevent leakage.
12. Replace medication into labeled box/bag and return medication to proper storage area (i.e., **LOCKED** refrigerator if required).
13. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
14. Remove and dispose of gloves. Discard barrier.
15. Wash hands thoroughly.
16. Monitor for side effects or adverse effects.



HOW TO ASSIST WITH NOSE MEDICATION (Nasal Preparations)

Proper Use of NASAL DROPS and NASAL SPRAYS

1. If NOSE medication requires **REFRIGERATION**, store in **REFRIGERATOR** and monitor temperature with daily log.
2. Wash hands and obtain necessary items (**Nose** drop or spray medication with label, MOR, gloves, cotton balls, clean tissues, barrier as disposable tray, etc.). Check expiration date of medication when retrieving medication.
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident. Be sure sufficient doses remain.
4. Follow facility policy for identifying resident. Address resident by name.
5. Identify which **NOSTRIL** (right, left, or both) to receive medication.
6. **Explain procedure.** Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If NOSE drops are suspension, then **“SHAKE WELL.”** Check label.



7. Assist the resident to a comfortable position and turn resident's head so that the affected **NOSTRIL** is facing up.
8. If bottle serves as dropper, remove cap and place it upright on barrier or on a clean, dry surface.
9. If possible, ask resident to blow nose gently to remove any excess mucus.
10. **IF NOSE DROPS**, instill prescribed number of **NOSE drops** into **NOSTRIL** or both **NOSTRILS**. Do **NOT** let tip of dropper touch the **NOSE** or any other surface. Recap container.
11. **IF NOSE SPRAY** (check package insert for specific instructions if possible), do the following:
 - a. Prime nasal inhaler device by holding bottle upright and away from face while spraying into air.
 - b. Resident should be sitting up, if possible. Instruct resident to hold head upright, slightly forward.
 - c. Gently press side of nostril that is not receiving drug using finger of other hand.
 - d. Keep bottle upright and insert spray tip into nostril (no more than 1/4 inch). Point the tip to the back outer side of nose. Ask resident to breathe out through mouth.
 - e. **Instill prescribed number of SPRAYS into one or both NOSTRILS as prescribed. Press actuator or spray tip firmly and quickly while resident breathes through nose and out mouth. If necessary, clean spray tip and device according to manufacturer's guidelines or facility policy. Recap container.**
12. Instruct resident to remain in same position about five minutes with affected **NOSTRIL** upwards. Wipe off any excess drainage with clean tissue and gently place a cotton ball in the external **NOSTRIL** to prevent leakage. Resident should avoid blowing nose for at least 15 minutes.
13. If another dose of the same or different nasal medication is required in the same nostril, wait the amount of time recommended by the manufacturer (see package insert) or as prescribed. Repeat dose in either nostril as prescribed.
14. Replace medication into labeled box/bag and return medication to proper storage area (i.e., **LOCKED** refrigerator if required).
15. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
16. Remove and dispose of gloves. Discard barrier.
17. Wash hands thoroughly.
18. Monitor for side effects or adverse effects.



Proper use of INHALERS and DISKUS (by MOUTH)

1. If Inhaler or Diskus medication requires **REFRIGERATION**, store in **locked REFRIGERATOR** and monitor temperature with daily log.
2. Wash hands and obtain necessary items (HFA Inhaler or Diskus medication with label, MOR, gloves, cotton balls, tissues, barrier as disposable tray, etc.). Check expiration date of medication when getting drug.
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
4. Follow facility policy for identifying resident. Address resident by name.
5. Identify whether SPACER is required to administer medication.
6. **Explain procedure.** Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If medication is suspension then **“SHAKE WELL.”**
7. If using spacer, examine spacer/holding chamber and remove any foreign objects.
8. Remove mouthpiece cap (and spacer cap). If not connected, place cap(s) on barrier or clean dry surface.
9. If necessary (see package insert), hold inhaler upright and **“SHAKE WELL.”** Prime inhaler.
10. **IF NOT using SPACER, open mouth with inhaler one to two inches away, or place inhaler mouthpiece under top teeth and keep mouth open.**
11. **IF using SPACER, insert mouthpiece of inhaler into the flexible rubber end of spacer/holding chamber and place chamber in resident’s mouth with lips closed around mouthpiece.**
12. Ask resident to breathe out. (Do NOT exhale into inhaler). Position inhaler for administration of medication.
13. Press down on inhaler once to release medication as resident starts to breathe in slowly through the mouth over 3-5 seconds. (**Do not spray more than one puff into spacer at a time**).
14. If necessary, wash and thoroughly dry mouthpiece (see package insert or facility policy). If using spacer, wash spacer/holding chamber according to manufacturer’s guidelines or facility policy. Recap container.
15. Resident should hold breath as long as possible.
16. **Dry Powder Inhaler or Diskus DOs. Do follow manufacturer package insert for device loading dose and preparation.**

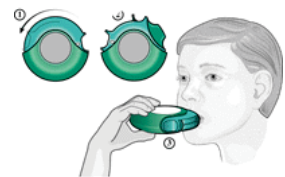


Figure 1: Diskus

Some devices require placement of capsule into inhaler/device and some already contain medication. Generally, the device should be held horizontally when used. Bring inhaler to mouth and close lips around mouthpiece. For best results, breathe in quickly and deeply through the mouth. Some inhalers require more than one inhalation in order to receive the full dose (see manufacturer’s package insert). If capsule was manually inserted prior to administration, remember to remove empty capsule when done.

17. Dry Powder Inhaler or Diskus **DON'Ts**. CAPSULES containing dry powder for inhalation should **NEVER BE SWALLOWED**. Never use capsules that are broken or have been exposed to water. Do not activate the dose (by pushing the lever or twisting the inhaler/device) more than once per dose. Most dry-powdered inhaler/devices should **NOT** be shaken. Do not use a spacer/holding chamber. Do **NOT** close device until all doses have been received.



18. If another puff of the same or different medication is required, wait 1-2 minutes (check package insert), then repeat procedures above. Close inhaler/device using manufacturer's package insert guidelines to ensure next dose will be ready when needed.
19. Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator if required).
20. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
21. Remove and dispose of gloves. Discard barrier.
22. Wash hands thoroughly.
23. Monitor for side effects or adverse effects.



**It is important to report, verbally and/or in writing
to incoming and outgoing staff,
any significant information
about residents and their medication.
Such communication facilitates the care of residents.**

WHEN IN DOUBT, DON T GIVE IT OUT!

Chapter 10. Common Medications, Classifications, Side Effects, and Adverse Drug Reactions (ADRs).

Caregivers usually assist residents with medications because of a physical or mental condition which limits their ability to self-administer medications. Caregivers can assist residents with prescription (Rx) medications as prescribed by a health care provider (HCP), over-the-counter (OTC) medications, vitamins, and other products a resident may choose to use. All OTC and other medications must be used carefully and safely with prescription medications. Everyone must promote and seek ways to improve medication safety. Part of a caregiver's role when assisting residents is to be aware that the resident may experience side-effects or adverse drug reactions (ADRs) as a result of taking a prescription (Rx) drug or over-the-counter (OTC) medication, including vitamins and supplements. Attention to detail is important. Learn about your residents and their medications.

DEFINITION OF DRUG OR MEDICATION

A pharmaceutical drug, also referred to as medicine, medication, or medicament, can be loosely defined as any chemical substance intended for use in the medical diagnosis, cure, treatment, or prevention of disease.

UNDERSTANDING SIDE EFFECTS OF MEDICATION

Normally we think a drug is given to make a person feel better, but all medications have side-effects. A side effect is the body's reaction to a medication that is different from what was intended by the physician or HCP. Some side effects may be tolerable while others may be very dangerous and sometimes life-threatening. It is not possible to know all potential side effects for all medications. Some mild side effects can be taken care of by simple techniques listed below. Look for all types of resident changes and contact the physician or HCP when side effects are moderate or serious. Check your facility policy.

PURPOSE AND EFFECTS OF MEDICATIONS

The human body does not always function perfectly. Sometimes, a person will take medication to help the body do its job better. There are four outcomes that may occur when a drug or medication is taken:

1. Desired effect,
2. Unwanted effect (commonly called side effects or adverse drug reactions or ADRs),
3. Drug interactions with another drug or with food, and
4. No apparent effect.

Side effects

A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

Adverse Drug Reactions (ADRs)

An adverse drug reaction (ADR) may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a drug that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term side effect is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions.

Drug-Drug and Drug-Food Interactions

Knowledge of common drug interactions can help prevent problems and promote good health. A “**drug-drug interaction**” results when a drug interacts with other drugs to cause side effects. A “**drug-food interaction**” occurs when a drug interacts with food and/or certain foods to cause side effects.

EXAMPLE OF DRUG-DRUG INTERACTIONS

DRUG Interactions: The levels/effects of Levothyroxine may be decreased by the following:

Aluminum Hydroxide; Bile Acid Sequestrates; Calcium Polystyrene Sulfonate; Calcium Salts; CarBAMazepine; Estrogen Derivatives; Fosphenytoin; Iron Salts; Lanthanum; Orlistat; Phenytoin; Raloxifene; Rifampin; Sevelamer; Sodium Polystyrene Sulfonate; Sucralfate

EXAMPLE OF FOOD-DRUG INTERACTIONS

FOOD Interactions: Decreased effect of Levothyroxine by certain foods below:

Taking levothyroxine with enteral nutrition may cause reduced bioavailability and may lower serum thyroxine levels leading to signs or symptoms of hypothyroidism. Soybean flour (infant formula), cottonseed meal, walnuts, and dietary fiber may decrease absorption of levothyroxine from the GI tract.

Desired Effects:

Medications are given or prescribed for many reasons. Some examples include the following:

- Promote health: example – nutritional supplement or vitamins
- Eliminate illness: example – antibiotics or cancer medications
- Control a disease: example – oral hypoglycemic or antihypertensive
- Reduce or prevent symptoms related to illness: example – cough suppressant or aspirin for stroke prevention, fever, or inflammation
- Alter behavior: example – anti-anxiety, anti-depressant, or anti-psychotic agents.

When the prescribed drug is working correctly, we say the medication is producing the desired effect. The desired effect is the beneficial effect we want the drug to accomplish.

The use of a drug should be based on the potential medical benefit versus the risk of unwanted effects such as side effects and adverse drug reactions (ADRs).

Unwanted Effects:

When a drug is taken, there is always the possibility that the resident may not have the response to the drug that was expected to occur. Some of the outcomes can be life threatening. Sometimes, the unwanted effects are predictable. These effects are called side effects or adverse effects. An example is drowsiness produced by sedating cold medications. Drowsiness may not occur in every person for whom the drug was prescribed, but it happens frequently. Constipation is an unwanted effect that may occur when taking iron preparations or opiates. Unwanted effects may be unexpected and unpredictable. Many elderly people become confused when starting a new drug. Some people are very allergic to drugs such as penicillin and have a reaction that could be fatal. Residents take many different kinds of medications. Each medication taken has a specific effect on the body. As a result, medications are **classified** according to how they will act in the body.

Knowing how the medication is classified will help you understand its effect on the body. It is important to have general knowledge of common medications and classifications of drugs and their potential side-effects, adverse drug reactions (ADRs) and drug-drug and drug-food interactions. Common classifications are listed below.

WARNING: Use of "aspirin" can be dangerous with "anticoagulants."

Facility Policy

A facility should have clear procedures for responding to changes in a resident's condition. Such procedures should describe the type of changes that should be documented in the resident's record; when changes should be reported to the administrator, nurse, physician, or HCP; and who should call the physician when necessary. The tables at the end of this chapter are lists of common medication side effects. Please discuss with your employer or nurse to determine the best course of action to be taken if a resident experiences any of these side effects or adverse drug reactions (ADRs).

EXAMPLE of Adverse Drug Reaction profile for memantine (NAMENDA) 1% to 10%:

Cardiovascular: Hypertension (4%), hypotension (2%), cardiac failure, cerebrovascular accident, syncope, transient ischemic attack

Central nervous system: Dizziness (5% to 7%), confusion (6%), headache (6%), anxiety (4%), depression (3%), hallucinations (3%), pain (3%), somnolence (3%), fatigue (2%), aggressive reaction (1% to 2%), ataxia, vertigo

Dermatologic: Rash

Gastrointestinal: Constipation (3% to 5%), diarrhea (5%), weight gain (3%), vomiting (2% to 3%), abdominal pain (2%), weight loss

Genitourinary: Urinary incontinence (2%), micturition

Hematologic: Anemia

Hepatic: Alkaline phosphatase increased

Neuromuscular & skeletal: Back pain (3%), hypokinesia

Ocular: Cataract, conjunctivitis

Respiratory: Cough (4%), dyspnea (2%), pneumonia

Miscellaneous: Influenza (4%)

It is important to note that there is **ALWAYS ONLY ONE** generic name for a drug such as the generic ampicillin, but there may be two or more **BRAND NAMES** (OMNIPEN, POLYPEN, PRIMAPEN) for the same single generic name.

This guide will generally present generic names in lower case hydromorphone and **BRAND NAMES** in UPPER CASE as (DILAUDID), and will not use trademark symbol as (Dilaudid®), due to some medication safety concerns with symbols such as ®.

Occasionally, the generic name will be printed in TALL MAN lettering as cloNIDine (CATAPRESS), glyBURIDE (DIABETA), glipiZIDE (GLUCOTROL).

COMMON MEDICATION CLASSIFICATIONS

Antibiotics/Anti-infectives

Used for treatment of various bacterial, fungal, and or viral infections, commonly found in the urinary and respiratory tracts. Examples of oral antibiotics, antifungals, and antivirals:

Penicillins: penicillin (PEN-VK), ampicillin (OMNIPEN, POLYPEN, PRIMAPEN), amoxicillin (AMOXIL), amoxicillin & clavulanate (AUGMENTIN).

Cephalosporins: cefuroxime (CEFTIN), cefaclor (CECLOR), cephalexin (KEFLEX), cefdinir (OMNICEF).

Macrolides: erythromycin (ERYTHROCIN), Azithromycin (ZITHROMAX as Z-PAK tablets, ZMAX as oral suspension),

Tetracyclines: tetracycline (ACHROMYCIN), doxycycline (VIBRAMYCIN),

Floroquinolones: levofloxacin (LEVAQUIN), ciprofloxacin (CIPRO), moxifloxacin (AVELOX).

Sulfa's: sulfamethoxazole/trimethoprim (BACTRIM, SEPTRA, BACTRIM or SEPTRA DS),

Misc: clindamycin (CLEOCIN), metronidazole (FLAGYL), nitrofurantoin (MACRODANTIN), nitrofurantoin P&G (MACROBID),

Antifungals: fluconazole (DIFLUCAN), nystatin (NYSTATIN).

Antivirals: acyclovir (ZOVIRAX), valacyclovir (VALTREX).

SIDE EFFECTS: Diarrhea; nausea; vomiting.

Seek medical attention right away (i.e., call 911 if HCP not available), if any of these SEVERE side effects occur when using antibiotics: severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the mouth, face, lips, or tongue); bloody stools; confusion; dark urine; fever, chills, or persistent sore throat; red, swollen, blistered, or peeling skin; seizures; severe diarrhea; stomach pain/cramps; unusual bruising or bleeding; yellowing of the skin or eyes. This is not a complete list of all side effects. If you have questions about side effects, contact your health care provider.

Analgesic Medications – Non Narcotic

Used in the treatment of acute or chronic pain. OTC (over-the-counter) acetaminophen = “APAP” also known as brand name TYLENOL. Acetaminophen-APAP also known as TYLENOL is mild to moderate analgesic (pain reliever). All medicines may cause side effects, but many people have no, or minor, side effects. When used in small doses, no COMMON side effects have been reported with APAP. Seek medical attention right away (i.e., call 911 if no HCP available), if any of these **SEVERE side effects** occur: severe allergic reactions (rash; hives; itching; difficulty breathing; chest tightness; swelling of the mouth, face, lips, or tongue); dark urine or pale stools; unusual fatigue; yellowing of the skin or eyes. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your health care provider (HCP), nurse, or pharmacist.

NSAIDS Non-steroidal anti-inflammatory drugs (NSAIDS) are used to treat the pain of Osteoarthritis and Rheumatoid Arthritis.

Examples: aspirin (BAYER), ibuprofen (MOTRIN or ADVIL), naproxen (ALEVE, NAPROSYN), meloxicam (MOBIC), diclofenac (VOLTAREN), celecoxib (CELEBREX).

SIDE EFFECTS of NSAIDS: rash; itching; nausea; vomiting; diarrhea; **signs of bleeding (bruising, blood, dark tarry stools)**; lethargy; sleepiness; tremors; constipation; diarrhea; dizziness; gas; headache; heartburn; mild stomach pain; nausea; stomach upset; trouble sleeping; vomiting.

Analgesic Medications - Opiate Narcotic

Opiate narcotic analgesics are used to treat pain.

Examples: codeine (CONTIN) morphine (MS CONTIN), hydrocodone & acetaminophen (LORCET, LORTAB, VICODIN), oxycodone (OXYCONTIN), hydromorphone (DILAUDID), and oxycodone & acetaminophen-APAP (PERCOCET), acetaminophen & codeine (TYLENOL with CODEINE) and tramadol (ULTRAM).

SIDE EFFECTS: nausea, vomiting, constipation, drowsiness, mental confusion, blurred vision, difficulty breathing, dizziness, flushing, lightheadedness, mental/mood changes.

Bisphosphonates

Used to prevent or treat osteoporosis in males and females.

Examples: alendronate (FOSAMAX), ibandronate (BONIVA).

In order to reduce esophagitis and esophageal events associated with oral bisphosphonates, patients should be advised to follow administration instructions carefully. Oral bisphosphonates should be taken first thing in the morning after awakening, with a full glass of plain water. Patients should remain in an upright position for at least 30-60 minutes after the dose. Any swallowing difficulties, chest pain, or heartburn may indicate signs of esophageal problems and should be reported.

SIDE EFFECTS: diarrhea; dizziness; headache; heartburn; mild arm, back, leg, muscle, or joint pain; mild flu-like symptoms (i.e., mild fever, chills, tiredness, weakness, joint or muscle aches); nausea; pain, swelling, or redness at the injection site, stomach upset.

Anti-Diabetic Agents

Anti-diabetic agents aim to achieve normoglycemia and relieve diabetes symptoms, such as thirst, polyuria, weight loss, ketoacidosis. The long-term goals are to prevent the development of or slow the progression of long term complications of the disease. Choice of anti-diabetic agent depends on the type of diabetes.

Type 1 Diabetes occurs when the body does not produce insulin, so insulin is the only treatment choice. Injected insulin acts similar to the body's insulin to lower blood glucose.

Type 2 Diabetes is first treated with oral anti-diabetic medicines. These medicines either make the pancreas produce more insulin or help decrease insulin requirements by the body. If normal blood sugar is not achieved with oral medicines then insulin can be added to the therapy. For patients with Non-Insulin Dependent Diabetes Mellitus (NIDDM) oral diabetic medication is used along with diet management to control blood sugar levels.

Examples: glipiZIDE (GLUCOTROL), metformin (GLUCOPHAGE), glyBURIDE (DIABETA), ezetimibe (ZETIA), glimepiride (AMARYL), ezetimibe & simvastatin (VYTORIN).

SIDE EFFECTS: Cold-like symptoms, diarrhea, headache, indigestion, mild weight gain, nausea, stomach upset, hypoglycemia (low blood sugar). Caution should be taken when administering to the elderly patient as they are more sensitive to these drugs, and it may be more difficult to recognize signs and symptoms of hypoglycemia. All medicines may cause side effects, but many people have no, or minor, side effects. Check with your doctor if any of these **COMMON side effects** persist or become bothersome when using these drugs: Diarrhea, dizziness, drowsiness, headache, nausea.

**INSULINS are INJECTABLE DRUGS AND SHOULD NEVER
BE HANDLED BY UNLICENSED STAFF.
ONLY LICENSED PERSONS CAN HANDLE THESE DRUGS.**

Insulin is an “injectable” anti-diabetic agent. Common types of insulin include: (LEVIMER, LANTUS, HUMALOG, NOVALOG, NOVULIN, HUMULIN, NPH, and Regular). Although you will not be administering these drugs, your patient may be receiving this medication. Most serious side effect is hypoglycemia. Signs and symptoms of hypoglycemia include diaphoresis, trembling, hunger, blurred vision, weakness, increased confusion, and coma. Insulin is a “high alert” drug since it is dangerous.

Antilipemic Agents (Cholesterol reducing agents)

These agents are used for lowering cholesterol levels in the blood.

Examples: atorvastatin (LIPITOR), lovastatin (MEVACOR), rosuvastatin (CRESTOR), simvastatin (ZOCOR).

SIDE EFFECTS: Constipation, headache, nausea, stomach upset or pain, weakness, diarrhea, joint pain, mild sore throat, runny or stuffy nose.

Examples: gemfibrozil (LOPID).

SIDE EFFECTS: Diarrhea, indigestion, stomach pain.

Examples: fenofibrate (TRICOR).

SIDE EFFECTS: Headache, nausea.

Examples: Niacin ER (NIASPAN).

SIDE EFFECTS: Diarrhea, dizziness, headache, heartburn, increased cough, indigestion, or upset stomach, nausea, temporary skin redness, itching, tingling, or feelings of warmth (flushing), vomiting.

Cardiovascular Medications

Used to prevent or treat Congestive Heart Failure (CHF), hypertension, arrhythmias. Most side effects come from over dosage. Report any of the following **SIDE EFFECTS** to the health care provider immediately: headache, nervousness, “pounding pulse,” weakness, flushing of skin, fainting (especially when a person stands after lying down).

Vasodilators

Used to relax or dilate the walls of arteries so that less force is needed to push the blood through the circulatory system. Used to control angina (chest pain).

Examples: sublingual nitroglycerin (NITROSTAT) and isosorbide (ISORDIL, IMDUR).

SIDE EFFECTS: Burning or tingling sensation; dizziness, lightheadedness, or fainting when sitting up or standing; flushing of the face and neck; headache; nausea; vomiting.

Cardiotonics

Used to control the rate and rhythm of the heart, improves the force of contraction of heart.

Examples: Digoxin (LANOXIN).

SIDE EFFECTS may indicate drug toxicity: Loss of appetite, nausea and vomiting, diarrhea, confusion, headache.

Antiarrhythmics

Used to treat irregular heartbeats by slowing the heart so it does not beat too rapidly.

Examples are Procainamide (PRONESTYL), amiodarone (CORDARONE, PACERONE), sotalol (BETAPACE).

SIDE EFFECTS: Nausea, vomiting, dizziness, nervousness, “pounding pulse,” headache.

Anticoagulants

Also sometimes called “blood thinners” to **prevent formation of blood clots.**

Example: **warfarin (COUMADIN).** Too much warfarin can lead to bleeding including ulcers or cranial bleeding which can lead to death. Too little can lead to clots including stroke, thrombophlebitis, or pulmonary embolism. Never administer aspirin or aspirin products without a doctor’s or health care provider’s (HCP) order. **These are “high alert” medications or very dangerous. Be extra careful with these drugs.**

WARNING: Use of aspirin can be dangerous with anticoagulants.

SIDE EFFECTS: Bruising, bleeding gums, nosebleeds, black tarry stools. Caution: Men should use electric razor when taking these drugs.

WARNING: Use of "aspirin" can be dangerous with "anticoagulants."

Anti-platelet drugs

Used to prevent blood clots.

Examples: **clopidogrel (PLAVIX)**, dipyridamole (PERSANTINE), dipyridamole & aspirin (AGGRENOX). **Be extra careful with these drugs.**

SIDE EFFECTS include easy bruising, minor bleeding, bleeding gums, nosebleeds, black tarry stools. Caution: men should use an electric razor when taking these drugs.

Antihypertensives

Antihypertensive medications normalize hypertension (high BP), by lowering blood pressure in various ways.

Alpha Adrenergic Agonists

Examples: **clonidine (CATAPRESS)**.

SIDE EFFECTS: Constipation, dizziness, drowsiness, dry mouth, headache, nausea, tiredness, trouble sleeping.

Angiotensin-converting enzyme (ACE) inhibitors

Examples: **enalapril (VASOTEC)**, **lisinopril (ZESTRIL or PRINIVIL)**, **Captopril (CAPOTEN)**, **benazepril (LOTENSIN)**.

SIDE EFFECTS: Cough, diarrhea, dizziness, headache, tiredness, taste changes.

Beta Blockers

Examples: **Propranolol (INDERAL)**, **atenolol (TENORMIN)**, **metoprolol tartrate (LOPRESSOR)**, **metoprolol succinate (TOPROL-XL)**, **carvedilol (COREG)**.

SIDE EFFECTS: Cold fingers or toes, diarrhea, dizziness, drowsiness, headache, lack of energy, lightheadedness, nausea, tiredness.

Calcium Channel Blockers

Some calcium channel blockers like **amlodipine (NORVASC)** are used in angina and hypertension to control the heart rate and help to decrease the heart's pumping strength and relax blood vessels.

Examples: **amlodipine (NORVASC)**, **nifedipine (PROCARDIA)**, **diltiazem (CARDIZEM)**, and **verapamil (ISOPTIN)**.

SIDE EFFECTS: Constipation; dizziness; facial flushing; headache; lightheadedness; tiredness; weakness; persistent, dry cough.

Angiotensin II receptor Blocker (ARB)

Angiotensin II (which is formed by enzymatic conversion from angiotensin I) is the primary pressor agent of the renin-angiotensin system. Effects of angiotensin II include vasoconstriction, stimulation of aldosterone synthesis/release, cardiac stimulation, and renal sodium reabsorption.

Examples: olmesartan (BENICAR), losartan (COZAAR), telmisartan (MICARDIS), valsartan (DIOVAN).

SIDE EFFECTS: Diarrhea, dizziness, tiredness.

Diuretics

Sometimes called “water pills,” they help the body eliminate excess fluids through urinary excretion. Certain diuretics are often given along with antihypertensive drugs to treat high blood pressure. Diuretics are often used to treat congestive heart failure (CHF).

Examples: hydrochlorothiazide (HYDRODIURIL), spironolactone (ALDACTONE), furosemide (LASIX), and torsemide (DEMADEX). Triamterene (DYRINIUM), triamterene & hydrochlorothiazide (DIAZIDE, MAXZIDE).

SIDE EFFECTS: Dizziness, lightheadedness, diarrhea, dizziness or light-headedness when standing or sitting up, headache, loss of appetite, nausea.

Central Nervous System Medications

Used to decrease the symptoms of mental disorders such as depression, anxiety, agitation, Alzheimer's, dementia, psychosis, schizophrenia, or other organic brain disorders.

ALZHEIMER'S/DEMENTIA

Alzheimer's disease is characterized by cholinergic deficiency in the cortex and basal forebrain, which contributes to cognitive deficits.

Examples: donepezil (ARICEPT), memantine (NAMENDA), rivastigmine (EXELON).

SIDE EFFECTS: Constipation; dizziness; drowsiness; dry mouth; lightheadedness; pain, redness, or swelling at the injection site; weakness; weight gain.

Anti-Anxiety

Used to decrease symptoms of anxiety such as intense fears, panic, repetitious thoughts or actions, tremors, fast heart rate or breathing. These drugs can be habit forming.

Examples: diazepam (VALIUM), lorazepam (ATIVAN), and alprazolam (XANAX), and busPIRone (BUSPAR).

SIDE EFFECTS: Drowsiness, dizziness, headache, confusion, depression, nausea, rash, vomiting, dry mouth, loss of appetite, headache, constipation, itching, loss of balance, and lethargy.

Anticonvulsant Agents

Used in the treatment and prevention of seizure activity. If you care for a patient who is on an anticonvulsant drug, it is important that you know what to do for a seizure.

SIDE EFFECTS: Nausea, vomiting, blurred vision, and fatigue.

Examples: phenytoin (DILANTIN), carbamazepine (TEGRETOL), clonazepam (KLONOPIN), gabapentin (NEURONTIN), topiramate (TOPAMAX), divalproex ER (DEPAKOTE ER), lamotrigine (LAMACTIL), levetiracetam (KEPPRA), oxcarbazepine (TRILEPTAL), pregabalin (LYRICA), and Phenobarbital.

Anti-Depressants

Used to decrease symptoms of depression such as trouble concentrating, changes in sleeping and eating patterns or thoughts of wishing to die. Antidepressants are used to improve mood and may take up to 7-10 days to be effective.

Examples: amitriptyline (ELAVIL), citalopram (CELEXA), desvenlafaxine (PRISTIQ), escitalopram (LEXAPRO), duloxetine (CYMBALTA), fluoxetine (PROZAC), paroxetine (PAXIL), zoloft, bupropion (WELLBUTRIN SR, XL, ZYBAN), sertraline (ZOLOFT), mirtazapine (REMERON), traZODone (OLEPTRO), venlafaxine (EFFEXOR), and doxepin (SINEQUAN).

SIDE EFFECTS: orthostatic hypotension, drowsiness, confusion, Parkinson-like tremors, constipation, decreased sexual desire or ability, diarrhea, dizziness, dry mouth, increased sweating, light-headedness when you stand or sit up, loss of appetite, nausea, stuffy nose, tiredness, weakness, yawning.

Anti-psychotics

Used to decrease symptoms of psychosis such as hallucinations, delusions or disorganized thinking. Examples include haloperidol (HALDOL), risperidone (RISPERDAL), OLANzapine (ZYPREXA), quetiapine (SEROQUEL), and ziprasidone (GEODON). Antipsychotic drugs can take as long as a month of administration before they are effective.

SIDE EFFECTS: drowsiness, confusion, dry mouth, difficult urination, constipation, tremors, loss of balance.

Side effects associated with antipsychotic drugs can be particularly dangerous. Tardive Dyskinesia can have nonreversible side effect such as lip smacking, facial tics, eye blinking, tongue thrusting, shuffling gait, and head nodding. If any symptoms are noticed notify the physician or HCP as soon as possible.

Mood Stabilizers

Used to treat the symptoms of bipolar disorder, such as not sleeping for several nights, and frantic highs (mania) and drastic lows.

Examples: lithium (ESKALITH, LITOBID), valproic acid (DEPAKENE), divalproex sodium (DEPAKOTE), and carbamazepine (TEGRETOL).

SIDE EFFECTS: Constipation, diarrhea, dizziness, drowsiness, headache, increased or decreased appetite, mild hair loss, nausea, sore throat, stomach pain or upset, trouble sleeping, vomiting, weakness, weight gain.

Sedatives/Hypnotics

Used to calm the emotionally upset patient, to promote sleep and rest.

Examples: zolpidem (AMBIEN), temazepam (RESTORIL), eszopiclone (LUNESTA), lorazepam (ATIVAN), and alprazolam (XANAX).

SIDE EFFECTS: headache, confusion, diarrhea, dizziness, drowsiness (including daytime drowsiness), “drugged” feeling, dry mouth, nausea, nose or throat irritation, sluggishness, stomach upset, and weakness.

Stimulants

Used to treat of attention-deficit/hyperactivity disorder (ADHD).

Examples: amphetamine & dextroamphetamine XR (ADDERALL), lisdexamfetamine (VYVANSE), methylphenidate ER (CONCERTA).

SIDE EFFECTS: Constipation, decreased appetite, diarrhea, dizziness, dry mouth, headache, increased sweating, mild irritability, nervousness or restlessness, nausea, trouble sleeping, unpleasant taste, upper stomach pain, vomiting, weight loss.

Gastrointestinal Tract Medications

Used in the treatment and preventions of GERD (Gastro Esophageal Reflux Disease), heartburn, gastric ulcers, and indigestion.

Antacids

Used to relieve gastric and ulcer pain by neutralizing stomach acids. Too many antacids can interfere with digestion. Examples: aluminum/magnesium hydroxide (MYLANTA, MAALOX), calcium carbonate (TUMS). Shake liquids well before using, and tablets should be chewed thoroughly.

Acid Blockers

Used to decrease gastric acid secretions thereby preventing gastric ulcers. These common acid blockers are known as **Histamine (H₂) antagonist**.

Examples: cimetidine (TAGAMET), ranitidine (ZANTAC), and famotidine (PEPCID).

SIDE EFFECTS: Confusion and B12 deficiency, headache, dizziness, rash, gas, diarrhea, and abdominal pain. Very low incidence of serious side effects.

Proton Pump Inhibitors (PPIs)

Used to decrease acid secretions and help prevent gastric ulcers and GERD.

Examples: esomeprazole (NEXIUM), omeprazole (PRILOSEC), pantoprazole (PROTONIX), and lansoprazole (PREVACID).

SIDE EFFECTS: Headache, dizziness, rash, gas, diarrhea, and abdominal pain.

Antidiarrheals

Used to treat diarrhea.

Examples: diphenoxylate & atropine (LOMOTIL), loperamide (IMODIUM).

SIDE EFFECTS: Severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the mouth, face, lips, or tongue); constipation; decreased urination; red, swollen, blistered, or peeling skin; stomach bloating, swelling, or pain.

Antiflatulents

Used to relieve gassiness and bloating that accompanies indigestion.

Examples: simethicone (MYLICON, PHAZYME).

SIDE EFFECTS: Severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the mouth, face, lips, or tongue).

Emetics

Used to produce vomiting in case of poisoning. **Always call poison information center.**

Example: Ipecac is an emetic syrup.

Anti-emetics

Used in the treatment of nausea and vomiting.

Examples: prochlorperazine (COMPAZINE), promethazine (PHENERGAN), ondansetron (ZOFTRAN), metoclopramide (REGLAN), meclizine (ANTIVERT), hydroxyzine (ATARAX).

SIDE EFFECTS: Constipation; diarrhea; dizziness; drowsiness; headache; irritation, redness, pain, or burning at the site of injection; tiredness.

Anticholinergics and antispasmodics

Used to treat ulcers and irritable bowel syndrome.

Examples: Dicyclomine (BENTYL) and hyoscyamine (LEVSIN).

SIDE EFFECTS: Blurred vision, constipation, decreased sweating, difficulty sleeping, dizziness, drowsiness, dry mouth, headache, lightheadedness, loss of taste, nausea, nervousness.

Laxatives

Used as cathartics in the treatment of several conditions. Some may relieve constipation, some provide bulk or fiber, some soften stool and/or may be used in a preparation for bowel examination. Laxatives and purgatives promote bowel movements. In small dosages, they gently relieve constipation and are called laxatives. In larger dosages, they clean out the gastrointestinal tract and are called purgatives. Purgatives are often given prior to surgery or exams. There are several sub-categories of laxatives and purgatives. Some elderly get in a cycle of use/abuse of laxatives.

Stimulant

Used to help push fecal matter through the intestines.

Examples: castor oil, senna (SENOKOT, EX-LAX), bisacodyl (DULCOLAX).

Saline

Used to soften feces and stimulates bowel movements.

Examples: milk of magnesia and Epsom salts.

Bulk formers

Used to stimulate bowel movements.

Examples: psyllium (METAMUCIL) and CITRACEL. Administration most often must be mixed with water or juice. The patient must drink the mixture immediately.

Emollients/lubricants

Used as lubricants and detergents which work to allow fecal matter to pass easily through the intestines. Also called “**stool softeners.**”

Examples: docusate (COLACE) and Senokot-S.

Osmotic

Example: polyethylene glycol (MIRALAX).

Hormonal Medications

Used for disorders related to problems related with the thyroid and pituitary glands, adrenal, pancreas, ovaries, and testes by regulating hormones.

Examples: levothyroxine (SYNTHROID), estrogen, and testosterone.

SIDE EFFECTS: Nervousness, insomnia, tremor, nausea, diarrhea, and headache. All medicines may cause side effects, but many people have no, or minor, side effects.

No COMMON side effects have been reported with the use of levothyroxine.

Example: ORAL: estradiol (ESTRACE).

Example: ORAL: progesterone (PROMETRIUM).

Example: TOPICAL: testosterone (ANDROGEL).

Respiratory Tract Medications

Used to treat Chronic Obstructive Pulmonary Disease (COPD), asthma, bronchitis, emphysema, and coughs.

Examples: montelukast (SINGULAR), fluticasone and salmeterol (ADVAIR DISKUS) is a combination of a steroid and beta agonist in a Diskus. Albuterol (PROVENTIL HFA, PROAIR HFA, and VENTOLIN HFA) are examples of HFA inhalers.

SIDE EFFECTS: nausea, fast heart rates, nervousness, and restlessness. It is best to wait one minute between inhalations of the same medication, wait five minutes between inhalants of any two different medications.

Antitussives

Used as cough suppressants. Codeine is a narcotic antitussive.

Examples: benzonatate (TESSALON), and dextromethorphan (Dimetapp-DM) are non-narcotic antitussives.

Bronchodilators

Used to cause the bronchioles to relax and expand which helps ease breathing. Bronchodilator medications are most often prescribed as inhalers and include Albuterol (PROVENTIL HFA, PROAIR HFA, and VENTOLIN HFA) are examples of HFA inhalers.

Expectorants

Used to break up thick mucus secretions of the lungs/bronchi so they can be coughed up.

Examples: guaifenesin (ROBITUSSIN) contains an expectorant.

Decongestants

Used to reduce swelling, and some dry up the mucous membranes.

Examples: phenylephrine (Neo-Synephrine) and oxymetozoline (AFRIN).

Anticholinergics

Example: tiotropium (SPIRIVA).

SIDE EFFECTS: Blurred vision, constipation, dry mouth, indigestion, mild nosebleed, runny nose, sinus inflammation or infection, sore throat, stomach pain, vomiting.

Antihistamines

Used to prevent and reduce histamine release.

Examples: diphenhydramine (BENADRYL), cetirizine (ZYRTEC), fexofenadine (ALLEGRA), levocetirizine (XYXAL).

SIDE EFFECTS: Drowsiness, dry mouth, stomach pain (in children), tiredness, trouble sleeping (in children).

Steroids/Anti-inflammatory drugs

Used to treat colitis and other inflammatory disease states.

Examples: **Oral tablets:** Prednisone (DELTASONE), prednisolone (ORAPRED), methylprednisolone (MEDROL, MEDROL-DOSEPAK).

SIDE EFFECTS: Difficulty sleeping; feeling of a whirling motion; increased appetite; increased sweating; indigestion; mood changes; nervousness.

Examples: **Topical:** fluocinonide (LIDEX).

Examples: **Nasal Inhalers:** fluticasone (FLONASE, FLOVENT), budesonide (PULMICORT), triamcinolone (NASACORT AQ).

Examples: **Nasal Sprays:** mometasone (NASONEX).

SIDE EFFECTS: Burning or irritation inside the nose; coughing; headache; muscle and joint pain; nosebleed or pink color to the mucus; painful menstruation; sinus pain or pressure; sore throat; upper respiratory tract infection; vomiting.

Urinary System Medications

Antibiotics

Used to treat urinary tract infections.

Examples of antibiotics: levofloxacin (LEVAQUIN), ciprofloxacin (CIPRO), doxycycline (VIBRAMYCIN), and sulfamethoxazole/trimethoprim (BACTRIM, SEPTRA).

Diuretics

Sometimes called “water pills,” used to help the body eliminate excess fluids through urination. Diuretics are used to increase the output of water. Diuretics are often given to maintain normal urine production for persons with kidney disorders. They are used to treat water retention and high blood pressure (hypertension).

Examples: spironalactone (ALDACTONE), furosemide (LASIX), bumetamide (BUMEX), hydrochlorothiazide-HCTZ (HYDRODIURIL).

SIDE EFFECTS: Dizziness, muscle cramps, weakness, due to loss of potassium (K+), orthostatic hypotension or low blood pressure when you stand up, especially when fast.

Alpha Blockers

Used to treat benign prostatic hyperplasia (BPH).

Example: tamsulosin (FLOMAX).

SIDE EFFECTS: Back pain, cough, decreased sexual ability, diarrhea, dizziness, drowsiness, headache, runny or stuffy nose, trouble sleeping, weakness.

Anticholinergic or Antispasmodics

Used to treat overactive bladder.

Example: tolterodine (DETROL).

Used to treat bladder spasms.

Example: oxybutynin (DITROPAN).

SIDE EFFECTS: Blurred vision; constipation; diarrhea; dizziness; drowsiness; dry eyes, nose, skin, or mouth; headache; nausea; stomach pain; taste changes; trouble sleeping.

Medications for the Skin

Each skin disorder has its own best treatment and drugs in the following categories.

Protectives and Astringents

Used to cover, cool, dry, or soothe inflamed skin. Protectives form a long-lasting film. They protect the skin from water, air, and clothing to allow healing. Astringents shrink blood vessels, dry up secretions from scrapes and cuts, and lessen the sensitivity of the skin.

Antipruritics

Used to relieve itching caused by inflammation. These drugs (emollients, oils, creams, and lotions) are soothing and relieve itching. Antihistamines such as cetirizine (ZYRTEC), diphenhydramine (BENADRYL) and meclizine HCL (ATARAX) also relieve itching.

Anti-inflammatory drugs

Used to decrease inflammation. These drugs (also called topical corticosteroids) have three actions which work to relieve the symptoms of skin disorders: relieve itching, suppress the body's natural reactions to irritation, and tighten the blood vessels in the area of the inflammation. Examples: triamcinolone (ARISTICORT, KENALOG), hydrocortisone (CORTONE).

Anti-infectives

Used to kill or inhibit organisms that cause skin infections. Antibiotic ointments, such as polymyxin, neomycin and bacitracin triple antibiotic (NEOSPORIN) and mupirocin (BACTROBAN), are anti-infective ointments and nystatin (NYSTOP) is an antifungal cream or ointment.

Antiseptics

Used to inhibit germs on skin surfaces. They are never given orally. Antiseptics are used to prevent infections in cuts, scratches, and surgical wounds.

Examples: Alcohol and povidone iodine (BETADINE).

Topical anesthetics

Used to relieve pain on the skin surface or mucous membranes by numbing the skin layers and mucous membranes. These are often used to treat wounds, hemorrhoids, and sunburn.

Example: SOLARCAINE is a topical anesthetic.

Parasiticides

Used to kill insect parasites that infest the skin such as scabies and lice.

Example: permethrin (NIX, RID, A200 Lice), KWELL.

COMMON 2010	MEDICATIONS	SIDE EFFECTS, ADRs
Top 10 Drugs of 2010 generic/BRAND	Reason for Use INDICATION	COMMON Side Effects/ Adverse Drug Reactions ADRs
1. Hydrocodone/ Apap LORCET, LORTAB, VICODIN	Pain	Hypotension, anxiety, dizziness, mood changes, sedation, nausea, constipation, rash.
2. Levothyroxine SYNTHROID	Hypothyroidism Low thyroid	Flushing, anxiety, nausea, palpitations, tremor, rash, alopecia, irritability.
3. Simvastatin ZOCOR	Hyperlipidemia High cholesterol	Diarrhea, joint or muscle pain, Atrial Fib, edema, vertigo, headache, abdominal pain, constipation, runny or stuffy nose, nausea, insomnia.
4. Amoxicillin AMOXIL	Infection	Upset stomach, diarrhea, yeast infection, nausea, loss of appetite, rash/hives, itching.
5. Atorvastatin LIPITOR	Hyperlipidemia High cholesterol	Diarrhea, joint or muscle pain, Atrial Fib, edema, vertigo, headache, abdominal pain, constipation, runny or stuffy nose, nausea, insomnia.
6. Lisinopril ZESTRIL	Hypertension High blood pressure	Loss of appetite, taste changes, nausea, vomiting, diarrhea, confusion, headache, weakness.
7. clopidogrel PLAVIX	Stroke prevention	Bruises easily, cannot stop bleeding, blood in stools or urine, gums, or vomit.
8. Esomeprazole NEXIUM	Acid reflux, GERD, stomach upset	Headache, dizziness, rash.
9. Montelukast SINGULAR	Asthma/Allergic Rhinitis	Dizziness, fatigue, fever, headache, rash, weakness, nasal congestion.
10. Metoprolol LOPRESSOR, TOPROL-XL	Hypertension/cardiac	Nausea, vomiting, diarrhea, confusion, headache, tiredness, dizziness, drowsiness.
Ref: Pharmacy Times 2011	Reference: Lexicomp	Reference: Lexicomp

MILD TO MODERATE SIDE EFFECTS/ADRs	
SYMPTOM of SIDE EFFECT	ACTION TO BE TAKEN
Eyes sensitive to strong light or sun	Wear sun glasses, hat or visor and/or avoid prolonged exposure to light.
Occasional upset stomach	Drink small amounts of water and/or try to eat dry saltines or toast. DO NOT GIVE antacids without consulting health care provider (HCP) or pharmacist.
Occasional constipation	Increase water intake and physical exercise. Eat bran cereals or green leafy vegetables, etc. NOTE: Caution with anticoagulants like warfarin (COUMADIN).
Occasional dizziness	Get up slowly from sitting or lying-down position.
Tiredness, sleepy in day	Take brief periods of rest during the day.
Mild restlessness or muscle stiffness	Take short walks, quiet music to relax, stretch out muscles.
Dryness of lips and/or mouth	Increase fluid intake and rinse mouth often with water and/or apply lip balm/Chapstick. Suck on ice chips and/or chew sugarless gum.
Dryness of skin	Use mild shampoo and soap. Use hand and body lotion after each bath and as needed during the day. Wear protective clothing depending on weather.
Weight gain	Increase exercise and decrease food intake, but only under physician or HCP authorization.

If no relief occurs following these guidelines, then contact the physician or health care provider (HCP).

Serious Side Effects

Call HCP (or 911 if HCP is not available), if any of the following symptoms occur.

Call immediately for any signs of “**anaphylaxis**” such as wheezing or trouble breathing, for any swelling in the face, lips, or throat and/or for a rash or hives. Seek medical attention right away if any of these **SEVERE side effects** occur when using a medication: Severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the hands, legs, mouth, face, lips, eyes, throat, or tongue; throat closing; unusual hoarseness); abnormal thinking; behavior changes; chest pain; confusion; decreased coordination; difficulty swallowing or breathing; fainting; fast or irregular heartbeat; hallucinations; memory problems

(i.e., memory loss); mental or mood changes (i.e., aggression, agitation, anxiety); new or worsening depression; severe dizziness; shortness of breath; suicidal thoughts or actions; vision changes, or seizures. **Contact physician or HCP if serious side effects are noticed by the resident's appearance or behavior.**

SERIOUS SIDE EFFECTS Call Health Care Provider	
SYMPTOM of SIDE EFFECT	EXPLANATION
Blurred vision/double vision	Difficulty focusing eyes, blurred or double vision.
Drooling, difficulty swallowing, or choking	Spasms of swallowing muscles can cause choking. Drooling may be sign of stroke.
Extreme difficulty urinating	Bladder tone relaxed.
Diarrhea	Liquid stools for more than two days.
Severe constipation	Unable to move bowels more than two days.
Muscle rigidity	Difficulty moving (i.e., mask-like face).
Nervousness, inability to sit or lie still, or inner turmoil	Muscle restlessness in body, arms, or legs.
Body tremors, twitches, or spasms	Involuntary shaking or tightening of muscles.
Tardive dyskinesia	Slow, involuntary movements of mouth, tongue, hand, or other parts of body.
Rash/hives	Skin eruptions or pimples on the body. Notice pattern of appearance and where the eruptions begin and end. A rash can involve internal lesions. Peeling skin can be dangerous.
Skin discoloration	Excessive pigmentation.
Sunburn	Sensitivity to sun's ultraviolet rays.
Sleepiness during the day	Excessive sedation. Many drugs cause sedation.
Sleepiness during the day	Excessive sedation. Many drugs cause sedation.
Sexual difficulty or irregular menstrual cycle	Male: delayed ejaculation, impotence, or unusual erections (i.e., Priapism). Female: changes in breast or periods.

SKILL EVALUATION 1.

READ and UNDERSTAND Rx LABELS



PRESCRIPTION (Rx) LABEL

(1) Ned Halftab
 (2)) Atenolol (generic for TENORMIN)
 (3) 50 mg
 (4) #45
 (5)) Take one-half (1/2) tablet two times daily.
 (6)) for Hypertension (high blood pressure).
 (7) Fill Date: January 21, 2012 3 Refills before 01/21/2013
 (8) Dr. Pill Splitter, MD. (10) Rx # 772001
 (9) ALF PHARMACY (11) Discard after 01/21/2013
 2300 Flagler Avenue
 Flagler Beach, FL 32136 386-555-
 1212



Rx LABEL	READ and UNDERSTAND the following:	Check List
1.	Location of resident's name	
2.	Medication name (brand versus generic)	
3.	Medication strength or dosage	
4.	Quantity of medication in container	
5.	Directions for use	
6.	Condition for which medication is used	
7.	Prescription fill date and number of refills allowed	
8.	Name of health care provider (HCP) - doctor	
9.	Name, address, and phone number of pharmacy	
10.	Prescription number or Rx number	
11.	When medication expires or when to discard	

SKILL EVALUATION 2.

ASSISTANCE with ORAL SOLIDS

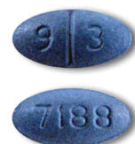
TABLETS or CAPSULES



ORAL MOUTH	Assistance With ORAL SOLIDS - Mouth	Check List
1.	Wash hands and obtain necessary items (medication container with label, MOR, water, juice, etc.). Check expiration date of medication.	
2.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
3.	Follow facility policy for identifying resident. Address resident by name.	
4.	Assist the resident to a comfortable sitting position and read the medication label to the alert resident and confirm understanding.	
5.	Open container in front of the resident and place medication in resident's hand or cup or other suitable device or container.	
6.	Assist the resident in taking the medication (Do not put in mouth).	
7.	Observe the resident swallowing the medication.	
8.	Return medication to proper storage area.	
9.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
10.	Always document on the MOR the assistance with PRN "as needed" medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
11.	Wash hands properly.	

SKILL EVALUATION 3. ASSISTANCE WITH ORAL SOLIDS

BREAK SCORED-TABLET



ORAL MOUTH	Assistance With ORAL SOLIDS - Break Scored Tablet	Check List
1.	Wash hands and gather necessary items (medication container with label, MOR, cups, facilities designated pill cutting device), see below.	
2.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
3.	Follow facility policy for identifying resident. Address resident by name.	
4.	Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.	
5.	Open container in front of the resident, split scored medication using pill splitter or cutting device and place medication in resident's hand or cup or other suitable container.	
6.	Assist the resident in taking medication (Do not put in mouth).	
7.	Observe the resident swallowing the medication.	
8.	Return medication to proper storage area.	
9.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
10.	Always document on the MOR the assistance with PRN "as needed" medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
11.	Wash hands properly.	

Examples of pill splitters or cutters.



SKILL EVALUATION 4. CRUSHING MEDICATION (PILL)

**CRUSHING TABLETS or CAPLETS - only
crush if prescribed to do so
by health care provider (HCP).**



CRUSH	Assistance With ORAL SOLIDS – “Crushing”	Check List
1.	Wash hands and gather necessary items (medication container with label, MOR, pill crusher , paper cups , water, food, juice, etc.).	
2.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
3.	Follow facility policy for identifying resident. Address resident by name.	
4.	Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.	
5.	Open container in front of the resident, crush medication (see below) , and place medication in resident’s hand or cup or other suitable device (i.e., spoon with food like applesauce or pudding).	
6.	Crushing medication: Place medication in paper cup and cover with another paper cup, and use pill crusher or firm instrument on top of cup to crush the medication.	
7.	Assist the resident in taking medication with food. (Do not put in mouth.)	
8.	Observe the resident swallowing the medication.	
9.	Return medication and supplies to proper storage area.	
10.	Record assistance with medication on MOR.	
11.	Wash hands properly.	

MEDICATIONS THAT SHOULD NOT BE CRUSHED OR CHEWED

Buccal tablets (cheeks or oral cavity)
Enteric coated tablets (special coating)
Sustained or time release capsules
Sustained or time release tablets
Sublingual (under the tongue)

Examples of pill crushers
for medication



SKILL EVALUATION 5. ASSISTANCE with ORAL LIQUIDS



MEASURE and POUR
SOLUTIONS or SUSPENSIONS
(SHAKE WELL)



ORAL LIQUID	Assistance With ORAL LIQUIDS (i.e., Suspensions)	Check List
1.	If LIQUID medication requires REFRIGERATION , store in REFRIGERATOR and monitor temperature with daily log.	
2.	Wash hands and obtain necessary items (medication with label, MOR, cups, accurate measuring container or device), etc.	
3.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
4.	Follow facility policy for identifying resident. Address resident by name.	
5.	If LIQUID medication is a suspension , “ SHAKE WELL. ”	
6.	Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.	
7.	Measure and pour liquids using a container with measurements on it (oral syringes, unit dose cups, cooking spoons, etc.). Remove the cap and place it with the open side up. Hold the bottle with the label toward the palm of the hand to avoid soiling the label. Locate the marking on the container for the amount to be poured in a container at eye level.	
8.	Measure with container at eye level and pour medication using thumb to identify the correct level (dose) and then close container properly.	
9.	Assist the resident in taking the right medication (do not place in mouth). Pour right amount of medication in cup or other suitable container and place in the right resident’s hand.	
10.	Observe the resident swallowing the medication.	
11.	Return medication to proper storage area (i.e., LOCKED refrigerator).	
12.	Always document on the MOR the assistance with PRN “as needed” medication orders that have clear specific directions for use and that DO NOT require judgment or discretion by the unlicensed staff	
13.	Wash hands properly.	

SKILL EVALUATION 6.

ASSISTANCE WITH TOPICAL for SKIN: CREAMS, LOTIONS, OINTMENTS, and SPRAYS.



HOW to APPLY TOPICAL MEDICATIONS to the SKIN.



SKIN	Assistance With TOPICAL MEDICATION for SKIN: CREAMS, LOTIONS, OINTMENTS, and SPRAYS	Check List
1.	Wash hands, identify right resident, provide for privacy , and obtain necessary items (topical medication container with label, MOR, gloves, applicator such as tongue blades, clean gauze pads, Q-tips).	
2.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR again before providing the medication to the resident.	
3.	Follow facility policy for identifying resident. Address resident by name.	
4.	Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.	
5.	Use gloves or an applicator, such as a wooden tongue depressor, clean Q-tip, or gauze pad, so that your hands do not come into contact with medication or affected skin. Using gloved hand, apply thin film of cream, ointment, lotion, or spray to affected area. Do not cover with a bandage unless directed by the HCP. Replace container top promptly.	
6.	Spread onto affected area as prescribed by a physician until absorbed, unless the directions say to leave a film. Avoid rubbing the skin.	
7.	Dispose of tongue depressor, gauze pads, and gloves, and wash hands immediately.	
8.	Return medication to proper storage area (i.e., LOCKED area).	
9.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
10.	Always document on the MOR the assistance with PRN “as needed” medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
11.	Wash hands properly.	

SKILL EVALUATION 7.

ASSISTANCE WITH TOPICAL PATCH

HOW to APPLY TOPICAL PATCHES to the SKIN.

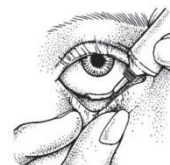


SKIN	Assistance With TOPICAL PATCHES for the SKIN	Check List
1.	Wash hands, identify right resident, provide for privacy, and obtain necessary items (topical medication container with label, GLOVES, MOR, etc.).	
2.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR again before providing the medication to the resident.	
3.	Follow facility policy for identifying resident. Address resident by name.	
4.	Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.	
5.	If replacing existing patch, using gloved hands, remove old patch. Open the package and remove the new patch. Date and initial the patch (and time, if appropriate).	
6.	Remove the backing from the patch, using care not to touch medication with hands.	
7.	Apply the patch to a dry, hairless part of the body, according to package instructions. Watch for old patches that should be removed or absence of a patch that should be present. Alternate the application sites to avoid skin irritation. Notify the health care provider of irritation.	
8.	Dispose of supplies and wash hands immediately to avoid absorbing the medication yourself.	
9.	Return medication to proper storage area (i.e., LOCKED area).	
10.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
11.	Always document on the MOR the assistance with PRN “as needed” medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
12.	Wash hands properly.	

SKILL EVALUATION 8.

ASSISTANCE WITH EYE MEDICATION

HOW to INSTILL EYES DROPS and EYE OINTMENTS or OPHTHALMIC MEDICATIONS



EYE	Assistance With EYE DROPS and EYE OINTMENTS	Check List
1.	If EYE medication requires REFRIGERATION , store in REFRIGERATOR and monitor temperature with daily log.	
2.	Wash hands and obtain necessary items (eye medication with label, gloves, MOR, warm cloth, gauze, tissues, barrier or disposable tray, etc.). Check expiration date of medication when retrieving medication.	
3.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
4.	Follow facility policy for identifying resident. Address resident by name.	
5.	Identify which eye (right, left, or both) to receive medication.	
6.	Ask the resident to sit or lie down, and clean the eye with warm water if needed to remove any discharge from the eye. If crusting or discharge is present, the eye should be cleaned with a clean, warm washcloth. Use a clean area of the cloth for each eye. When cleaning the eye, wipe from the inner eye to the outer eye (from closest to the nose, to away from the nose). Wash hands again. Put on examination gloves . If drops are a suspension, then "SHAKE WELL."	
7.	Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.	
8.	Remove cap and place it upright on barrier or on a clean dry surface.	
9.	Explain procedure. Tilt resident's head slightly back and with gloved finger assist resident to pull down gently on the lower eyelid to form a "pouch," while instructing the resident to look up. Place other hand against resident's forehead to steady. Hold inverted medication container between the thumb and index finger, and press gently to instill prescribed amount into "pouch" near outer corner of eye.	
10.	IF DROPS, place drops in "pouch" in the lower eye lid. Do NOT let tip of dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration. Recap container.	

11.	IF OINTMENT, run a strip of ointment in “pouch” in the lower eye lid. Recap container.	
12.	Instruct resident to close eyes gently to allow for even distribution over surface of eye. Resident should not blink or squeeze eyes shut.	
13.	Wipe off tears or excess from the eye with a clean gauze, cotton ball, or tissue.	
14.	Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator).	
15.	If administering medication to BOTH eyes, use a different gloved finger to apply pressure to other eye tear duct.	
16.	If additional drops of the same or different medication are required in the same eye, wait 3-10 minutes (check package insert) and repeat procedures above.	
17.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
18.	Always document on the MOR the assistance with PRN “as needed” medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
19.	Remove and dispose of gloves. Discard barrier.	
20.	Wash hands thoroughly.	
21.	Monitor for side effects or adverse effects.	
22.	When two or more eye medications are being administered, they should be scheduled at least 10 minutes apart. Check package insert.	
23.	Special Note: If more than one eye medication is to be administered at same time as ointment, consult physician or pharmacist for direction.	
24.	Some medications require longer waiting periods. Always refer to the individual package insert or other reliable reference for complete administration information of eye medications.	
25.	Resident’s vision may be blurred after application. Instruct resident to remain seated until vision clears up to reduce chance of falling.	

SKILL EVALUATION 9. ASSISTANCE WITH EAR MEDICATION

HOW to INSTILL EAR DROPS and EAR SUSPENSIONS or OTIC MEDICATIONS

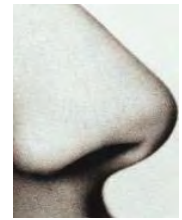


EAR	Assistance With EAR DROPS and EAR SUSPENSIONS	Check List
1.	If EAR medication requires REFRIGERATION , store in REFRIGERATOR and monitor temperature with daily log.	
2.	Wash hands and obtain necessary items (ear drop medication with label, MOR, gloves, cotton balls, tissues, barrier or disposable tray, etc.). Check expiration date of medication when retrieving medication.	
3.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
4.	Follow facility policy for identifying resident. Address resident by name.	
5.	Identify which ear (right, left, or both) to receive medication.	
6.	Explain procedure. Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If drops are suspension, then “SHAKE WELL.”	
7.	Assist the resident to a comfortable position and turn resident’s head so that the affected ear is facing up.	
8.	If bottle serves as dropper, remove cap and place it upright on barrier or on a clean, dry surface.	
9.	Straighten ear canal by gently pulling earlobe up and back.	
10.	IF DROPS, instill prescribed number of drops into ear canal. Do NOT let tip of dropper touch the ear or any other surface. Recap container.	
11.	Instruct resident to remain in same position about five minutes with affected ear upwards. Gently place a cotton ball in the external ear canal to prevent leakage.	
12.	If ear drops are to be placed in both ears , wait five minutes and repeat steps 7 through 11 in other ear .	
13.	Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator if required).	

14.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
15.	Always document on the MOR the assistance with PRN “as needed” medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
16.	Remove and dispose of gloves. Discard barrier.	
17.	Wash hands thoroughly.	
18.	Monitor for side effects or adverse effects.	

SKILL EVALUATION 10. ASSISTANCE WITH NOSE MEDICATION

HOW to ASSIST with NOSE DROPS and NASAL SPRAYS NASAL MEDICATIONS



NOSE	Assistance With NOSE DROPS and NASAL SPRAYS	Check List
1.	If NOSE medication requires REFRIGERATION , store in REFRIGERATOR and monitor temperature with daily log.	
2.	Wash hands and obtain necessary items (nose drop or spray medication with label, MOR, gloves, cotton balls, clean tissues, barrier or disposable tray, etc.). Check expiration date of medication when retrieving medication.	
3.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident. Be sure sufficient doses remain.	
4.	Follow facility policy for identifying resident. Address resident by name.	
5.	Identify which NOSTRIL (right, left, or both) to receive medication.	
6.	Explain procedure. Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If nose drops are suspension, then “SHAKE WELL.” Check label.	
7.	Assist the resident to a comfortable position and turn resident’s head so that the affected NOSTRIL is facing up.	
8.	If bottle serves as dropper, remove cap and place it upright on barrier or on a clean, dry surface.	
9.	If possible, ask resident to blow nose gently to remove any excess mucus.	
10.	IF NOSE DROPS, instill prescribed number of NOSE drops into NOSTRIL or both NOSTRILS. Do NOT let tip of dropper touch the NOSE or any other surface. Recap container.	

11.	<p>IF NOSE SPRAY, (check package insert for specific instructions if possible),</p> <ol style="list-style-type: none"> 1. Prime nasal inhaler device by holding bottle upright and away from face while spraying into air. 2. Resident should be sitting up, if possible. Instruct resident to hold head upright, slightly forward. 3. Gently press side of nostril that is not receiving drug using finger of other hand. 4. Keep bottle upright and insert spray tip into nostril (no more than 1/4 inch). <p>Point the tip to the back outer side of nose. Ask resident to breathe out through mouth.</p> <ol style="list-style-type: none"> 5. Instill prescribed number of SPRAYS into one or both NOSTRILS as prescribed. Press actuator or spray tip firmly and quickly while resident breathes through nose and out mouth. If necessary, clean spray tip and device according to manufacturer's guidelines or facility policy. Recap container. 	
12.	Instruct resident to remain in same position about five minutes with affected NOSTRIL upwards. Wipe off any excess drainage with clean tissue and gently place a cotton ball in the external NOSTRIL to prevent leakage. Resident should avoid blowing nose for at least 15 minutes.	
13.	If another dose of the same or different nasal medication is required in the same nostril, wait the amount of time recommended by the manufacturer (see package insert) or as prescribed. Repeat dose in either nostril as prescribed.	
14.	Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator if required).	
15.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
16.	Always document on the MOR the assistance with PRN "as needed" medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
17.	Remove and dispose of gloves. Discard barrier.	
18.	Wash hands thoroughly.	
19.	Monitor for side effects or adverse effects.	

SKILL EVALUATION 11. ASSISTANCE WITH HFA INHALERS and DISKUS

HOW to ASSIST with INHALERS and DISKUS MOUTH INHALATION MEDICATIONS



MOUTH	Assistance With INHALERS and DISKUS	Check List
1.	If Inhaler or Diskus medication requires REFRIGERATION , store in REFRIGERATOR and monitor temperature with daily log.	
2.	Wash hands and obtain necessary items (HFA Inhaler or Diskus medication with label, MOR, gloves, cotton balls, tissues, barrier or disposable tray, etc.). Check expiration date of medication when getting drug.	
3.	Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.	
4.	Follow facility policy for identifying resident. Address resident by name.	
5.	Identify whether SPACER is required to administer medication.	
6.	Explain procedure. Read the medication label to the resident and confirm understanding. Ask the resident to sit or lie down. Wash hands again. Put on gloves. If medication is suspension, then “ SHAKE WELL. ”	
7.	If using spacer, examine spacer/holding chamber and remove any foreign objects.	
8.	Remove mouthpiece cap (and spacer cap). If not connected, place cap(s) on barrier or clean dry surface.	
9.	If necessary (see package insert), hold inhaler upright and “ SHAKE WELL. ” Prime inhaler.	
10.	IF NOT using SPACER, open mouth with inhaler one to two inches away, or place inhaler mouthpiece under top teeth and keep mouth open.	
11.	IF using SPACER, insert mouthpiece of inhaler into the flexible rubber end of spacer/holding chamber and place chamber in resident's mouth with lips closed around mouthpiece.	
12.	Ask resident to breathe out. (Do NOT exhale into inhaler.) Position inhaler for administration of medication.	

13.	Press down on inhaler once to release medication as resident starts to breathe in slowly through the mouth over 3-5 seconds. (Do not spray more than one puff into spacer at a time.)	
14.	If necessary, wash and thoroughly dry mouthpiece (see package insert or facility policy). If using spacer, wash spacer/holding chamber according to manufacturer's guidelines or facility policy. Recap container.	
15.	Resident should hold breath as long as possible.	
16.	Dry Powder Inhaler or Diskus <u>DOs</u>. Do follow manufacturer package insert for device loading dose and preparation. Some devices require placement of capsule into inhaler/device and some already contain medication. Generally, the device should be held horizontally when used. Bring inhaler to mouth and close lips around mouthpiece. For best results, breathe in quickly and deeply through the mouth. Some inhalers require more than one inhalation in order to receive the full dose (see manufacturer's package insert). If capsule was manually inserted prior to administration, remember to remove empty capsule when done.	
17.	Dry Powder Inhaler or Diskus <u>DON'Ts</u>. CAPSULES containing dry powder for inhalation should NEVER BE SWALLOWED. Never use capsules that are broken or have been exposed to water. Do not activate the dose (by pushing the lever or twisting the inhaler/device) more than once per dose. Most dry-powdered inhaler/devices should NOT be shaken. Do not use a spacer/holding chamber. Do NOT close device until all doses have been received.	
18.	If another puff of the same or different medication is required, wait 1-2 minutes (check package insert), then repeat procedures above. Close inhaler/device using manufacturer's package insert guidelines to ensure next dose will be ready when needed.	
19.	Replace medication into labeled box/bag and return medication to proper storage area (i.e., LOCKED refrigerator if required).	
20.	Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.	
21.	Always document on the MOR the assistance with PRN "as needed" medication orders that have <u>clear specific directions</u> for use and that <u>DO NOT</u> require judgment or discretion by the unlicensed staff.	
22.	Remove and dispose of gloves. Discard barrier.	
23.	Wash hands thoroughly.	
24.	Monitor for side effects or adverse effects.	

ASSISTANCE WITH SELF-ADMINISTERED MEDICATIONS
POST-TEST 1. True/False

Mark your answers “T” (True) or “F” (False).

#	Pre Test	Post Test	ASSISTANCE WITH SELF-ADMINISTERED MEDICATIONS
1.			“Health care provider” (HCP) means a physician or physician’s assistant licensed under Chapter 458 or 459, F.S., or advanced registered nurse practitioner (ARNP) licensed under Chapter 464, F.S.
2.			A nurse, pharmacist, family member, or friend can assist a resident with a pill organizer in an ALF in Florida, but an unlicensed person cannot.
3.			The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of drugs by a resident poses a safety hazard to other residents; therefore, the facility may centrally store the medication.
4.			When an OTC product is prescribed by a physician, the medication becomes a prescription and must be properly labeled by a pharmacist or physician.
5.			Medication administration includes the conducting of any examination or testing such as blood glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff.
6.			A “pill organizer” means a container which is designed to hold solid doses of medication for one week only and is divided according to day and time increments.
7.			A resident who self-administers medications may use a pill organizer managed by a nurse.
8.			An unlicensed person trained in accordance with Section 429.256, F.S., and Rule 58A-5.0185 may measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions.
9.			An unlicensed person trained in accordance with Section 429.256, F.S., and Rule 58A-5.0185 should recognize the need to obtain clarification of a PRN “as needed” prescription order.
10.			An unlicensed person trained under Section 429.256, F.S., and Rule 58A-5.0185 should recognize a medication order which requires judgment or discretion, and advise the resident, HCP, and/or facility employer of inability to assist in the administration of such orders.

11.			The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident.
12.			Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility.
13.			A nurse, pharmacist, family member, friend, or unlicensed person can assist a resident with a pill organizer in an ALF in Florida.
14.			Unlicensed persons can NOT assist with medications ordered by the physician or health care professional to be given "as needed," unless the order is written with specific parameters that do not require independent judgment on the part of the unlicensed person.
15.			Unlicensed persons can NOT assist with medications if the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.
16.			Unlicensed staff may take vital signs – temperature, blood pressure, heart rate/pulse, and respiration, if medication orders require it.
17.			Reassess resident's ability to safely store and self-administer medications at least every six months to a year.
18.			Discontinued medications must be stored separately from medications in current use and marked "discontinued medications."
19.			To save time, unlicensed staff may use a pill organizer for any resident when assisting with self-administration of medication in an ALF.
20.			Unlicensed staff must have initial four (4) hour training in assisting with self-administration of medication before providing assistance to any resident.
21.			If a doctor prescribes a nebulizer for a resident, unlicensed staff may assist with this as long as there is a doctor's order and the unlicensed staff assisting has been trained to use a nebulizer.

22.			A nurse could jeopardize his/her license by delegating responsibility to an unlicensed person to assist with self-administration of medication that requires the judgment of a licensed person.
23.			All health care providers should be aware of the laws that assisted living facilities must follow with regard to medication orders.
24.			A doctor must review and sign a new order for the continuing need for a chemical restraint annually for each resident using a chemical restraint in an assisted living facility.
25.			An order written on the MOR must always exactly match the prescription label.
26.			You should always document all mediations on the MOR at the end of your shift for consistency and to make sure you correctly initialed all medications you assisted with that day.
27.			If the doctor changes a prescription order for a resident's medication, you should correct the original entry on the MOR.
28.			If you make a mistake on the MOR, always use whiteout so that the entry looks neat.
29.			If you are unsure of a medication that you are assisting with, it is better to have the resident take the medication until you have time to contact the administrator.
30.			It is not necessary to keep the box from a tube of medication, as long as you understand how to assist the resident with this medication.
31.			If you have an over-the-counter medication, like Tylenol, it is fine to use this for any of the residents who have a headache.
32.			A resident's medication was temporarily discontinued, but it is not expired. You should store this with his current medications for the resident's future use.
33.			An as-needed prescription must always have clear specific directions for use and the condition for which the medication should be given.
34.			Medication which has been abandoned or expired must be disposed of within 30 days.
35.			If a resident's ankles are swollen, and the resident has an as needed medication for fluid retention, an unlicensed person may NOT assist.

36.		An alert label on a medication container will help let the staff know there are revised directions on the MOR.
37.		Prescription labels sometimes have abbreviations.
38.		If you assist with medications, will there be times when you won't understand a doctor's order or a prescription label?
39.		A nurse or CNA can also change a prescription label.
40.		You just received a refill of a resident's medication and you have two tablets left in the bottle currently being used. Best practice is to place the two tablets in the refill bottle that you just received.
41.		If a doctor gives a resident medication samples from his office, the facility does not need a signed, written prescription order or fax copy of the same because the medication came directly from the doctor's office.
42.		Unlicensed trained staff may assess resident's pain levels in order to determine how much medication to be provided that day.
43.		A competent resident would be a resident that understands in general their medications and what they are used for medically.
44.		A unlicensed trained staff may take a telephone order from a physician and change the order on the MOR.
45.		MORs can be initialed or completed for up to 24 hours after the medication observation has been used for that resident that shift.
46.		Unlicensed trained staff may assist residents with their insulin injections if a nurse has pre-filled the syringe with specific instructions.
47.		Prescription medications may be given without a doctor's order.
48.		The medication observation record (MOR) is completed at the end of each shift to assure accuracy.
49.		An unlicensed staff person who receives the four (4) hour training may crush medications if the prescription label directs you to do so.
50.		Assistance with medication by an unlicensed person requires the written informed consent of the resident.
51.		The resident does not have to be present when you take the medication from the bottle.

52.		Unlicensed staff may assist with “as needed” or “as directed” medication only at the request of a competent resident.
53.		The facility may maintain a stock supply of over-the-counter medications for multiple resident use.
54.		Trained unlicensed staff may transfer medications from one storage container to another.
55.		Assistance with medications includes application of creams or ointments that require a dressing.
56.		Centrally stored medications shall be kept in a locked/secured cabinet or locked storage area at all times.

1. List the nine (9) rights of medication assistance the employee in an ALF must follow each time a medication is given:_____.
2. Name the three (3) methods of medication management allowed in an ALF._____.
3. Define Side Effect:_____.
4. How many days do you have to dispose of abandoned or expired medications? #_____days.
5. Who is ultimately responsible for determining which type of medication management a resident requires?_____.
6. Under what method of medication management can a resident use a weekly pill organizer while in an ALF?_____.
7. The_____is the record keeping system for a resident's medication management.
8. A medication label can only be changed by a_____.
9. Only a_____tablet can be broken in half.
10. _____is the single most effective method of controlling the spread of germs.
11. _____must be used when assisting with ointments.

MULTIPLE CHOICE (Circle correct answer)

1. A resident is experiencing diarrhea of unknown source; you should:
 - a. Put him/her on a liquid diet
 - b. Call the doctor
 - c. Stop all medication
 - d. All of the above
2. Assistance with medications does NOT include:
 - a. Mixing, compounding, converting, or calculating dosages
 - b. Preparing or giving injections or suppositories
 - c. Medications which require judgment
 - d. All of the above
3. Before assisting a resident with self-administered medications, the caregiver should first:
 - a. Obtain the medication from the storage area
 - b. Sign off the medication in the Medication Observation Record
 - c. Wash hands properly
 - d. All of the above
4. Who may teach the four-hour assistance with self-administered medications course?
 - a. Administrator
 - b. RNs / LPNs
 - c. RNs / Pharmacists
 - d. RNs / LPNs / Pharmacists
5. Medication orders may be taken over the phone by:
 - a. Administrator
 - b. Trained unlicensed staff
 - c. Nurses
 - d. None of the above
6. Use of the medication observation record (MOR) is not required for which of the following:
 - a. Medication administration
 - b. Assistance with self-administration of medication
 - c. Self-administration of medication
 - d. None of the above

Appendix 1. Informed Consent

INFORMED CONSENT TO PROVIDE ASSISTANCE WITH MEDICATION BY TRAINED, UNLICENSED PERSONNEL

Assisted living facility (ALF) law permits an ALF to administer medications to residents if the facility has a licensed nurse on staff, or to assist with self-administered medications by trained, unlicensed staff under Sec 429.256 FS, Sec 429.52 FS and Rule 58A-5.0185 FAC.

Under ALF law, “assistance with self-administrated medication” means that trained, unlicensed staff can help a person to self-administer their medications by performing such tasks as bringing the resident's medication to the resident; reading a prescription label and removing the prescribed amount of medication from the container; placing the medication in the resident's hand or in another container and helping the resident to lift it to their mouth; applying topical medications; applying eye, ear, and nose drops/sprays/ointments; returning the medication to storage; and keeping a record of medications that the resident has self-administered with assistance from facility staff.

“Assistance with self-administration” does not include calculating medication dosages; putting medications in resident's mouth; preparing or administering injections; applying rectal, urethral, or vaginal preparations; administering medications by way of a tube inserted in a body cavity; administering parenteral medications; conducting irrigations or using debriding agents for treating skin conditions; administering medications through intermittent positive pressure breathing (IPPB) machines or nebulizers; or performing any medication task which requires judgment or discretion. The unlicensed individual who will be providing “assistance” must have completed a four (4) hour training course and demonstrated their ability to assist residents with medication to the administrator or nurse.

In our facility, _____, staff assisting residents with self-administration: **will** or, **will not** be overseen by a licensed nurse.

I, _____ have been informed of this policy and agree to have trained, unlicensed facility staff provide me with assistance in self-administration of my medications.

Signed (resident or representative) Date: ____/____/____

Signed (owner or administrator) Date ____/____/____

Appendix 2. Resident Assessment

SELF-ADMINISTRATION OF MEDICATION RESIDENT ASSESSMENT

Resident's Name _____

DOB _____/_____/_____

Assessment Date _____/_____/_____

YES NO MENTAL ASSESSMENT

- | | | | |
|-------|-------|-----|--|
| _____ | _____ | 1. | Can demonstrate secure storage for medications kept in room. |
| _____ | _____ | 2. | Can read and understand the medication label. |
| _____ | _____ | 3. | Can correctly state the proper dose for each medication. |
| _____ | _____ | 4. | Can correctly state what each medication is for. |
| _____ | _____ | 5. | Can tell time. |
| _____ | _____ | 6. | Can state what time or how often medication is to be taken. |
| _____ | _____ | 7. | Remembers to take medication. |
| _____ | _____ | 8. | Knows any special instructions for medications (i.e., shake well). |
| _____ | _____ | 9. | Can state what side effects should be watched for with each medication. |
| _____ | _____ | 10. | Can correctly state when and why (conditions) to take "as needed" medication. |
| _____ | _____ | 11. | Has knowledge and understanding of how to get a refill from a physician or pharmacy and be able to check that the correct medication was refilled. |

PHYSICAL ASSESSMENT

- | | | | |
|-------|-------|-----|--|
| _____ | _____ | 1. | Can distinguish and match colors. |
| _____ | _____ | 2. | Can distinguish and match shapes. |
| _____ | _____ | 3. | Can see clearly to read the medication label (visual acuity). |
| _____ | _____ | 4. | Can open/close medication container, remove medication. |
| _____ | _____ | 5. | Can correctly measure the appropriate amount of medication from the container. |
| _____ | _____ | 6. | Can correctly self-administer oral medications. |
| _____ | _____ | 7. | Can correctly self-administer eye drops/ointments. |
| _____ | _____ | 8. | Can correctly self-administer ear drops. |
| _____ | _____ | 9. | Can correctly self-administer nasal drops/sprays. |
| _____ | _____ | 10. | Can correctly self-administer inhalants/diskus. |
| _____ | _____ | 11. | Can correctly administer ointments/creams. |
| _____ | _____ | 12. | Can correctly self-administer transdermal patches. |
| _____ | _____ | 13. | Can correctly self-administer vaginal or rectal suppositories. |
| _____ | _____ | 14. | Can correctly self-administer subcutaneous injections. |

15.

The resident is deemed able to safely self-administer medications.

_____ _____
The resident is deemed unable to safely self-administer medications for these reasons:

15.

Assessment completed by:

Signature _____

Date _____/_____/_____

Title _____

Appendix 3. Training Certificate



Certificate of Attendance

Presented to:

John Doe

For completion of:

Assistance with Self-Administration of Medication Lecture and Training

April 4, 2013

The Name of the Training Location, City, State

The above individual has met the requirements specified in Section 429.54(5), F.S., and Rule 58A-5.0185, F.A.C. for 6 hours of continuing education

Training Certification Number: 00001

<hr/> <p>Pharmacist Name , M.S., CPh., RPh. Licensed Consultant and Registered Pharmacist Florida PU# and PS#</p>	<hr/> <p>Nurses Name, RN, LNC Affiliation RN#</p>
---	---

Appendix 4. AHCA Form 1823, page 4

TO BE COMPLETED BY FACILITY:

Resident's Name _____

DOB: _____

SECTION 2-B: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MEDICATIONS (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.)

A. Please list all current medications prescribed below (additional pages may be attached):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

B. Does the individual need help with taking his or her medications (meds)? Yes ____ No _____. If yes, please place a checkmark (✓) in front of the appropriate box below:

<input type="checkbox"/> Needs Assistance with Self-Administration of Medications	<input type="checkbox"/> Needs Medication Administration
---	--

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary):

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:

NAME OF EXAMINER (Please Print): _____

SIGNATURE OF EXAMINER: _____

MEDICAL LICENSE #: _____

ADDRESS OF EXAMINER: _____

TELEPHONE #: _____

TITLE OF EXAMINER (Please check the appropriate box):

☐ MD ☐ DO ☐ ARNP ☐ PA

DATE OF EXAMINATION: _____

Appendix 5. Medication Observation Record (MOR)

Resident _____ DOB: _____ **20** Physician _____ Phone _____

Allergies _____ Pharmacy _____ Phone _____

Diagnosis _____ **ALF MEDICATION OBSERVATION RECORD (MOR)** Page ____ of ____

Medication/Directions	Hour Due	Dose																															
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

CODES: D/C - Discontinued E - Charted in Error H - In Hospital/Rehab O - Out of Facility U - Drug Unavailable V - Vomited or Spit Out Medication X - Held by Medical Order

Stop and Watch

Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S
T
O
P
a
n
d
W
A
T
C
H

Seems different than usual

Talks or communicates less

Overall needs more help

Pain – new or worsening; Participated less in activities

Ate less

No bowel movement in 3 days; or diarrhea

Drank less

Weight change

Agitated or nervous more than usual

Tired, weak, confused, or drowsy

Change in skin color or condition

Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)

Nurse's Name



Incubator Phase of the National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care

Shift Huddles Tip Sheet

What It Is:

A **Huddle** is a quick meeting to share and discuss important information. **Start of Shift and End of Shift Huddles** provide a way to share information about each resident as everyone starts work and to recap any information at the end of the shift that needs to be shared with the next shift. They can be done in a stand-up meeting or as room to room walking rounds with the charge nurse and CNAs together checking on each resident. It helps to have other disciplines join in to share their information and to hear information that can help them contribute to the team caring for residents.

Why Do It:

A shift huddle reinforces teamwork and allows everyone to hear about every resident so staff can provide help to residents not on their assignment. Communication of essential information cannot be left to chance. When it is shared in a group, everyone hears **EXACTLY** the same information and can share what they know. The group can problem-solve any issues on the spot.

Who Participates:

Shift Huddle is a gathering of the nurses and CNAs working together by unit and shift. It is good to include housekeeping, social work, activities, and therapy or to huddle again quickly later in the shift when these others can participate.

When To Do It:

Shift huddle should occur at the beginning and at the end of the shift. If there is a paid shift overlap, it can be done with staff from both shifts. Huddles can also occur at other times as needed, such as before staff go on break, when a new resident arrives, when an issue arises that needs the team to come together, or when other departments can participate in a short discussion.

How Long:

Start and end of shift huddles should take no more than 15 minutes. In-the-moment huddles can often complete business in less than 5 minutes but may take longer.

How To Do It:

This needs to be a positive mutual exchange of information needed to care for each resident on the hall. Standing Agenda Items may include:

- **Resident by resident report by exception**, focused on *risks and opportunities, including quality of life and quality of care*, using MDS areas of functional status, mood, and customary routines as a guide. INTERACT^{II} *Stop and Watch* is an excellent tool to focus the end of shift exchange.
- Anyone due for their **MDS** (in their **Assessment Reference Date - ARD**)
- **Changes in Census – people coming in or leaving**



Incubator Phase of the National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care

- **Information about new residents**, including social history, family information, medical needs, customary routines and special needs
- **Reportable Events, Incidents, Accidents** for any resident
- **Complaints and Compliments** for any resident
- **Follow-up on any issues** raised for which the loop needs to be closed
- Any **clinical area** that is being worked on (e.g., pressure ulcers)
- **News from any department** requiring staff knowledge or coordination
- Introduction of and check-in with **new employees**

Keys to Success:

Be on time, this is a short meeting. It needs to start and end on time. **Everyone** needs to be there on time and be prepared to share.

Process:

This is an exchange among CNAs and with the charge nurse and other staff. At the end of the shift, **CNAs share information** for each resident on their assignment. At the start of shift, nurses give information provided by CNAs and nursing from the previous shift's end of shift report. Other staff may add relevant information about that resident.

Report is **by exception**, focused on risks and opportunities in **quality of care and quality of life**. For example if someone is at risk for pressure ulcers, discussion will include how well they ate and drank, and any positioning issues. If someone has been depressed, the discussion will include their interactions and participation in activities. If a resident does not seem to be oneself that day, this is noted and discussed. See **INTERACT^{II} Stop and Watch** for good examples of issues to note.

Critical Thinking:

To be successful shift huddles have to be valuable to the participants. These are not rote reports. They are opportunities for critical thinking and problem-solving together to ensure the best care for each resident.

Provide Support:

It is optimal to have the support of nursing management answering lights and meeting residents' needs while CNAs and the charge nurse are rounding or having stand-up so that they can have uninterrupted time.

Huddles should be supportive, not negative. Provide mentoring to those nurses who need help on how to facilitate positive team building huddles.

For a short video How-to on Shift Huddles go to
www.BandFConsultingInc.com/WhatYouDoMatters

**RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES**

❖ This form must be completed annually for residents receiving assistive care services in order to comply with Medicaid

TO BE COMPLETED BY FACILITY:

Resident's Name _____ DOB: _____

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS: *AFTER COMPLETION OF ALL ITEMS IN SECTIONS 1 AND 2 OF THIS FORM (pages 1 through 4), PLEASE RETURN TO:*

FACILITY NAME: _____

FACILITY ADDRESS: _____

TELEPHONE NUMBER: _____ CONTACT PERSON: _____

SECTION 1: HEALTH ASSESSMENT (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.)

Known Allergies:

Height:

Weight:

Medical history and diagnoses:

Physical or sensory limitations:

Cognitive or behavioral status:

Nursing/treatment/therapy service requirements:

Special precautions:

Elopement Risk:

Yes ☐ No ☐

TO BE COMPLETED BY FACILITY:

Resident's Name _____ DOB: _____

SECTION 1: HEALTH ASSESSMENT (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.)

A. To what extent does the individual need supervision or assistance with the following?

Key	I = Independent	S = Needs Supervision	A = Needs Assistance	T = Total Care
-----	-----------------	-----------------------	----------------------	----------------

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individuals is able to perform each of the activities of daily living. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance needed in the comments column.*

ACTIVITIES OF DAILY LIVING	I	S*	A*	T	COMMENTS*
Ambulation					
Bathing					
Dressing					
Eating					
Self Care (grooming)					
Toileting					
Transferring					

B. Special Diet Instructions

___ Regular

___ Calorie Controlled

___ No Added Salt

___ Low Fat/Low Cholesterol

___ Other, please describe: _____

C. Does the individual have any of the following conditions/requirements? If yes, please include an explanation in the comments column.

STATUS	YES/NO (Y/N)	COMMENTS
1. A communicable disease, which could be transmitted to other residents or staff?		
2. Bedridden?		
3. Any stage 2, 3, or 4 pressure sores?		
4. Pose a danger to self or others?		
5. Require 24-hour nursing or psychiatric care?		

D. In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or psychiatric facility? Yes ___ No ___

Comments (Use additional page if necessary): _____

TO BE COMPLETED BY FACILITY:

Resident's Name _____

DOB: _____

SECTION 2-A: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. ABILITY TO PERFORM SELF-CARE TASKS:

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individual is able to perform each of the listed self-care tasks. If "needs supervision" or "needs assistance" is indicated, please explain the extent and type of supervision or assistance necessary in the comments column.*

KEY: I = Independent S = Needs Supervision A = Needs Assistance

TASKS	I	S*	A*	COMMENTS*
Preparing Meals				
Shopping				
Making Phone Calls				
Handling Personal Affairs				
Handling Financial Affairs				
Other				

B. GENERAL OVERSIGHT:

Indicate by a checkmark (✓) in the appropriate column below the extent to which the individual needs general oversight. If other, please explain in the comments column*.

KEY: I = Independent W = Weekly D = Daily O* = Other

TASKS	I	W	D	O*	COMMENTS*
Observing Wellbeing					
Observing Whereabouts					
Reminders for Important Tasks					
Other					
Other					
Other					
Other					

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary):

TO BE COMPLETED BY FACILITY:

Resident's Name _____

DOB: _____

SECTION 2-B: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MEDICATIONS (*MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.*)

A. Please list all current medications prescribed below (additional pages may be attached):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

B. Does the individual need help with taking his or her medications (meds)? Yes ____ No _____. If yes, please place a checkmark (✓) in front of the appropriate box below:

<input type="checkbox"/>	Needs Assistance with Self-Administration of Medications ❖ This allows unlicensed staff to assist with orals and topical medication.	<input type="checkbox"/>	Needs Medication Administration ❖ Not all ALFs have licensed staff to provide this service.
<input type="checkbox"/>	Able to Administer w/o Assistance	<input type="checkbox"/>	

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary): _____

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:

NAME OF EXAMINER (Please Print): _____

SIGNATURE OF EXAMINER: _____

MEDICAL LICENSE #: _____

ADDRESS OF EXAMINER: _____

TELEPHONE #: _____

TITLE OF EXAMINER (Please check the appropriate box):

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MD	DO	ARNP	PA			

DATE OF EXAMINATION: _____

TO BE COMPLETED BY FACILITY:

Resident's Name _____

DOB: _____

SECTION 3: SERVICES OFFERED OR ARRANGED BY THE FACILITY FOR THE RESIDENT (*MUST BE COMPLETED BY THE ALF ADMINISTRATOR OR DESIGNEE.*)

Note: This section must be completed for all residents based on needs identified in Sections 1 and 2 of this form, or electronic documentation, which at a minimum includes the elements below. The facility may attach the resident's service plan, care plan, or community living support plan to this document to satisfy this requirement provided the documentation captures the information listed below.

#	(Column 1) Needs Identified from Sections 1 & 2	(Column 2) Service Needed	(Column 3) Service Frequency & Duration	(Column 4) Service Provider Name	(Column 5) Date Service Began
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

NAME OF RECIPIENT OR GUARDIAN:

(Please Print) _____

SIGNATURE OF RECIPIENT OR GUARDIAN: _____

NAME OF ADMINISTRATOR OR DESIGNEE:

(Please Print) _____

SIGNATURE OF ADMINISTRATOR OR DESIGNEE: _____

Does the facility intend to use this form to satisfy the Medicaid assessment for assistive care services? Yes ☐ No ☐

If yes, page 6 is required to be completed. If no, Stop.

CERTIFICATE OF MEDICAID NECESSITY
THIS PAGE MUST ALSO BE FILLED OUT FOR RESIDENTS THAT RECEIVE
MEDICAID ASSISTIVE CARE SERVICES

Resident Name _____ DOB _____

This is to certify that this recipient is in need of an integrated set of assistive care services on a 24-hour basis, including at least two of the following four service components on a daily basis (check as applicable):

_____ Assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and/or toileting.

_____ Assistance with instrumental activities of daily living, which is defined as individual assistance with shopping for personal items, making telephone calls, managing money, etc.

_____ Health support, which is defined as observing the resident's whereabouts and well-being; reminding the resident of any important tasks; and recording and reporting any significant changes in appearance, behavior, or state of health to the health care provider, designated representative, or case manager.

_____ Assistance with self-administration of medication, which is defined as assistance with or supervision of self-administration of medication as permitted by law.

HEALTH CARE PROVIDER

Facility Name: _____

License Number: _____

Administrators' Signature: _____

Date Signed: _____

CERTIFICATION OF MEDICAL NECESSITY:

Physician/Physician Assistant/
Advanced Registered Nurse Practitioner/
Registered Nurse: _____

Date: _____

The resident service log is still required for Medicaid residents.

Medication Management

The management of medication and use of chemical restraints is limited to prescribed dosages of medication authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medication that can serve as chemical restraints must be **evaluated by their physician at least annually** to assess:

1. The continued need for the medication.
2. The level of the medication in the resident's blood.
3. The need for adjustments in the prescription.

EXAMPLES of common chemical restraints include lorazepam (ATIVAN), diazepam (VALIUM), etc.

Supervision and Assistance With Medication by Unlicensed Staff

Assistance with or supervision of self-administered medications includes reminding residents to properly take self-administered medications and, when appropriate or necessary, to observe or provide verbal instructions to residents while they perform this task.

Supervision of a resident's medication includes and is limited to:

- Reminders to take medications at the prescribed time.
- Opening containers or packages and replacing lids.
- Pouring liquid dosages and crushing or breaking scored tablets as prescribed.
- Applying topical medications including eye, ear, nose, and skin application.
- Returning medications to the proper locked areas.
- Obtaining medications from a pharmacy.
- Listing the medication on a resident's Medication Observation Record.
- A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, **changes in the method of medication administration**, or other changes which resulted in the provision of additional services. The owner, administrator, doctor, pharmacist, nurse, CAN, health care provider (HCP), and/or unlicensed personnel may be responsible for medication therapy and must provide written records as required by law.

Assistance With Self-Administration of Medication

One of the most important services an ALF may provide is assisting a resident with medications. For caregivers in ALFs, this is often a crucial component of caring for residents. Unlicensed staff who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, FAC, must meet the training requirements pursuant to Section 429.52(5), FS, prior to assuming this responsibility. Most people move to an ALF because of a need for assistance with personal care, **including assistance with medications**, and other activities of daily living. As a caregiver, you may need to assist a resident with medications. You may be required to pick up medications at the pharmacy, check them when they are delivered, and make sure that they are taken as prescribed.

This guide describes the process for assisting residents with safely taking their medications; provides an overview of the law and rule requirements with respect to assistance; and describes procedures relating to the management and supervision of medications in the assisted living setting.

Auxiliary Labels

Auxiliary labels are additional labels (usually colored) added by the pharmacist.



Example:

If a customized patient medication package is prepared for a resident and separated into individual drug containers, then the following information must be recorded on each individual container:

The resident's name and Identification of each drug product in the container.

Except for pill organizers filled by nurses, no person other than a pharmacist may transfer medications from one storage container to another.

Customized pre-packaged unit dose packages must be labeled with resident and medication names.

Except for the use of pill organizers filled by nurses, only a pharmacist may transfer medications from one storage container to another.



SAMPLE MEDICATIONS

Sample or complimentary prescription drugs that are dispensed by a health care provider must be kept in their original manufacturer's packaging, which shall also include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed.

If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they shall be kept in a container that bears a label containing the following information:

1. Practitioner's name
2. Name and strength of the drug
3. Resident's name
4. Directions for use
5. Date dispensed
6. Expiration date

Note: Before dispensing any sample or complimentary prescription drug, the resident's health care provider shall provide the resident with a written prescription, or a fax copy of such order.

Sample medications must have a written prescription or fax copy of such order.

PRACTICE MOR (BACK)

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

INITIALS	Print Name	Signature	INITIALS	Print Name	Signature

Blood Pressure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Systolic																															
Diastolic																															
Heart Rate																															
Temperature																															
Blood Sugar - 8 am																															
Initials																															

CHARTING INSTRUCTIONS	CHARTING CODES	CHARTING CODES
1. Put INITIALS In appropriate box when MED given.	A. Charted in ERROR	E. Resident vomited or spit out MED
2. Circle INITIALS when medication REFUSED or NOT GIVEN	B. Drug temporarily unavailable	F. Drug Held by Medical Order
3. State REASON for refusal on medication NOTES below.	C. Resident REFUSED	G. Drug Holiday
4. As needed MED: REASON should be NOTED below.	D. Discontinued by Health Care Provider	H. Home / Pass / Out of Facility

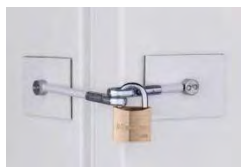
DATE	HOUR	MEDICATION / DOSE	CODE	REASON	RESULTS / RESPONSE	TIME NOTED	SIGNATURE



Name: _____ **DOB:** ____ / ____ / ____ **AGE** ____ yrs **Month / Yr** ____ / ____
Allergies: _____ **Height** ____ ' ____ " **Weight** ____ lbs **MEDICATION OBSERVATION RECORD MOR**

REFRIGERATED MEDICATIONS MUST BE KEPT LOCKED

Always check medications for proper storage requirements.



- Once opened, most insulin should be stored in a REFRIGERATOR.
- Once mixed, most antibiotics should be REFRIGERATED.
- Medications shall be properly stored and safeguarded to prevent access by unauthorized persons.
- Expired or discontinued medications shall not be stored with current medications.
- Storage areas shall be locked, and of sufficient size for clean and orderly storage.
- Storage areas shall not be located near sources of heat, humidity, or other hazards that may negatively affect medication effectiveness or shelf life.
- Medications requiring refrigeration shall be stored in a refrigerator at the temperature established by the U.S. Pharmacopeia (36 - 46 degrees F.). If a multi-use refrigerator is used to store medications outside the secured medication storage area, a separate locked box shall be used to store medications, provided the refrigerator is near the medication storage area. Accurate thermometers (within ± 3 degrees) shall be provided in all refrigerators storing medications.

Do not expose medications to extremes in temperature or moisture unless medications are supposed to be refrigerated.

E. STORAGE OF OVER-THE-COUNTER (OTC) MEDICATIONS

An ALF cannot have a “stock supply” of over-the-counter (OTC) medications. Bottles of ibuprofen, aspirin, Maalox, Tums, creams, ointments, etc., may not be kept for use by multiple residents. However, individual residents may have their own OTC medications.

Residents may be allowed to keep over-the-counter medication in their rooms if they self-administer their medications, with or without assistance. If the resident requires medication to be administered, they should not store OTC medications in their room.

An ALF may centrally store OTC medications for residents. An ALF may store OTC medications for residents that have not been prescribed by a health care provider. OTC medications must be labeled with the resident’s name and the manufacturer’s instructions for use and kept with the medication at all times. When an OTC medication is prescribed by a health care provider, the medication must be stored in the same manner as a prescription and managed just like a prescribed medication.

Chapter 9. How to Assist With Self-Administration of Medication

Unlicensed persons may, consistent with a dispensed prescription label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered.

ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION FOR UNLICENSED ALF STAFF INCLUDES the following: Oral and Topical Dosage Forms including skin, ophthalmic (eye), otic (ear), and nasal (nose) forms.

Assistance with self-administration of medication includes the following:

- Preparing and making available such items as water, juice, cups, spoons, tongue blades, tissues, etc.
- Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.
- In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
- Observing the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record.
- Returning unused doses to the medication container.
- Documenting assistance with self-administered medications on the MOR immediately.
- Self-administered medications include both legend and over-the-counter oral dosage forms; topical dosage forms; and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, inhalers, and diskus.

Understand what “assistance” with medication includes and does not include.

**ASSISTANCE DOES NOT INCLUDE the following:
Injectables by any route, parenterals,
IPPB machines or nebulizers, irrigations for wound care,
PRN “as needed” orders that require
“judgment” or “discretion.”**

9. Dry hands with clean paper towel and use paper towel to turn off faucet. Dispose of paper towel in wastebasket.
10. The fingernails should be cleaned with the first hand washing of the day and if they are contaminated or soiled in any way.

Always wash hands before and after handling medications.

HOW TO ASSIST WITH ORAL SOLID AND LIQUID MEDICATIONS

ORAL SOLID MEDICATIONS

- First, the unlicensed person must ensure that the patient is alert and able to swallow the medication without difficulty. If patients have a difficult time swallowing the pills, instruct them to first drink some water or juice and then attempt to swallow the medication again. If a resident seems to be having difficulty swallowing medications, talk to the health care provider regarding the need for a more convenient dosage form such as a liquid or capsule.
- Obtain needed supplies (water, juice, cups, spoon, pill splitter, etc.) before assisting with the administration of medications to a resident.
- It is usually best to take medications with a full glass of water (check MOR for directions).
- Breaking, cutting, splitting, or crushing any oral solid tablet or capsule requires judgment or discretion and must be decided by a licensed health care provider or pharmacist.
- Only break, cut, or split SCORED TABLETS or crush oral solid tablets or capsules as prescribed or authorized by licensed health care provider.
- Long-acting forms of medication (i.e., extended-ER or sustained release-SR) should not be broken, crushed, or chewed before swallowing.
- Medication that appears to have been contaminated (dropped on floor, etc.), shall not be returned to the container.
- Assist with medication only when you are sure the “nine rights” are being carried out and the resident does not have any drug or latex allergies: Right resident, drug, dose, route, time, reason, response, right to refuse, and record/document.
- Compare medication label with the MOR three times to ensure accuracy.
- Verify the medication label with the MOR before retrieving medication.
- Check to ensure proper medication was taken from storage with the MOR.
- Check pharmacy label and MOR for any change in directions or dose change.



- If the medication is a tablet or capsule in special or unit dose packaging, the medication is removed from the individually wrapped package and placed into a cup. Hand the cup to the resident along with a fresh glass of water. The unlicensed person must observe the patient put the medication into his/her mouth and swallow the medication completely without difficulty. The medication cup is then disposed of properly.

Always observe the resident swallow the medication.

- Have resident place tablets, capsules, etc., in middle of the tongue, and if sublingual under the tongue or buccal in the cheek, if applicable. Removing dentures helps with swallowing if edentulous (without teeth). Follow with at least a half (1/2) cup water, preferably a full 8 ounce glass of water.

**ALWAYS CHECK EXPIRATION DATES
when retrieving medication from locked storage area.**

How to Assist With Oral SOLID Medications:

1. Wash hands and obtain necessary items (medication container with label, MOR, water, juice, etc.). Check expiration date of medication.
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the alert resident and confirm understanding.
5. Open container in front of the resident and place medication in resident's hand or cup or other suitable device or container.
6. Assist the resident in taking the medication. (Do not put in mouth.)
7. Observe the resident swallowing the medication.
8. Return medication to proper storage area.
9. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
10. Always document the administration of a PRN "as needed" medication and the resident's response.
11. Wash hands properly.

Do not SPLIT or CRUSH medication WITHOUT a health care provider ORDER or Rx LABEL.



Breaking, cutting, or splitting scored tablets

- Only scored tablets can be broken by unlicensed personnel or staff. A medication label may state “take half a tablet”; **however**, you may **only** break tablets and caplets that are “scored.”
- A scored tablet has been imbedded for easier and even breakage; it assures the correct amount is divided.
- You may use a pill cutter or other devices to break a scored medication.
- You must wear gloves if you handle the pill to break it with your thumbs.



How to BREAK tablets

1. Wash hands and gather necessary items (medication container with label, MOR, cups, facility’s designated pill cutting device).
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
5. Open container in front of the resident, split scored medication using pill splitter or cutting device and place medication in resident’s hand or cup or other suitable container.
6. Assist the resident in taking medication. (Do not put in mouth.)
7. Observe the resident swallowing the medication.
8. Return medication to proper storage area.
9. Record assistance with self-administration on MOR. Document any refusal or other reason medication was not administered as ordered.
10. Always document the administration of a PRN “as needed” medication and the resident’s response.
11. Wash hands properly.

Crushing Tablets

Can the medication be crushed?

You may crush a medication only when the medication label specifically directs you to do so. Some medications are not meant to be crushed. In general, medications that are “sustained-release,” “controlled release,” “extended release,” or which have an “enteric coating” may not be crushed.



Can the capsule be opened and mixed with food?

- Most crushed tablets or emptied capsules may be mixed with certain foods including applesauce, pudding, or jelly immediately prior to administration.
- Medications cannot be “hidden” in foods for residents who are refusing them.
- Residents may only **knowingly** take a medication with food if it is easier for them.
- Remember that you are assisting residents to take medications, not administering medications.
- Pay close attention to the instructions on the label. It’s a good idea to check with the pharmacist to **be certain** a particular medication can be broken or crushed.
- Request specific directions for crushing medication. Could the medication be given in liquid form? Is there another medication which may be easier for the resident to swallow?

How to CRUSH a Medication, Using a Pill Crusher

1. Wash hands and obtain necessary items.
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying a resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
5. Open container in front of the resident, **crush medication (see below)**, and place medication in resident’s hand or cup or other suitable device.
6. **Crushing medication: Place medication in paper cup and cover with another paper cup, and use pill crusher or firm instrument on top of cup to crush the medication.**
7. Assist the resident in taking medication with food. (Do not put in mouth.) Place all of the crushed medication onto a spoon with food.
8. Observe the resident swallowing the medication.
9. Return medication and supplies to proper storage area.
10. Record assistance with medication on MOR.
11. Wash hands properly.



How to Measure and Pour Oral LIQUID Medication:

1. If LIQUID medication requires **REFRIGERATION**, store in **locked REFRIGERATOR** and monitor temperature with daily log.
2. Wash hands and obtain necessary items (medication with label, MOR, cups, **accurate measuring container or device**, etc.).
3. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
4. Follow facility policy for identifying a resident. Address resident by name.
5. If LIQUID medication is a **suspension**, **"SHAKE WELL."**
6. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
7. Measure and pour liquids using a container with measurements on it (oral syringes, unit dose cups, cooking spoons, etc.). Remove the cap and place it with the open side up. Hold the bottle with the label toward the palm of the hand to avoid soiling the label. Locate the marking on the container for the amount to be poured in a container at eye level.
8. Measure with container at eye level and pour medication using thumb to identify the correct level (dose) and then close container properly.
9. Assist the resident in taking the right medication. (Do not place in mouth.) Pour right amount of medication in cup or other suitable container and place in the resident's hand.
10. Observe the resident swallowing the medication.
11. Check to see that the cap of the bottle is on securely. Return medication container to proper storage area (i.e., LOCKED refrigerator).
12. Record that assistance was provided on the MOR.
13. Wash hands properly.



Unit conversions

- 1 mL = 1 mL (Do not use cc)
- 2.5 mL = 1/2 teaspoonful
- 5 mL = 1 teaspoonful
- 15 mL = 1 tablespoonful = 3 teaspoonfuls
- 3 teaspoonfuls (15 mL) = 1 tablespoonful (15 mL).

- Many liquid medications are pre-measured and come individually wrapped.
- When dispensing from a bottle the health care provider must measure the liquid carefully. Locate the desired ml mark on the cup and put your thumbnail on the mark. At eye level, pour the liquid up to the exact mark. Place measuring cup on level surface. Pour the medication on the side away from the label to keep the label clean. Wipe off excess from the bottle.
- The suspension may be drawn up into a syringe for ease of delivery; remember to have the patient upright and push slowly so as not to eject the fluid into the patient's mouth.
- If resident has trouble swallowing a medication, check with the health care provider (HCP) for other available forms of the medication or ask your pharmacist for advice.

Unit Conversions
1mL = 1mL (Do not use cc)
2.5 mL = 1/2 teaspoonful
5 mL = 1 teaspoonful
15 mL = 1 tablespoonful
3 teaspoons (15 mL) =
1 tablespoonful (15 mL)

HOW TO ASSIST WITH TOPICAL MEDICATIONS FOR THE SKIN (creams, lotions, ointments, patches, and sprays)

- Medications should be applied as directed by HCP. Examine the skin site to observe the condition both before and after applying the topical medication.
- It is best to use latex gloves during the application process to prevent any unwanted reactions from the medication, and always wash your hands after removing gloves as per OSHA standards.
- Be gentle when applying medication as the area may be sensitive or painful.
- **YOU ARE NOT ALLOWED TO ASSIST WITH CREMES OR OINTMENTS THAT REQUIRE A DRESSING (i.e., wound care).**



How to Assist With TOPICAL Creams, Lotions, Ointments, and Sprays

1. Wash hands, identify right resident, **provide for privacy**, and obtain necessary items (medication container with label, MOR, tongue blades, clean gauze pads, etc.).
2. TRIPLE CHECK. Verify the medication label with the MOR. Check the MOR, then the medication label, then the MOR before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable position, and read the medication label to the resident and confirm understanding.
5. Use gloves or an applicator, such as a wooden tongue depressor, clean Q-tip, or gauze pad, so that your hands don't come into contact with medication or affected skin. Using gloved hand, apply thin film of cream, ointment, lotion, or spray to affected area. **Do not cover with a bandage unless directed by the HCP.** Replace container top promptly.
6. Spread onto affected area as prescribed by a physician until absorbed, unless the directions say to leave a film. Avoid rubbing the skin.
7. Dispose of tongue depressor, gauze pads, and gloves, and wash hands immediately.
8. Return medication to proper storage area (i.e., LOCKED area).
9. Record that assistance was provided on the MOR.
10. Always document the administration of a PRN "as needed" medication and the resident's response.

How to Assist With the Application of Transdermal PATCHES

1. Wash hands, identify right resident, **provide for privacy**, and obtain necessary items (medication patch with label, MOR, etc.).
2. Triple check the medication label with the medication observation record (MOR). Check the MOR, then the medication label, then the MOR again before providing the medication to the resident.
3. Follow facility policy for identifying resident. Address resident by name.
4. Assist the resident to a comfortable sitting position and read the medication label to the resident and confirm understanding.
5. Open the package and remove the patch. Date and initial the patch (and time, if appropriate).
6. Remove the backing from the patch, using care not to touch medication with hands.
7. Apply the patch to a dry, hairless part of the body, according to package instructions. Watch for old patches that should be removed or absence of a patch that should be present. Alternate the application sites to avoid skin irritation. Notify the health care provider of irritation.
8. Dispose of supplies and wash hands immediately to avoid absorbing the medication yourself.



Drug-Drug and Drug-Food Interactions

Knowledge of common drug interactions can help prevent problems and promote good health. A “**drug-drug interaction**” results when a drug interacts with other drugs to cause side effects. A “**drug-food interaction**” occurs when a drug interacts with food and/or certain foods to cause side effects.

EXAMPLE OF DRUG-DRUG INTERACTIONS

DRUG Interactions: The levels/effects of Levothyroxine may be decreased by the following:

Aluminum Hydroxide; Bile Acid Sequestrates; Calcium Polystyrene Sulfonate; Calcium Salts; CarBAMazepine; Estrogen Derivatives; Fosphenytoin; Iron Salts; Lanthanum; Orlistat; Phenytoin; Raloxifene; Rifampin; Sevelamer; Sodium Polystyrene Sulfonate; Sucralfate

EXAMPLE OF FOOD-DRUG INTERACTIONS

FOOD Interactions: Decreased effect of Levothyroxine by certain foods below:

Taking levothyroxine with enteral nutrition may cause reduced bioavailability and may lower serum thyroxine levels leading to signs or symptoms of hypothyroidism. Soybean flour (infant formula), cottonseed meal, walnuts, and dietary fiber may decrease absorption of levothyroxine from the GI tract.

Desired Effects:

Medications are given or prescribed for many reasons. Some examples include the following:

- Promote health: example – nutritional supplement or vitamins
- Eliminate illness: example – antibiotics or cancer medications
- Control a disease: example – oral hypoglycemic or antihypertensive
- Reduce or prevent symptoms related to illness: example – cough suppressant or aspirin for stroke prevention, fever, or inflammation
- Alter behavior: example – anti-anxiety, anti-depressant, or anti-psychotic agents.

When the prescribed drug is working correctly, we say the medication is producing the desired effect. The desired effect is the beneficial effect we want the drug to accomplish.

The use of a drug should be based on the potential medical benefit versus the risk of unwanted effects such as side effects and adverse drug reactions (ADRs).

Unwanted Effects:

When a drug is taken, there is always the possibility that the resident may not have the response to the drug that was expected to occur. Some of the outcomes can be life threatening. Sometimes, the unwanted effects are predictable. These effects are called side effects or adverse effects. An example is drowsiness produced by sedating cold medications. Drowsiness may not occur in every person for whom the drug was prescribed, but it happens frequently. Constipation is an unwanted effect that may occur when taking iron preparations or opiates. Unwanted effects may be unexpected and unpredictable. Many elderly people become confused when starting a new drug. Some people are very allergic to drugs such as penicillin and have a reaction that could be fatal. Residents take many different kinds of medications. Each medication taken has a specific effect on the body. As a result, medications are **classified** according to how they will act in the body.

Appendix 4. AHCA Form 1823, page 4

TO BE COMPLETED BY FACILITY:

Resident's Name _____ DOB: _____

SECTION 2-B: SELF-CARE AND GENERAL OVERSIGHT ASSESSMENT—MEDICATIONS (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.)

A. Please list all current medications prescribed below (additional pages may be attached):

	MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

B. Does the individual need help with taking his or her medications (meds)? Yes ____ No _____. If yes, please place a checkmark (✓) in front of the appropriate box below:

<input type="checkbox"/> Needs Assistance with Self-Administration of Medications	<input type="checkbox"/> Needs Medication Administration
---	--

C. ADDITIONAL COMMENTS/OBSERVATIONS (Use additional page if necessary):

NOTE: MEDICAL CERTIFICATION IS INCOMPLETE WITHOUT THE FOLLOWING INFORMATION:

NAME OF EXAMINER (Please Print): _____

SIGNATURE OF EXAMINER: _____

MEDICAL LICENSE #: _____

ADDRESS OF EXAMINER: _____

TELEPHONE #: _____

TITLE OF EXAMINER (Please check the appropriate box): ☐ MD ☐ DO ☐ ARNP ☐ PA

DATE OF EXAMINATION: _____

Appendix 5. Medication Observation Record (MOR)

Resident _____ DOB: _____ **20** Physician _____ Phone _____

Allergies _____ Pharmacy _____ Phone _____

Diagnosis _____ **ALF MEDICATION OBSERVATION RECORD (MOR)** Page ____ of ____

Medication/Directions	Hour Due	Dose																														
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

CODES: D/C - Discontinued E - Charted in Error H - In Hospital/Rehab O - Out of Facility U - Drug Unavailable V - Vomited or Spit Out Medication X - Held by Medical Order

Stop and Watch

Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- S** Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities
a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less
W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)

Nurse's Name



Incubator Phase of the National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care

Shift Huddles Tip Sheet

What It Is:

A **Huddle** is a quick meeting to share and discuss important information. **Start of Shift and End of Shift Huddles** provide a way to share information about each resident as everyone starts work and to recap any information at the end of the shift that needs to be shared with the next shift. They can be done in a stand-up meeting or as room to room walking rounds with the charge nurse and CNAs together checking on each resident. It helps to have other disciplines join in to share their information and to hear information that can help them contribute to the team caring for residents.

Why Do It:

A shift huddle reinforces teamwork and allows everyone to hear about every resident so staff can provide help to residents not on their assignment. Communication of essential information cannot be left to chance. When it is shared in a group, everyone hears EXACTLY the same information and can share what they know. The group can problem-solve any issues on the spot.

Who Participates:

Shift Huddle is a gathering of the nurses and CNAs working together by unit and shift. It is good to include housekeeping, social work, activities, and therapy or to huddle again quickly later in the shift when these others can participate.

When To Do It:

Shift huddle should occur at the beginning and at the end of the shift. If there is a paid shift overlap, it can be done with staff from both shifts. Huddles can also occur at other times as needed, such as before staff go on break, when a new resident arrives, when an issue arises that needs the team to come together, or when other departments can participate in a short discussion.

How Long:

Start and end of shift huddles should take no more than 15 minutes. In-the-moment huddles can often complete business in less than 5 minutes but may take longer.

How To Do It:

This needs to be a positive mutual exchange of information needed to care for each resident on the hall. Standing Agenda Items may include:

- **Resident by resident report by exception**, focused on *risks and opportunities, including quality of life and quality of care*, using MDS areas of functional status, mood, and customary routines as a guide. INTERACT^{II} *Stop and Watch* is an excellent tool to focus the end of shift exchange.
- Anyone due for their **MDS** (in their **Assessment Reference Date - ARD**)
- **Changes in Census – people coming in or leaving**



Incubator Phase of the National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care

- **Information about new residents**, including social history, family information, medical needs, customary routines and special needs
- **Reportable Events, Incidents, Accidents** for any resident
- **Complaints and Compliments** for any resident
- **Follow-up on any issues** raised for which the loop needs to be closed
- Any **clinical area** that is being worked on (e.g., pressure ulcers)
- **News from any department** requiring staff knowledge or coordination
- Introduction of and check-in with **new employees**

Keys to Success:

Be on time, this is a short meeting. It needs to start and end on time. **Everyone** needs to be there on time and be prepared to share.

Process:

This is an exchange among CNAs and with the charge nurse and other staff. At the end of the shift, **CNAs share information** for each resident on their assignment. At the start of shift, nurses give information provided by CNAs and nursing from the previous shift's end of shift report. Other staff may add relevant information about that resident.

Report is **by exception**, focused on risks and opportunities in **quality of care and quality of life**. For example if someone is at risk for pressure ulcers, discussion will include how well they ate and drank, and any positioning issues. If someone has been depressed, the discussion will include their interactions and participation in activities. If a resident does not seem to be oneself that day, this is noted and discussed. See **INTERACT^{II} Stop and Watch** for good examples of issues to note.

Critical Thinking:

To be successful shift huddles have to be valuable to the participants. These are not rote reports. They are opportunities for critical thinking and problem-solving together to ensure the best care for each resident.

Provide Support:

It is optimal to have the support of nursing management answering lights and meeting residents' needs while CNAs and the charge nurse are rounding or having stand-up so that they can have uninterrupted time.

Huddles should be supportive, not negative. Provide mentoring to those nurses who need help on how to facilitate positive team building huddles.

For a short video How-to on Shift Huddles go to
www.BandFConsultingInc.com/WhatYouDoMatters

**RESIDENT HEALTH ASSESSMENT for ASSISTED LIVING FACILITIES**

❖ This form must be completed annually for residents receiving assistive care services in order to comply with Medicaid

TO BE COMPLETED BY FACILITY:

Resident's Name _____ DOB: _____

INSTRUCTIONS TO LICENSED HEALTH CARE PROVIDERS: *AFTER COMPLETION OF ALL ITEMS IN SECTIONS 1 AND 2 OF THIS FORM (pages 1 through 4), PLEASE RETURN TO:*

FACILITY NAME: _____

FACILITY ADDRESS: _____

TELEPHONE NUMBER: _____ CONTACT PERSON: _____

SECTION 1: HEALTH ASSESSMENT (MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER BY MEANS OF A FACE-TO-FACE EXAMINATION WITH THE RESIDENT.)

Known Allergies:

Height:

Weight:

Medical history and diagnoses:

Physical or sensory limitations:

Cognitive or behavioral status:

Nursing/treatment/therapy service requirements:

Special precautions:

Elopement Risk:

Yes ☐ No ☐

TO BE COMPLETED BY FACILITY: Resident's Name _____ DOB: _____

SECTION 3: SERVICES OFFERED OR ARRANGED BY THE FACILITY FOR THE RESIDENT (<i>MUST BE COMPLETED BY THE ALF ADMINISTRATOR OR DESIGNEE.</i>)
--

Note: This section must be completed for all residents based on needs identified in Sections 1 and 2 of this form, or electronic documentation, which at a minimum includes the elements below. The facility may attach the resident's service plan, care plan, or community living support plan to this document to satisfy this requirement provided the documentation captures the information listed below.

#	(Column 1) Needs Identified from Sections 1 & 2	(Column 2) Service Needed	(Column 3) Service Frequency & Duration	(Column 4) Service Provider Name	(Column 5) Date Service Began
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

NAME OF RECIPIENT OR GUARDIAN:
 (Please Print) _____

SIGNATURE OF RECIPIENT OR GUARDIAN: _____

NAME OF ADMINISTRATOR OR DESIGNEE:
 (Please Print) _____

SIGNATURE OF ADMINISTRATOR OR DESIGNEE: _____

Does the facility intend to use this form to satisfy the Medicaid assessment for assistive care services? Yes ☐ No ☐
 If yes, page 6 is required to be completed. If no, Stop.

Title: Care Plan Team Meeting Agenda		
Latest Revision: 7-1-13	Regulatory: F279, F280	# of Pages: 3
Approved By:		

Care Plan Team Meeting Agenda

Date: _____ Time _____ Location: _____

Content:

1. Resident and/or Resident Representative present, included by phone, or who will be updating them with outcomes of Care Plan Meeting
2. Clarify the Objective: To provide a comprehensive care plan that includes person centered measurable objectives and timetables to meet a residents highest practicable physical, mental, and psychosocial well being
3. Introduce Interdisciplinary Team to the resident and/or resident representative
4. Review Team Roles: Leader, Timekeeper, Recorder
5. Review the Care Plan Meeting Agenda items:
 - A. Advance Directives Status/end of life issues
 - i. Competency and decision making
 1. Remains competent?
 2. Surrogate/DPOA/Guardian/ Proxy Status
 3. Appointment/Acceptance of Surrogate/Proxy
 - ii. Resuscitation status
 1. Statement of status
 2. Documented within the record
 3. Identified on the care plan/Kardex
 - iii. Reviewed on readmission and periodically during course of stay to ensure it remains in effect and/or in keeping with resident wishes, Living Will
 1. Specific instructions regarding interventions
 2. Appropriate physician(s) diagnosis and supportive documentation
 3. Reflected in the care plan
 - iv. Educational resources or referrals: INTERACT handouts, other
 - v. Ethical concerns
 1. Resident/Resident Representative statements are documented and reviewed
 2. Any requested follow up is assigned and documented
 - B. Review current status of Resident and care plan problems as applicable to the resident, including:
 - i. Primary/Secondary Diagnoses

1. Recent hospitalizations/re hospitalizations
2. Functional Needs: ADL's
3. Behavioral Management Plan – non medication interventions and parameters (Example: aroma therapy, soft music, a quiet preferred area with one to one conversation or activity of choice, etc.)
4. At risk behaviors: Wandering/Elopement/Resident to Resident (review of current interventions/revisions)
5. Person Centered Care initiatives/resident choice, routines
- ii. Tests/Procedures
- iii. Treatments
- iv. Medications
 1. Diagnosis for all medications: Necessity, documented parameters for 'as needed' medications; non pharmacological approaches (Activities, SS, Nursing, Other)
 2. Questions regarding risk/benefit and side effects
 3. Pain Management Plan
- v. Recent or Pending Referrals – status, plans and goals
 1. Therapy: PT, OT, ST, Respiratory: ADL review
 2. Dental
 3. Podiatry
 4. Mental Health
 5. Vision
 6. Hearing
 7. Physician Consultant
 8. Hospice
 9. Dialysis
 10. Vent/RT
 11. Other:
- vi. Person centered care interventions: Address resident preferences and routines
- vii. Special Needs/Consents

C. Additions/Revisions to the Care plan

D. Customer Satisfaction Questionnaires (QIS as indicated)

E. Review of Action Steps

F. Complete Care Plan Conference Summary

G. Adjournment

Contracts and negotiations with managed care organizations

Rights of ALF Providers and Residents

Why this session???

- Questions to
- Florida Health Care Association
- Florida Assisted Living Association
- LeadingAge
- AHCA
- DOEA

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Session tips

- Get and read contract and all addendums **before signing**
- Read and master ALF contract statute 429.24 and ALF contract rule 58A-5.025
- Read and master resident rights statute: 429.28
- Use session's contracting checklist

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Today's session

- Context
- Plan contracts and provider rights
- Resident rights
- Choice counseling
- Care planning
- ALF contracts
- House rules
- Session resources
- Session take-aways

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Context – changes in Florida law

- ALFs and Adult Family Care Homes are eligible to provide Assisted Living Services
- Assistive Care services are included in Assisted Living Services
- ALFs are to bill plans based on contract
- ALFs must be offered plan contract if billed for Medicaid waiver services during July 2012
- ALFs can be excluded after first contract year for quality or performance shortfalls

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Session tip

- ALFs can be excluded after first contract year for quality or performance shortfalls
- Find out applicable measures
- Measure performance monthly

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Plan notifications to enrollees

- Complaint
- Grievance
- Appeal
- Medicaid Fair Hearing
- Report abuse, neglect and exploitation

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Plan contracts and ALF rights

- Plan relations and communications
- Authorization process including denials and appeals
- Timely claims payment
- Assistance with claims processing
- Complaint resolution process

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ALF training

- Mental illness
- Behavioral management
- Suicide risk and management

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Home-like environment

- Plan contracts require home-like environment
- Plans to ensure all home-like requirements are met

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Characteristics of Home-Like Environment

- Entrance doors must have locks with appropriate staff having keys
- Freedom to furnish and/or decorate sleeping or personal living areas
- Choice of private or semi-private rooms
- Choice of roommate
- Reasonable access to telephone service
- Freedom to engage in private communications
- Freedom to control daily schedule and activities
- Choice of visitation options
- Access to food and preparation areas
- Personal sleeping schedule
- Participation in ALF and community activities
- Participation in unscheduled activities

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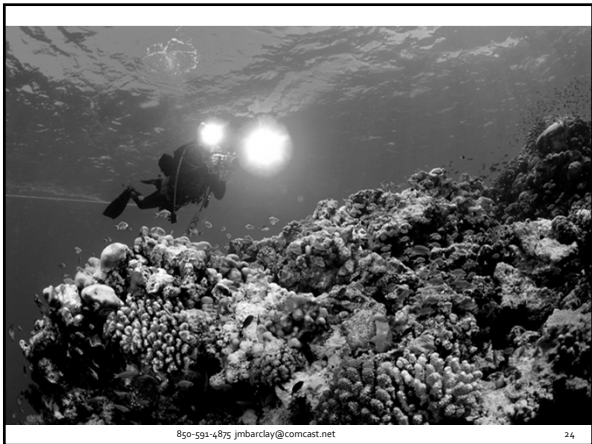












Enforcing home-like environment

- AHCA on-site monitoring reviews
- Credentialing and re-credentialing process
- Upon discovery, remediation proposals are due within 3 days

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Choice counseling

- Offered by AHCA through contracted broker
- Counseling to be unbiased and objective
- Materials mailed 2 months before start of services

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Choice counseling goals

- Understand managed care
- Available plan choices and differences
- Enrollment and plan change processes

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Understanding managed care

- AHCA contracts with plans
- AHCA pays plans for services
- Plans create networks by contracting with service providers such as ALFs
- Service providers furnish contracted services to enrollees

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Care planning

- Resident-centered
- Developed by resident with help of plan's case manager
- Based on assessment

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Individual care plan

- Personal preferences
- Personal choices
- Personal goals
- Personal outcomes
- Services

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Level of care

- Established by Elder Affairs' CARES staff
- CARES performs assessment
- Level of care established with least restrictive most appropriate placement recommended

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Resident rights

- Choice of any ALF or AFCH in plan's network
- Same rights in law now, including Chapter 429 Resident Rights

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Approach to ALF contracting

- Consider the actual paper – the documents
- Learn service provisions – drill down on Resident Rights Law
- Master financial aspects
- Understand other permissible contract provisions
- Learn how to document and manage contract changes
- Remember rules for large ALFs and CCRCs

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5 features of ALF contract documents

- Executed before or at time of admission between ALF and resident, designee or legal representative
- Duplicate original
- Copy of contract and addendums provided - including house rules
- ALF to keep contract on file for at least 5 years after expiration
- Contract may include other appropriate matters

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Examples of other permissible ALF contract provisions

- Venue – where cases will be tried
- Waiver provisions
- Attorneys fees
- Notice
- How house rules are changed
- Effective date of house rules
- Notice of house rules

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Resident Rights Law – 429.28

- Residents retain Florida and US constitutional rights
- Live in safe and decent living environment free from abuse and neglect
- Treatment with respect, dignity, individuality and need for privacy
- Retain and use own clothes and personal items
- Unrestricted communication

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Unrestricted communication

- Correspondence
- Telephone
- Visitation between 9 am and 9 pm
- Time to be extended for caregivers and out-of-town guests

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Resident Rights (continued)

- Community services and activities to highest level of independence
- Manage financial affairs
- Share room with spouse if both are residents
- Regular exercise several times a week
- Exercise civil and religious liberties
- Access to "adequate and appropriate" healthcare consistent with community standards
- 45 days written notice of relocation

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Advocacy rights

- Present grievances
- Recommend changes to ALF policies, procedures and services
- Use grievance procedure
- Access to ombudsman
- Join and participate in advocacy or special interest groups

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Notice of Residents Rights

- Posted prominently
- Contact information for local ombudsman
- Central abuse hotline

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ALF contract service provisions

- **Contract sets forth rights, duties, and obligations of residents other than in "Residents' Rights" law**
- **Assessment upon admission, every 3 years thereafter and after significant change**

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Session tip

- 1823 and other ALF documentation
- Best friend
- Worst enemy
- Better to have documentation and not need it than ...

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ALF contract service provisions (continued)

- Services and accommodations to be provided by ALF
- Limited nursing and extended congregate care services if ALF is licensed to provide such services
- ALF's policies and procedures for administration of medications
- Addresses or incorporates ALF's "house rules"
- Provisions when ALF can no longer meet resident's needs
- ALF's policies and procedures related to Do Not Resuscitate Orders
- Contract does not relieve ALF of any requirement or obligation imposed upon it by statute or rule

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ALF contract financial provisions

- Sets forth daily, weekly, or monthly rates or charges
- Lists any additional services and charges to be provided
- Reference to a separate fee schedule to be attached to contract
- Purpose of advance payments or deposit payments including any advance payment for housing, meals, or personal services
- Refund policy
- Other conditions under which claims will be made against refund
- Bed-hold or bed reservation policies
- Provisions for terminating bed hold agreement
- At least 30 days' written prior notice of rate increase

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Session tips

- Issue refunds within 45 days of termination
- Unit vacated when vacated and cleared of all personal belongings

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Other required ALF contract provisions

- Whether ALF is affiliated with any religious organization and, if so, other details
- Termination by ALF or resident

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Immediate termination

- Physician requires relocation to facility with more skilled level of care
- Resident engages in harmful or offensive behavior

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Changes to ALF contract

- Addendums reflect additional services, supplies, or accommodations not provided under original agreement
- Dated and signed by ALF and resident or resident's legal representative

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Contracting with Continuing Care Facilities or large ALFs

- **Contracts with Continuing Care Facilities must comply with the requirements of s. 651.055**
- **Contracts with ALFs that consist of 60 or more apartments may require refund policies and termination notices in accordance with Florida's "Landlord-Tenant" laws**

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Session tip

- **Insert date/version of document in page footer**

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House rules

- **Must be written and in admissions package**
- **Should be in ALF contract or in an addendum**
- **May not violate Resident's Rights law**
- **Administrative and housekeeping practices, schedules and requirements**

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House rule topics

- Resident responsibilities
- Alcohol and tobacco
- Third-party services
- Elopement
- Visitation
- Use of common areas
- Meals
- Behavior
- Medications
- Departure log
- Complaints

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Examples of house rules

- We provide 3 nutritious meals and 2 snacks every day on a regular schedule
- All food and drink – except water – must be consumed in dining area
- Advise us when you leave, where you are going and when you expect to return
- Unrestricted use of common areas – including radio, TV, games, etc. - between 7 am and 10 pm

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Session resources in materials

1. ALF contract law 429.24
2. Resident's rights law 429.28
3. ALF contract rule 58A-5.025
4. ALF contracting checklist
5. Characteristics of home-like environment

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Session take-aways

- Obtain, read and understand contract and all addendums before signing
- Read and master at least Sections 24 and 28 of Chapter 429, Florida Statutes and Rule 58A-5.025
- Use the ALF contracting checklist when evaluating contract
- Monitor AHCA website
- Attend CE programs particularly those of Florida Health Care Association, Florida Assisted Living Association and LeadingAge

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Thank you for your time and attention

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Legal Resources for 2014 Joint Training for Assisted Living Facilities

January 8, 2014

1. § 429.24, Florida Statutes, ALF contracts Page 2
2. § 429.28, Florida Statutes, ALF residents' rights Page 6
3. § 58A-5.025, Florida Administrative Code, requirements for ALF
contracts Page 10
4. ALF contracting checklist Page 13
5. Characteristics of home-like environment Page 15

1. 429.24 Contracts. —

(1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration.

(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and obligations of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period:

(a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident.

(b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.

(3)

(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or death. The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of death or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or death of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18.

(b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or psychiatric facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee.

(c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.

(4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility.

(5) Neither the contract nor any provision thereof relieves any licensee of any requirement or obligation imposed upon it by this part or rules adopted under this part.

(6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055.

(7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's death or relocation due to psychiatric hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units.

(8) The department may by rule clarify terms, establish procedures, clarify refund policies and contract provisions, and specify documentation as necessary to administer this section.

History. — s. 11, ch. 75-233; ss. 12, 23, ch. 80-198; s. 2, ch. 81-318; ss. 52, 79, 83, ch. 83-181; s. 10, ch. 87-371; s. 1, ch. 88-364; s. 15, ch. 91-263; ss. 19, 38, 39, ch. 93-216; s. 775, ch. 95-148; s. 2, ch. 98-148; ss. 2, 46, ch. 2006-197.

Note. — Former s. 400.424.

2. 429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if **applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact** authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k) **At least 45 days' notice of** relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at **least 45 days' notice of a nonemergency relocation or residency** termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the **residents' exercise of this right. This right includes access to** ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. This notice shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, when applicable, the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council, where complaints may be lodged.

The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council.

(3)

(a) The agency shall conduct a survey to determine general compliance with facility **standards and compliance with residents' rights** as a prerequisite to initial licensure or licensure renewal.

(b) In order to determine whether the facility is adequately **protecting residents' rights, the biennial survey shall include private** informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is **located to discuss residents' experiences within the facility.**

(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.

(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.

(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.

(5) No facility or employee of a facility may serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

(6) Any facility which terminates the residency of an individual who participated in activities specified in subsection (5) shall show good cause in a court of competent jurisdiction.

(7) Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

History.—ss. 12, 31, ch. 80-198; s. 2, ch. 81-318; ss. 55, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 65, ch. 91-221; s. 19, ch. 91-263; ss. 23, 38, 39, ch. 93-216; s. 778, ch. 95-148; s. 11, ch. 95-418; s. 17, ch. 98-80; s. 20, ch. 2000-263; ss. 76, 143, ch. 2000-349; s. 63, ch. 2000-367; s. 38, ch. 2001-45; ss. 2, 51, ch. 2006-197.

Note.—Former s. 400.428.

3. 58A-5.025 Resident Contracts.

(1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions:

(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services.

(b) The daily, weekly, or monthly rate.

(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract.

(d) A provision giving at least 30 days written notice prior to any rate increase.

(e) Any rights, duties, or obligations of residents, other than those specified in Section 429.28, F.S.

(f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments.

(g) A refund policy which shall conform to Section 429.24(3), F.S.

(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or psychiatric facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, **weekly, or monthly rate may be charged by the facility unless the resident's medical condition, such as the resident's being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident's behalf.**

(i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.

(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the **facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, shall be notified in writing that** the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect.

(k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.

(l) **The facility's policies and procedures for self-administration,** assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule.

(m) **The facility's policies and procedures related to a properly** executed Do Not Resuscitate Order.

(2) The resident, **or the resident's representative, shall be provided with a** copy of the contract.

(3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident **or resident's representative shall be furnished in advance with an itemized** written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum shall be added to the resident contract to reflect the

additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or the **resident's legal representative and a copy given to the resident or the resident's representative.**

Rulemaking Authority 429.24, 429.41 FS. Law Implemented 429.24, 429.41 FS. History—New 10-17-99, Amended 7-30-06, 4-15-10.

4. ALF contracting checklist

ALF contract documents

- ☐ Contract executed before or at time of admission between ALF and resident, designee or legal representative
- ☐ Duplicate original of contract provided
- ☐ Resident or resident's representative is provided with a copy of the contract and addendums
- ☐ ALF to keep contract on file in facility for at least 5 years after expiration
- ☐ Contract may include other matters parties deem appropriate

ALF contract service provisions

- ☐ Contract sets forth rights, duties, and obligations of residents other than those specified in s. 429.28, Florida's "Residents' Rights" law
- ☐ Contract has provision that resident must be assessed upon admission, every 3 years thereafter and after a significant change
- ☐ Contract specifically sets forth services and accommodations to be provided by ALF - a list of specific services, supplies and accommodations to be provided including limited nursing and extended congregate care services if ALF is licensed to provide such services
- ☐ Contract addresses ALF's policies and procedures for self-administration, assistance with self-administration and administration of medications to include over-the-counter products
- ☐ Contract addresses or incorporates ALF's "house rules"
- ☐ Contract contains provisions when ALF can no longer meet resident's needs
- ☐ Contract addresses ALF's policies and procedures related to Do Not Resuscitate Orders
- ☐ Contract does not relieve ALF of any requirement or obligation imposed upon it by statute or rule

ALF contract financial provisions

- ☐ Contract specifically sets forth daily, weekly, or monthly rates or charges
- ☐ Contract lists any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract
- ☐ Contract describes purpose of advance payments or deposit payments including any advance payment for housing, meals, or personal services
- ☐ Contract includes refund policy to be implemented at the time of resident's transfer, discharge or death
- ☐ Contract to specify other conditions under which claims will be made against the refund due the resident

- ☐ Contract addresses bed-hold or bed reservation policies and provisions for terminating a bed hold agreement
- ☐ Contract gives at least 30 days' written prior notice of rate increase

Other required ALF contract provisions

- ☐ Contract to state whether ALF is affiliated with any religious organization and, if so, which organization and its general responsibility to the ALF
- ☐ Contract specifies termination by ALF or resident

Changes to ALF contract

- ☐ Addendum to be added to contract to reflect additional services, supplies, or accommodations not provided under original agreement
- ☐ Addendums must be dated and signed by ALF and resident or resident's legal representative

Contracting with Continuing Care Facilities and large ALFs

- ☐ Contracts with Continuing Care Facilities certified under chapter 65I comply with the requirements of s. 65I.055
- ☐ Contracts with ALFs that consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of Florida's "Landlord-Tenant" laws, part II of chapter 83

5. Characteristics of Home-Like Environment

1. Entrance doors must have locks with appropriate staff having keys
2. Freedom to furnish and/or decorate sleeping or personal living areas
3. Choice of private or semi-private rooms
4. Choice of roommate
5. Reasonable access to telephone service
6. Freedom to engage in private communications
7. Freedom to control daily schedule and activities
8. Choice of visitation options
9. Access to food and preparation areas
10. Personal sleeping schedule
11. Participation in ALF and community activities
12. Participation in unscheduled activities

Agency for Health Care Administration Joint Training Assisted Living Facility 2014

Kimberly Smoak, MSH, QDDP
Bureau of Field Operations
Survey & Certification Support Branch



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Objectives

- Reminders about State Adverse Incidents
- Discuss the process for Quality Assurance Reviews
- Discuss Directed Plans of Correction



2

Adverse Incidents

- 429.23 Internal risk management and quality assurance program
 - Every facility is required to maintain adverse incident reports
 - An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:
 - Death;
 - Brain or
 - Spinal damage;
 - Permanent disfigurement;
 - Fracture or dislocation of bones or joints;



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Adverse Incidents

- Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives;
 - Any condition that required the transfer of the resident, to a unit providing a more acute level of care due to the incident, rather than the resident's condition prior to the incident; or
 - An event that is reported to law enforcement or its personnel for investigation; or
- Resident elopement, if the elopement places the resident at risk of harm or injury



4

Adverse Incidents

- Within **1 business day** after the occurrence of an adverse incident report to the agency.
- The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
- Within **15 days** provide a full report to the agency on all adverse incidents. The report must include the results of the facility's investigation into the adverse incident.



5

Directed Plans of Correction

- Used to address Class I and Class II deficiencies which require immediate action to alleviate ongoing deficient practice
- Help improve services and assist providers in attaining compliance



6

Directed Plans of Correction

- Not intended as a sole intervention by a provider
- Intended to impose directed interventions to address immediate concerns with identified deficient practice
- Provider must still complete and implement a plan of correction



7

Directed Plans of Correction Process

- Class I
 - Receive a hand-delivered DPoC letter within 2-business days outlining what the facility needs to do to immediately address the deficient practice
 - Facility representative will be required to sign the DPoC letter



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Directed Plans of Correction Process


- Class II
 - Receive a hand-delivered DPoC letter within 10-business days outlining what the facility needs to do to immediately address the deficient practice
 - Facility representative will be required to sign the DPoC letter



9


Request for Quality Assurance Reviews

- To appeal particular deficiencies identified during the survey;
 - Contact the appropriate Field Office Manager
 - Field Office Manager or designee may modify or remove deficiencies based on information supplied by the provider
 - Surveyor maybe consulted


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Request for Quality Assurance Reviews


- If the facility wishes to appeal the decision of the Field Office Manager:
 - The appeal and supporting documentation is sent to the Chief of Field Operations
 - Will be assigned as a Quality Assurance Review to designated staff
 - Based on outcome of the review, if warranted modifications will be made to the deficiencies


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Contact Information

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