TOTAL COMMUNICATION ENVIRONMENT

Section D: Medication

Policies and Procedures

Revised 2013

April 2013

Section D: Medication

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D.1 INTRODUCTION

The drug distribution system in use at TCE is a type of unit dose system called the "Controlled Dosage System". This is a type of drug distribution system which provides the prescribed doses of a specific drug for a certain resident. Each dose of a prescribed drug is packaged in a card, in a ready-to-administer form. This type of pre-packaging eliminates contamination which results from the pouring and transferring of medication, as well as the need for dosage calculations.

Under the "Controlled Dosage System" the pharmacy provides pre-packaged solid oral medication ready for administration, and the pharmacist interprets all the medication orders.

Each blister dose is numbered from #35 to #1 so that the number of doses remaining in the card can be determined easily and quickly. Once the card has been sealed, the medication cannot be contaminated or tampered with, without there being evidence of this, such as a tear in the foil.

The "Medication and Treatment Record" more commonly referred to as the MAR sheet (Appendix A) is a very important document as it records all the medication and /or treatments received by the residents. Therefore this document is to be filled out carefully and accurately as it has legal status, and forms part of the residents file.

D.2 TRAINING EMPLOYEES IN THE ADMINISTRATION OF MEDICATION

All new employees being trained shall be assessed as to their ability to correctly and responsibly administer medication to the residents in the care of TCE A training program shall be followed to ensure all employees are competent in this area of responsibility.

During the agency orientation for new employees of TCE the following medication procedures information is presented to the employees by a designated Program Supervisor and will document on standard checklist the procedure covered.

1. Explain that TCE has a specific medication training program for employees. Medication procedures are written and contained in the medication binders in all program locations.
2. Stress importance of all employees following agency medication procedures, the need for respect, dignity, safety and security for residents, employees and others that are responsible to administer any medication or participate in procedures.
3. Give overview of medication training program.
    - 3.1. Read and learn about medication given at the location.
    - 3.2. Once initial orientation is complete, employees are responsible to meet with the Program Supervisor to discuss any further questions they may have pertaining to the medication policy.
    - 3.3. Locate the items listed on the new employee medication training checklist (Appendix B).
    - 3.4. New employees are observed administering medication five times by employees who have been authorized by the Program Supervisor.
    - 3.5. Once these steps are completed, they are signed off on the appropriate form. A statement of having completed the new employee medication training checklist is signed by the employee and Program Supervisor.
    - 3.6. The form is submitted by the Program Supervisor to the Human Resources Department.
    - 3.7. Upon successful completion of the above steps, the employee will be trained and approved to administer medication to any resident independently.
4. Review responsibilities of employee and Program Supervisor for timely completion of training.
5. Review contents of the medication program package in the orientation binder:
    - 5.1. copy of policies,
    - 5.2. procedures,
    - 5.3. forms.
6. Review with the employees the importance of following TCE medication procedures exactly as they are written. The procedures are written for the safety and security of the employees and the resident to ensure that physician/pharmacist directions for the resident are followed as prescribed. Failure to follow these procedures will not be tolerated. Discipline will be initiated with employee for medication errors that occur as a result of procedures not being followed.

D.3 SAFETY AND SECURITY

For the residents' safety, employees must observe certain security measures.

1. No resident shall have access to the medicine cupboard or any other area where medication, including treatments, are stored.
2. The medication key must be kept with employee responsible for administering medication during the shift. Employee will return the key to a designated area prior to leaving the shift. Exception is noted at Kirkwood and Eleanor locations due to the program needs.
3. All medication is to be locked in the medication cabinet at all times, except when being administered, reconciled, or when requiring refrigeration.
4. All unnecessary or outdated medication shall be returned to the pharmacy along with the surplus prescribed medication form.
5. In the event that a resident requires medication during a home visit, the designated employee will place the medication in a packet/dosett, depending on family preference. The label will identify the medication-dosage-time(s) to be administered and any other pertinent or relevant information. The medication is to be given in person to the family member or person accompanying the resident. A note is to be left in the log book indicating the name of the person the medication was given to, and the employee who prepared it. If a resident is going to be away for an extended period of time or attending summer camp, employee will complete a separate MAR sheet and submit it to the pharmacist. The pharmacist will prepare the required medication for the specified time period. Employee will identify, by initialing on the MAR sheet, that the resident is on a leave of absence. copy of blank MAR to be added.
6. When a resident requires medication during an outing, the employee accompanying the resident will prepare the medication in a labeled packet/dosett. The employee preparing the medication must also administer the medication to the resident. As responsible professionals, employee will ensure the medication is kept in a safe environment until it has been administered. Employee will document on the MAR sheet upon returning to the program.
7. Resident photographs must be located in the medication binder. A computerized medication profile is prepared for each resident by the pharmacist. This is a record of all medication a resident is receiving. In this way, the pharmacist can review drug therapy, allergies and drug interactions.
8. Be alert to changes in the behavior and physical condition which may result from changes in medication-dosage, or accumulation of medication in the body. Any such changes must be reported to the Program Supervisor and the pharmacist or attending physician must be consulted.
9. Employees are not permitted to receive verbal orders from any physician or health care professional. The physician is to either fax or phone the order into the pharmacist or provide written orders. Employees are responsible to obtain the revised MAR sheet indicating the changes.
10. Health care professionals that are making recommendations relating to resident care will do

so in writing on the physician-consultant form.

11. When there are changes in medication and/or treatment procedures, the information must be documented in the log book and on the MAR sheet. Change in treatment means start-up, altered dosage, timing or discontinuation of medication, or any other change from the previous physician's orders.
12. TCE employees are not permitted to pre-package medication for any resident attending a day program. Vocational employees are responsible to administer required resident medication in accordance to their agency policy.
13. Residents will not consume any alcohol while taking prescribed and non-prescribed medication unless authorized in writing by their attending physician.
14. Never administer an unconscious or unresponsive resident oral medication, i.e.: post seizure.

D.4 PRINCIPLES FOR MEDICATION ADMINISTRATION

1. All employees must have extensive knowledge regarding the action and side effects of all medication they are administering.
2. All medication is kept in a locked medicine cupboard with the exception of refrigerated medication which is stored in a locked box in the refrigerator.
3. The thirteen rights are as follows:
    - **1.** the right resident,
    - **2.** the right medication,
    - **3.** the right dosage,
    - **4.** the right time,
    - **5.** the right route,
    - **6.** the right documentation,
    - **7.** the right frequency
    - **8.** the right site
    - **9.** the right assessment
    - **10.** the right reason
    - **11.** the right education
    - **12.** the right evaluation
    - **13.** the right to refuse
4. Policy on client's right to refuse and staff's right to refuse. REFUSAL POLICY. What to do if refused, when can staff override and when can staff refuse.
5. One employee per shift is identified responsible for medication administration. Exception noted at Quinn residence, one employee is designated but that employee delegates the administration of topical medication and ensures follow through is completed. There must be a physician's order for all medication given, including non prescription medication.
6. The employee administering the medication must document the administration on the MAR sheet immediately upon completion. When P.R.N. medication is administered a note in the log book is required. Employee must include the name of resident, medication which was administered, date and specific time.
7. Medication is to be given to one individual at a time. The employee who prepares the medication must administer the medication. If the employee who has prepared the medication is unable to administer, then the medication must be destroyed. The employee who is then to assume the medication responsibility must again prepare and then administer the medication.

8. If a resident vomits after a medication, attempt to determine how much, if any, of the medication was emitted. The resident's condition is to be observed. Appropriate medical advice should be solicited on the basis of the above information. Any significant change in a resident's physical state is to be documented and reported to the Program Supervisor or on call designate.

9. The employee giving the medication remains with the individual until the medication is taken. Concentrate on preparing and administering the medication. Do not talk or listen to others. Done in a quiet environment.

10. If a drug differs from the normal color, odor, or consistency, the drug must not be administered. If a difference is detected, contact the pharmacist to discuss the situation.

11. Medication is to be labeled by the pharmacy. If a prescription changes, the pharmacist is to be contacted and the medication is to be labeled accordingly.

12. If the wrong medication is administered to a resident, contact any one of the following immediately:

    1. the physician,

    2. the pharmacist.

    3. 911

13. Any of the above will determine what further action is to be taken. The error is to be reported to the Program Supervisor or "on call" upon discovery and a written medication incident report (Appendix C) completed. It is important to include the name of the person you spoke with concerning the incident.

14. The health and safety of residents shall be the primary concern in the monitoring, storage, and administration of medication. Residents have the right to regular medication reviews to ensure that the prescribed medication is reflecting their changing individual needs. Meds are reviewed annually at physicals.

D.5 PROTOCOL FOR MONITORING

Monitor as per professional recommendations

D.6 MEDICATION ADMINISTRATION PROCEDURE

1) Wash your hands.
2) Assemble all necessary equipment - measures, spoons, face cloth, cups, water, etc.
3) Never administer any medication if the instructions are not clear or if in doubt.
4) Unlock medication cupboard.
5) Assemble medication to be given to one individual at a time. Compare the drug label with the instructions on the MAR sheet.
6) Read the drug label when taking the medication out of the cupboard, preparing and returning it.
7) Make sure medication that is held, omitted or refused is documented and rational given. Dot the MAR sheet in the proper box, using one dot for each pill and checking the label against the MAR sheet once again. Once the medication has been administered then initial the MAR sheet. It is not necessary to initial the blister card since it will be discarded.
8) Return medication to the cupboard.
9) Lock cupboard.
10) Wash your hands.

D.7 TYPES OF MEDICATION

1. TABLETS

Administer the medication without touching it, i.e.: with the blister, push the tablet into dispensing container. Enteric coated tablets must not be crushed. If a resident requires pills to be crushed, a Doctors order is required. A written procedure must be followed and a pill crusher used.

2. LIQUIDS

    1. Pour the required amount of medication into the medicine cup from the unlabeled side of the bottle. This prevents from obscuring the label and thus making it difficult to read.
    2. Medication measured on a level surface and place thumbnail at the desired dosage. Wipe the neck of bottle with a damp paper towel before replacing lid. Never pour medication back into the bottle.

3. ADMINISTRATION OF RECTAL SUPPOSITORIES
(A suppository is a solid medication in a firm base which melts at body temperature and are often stored under refrigerated conditions, dependant on the type of suppository. This will be specified on the label by the pharmacy.)

    During administration, it is important to place the suppository past the internal sphincter and against the rectal wall. Improper placement can result in expulsion of the suppository before the medication dissolves and is absorbed.

    Never force a suppository into a mass of fecal material; it will not work appropriately. It should be placed against the rectal wall.

Steps	Rational
1. Wash your hands.	Reduces transmission of micro- organisms.
2. Assemble necessary equipment (e.g. disposable gloves, water-soluble lubricant, tissue and wash cloth, etc)	This eliminates the need to leave the workstation once the medication cupboard is unlocked. Medications should never be out of your sight.
3. Check the individual's MAR in the medication book for this information: • **NAME** of the medication (generic and brand names) • **FORMAT** of the drug • **STRENGTH** of the medication (i.e. 50 mg of the drug per suppository) • **ROUTE** of administration	Ensures correct administration.

Steps	Rational
• **DOSE** to give • **TIME** it is to be given... **ALL OF THE "RIGHTS" of MEDICATION ADMINISTRATION must be verified!**	
4. Compare the prescription on the box to the information written on the MAR to ensure they are the same and that Med Sheet is Correctly written on the MAR.	Ensures correct administration.
5. Check the medication sheet a second time and prepare the medication. Check the prescription on the box a second time as you are preparing the med.	Ensures correct administration.
6. Put a dot in the square on the MAR corresponding with current date and time.	Indicates that medication has been prepared/poured.
7. Compare medication and MAR one last time and lock the cupboard.	Ensures correct administration. Prevents children from accessing medication.
8. Identify the correct individual. If the individual is capable of understanding, explain the purpose of the medication. Always explain intended actions prior to carrying them out even if unsure if individual is able to understand. Administer the medication according to information on MAR using the following guidelines:	Ensures correct administration. Promotes dignity and increases likelihood of co-operation.
• Arrange supplies in area and ensure door is closed, or curtain drawn.	Ensures privacy and promotes dignity.
• Assist individual to a **LEFT** side-lying position (Sims') with the right knee flexed up and forward.	Position exposes anus and helps individual to relax external anal sphincter. Being on the left side straightens out the canal reducing the risk of injury to the mucous membrane.
• Keep individual draped as much as possible during procedure.	Maintains privacy and promotes relaxation.
• Put on gloves.	Prevents transmission of micro-organisms.
• Remove suppository from foil wrapper	Lubrication reduces friction as suppository

Steps	Rational
and lubricate rounded end with water-soluble lubricant; also lubricate gloved index finger of dominant hand.	enters rectal canal and therefore increases ease of insertion and decreases discomfort.
• Ask individual to take slow deep breaths through mouth and relax anal sphincter.	Decreases discomfort/pain and promotes relaxation. Provides distraction.
• Pull up on upper buttocks with non-dominant hand and insert suppository gently past internal sphincter and **against the rectal wall** (approximately 10 cm for adults and 5 cm for children).	Should be placed against the rectal wall for eventual absorption and therapeutic action.
• Withdraw finger and wipe area.	Provides comfort and decreases transmission of micro-organisms.
9. Discard gloves by turning them inside out and disposing in appropriate receptacle. Wash hands.	Reduces transmission of micro- organisms.
10. Return to the MAR and sign off the drug by putting your initials in the appropriate square. Ensure that you have signed and initialled the bottom of the MAR.	Indicates that medication has been administered.

4. ADMINISTRATION OF PRE-PACKAGED DISPOSABLE ENEMAS
An enema is the instillation of a solution into the rectum and sigmoid colon (which attaches the descending colon to the rectum). They act by stimulating peristalsis (a wavelike movement that propels food through a canal) and, therefore, promotes defecation.

Steps	Rational
1. Wash your hands.	Reduces transmission of micro- organisms.
2. Assemble necessary equipment (e.g. disposable gloves, water-soluble lubricating jelly, waterproof pad, wash cloth and enema.	This eliminates the need to leave the workstation once the medication cupboard is unlocked. Medications should never be out of your sight.
3. Check the individual's MAR in the medication book for this information: • **NAME** of the medication • **FORMAT** of the drug • **STRENGTH** of the medication • **ROUTE** of administration • **DOSE** to give	Ensures correct administration.

Steps	Rational
• **TIME** it is to be given **SEE ATTACHED for the "RIGHTS" of MEDICATION ADMINISTRATION**	
4. Compare the prescription on the bottle/box to the information on the MAR to ensure that they are the same.	Ensures correct administration.
5. Check the medication sheet a second time and prepare the medication • TIP: running WARM tap water over the body of the enema bottle will warm the solution and make it more comfortable for the individual receiving the enema. • Check the prescription on the bottle a second time as you are preparing the med.	Ensures correct administration.
6. Put a dot in the square on the MAR corresponding with the current date and time.	Indicates that med has been prepared/poured.
7. Compare medication bottle and MAR one last time lock the cupboard.	Ensures correct administration.
8. Identify the correct individual, explain the purpose of the medication. Always explain intended actions prior to carrying them out even if unsure if individual is capable of understanding. Administer the medication according to information on MAR using the following guidelines:	Ensures correct administration. Promotes dignity and increases likelihood of co-operation.
• Arrange supplies near where you will be administering the enema. Ensure privacy (close the door, draw curtain…)	Promotes privacy and dignity.
• Assist individual to a **LEFT** side-lying position (Sims') with the right knee flexed up and forward.	Position allows enema solution to flow downward by gravity along natural curve of sigmoid colon and rectum, thus improving retention of solution.
• Keep individual draped as much as possible during procedure.	Maintains privacy and promotes relaxation.
• Place waterproof pad under buttocks.	Prevents soiling of bed.
• Put on gloves.	Prevents transmission of micro-organisms.

Steps	Rational
• Remove plastic cap from rectal tip; apply water-soluble lubricant to tip, if necessary, (it will already be lubricated but more may be necessary).	Lubrication reduces risk of injury or irritation to rectum and prevents or decreases discomfort/pain associated with procedure.
• Ask individual to take slow deep breaths through mouth and relax anal sphincter. • If possible remove excess air from bottle. Do this by tipping it slightly on its side, and expel air.	Breathing through the mouth promotes relaxation of external rectal sphincter and therefore helps prevent injury to rectum and prevent or decrease any discomfort/pain associated with procedure.
• Pull up on upper buttocks with non-dominant hand and insert tip of bottle gently into rectum. Advance tip (approx 7.5 cm for adults, 5 cm for children, and 2.5 cm for infants). Squeeze bottle until all solution has entered rectum and colon. Wait a few seconds.	Administers medication to rectum/colon where it will be absorbed.
• Withdraw tip and clean area with wash cloth and/or wipes.	Provides comfort and decreases micro-organism transmission.
• Explain that a full feeling is normal and encourage the individual to hold the solution as long as possible while lying quietly in bed. If the individual does not have physical muscle control, it may be necessary to hold the buttocks together for a few minutes. Aim for ten minutes, but this is not always possible.	Solution distends bowel. Longer retention promotes absorption and therefore more effective stimulation of peristalsis and defecation.
9. Discard enema container & gloves by turning them inside out and disposing in appropriate receptacle. Wash hands.	Reduces transmission of micro- organisms.
10. Assist individual to bathroom or onto commode/bedpan after the prescribed time.	
11. Return to the MAR and sign off the administration of this drug (enema) by putting your initials in the appropriate square. Ensure that you have signed and initialled the bottom of the MAR.	Indicates that medication has been administered.

Steps	Rational
12. Document your finding. Ex: how the client tolerated the procedure, any complications/difficulties, amount of time the enema was held in, results and your evaluation of the efficacy of the procedure/medication.	

5. ADMINISTRATION OF EYE DROPS

Care must be taken when administering medication into the eyes, as the eyes are very sensitive. Drops should never be applied directly onto the cornea (the invisible membrane covering the iris and the pupil) as they are supplied with numerous nerve endings and are therefore extremely sensitive. To reduce the amount of drug absorbed into the blood via the lacrimal (tear) duct, apply eye drop as described in the procedure outlined below.

Bottles of ear/eye drops have an expiry date of 1 month (or if otherwise specified) from the date the bottle is opened due to loss of sterility.

Steps	Rational
1. Wash your hands.	Reduces transmission of micro- organisms.
2. Assemble necessary equipment (e.g. disposable glove, tissue or cotton balls, clean damp washcloth, etc)	This eliminates the need to leave the workstation once the medication cupboard is unlocked. Medications should never be out of your sight.
3. Unlock the medication cupboard.	
4. Check the individual's MAR in the medication book to assure the: **RIGHTS OF MEDICATION ADMINISTRATION have been met.**	Ensures correct administration.
5. Compare the prescription on the packaging to the information on the MAR to ensure that they are the same or that the Med Sheet Correct is written on the MAR.	Ensures correct administration.
6. Check the medication sheet a second time and prepare the medication. Check the prescription on the bottle a second time as you are preparing the med.	Ensures correct administration.
7. Put a dot in the square corresponding with the current date and time on the MAR.	Indicates that medication has been prepared/poured.
8. Compare medication bottle and MAR one last time. Lock the cupboard.	Ensures correct administration. Prevents children from accessing medication.
9. Identify the correct individual. If the individual is capable of understanding, explain the purpose of the medication. Always explain intended actions prior to carrying them out even if you are uncertain	Ensures correct administration. Promotes dignity and increases likelihood of co-operation.

Steps	Rational
if the individual is capable of understanding. Administer the medication according to information on MAR using the following guidelines:	
• If possible, position individual in chair or lying down with head slightly hyper-extended.	Position provides easy access to eye for medication instillation and minimizes drainage of medication through tear duct.
• Gently wash away any crusts or drainage that may be present along eyelid or corners of the eye with a clean damp washcloth. Always wipe from inside to outside. Do not use the same part of cloth if you need to wash both eyes.	Crusts and/or drainage may foster growth of micro-organisms. Washing from inside to outside decreases chance of micro-organisms entering tear duct.
• Hold cotton ball or tissue in non-dominant hand on individual's cheekbone just below lower eyelid; this hand should be gloved if condition is contagious.	Cotton or tissue will absorb medication that escapes eye. Reduces risk of transmission of micro-organisms to staff.
• With tissue or cotton resting below lower lid, gently press downward with thumb or forefinger against bony prominence.	Holding the skin in this fashion prevents pressure and injury to the eyeball and prevents fingers from touching the eye, while exposing the lower eyelid.
• Ask individual to look at the ceiling if able to follow instructions.	Positions eyeball ideally to decrease stimulation of cornea and reduces blink reflex.
• Gently rest dominant hand on individual's forehead, hold the medication bottle approximately 1-2 cm above the eyelid and instill the required number of drops onto the lower lid.	Helps prevent accidental contact of eye dropper with any part of the eye, thus reducing risk of injury and possible transmission of micro-organisms. Note: ophthalmic solutions are sterile. Instilling drops onto lower lid ensures equal distribution of medication across the eye.
• If drops do not enter eyelid due to individual blinking or moving, wipe away expelled liquid and repeat procedure.	Ensures individual receives prescribed dosage of medication.
• After instillation, ask individual to close eye gently if able to follow instructions. Apply a slight amount of pressure on the	Helps distribute medication; closing eye with too much force could push medication out of eye, thus decreasing desired therapeutic

Steps	Rational
inner corner of the eye by gently pinching over the bridge of the nose.	effect. **Applying pressure helps prevent absorption into the bloodstream via the lacrimal duct**.
10. Remove glove, dispose of soiled supplies and wash hands.	Reduces transmission of micro- organisms.
11. Return to the MAR and sign off the drug by putting your initials in the appropriate square. Ensure that you have signed and initialed the bottom of the MAR.	Indicates that medication has been administered.

6. ADMINISTRATION OF EAR DROPS

Ear drops should always be administered at room temperature as internal structures are very sensitive to temperature extremes. Failure to do this may result in severe dizziness and/or nausea.

Nothing should ever be forced into the ear as this can rupture the ear drum.

Bottles of ear/eye drops have an expiry date of 1 month (or if otherwise specified) from the date the bottle is opened due to loss of sterility.

Steps	Rational
1. Wash your hands.	Reduces transmission of micro- organisms.
2. Assemble necessary equipment (e.g. disposable glove, cotton tipped swab, tissue and cotton balls (may not be necessary). etc)	This eliminates the need to leave the workstation once the medication cupboard is unlocked. Medications should never be out of your sight.
3. Unlock the medication cupboard.	
4. Check the individual's MAR in the medication book for this information: • **REVIEW THE RIGHTS OF MEDICATION ADMINISTRATION (see attached)**	Ensures correct administration.
5. Compare the prescription on the bottle to the information on the MAR to ensure that they are the same.	Ensures correct administration.
6. Check the medication sheet a second time and prepare the medication. Check the prescription on the bottle a second time as you are preparing the med.	Ensures correct administration.
7. Put a dot in the square on the MAR corresponding with the current date and time.	Helps eliminate the risk of giving a medication twice – if you forget to sign a med off it tells the next person that you did prepare the med.
8. Compare medication bottle and MAR one last time lock the cupboard.	Ensures correct administration. Prevents children from accessing medications.
9. Identify the correct individual. If the individual is capable of understanding, explain the purpose of the medication. Always explain intended actions prior to	Ensures correct administration. Promotes dignity and increases likelihood of co-operation.

Steps	Rational
carrying them out even if unsure if individual is able to understand. Administer the medication according to information on MAR using the following guidelines:	
• Arrange supplies in a quiet, relaxed area.	Increases ease of administration by helping client to relax.
• If possible, assist individual to a side-lying position with ear to be treated facing up.	Position provides easy access to ear for instillation of medication and places ear canal in ideal position for instillation of drops.
• If ear wax or drainage is blocking the outermost portion of the ear canal, wipe out gently with damp washcloth. **Do not force wax inwards to block canal.**	Ear wax may foster growth of micro-organisms and may block medication from entering ear canal.
• Straighten out ear canal by gently pulling the ear lobe down and back for children, or the upper portion of the ear up and out for adults.	Straightening of the ear canal allows direct access with medication.
• Instil prescribed number of drops by holding dropper 1 cm above ear canal.	Decreases the chance that dropper will touch the ear causing contamination.
• Ask individual to remain in a side-lying position for 2-3 minutes and gently massage the part of the outer ear closest to the facial area.	Allows for complete distribution of medication and moves the medication inward.
• Gently apply a piece of cotton ball into the ear, if ordered by a physician. Pre-moisten the cotton with a few drops of medication if appropriate according to directions/order. Do not press the cotton into the canal.	Prevents escape of medication when individual sits or stands. Pre-moistening the cotton prevents wicking action from absorbing medication instilled in ear. If cotton is pressed into canal, it may damage the ear drum or prevent discharge from exiting the ear.
• Remove cotton, if prescribed, in 15 minutes.	Medication has been absorbed. Promotes comfort and hearing as per client's norm.
10. Dispose of soiled items and wash hands.	Reduces transmission of micro- organisms.
11. Return to the MAR and sign off the drug by putting your initials in the appropriate square. Ensure that you have signed and initialed the bottom of the MAR.	Indicates that medication has been administered.

7. NARCOTIC PROTOCOL

Administering Narcotics

- Narcotics that have been prescribed at regular intervals or to be administered as a PRN can be given by any staff member trained in medication administration, as per Physician's orders.

Administering Narcotics

A Narcotic Tracking Form should be completed for each Narcotic at the beginning/end of each shift as well as at each administration time. This form should include:

- Name of the client
- Name of the medication
- Date and time of administration
- Amount of medication administered
- Amount of medication remaining
- Signature of the staff member administering the medication
- Signature of a staff member witnessing the administration.

8. TOPICAL MEDICATION

1. Lotions must be shaken well prior to application.
2. Position resident appropriately so that the area to be medicated is well exposed and easily accessible.
3. Wash hands.
4. Gloves or a finger cot must be worn when applying topical medication to avoid self-treatment and to avoid picking up and transferring of organisms either to yourself or the resident.
5. Apply as per prescribed. In one hand, gently rub it on the affected area. Use a long, smooth and gentle stroke to provide even distribution.

D.8 PREVENTION OF NEEDLE STICK INJURIES

Staff members providing injections or glucose testing to clients will utilize approved disposal containers on site.

- Staff members shall not re-cap needles.
- Training shall be provided to staff members who administer injections/glucose testing regarding safe disposal of needles.
- The use of safer needle technology will be explored based on identified risks, as needed.

D.9 DOCUMENTATION

The following information must be included on the MAR sheet:

1. resident name,
2. the generic and brand name of the specific drug,
3. the dosage in metric quantities,
4. the time of administration based on 24-hour method,
5. the administration of all P.R.N.'s,
6. the administration of any prescribed medication,
7. any known drug allergies.

When a medication is to be discontinued, a line is drawn in a red pen from the discontinued date to the end of the month. The word "discontinued" is printed on the line and employees are to initial. A note is to documented in the log book advising employees of this change.

All resident MAR sheets must be reviewed at the end of each shift by the designated employee. At the end of each month the MAR sheets shall be removed and filed up to one year.

D.10 ACCOUNTABILITY

Whenever possible, only one employee will be designated per shift to administer medication to residents. New employees will only administer medication if they have successfully completed the orientation training offered by the designated Program Supervisor. Once the Program Supervisor is satisfied that the employee can demonstrate the knowledge and competence required to implement the medication procedures, then the employee will be informed in writing and a signed copy placed in the employee file.

In the event that the procedures outlined cannot be followed, the "on call" must be notified prior to any changes.

All detected errors in the dispensing of, or documentation of medication, should be treated as a potential serious occurrence or a medication error. The appropriate forms must be completed immediately and the procedural guidelines for medication incidents followed.

All medication incident reports will be submitted to the Program Supervisors and reviewed on a regular basis.

The VON or Para-med nursing services will administer all prescribed intramuscular and subcutaneous medication. The doctor prescribing the medication is responsible to either give the intake nurse a verbal or written order for these procedures. TCE employees are responsible to either obtain a written prescription from the doctor or request that they contact the pharmacist.

MARS and TARS are kept on the premises for 1yr and then filed off premises and kept for 7 years.

D.11 MEDICATION ORDERING

1. All prescription medication that is currently being administered as identified on the medication administration record (MAR) sheet is to be reordered. The method for reordering is to write FILL under the name of the medication.
2. All PRN's are checked on the rack to ensure there is an adequate supply of medication for the month. The expiry date on the blister pack is to be checked. If reordering is required then write FILL under the name of the medication. Travel packets are available upon request.
3. All topical medication is to be checked to ensure there is an adequate supply for the upcoming month. If there is an inadequate amount then follow the above procedure.
4. All discontinued medication and any medically related procedures that are not currently being implemented need to be identified as DO NOT FILL/ DO NOT TYPE.
5. The MAR sheets are to be dropped off at Shoppers Drug Mart on Merivale Road by the 15th of each month. The medication for the following month will be delivered to each residence and medication check done by two staff by the following day of delivery.

D.12 CONTROLLED ACTS

1. **What is a Controlled Act?**
   Controlled acts are procedures that are considered potentially harmful if performed by unqualified persons. Professionals are authorized to perform specific controlled acts based on their scope of practice. There are thirteen of them. Procedures that are not included in the list of controlled acts do not require authorization and can therefore be performed by anyone, including Unregulated Health Care Providers (UCPs).

2. **Who are Unregulated Care Providers (UCPs)?**
   UCPs assist clients with personal care and activities of daily living (e.g. feeding, dressing, bathing) and may deliver some basic elements of Nursing care (e.g. medication administration). Their preparation varies from college training to on the job training. Some examples include Personal Support Workers (PSWs), Developmental Service Workers (DSWs), Health Care Aides, and Client Care Assistants.

3. **Which Controlled Acts Can Nurses Perform and Delegate?**
   Nurses are authorized to perform 3 of the 13 controlled acts. They include:
   1. Performing a prescribed procedure below the dermis or a mucous membrane;
   2. Administering a substance by injection or inhalation;
   3. Putting an instrument, hand or finger:
      - beyond the external ear canal;
      - beyond the point in the nasal passages where they normally narrow;
      - beyond the larynx;
      - beyond the opening of the urethra;
      - beyond the labia majora;
      - beyond the anal verge; or
      - into an artificial opening into the body.

4. **What Controlled Acts Can UCPs Perform?**
   There are two exceptions that enable UCPs to perform some controlled acts. They may perform the 2nd and 3rd acts that Nurses are authorized to perform (listed above) if they are routine activities of daily living for a client. A procedure is considered a routine activity of daily living when:
   - the need for the procedure;
   - the response to the procedure; and
   - the outcomes of performing the procedure have been established over time and, as a result, are quite predictable.

   This being said, these procedures need to be taught to the UCP by a Nurse.
   1) Example # 1: If a client is regularly catheterized to drain their bladder and the outcomes of the procedure are predictable it is considered a routine activity of daily living. However, if a client needs a catheterization due to an unusual episode of urinary retention it is NOT considered a routine activity of daily living.

   2) Example # 2: If a client receives regular insulin injections and the outcome of the injections is predictable, the procedure is considered a routine activity of daily living.

However, if a client's insulin prescriptions are frequently changed and their response is unpredictable, the procedure is NOT considered a routine activity of daily living.

Besides these exceptions, UCPs may perform the 3 controlled acts that Nurses are authorized to perform if they have been officially delegated by a Nurse.

5. What Does Teaching a Controlled Act Involve?

Teaching is providing instruction and determining that an individual is competent to perform a Controlled Act. Teaching does NOT include transferring the authority to perform a controlled act whereas delegation does (see Delegating a Controlled Act). Teaching is part of the process of delegation. See *What Controlled Acts Can UCPs Perform?* for guidelines on when Controlled Acts can be taught and when they need to be delegated.

6. Who May Teach Controlled Acts?

As per the College of Nurses of Ontario, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) may teach a controlled act to a UCP when all of the following conditions have been met:

1) The nurse has the knowledge, skill and judgment to perform the procedure competently.
2) The nurse has the additional knowledge, skill and judgment to teach the procedure.
3) The nurse accepts accountability for the decision to teach the procedure after considering the following:
    - the known risks and benefits of performing the procedure;
    - the predictability of the outcomes of performing the procedure;
    - the safeguards and resources required in the situation; and
    - other factors specific to the situation.
4) The nurse has determined that the UCP has acquired, through teaching and supervision of practice, the knowledge, skill and judgment to perform the procedure safely, effectively and ethically.
5) The nurse teaches the procedure to a UCP who will perform the procedure for one specific client. The nurse may teach the performance of the procedure for more than one client if she/he has determined that the factors in Conditions 3 and 4 are conducive to performing the procedure.
6) Considering the factors in Conditions 3 and 4, the nurse evaluates the continuing competence of the UCP to perform the procedure or reasonably believes that a mechanism is in place to determine continuing competence.

7. What Does Delegation of a Controlled Act Involve?

Delegation is the transfer of authority to a person who is not otherwise authorized to perform a procedure within one of the controlled acts authorized to Nursing. It includes teaching and may involve assigning. The Nurse must provide the teaching then watch the staff member perform the act with the specific client involved to his/her satisfaction. The Nurse must then

delegate the act to that specific UCP in writing. Delegating acts should be a last resort and must be done based on the rationale that the person to whom the act is delegated is the most appropriate person to perform the act. Without delegation of a controlled act, a Nurse must perform the act until it is considered a routine act of daily living.
Delegation of acts may include stipulations from the Nurse involved. It is the responsibility of the Agency Supervisor to ensure that these stipulations are met.

8. Who may Delegate Controlled Acts?

Registered Nurses (RNs) and Registered Practical Nurses (RPNs) who meet the conditions listed above and who hold a General Class Certificate of Registration may delegate authorized act procedures to UCPs. The Nurse must be capable of solving complex problems and of teaching effectively.

9. The Nurse Teaching or Delegating Controlled Acts is Responsible To:

1. Know that the UCP is capable of safely and properly performing the procedure.

2. Ensure that the UCP knows what their responsibilities entail and when to ask for assistance from or report to a Nurse or other Health Care Professional.

3. Ensure that a Nurse or other Health Care Professional is assigned and will be responsible for the ongoing evaluation of the client's health needs and status. UCPs do not have the knowledge base to do so. The type and frequency of evaluation will depend on the client and the procedure(s) being performed. There is no specific routine for controlled acts.

4. Document the following information and ensure it is available to the those who will be monitoring the UCPs ongoing competence at performing the procedure:
    - The knowledge provided
    - The steps of the procedure as taught
    - Conditions for performing the procedure taught
    - General indicators taught for seeking assistance
5. Provide Written Instructions on the Procedure Including:
    - Expected outcomes of procedure
    - When to call a Nurse or other Health Care Provider

6. Ensure that a Suitable Evaluation and Monitoring Process is in Place. Not only must the UCP be evaluated at the time of the teaching session for competence, but there must also be a process in place for the ongoing evaluation of their ability to safely and properly perform the procedure. The nature and frequency of evaluation will depend on the procedure. There is no set routine for the evaluation of the performance of controlled acts. For example, in the setting of a residential facility, a Nurse may know that a Manager will include monitoring as part of the UCPs ongoing performance appraisal.

Based on the 3rd and 6th points above, an agreement will be signed between the agency and the Nurse regarding the measures that must be in place for the ongoing assessment of the

client's health status and the competency of the staff members trained to perform the procedure. It is the responsibility of the Agency Supervisor to ensure that the stipulations outlined in this agreement are met.

D.13 MEDICATION RECONCILIATION

All medication at the end of the month are reconciled by the Program Supervisor and another employee. In the absence of the Program Supervisor the designate would reconcile with another employee.

1. Take all MAR sheets for the month, medication incident forms for the month and all blister packs and place them in order per resident. Take the form Surplus Prescribed Drugs and write the prescription on it with the name, dosage of medication and prescription number.
2. Count the pills in the blister pack left and place the numbers in the quantity column.
3. The numbers of pills left, the number of days in the month and the numbers of medication incident forms must reconcile to the numbers of pills sent by Shoppers. This is determined by the number of bubbles popped or last pill left in the bubble.
4. Both employees must sign in designated areas on the form. All surplus medication and the forms are taken to Shoppers Drug Mart on the same day by one of the employees who checked the medication.
5. The previous steps 1 - 4 are followed for all discontinued medication.

D.14 MEDICATION CHECKING PROCEDURE

MAR sheets must be submitted to Shoppers Drug Mart -Merivale by the 15th of each month. All medication including PRN's, creams and topical must be checked for extras. On the MAR sheet write FILL when the medication is needed and write DO NOT FILL when the medication is not needed.

1. Sort medication out by resident.
2. Place the MAR sheet next to the pile.
3. With a pencil check the name of the medication on the blister pack, dosage on the MAR sheet and blister pack, and the time on the MAR sheet and blister pack. If all information is correct then place a check mark on the MAR sheet against the drug.
4. Repeat step 11.3 with all medication for the same resident.
5. At the end of the MAR sheet if all the information is correct, sign next to the line stating "checked by".
6. Complete 11.3 and 11.5 for all the medication and residents.
7. On the blister pack using a black marker write the time on it and place it on a rack under the appropriate time.
8. Another employee on shift must check all medication in the blister pack against the MAR sheet for all residents and sign next to the second line "checked by".
9. If there are any discrepancies between the present MAR sheet and the previous months the employee must leave a note for the Program Supervisor to do follow through with the pharmacist.

D.15 DISPOSAL OF MEDICATION PROCEDURE

1. When more than two tablets/pills/capsules are contaminated, expired or discontinued, they must be returned to the pharmacy for disposal. The number of pills returned to the pharmacy must be noted on the surplus prescribed medication form (Appendix E).
2. When two or less tablets/pills/capsules are contaminated, they can be placed in a marked envelope with name of client, pill name and dosage. Missed medication, expired or discontinued meds can remain in the blister. This procedure must be witnessed by another employee. If employee is working alone on the shift and there is an issue of contamination, the medication is to be placed in a labeled packet and returned to the locked medicine cabinet until the next employee arrives.
3. Employee must inform the Program Supervisor as well as complete a medication incident form. The incident is to be documented in the log book.

D.16 MEDICATION INCIDENTS

1. MEDICATION INCIDENT
   A medication incident is the prescribing, dispensing and/or administration of the wrong medication or dose of medication to the wrong resident, or at the wrong time, or the failure to administer such agents at the specific time or in the manner prescribed or normally considered as accepted practice. The employee in consultation with a pharmacist or other medical professional will use their judgment to determine whether the medication incident is a critical or non-critical incident.

2. CRITICAL INCIDENT
   Is a medication incident having a major adverse effect to a resident and requiring medical intervention.

3. NON-CRITICAL INCIDENT
   A medication incident that has no major adverse effect to a resident and no medical intervention is required.

D.17 THE FOLLOWING CRITERIA SHOULD BE USED FOR DEFINING RESIDENT INVOLVED MEDICATION INCIDENTS

1. WRONG TIME/DATE
   Includes a dose of medication given 60 minutes earlier or later than the scheduled time.

2. WRONG DOSAGE
   When the dose given differs from the ordered dose.

3. UNORDERED DRUG
   Selection of the wrong drug or administration of a drug to the wrong resident.

4. RESIDENT REFUSAL

5. OMISSION
   Any dose not given by the time the next dose is due. Exceptions: when a medication dose is held (rational as to why held) or refused, it must be recorded in the log book and noted on the MAR sheet. If medication is withheld for diagnostic purposes or in the best interest of the resident's safety due to a possible behavioral concern, supporting documentation is required. Unusual circumstances such as having to wait for an extended period of time at a doctor's office, or in the emergency department at a hospital would be an example.

6. WRONG PERSON

7. WRONG MEDICATION

8. WRONG ROUTE

9. WRONG FREQUENCY

10. WRONG SITE

11. WRONG ASSESSMENT

12. WRONG REASON

13. WRONG EDUCATION

14. WRONG DOCUMENTATION

15. WRONG EVALUATION

16. REFUSED

17. EXTRA DOSE
An extra unscheduled dose of medication.

18. OUT DATED DRUGS
When a medication older than its labeled expiry date has been administered.

19. ALLERGY
Administration of a drug to a resident to which a documented allergy has been noted on their files.

20. INCORRECT DOSAGE ADMINISTRATION
When a dose has been prepared incorrectly i.e.:

1. enteric coated tablets that have been crushed,
2. specific antibiotics given with meals instead of on a empty stomach either 1 hour before or 2 to 3 hours after a meal.

D.18 PROCEDURAL GUIDELINES

1. Each medication incident will be investigated by the Program Supervisor. Each medication incident will be assessed and action taken on an individual basis. In all cases, the following factors will be considered when determining necessary action by management:
    1. circumstances surrounding the medication incident,
    2. severity of the medication incident,
    3. previous medication incidents,
    4. clinical effect on the resident involved.

2. Management reserves the right to institute immediate disciplinary actions for any medication incident that is extremely serious in nature that is:
    1. one which causes potential or actual irreversible damage to the resident,
    2. one in which employee demonstrates negligence or irresponsibility in their reaction to the medication incident.

D.19 REPORTING PROCEDURE

Upon discovering that a medication incident has occurred, the employee witnessing or first becoming aware of the medication incident shall:

1. inform the physician or pharmacist immediately if the medication incident is of major clinical significance,
2. inform either the Program Supervisor or "on call" who will ensure the proper procedures is followed.

D.20 DOCUMENTATION FOR COMPLETING MEDICATION INCIDENT REPORTS

In addition to informing either the Program Supervisor or "on call", the employee involved with, and/or becoming aware of, a medication incident is accountable for completing the incident report.

1. ALL MEDICATION INCIDENTS WILL BE REPORTED AS FOLLOWS:

    1) Complete all sections of the incident report as appropriate, so that the exact nature of the incident can be determined. The reports must be completed as thoroughly and objectively as possible, documenting the known facts. Suggestions and inferences of blame or speculation as to the cause of the incident are not to be reported. Additionally, events not observed firsthand by the employee completing the record will not be written on the report, neither will opinions or assumptions.

    2) In the section provided, describe the medication incident including the following:
        1. name of the drug,
        2. dosage,
        3. a factual and concise description of the incident
        4. monitoring of the resident after the incident i.e. vomiting, fatigue etc.

Incident report form may be kept for up to 24 hours from the time the incident was discovered to ensure completion of all sections. The form must be reviewed and signed by the employee involved and Program Supervisor before proceeding to the next stage of reporting to the Executive Director or their designate.

Analysis and recommended actions will be made, as necessary, with a view of reducing the number of medication incidents in the future.

2. DISPOSITION OF THE REPORT

Completed incidents reports are returned to the Program Supervisor, for submission to the Human Resources Department. The report will be reviewed in conjunction with the evaluation process.

D.21 RESIDENT REFUSAL POLICY

1. RESIDENT REFUSAL OF RECOMMENDED MEDICAL ADVICE

Persons supported may refuse to obtain, accept or comply with recommended medical advice. In these situations, employees will:

1) Try to find the reasons why the treatment is being refused and help the person explore options.

2) Encourage the person to seek input from others in their life (i.e., family, friends).

3) Assist the health care professionals in explaining the medical information and potential consequences.

4) Clearly document on Physician Consult Form and complete a Refusal of Medical Treatment Form

2. RESIDENT REFUSAL OF MEDICATION

Medication refusals are not considered medication errors; however, they, too, must be documented on an ***Medication Incident Form*****.**

1) When a person states or demonstrates that s/he is refusing his/her medication, the employee will:

1. Try to find the reason why the medication is being refused.

2. Explain medical or other consequences of refusal to take medication.

3. Provide time for the person to change his/her mind.

4. Be creative with options and alternatives to encourage taking the medication while avoiding a power struggle.

2) If the person refuses to take the medication, and it is already one hour beyond the prescribed time to take the medication, employees will:

1. Contact the doctor or pharmacist to find out what steps should be taken.

2. Indicate on the medication record that the person refused his/her medication.

3. Complete a ***Medication Incident Form*** and indicate "medication refused". ***See also Section Occurrence/Incident, Serious Occurrence and Enhanced Serious Occurrence***

4. Communicate to Program Supervisor or On Call Supervisor that a medication was refused and any advice or caution that was given by the doctor or pharmacist.

3. In situations where medication refusal will result in serious medical or psychiatric complications, the supporting team and Program Supervisor must be proactive by developing and following written procedures and protocols. Any procedures that meet the criteria of an intrusive procedure must be approved by the Multi-Disciplinary Review Team. ***See also Section - Multi-Disciplinary Review Team and Medication Administration***.

D.22 RESIDENT SELF MEDICATION ADMINISTRATION

1. For persons who strive for independence in taking their medication:

2. An **Individual Training Support** must be prepared and successfully completed.

3. The medication used must continue to be recorded by the person until the person has no need for reminders and accountability is transferred to the person.

4. Employees must work with the person to develop and follow systems to ensure medications continue to be taken safely (e.g., random checks, double-checking medication supplies, etc.).

D. 23 APPENDIXES

Appendix A

TOTAL COMMUNICATION ENVIRONMENT

NEW EMPLOYEE MEDICATION TRAINING CHECKLIST

NAME:_____

LOCATION: _____

A. Knows location of:
- ☐ medication cabinet
- ☐ medication cabinet keys
- ☐ medication book
- ☐ medication
- ☐ first aid kit.

Read and sign:
- ☐ Medication policy and procedures section (site manual).

B. The thirteen rights are as follows:
- the right resident,
- the right medication,
- the right dosage,
- the right time,
- the right route,
- the right documentation,
- the right frequency
- the right site
- the right assessment
- the right reason
- the right education
- the right evaluation
- the right to refuse

C.

	Date	**Trainee Name**	**Trainee Signature**
Gave medication under supervision of trained person	1._____	1._____	1._____
	2._____	2._____	2._____
	3._____	3._____	3._____
	4._____	4._____	4._____
	5._____	5._____	5._____

D.
Program Supervisor

This certifies that _____ has successfully completed the Medication Training and is approved to give medication to the program individuals independently.

_____ _____

(Date) (Program Supervisor Signature)

Employee

I, hereby acknowledge and understand that I have been fully trained in the medication procedures at TCE as of _____(date). This completes the medication training and I now understand that I am able to give medication on my own and I am responsible for my actions in the following procedures. I hereby agree to follow all medication procedures as established by the Agency. I also understand that failure to follow these procedures will result in discipline up to and including dismissal.

_____ _____

(Date) (Employee Signature)

Appendix B

TOTAL COMMUNICATION ENVIRONMENT

MEDICATION INCIDENT FORM

Date of Report: _____

Date of Incident: _____

Time: _____

Staff responsible for Error: _____

Name of employee reporting: _____

Name of others involved:_____

_____

Medication/dosage: _____

Type of medication incident:

(T)-check as many as apply.

- ☐ medication dropped
- ☐ resident refusal
- ☐ care giver (ie: parent) forgot to give medication
- ☐ omission of medication by employee
- ☐ pharmacy issue(specify under comments)
- ☐ late delivery of medication
- ☐ wrong medication given
- ☐ wrong dose of medication given
- ☐ wrong route of administration
- ☐ medication given at wrong time
- ☐ failure to sign for medication/incorrect signing
- ☐ resident vomiting/expelling medication
- ☐ allergy to medication
- ☐ surplus medication does not balance
- ☐ medication expired
- ☐ medication discontinued
- ☐ improper documentation
- ☐ other (specify)_____

_____.

Action Taken:

- ☐ disposed of medication
- ☐ co-worker informed
- ☐ contacted physician/pharmacist /other (specify under comments)
- ☐ Program Supervisor advised
- ☐ notified on call
- ☐ followed physician/pharmacist direction (include name of professional)
- ☐ next dose to be omitted
- ☐ next dose to be administered as prescribed
- ☐ resident to be observed carefully (monitoring)
- ☐ other(specify)_____

_____

_____

_____.

Comments (be specific):_____

_____

_____

_____

_____

_____

How was client monitored:

_____

_____

_____

_____

Employee signature (print and sign): _____

Program Supervisor signature: _____

Program Supervisor reviewed with Staff involved: Date: _____

P.S. Signature: _____

Date: _____

Staff Signature: _____

An incident report is to be written for every medication incident as well as a notation in the log book advising employee to read the report.

Appendix C

TOTAL COMMUNICATION ENVIRONMENT

MEDICATION RETRAINING ACKNOWLEDGMENT

I, _____hereby acknowledge that on
(Employee name)

_____I was retrained on TCE Medication procedures.
(Date)

I now fully understand the content of the medication procedures as established by the agency and I hereby agree to follow them at all times.

I also understand that failure to follow these procedures will result in further discipline up to and including dismissal.

_____ _____
(Date) (Employee Signature)

_____ _____
(Date) (Program Supervisor)

Appendix D

TOTAL COMMUNICATION ENVIRONMENT

ACCUMULATIVE RECORD OF P.R.N. MEDICATION ADMINISTRATION

RESIDENT NAME: _____

LOCATION: _____

Date	Time	Purpose	Medication & Dosage	Desired Results	Outcome (be specific i.e. resumed activity)	Effectiveness Yes or NO Time	Signature (print and signature)

S12

Appendix E

TOTAL COMMUNICATION ENVIRONMENT
RESIDENT ANNUAL MEDICAL

NAME: _____ DATE OF EXAMINATION: _____

WEIGHT: _____ DATE OF BIRTH: _____

BLOOD PRESSURE: _____

Examination	Normal	Abnormal	Explanation of Abnormal Findings
Head	☐	☐	_____
Eyes	☐	☐	_____
Vision	☐	☐	_____
Hearing	☐	☐	_____
Neck	☐	☐	_____
Thorax	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Abdomen	☐	☐	_____
Genitalia	☐	☐	_____
Back	☐	☐	_____
Extremities	☐	☐	_____
Neurological	☐	☐	_____
Skin	☐	☐	_____
Lymphatics	☐	☐	_____
Bloodwork	☐	☐	_____
Urinalysis	☐	☐	_____

MEDICATION REVIEW: _____

_____

_____

PROTOCOLS UPDATED AND/OR REVIEWED:

_____

_____

_____

_____

FINDINGS AND RECOMMENDATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

(Printed Name of Physician) (Signature of Physician)

_____

Staff attending

R05

Appendix F

TOTAL COMMUNICATION ENVIRONMENT

PHYSICIAN/CONSULTANT RECORD

Resident: _____ **DOB:** _____

Program: _____ **Date:** _____

Health Card #: _____

Doctor: _____ **Phone:** _____

Address: _____

Presenting Complaint (ACCORDING TO STAFF):

_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ **Date:** _____

TO BE COMPLETED BY PHYSICIAN/CONSULTANT

Findings:

_____
_____
_____
_____
_____
_____

Recommendations:

Signature: _____ **Date:** _____

Outcome: (ACCORDING TO STAFF):

Signature: _____**Date**: _____

Appendix G

CUMULATIVE MEDICAL RECORD

MEDICAL

Date of Appointment	Name of Doctor	Reason for Consultation	Recommendations & Follow-up	Employee Signature

Appendix H

HISTORICAL MEDICATION RECORD

			Please list all medications currently being taken.		
Date Started	**Who prescribed**	**Why medication Prescribed.**	**Medication Name & Dosage**	**Date Discontinued**	**Results**

Appendix O

IMMUNIZATION RECORD

Resident's Name:

Program:

TYPE OF IMMUNIZATION	DATE GIVEN	DUE DATES
Polio (every 10 years)		
Tetanus (every 10 years)		
Flu Shot		
Hepatitis B		
TB ??		
HIV??		
H1N1		
Other:		

_____

Staff Signature

Appendix R

TOTAL COMMUNICATION ENVIRONMENT
Unit 5, 203 Colonnade Road, Nepean, ON K2E 7K3
Telephone 613-228-0999 Facsimile 613-228-1402 TDD 613-228-8669

MONTHLY MEDICATION INVENTORY CHECK FORM

PROGRAM_____ MONTH_____

STAFF (1ST CHECK)_____ DATE:_____ TIME_____

STAFF (2ND CHECK)_____ DATE:_____ TIME_____

_____NO ISSUES

ISSUE OF INCORRECTNESS

(check as many as apply and specify concern/finding below)

___Late delivery of medication

___Incorrect Blistering

___Incorrect dosage in blister pack

___Omission on MAR sheet

___Incorrect directions on MARS

___Other

COMMENTS (be specific)_____

Was the pharmacy informed of error _____Yes ___ No

Date: _____Time _____

If so with whom did you speak_____

_____

Any follow up from TCE staff required _____Yes _____No

If so, what? _____

_____

_____

_____

_____

_____

_____

_____

Was Medication error picked up late? ___Yes ____No

Date_____

Medication_____

Name of Resident_____

(This will be primarily when the checks have finished and later an error was noticed. Then this form will be filled in with just this section completed and placed with the original at the head office by your Program Supervisor)

Please file this form in the medication binder under medication incident reports.

Please leave a note in the log ensuring staff are aware of the completion of this check.

Program Supervisors please forward a copy to the Pharmacy file at the head office.

Program Supervisor signature

_____Date:_____

Staff Signature and Initials List
Medication Book

DATE	PRINT NAME	SIGNATURE	INITIALS

INTAKE MEDICAL RECORD

A person who is your patient has applied for support with our organization. In order to assist us in adequately planning for the person's medical care, please answer the following questions as accurately as possible. A consent form to release this information has been signed by the person and attached with this form. Ideally, this form is completed 30 days prior to intake.

Name of Patient:	Date of Birth:
Current Residence:	
Name of Doctor:	Telephone:
Signature of Doctor:	Date:

How long has this person been your patient?

MEDICAL HISTORY:

Does the person have any of the following illnesses at the present time?

MEDICAL STATUS	*YES*	*NO*	*MEDICAL STATUS*			*MEDICAL STATUS*		
Arthritis or Rheumatism	❑	❑	Glaucoma	❑	❑	Measles	❑	❑
Asthma	❑	❑	Emphysema or Chronic Bronchitis	❑	❑	German Measles	❑	❑
Tuberculosis	❑	❑	High blood pressure	❑	❑	Mumps	❑	❑
Heart trouble	❑	❑	Circulation trouble in arms or legs	❑	❑	Rheumatic Fever	❑	❑
Diabetes	❑	❑	Ulcer of digestive system	❑	❑	Chicken Pox	❑	❑
Other stomach or intestinal disorders	❑	❑	Liver disease	❑	❑	Pertussis	❑	❑
Kidney disease	❑	❑	Other urinary tract disorders	❑	❑	Scarlet Fever	❑	❑
Cancer or Leukemia	❑	❑	Anemia	❑	❑	Pneumonia	❑	❑
Effects of stroke	❑	❑	Parkinson's Disease	❑	❑	Hepatitis B Carrier	❑	❑
Epilepsy	❑	❑	Cerebral Palsy	❑	❑	Otitis Media	❑	❑
Multiple sclerosis	❑	❑	Muscular Dystrophy	❑	❑	AIDS	❑	❑
Effects of polio	❑	❑	Thyroid or other glandular disorder	❑	❑	Other (specify):	❑	❑
Skin disorder (press sore, leg ulcer, severe bums)	❑	❑	Past surgery (name):	❑	❑			

Family Medical History (please list familial diseases such as heart, cancer, diabetes, etc.):

Section D: Medication

IMMUNIZATION:

Please list the individual's immunization history:

NAME	*YES*	*NO*	*DATE*	*NAME*	*YES*	*NO*	*DATE*
DPT	❑	❑		Measles	❑	❑	
Polio	❑	❑		Hepatitis B	❑	❑	
Small	❑	❑		TB Skin Test	❑	❑	
Mumps	❑	❑		Other	❑	❑	

DIETARY:

Please list any dietary restrictions:
Please list any special diet required for the individual:
Please list any food, drugs, inhalants or other allergies:

SEIZURES:

Type of Seizures:
Frequency:
Are seizures controlled by medication?

PHYSICAL DISABILITIES:

Does the individual have any physical disabilities (e.g., total or partial paralysis, missing or non-functional limbs, broken bones)?
How is the individual's eyesight (e.g., totally blind, wears glasses, contacts)?
How is the individual's hearing (e.g., total, hearing loss, hearing aid, etc.)?
What supportive devices and prostheses does the individual use (e.g., cane, walker, wheelchair, back brace, leg brace, colostomy equipment, catheter, hearing aid, kidney dialysis, etc.)?
List any aids (supportive or prosthetic devices) that would have to be purchased over the next 12 months.

PSYCHOLOGICAL HISTORY:

Please tell us if the individual has significant psychological and behavioural disorders (e.g., delirium and dementia, amnesiac syndrome and. organic hallucination, delusional syndrome, intoxication, withdrawal, anxiety disorder, paranoid and schizophrenic disorder, substance use disorder, psychosexual disorder, sleep disorder, adjustment disorder, etc.)?
Please list all treatments that the individual may have received for nervous or emotional problems over the past one year.
Does the individual take psychotropic drugs (if yes, specify medicine, dosage and reasons)?

NURSING CARE:

During the past one year, has the individual received any nursing care (if yes, how many hours per day or week)?
Does the individual need assistance with special care (e.g., bathing, dressing, feeding, toilet care, etc.)?
In the past year, has the individual received any physical therapy (if yes, how many hours per week)?
Please review individual's medical history and tell us if there are recurring medical conditions that we should be aware of (including eyes, ears, abdomen, cardia-pulmonary, musculoskeletal, neurological and genitourinary)?

MEDICATION:

Please list the drugs that the individual is currently taking (including psychotropic and P.R.N. drugs).

GENERIC NAME	*TRADE NAME*	*DOSE*	*SIDE EFFECTS TO REPORT TO A DOCTOR*

Cumulative Transfer of Medication Tracking Sheet

Resident: _____

Day Program Involved: _____

Date	Medication and Dosage	Staff Handing off Medication (Name)	Staff Receiving Medication (Name)	Number of Pills Involved	Regular Medication or PRN

This form is to remain in Program Medication binder. Staff are to ensure they get the name of the person handing over medication to or receiving from and complete this form upon returning to program. If any follow up is required, a note must be left in the logbook.

Narcotic Tracking Form

Resident:_____ Total mg/mL:_____
Medication and Dose:_____ Date Prescribed:_____
Procedure :_____

Date	Shift	Number of mg/mL at start of shift	Number of mg/mL administered during shift	Number of mg/mL at end of shift	Staff Signature	Staff Signature

Date	Shift	Number of mg/mL at start of shift	Number of mg/mL administered during shift	Number of mg/mL at end of shift	Staff Signature	Staff Signature

D.24 CANNABIS FOR MEDICAL PURPOSES

PURPOSE / SCOPE:

Total Communication Environment (TCE) *Cannabis for Medical Purposes Policy* facilitates client use of Cannabis (aka Medical Marijuana) in our residential homes in compliance with the *Access to Cannabis for Medical Purposes Regulations (SOR/2016-230)*. This policy will outline appropriate use of cannabis for medical purposes, compliance with government regulations, administration guidelines, and storage.

POLICY:

TCE is committed to providing clients with reasonable access to cannabis when it is safe, medically indicated and a prescribed treatment in accordance with Health Canada's *Access to Cannabis for Medical Purposes Regulations* (ACMPR).

TCE staff are permitted to administer cannabis for medical purposes to individuals in our care with a valid Practitioner's Order which permits the client to be in possession of and consume cannabis.

Cannabis must be accompanied by the labelled container from a Licensed Provider. The label must indicate brand name, lot number, potency (percentage) of ingredients, net weight, and packaging date of the cannabis.

Cannabis is a controlled substance under the *Controlled Drugs and Substances Act* (S.C. 1996, c. 19). All forms of cannabis must be counted by two individuals immediately upon receipt and must be stored in accordance with the *Controlled Drugs and Substances Act.*

Cannabis must be supplied by the individual or family in a manner that allows staff to track administration amounts in accordance with our controlled substance tracking procedures.

The administration of cannabis must comply with our smoke-free environment policy and therefore clients are not permitted to smoke or vaporize cannabis on our property.

In accordance with the ACMPR, we can only accept the lesser of 150 g or 30 times the authorized daily quantity of dried cannabis for an individual. In the case of oils, teas, and edible items, the measurement is on the amount of dried cannabis it took to make the item.

APPLICABLE LEGISLATION, STANDARDS, GUIDELINES:

Access to Cannabis for Medical Purposes Regulations (SOR/2016-230)

Controlled Drugs and Substances Act (S.C. 1996, c. 19)

PROCEDURES:

PROCESSING A NEW ORDER FOR CANNABIS

1. When a client presents with a new order for cannabis for medical purposes, the staff member will immediately notify the Program Supervisor who will then notify the Director of Operations.

2. The Director of Operations is responsible for ensuring staff are aware of the documentation that needs to be obtained and placed on file and for reviewing all documentation to ensure it meets our policy.

3. For the purposes of this policy, the term *Practitioner* is defined as only a Physician. The practitioner's order which permits the client to be in possession of and consume cannabis will be placed on the client's master file. The order must include the following:

    a) the client's full name and date of birth,

    b) the name of the prescriber, profession, full business address, province of practice and registration number,

    c) the client's daily quantity to be used in grams, and

    d) the name and contact information of the Licensed Producer

    e) the expiry date of the client's registration,

    f) health care practitioner's signature and date of order.

4. The practitioner's order is valid for a one year period. The client and/or family must provide an updated order for our records on or before the current order expires. We are not permitted to administer cannabis without a valid order.

5. Provide the family with TCE's *Cannabis for Medical Purposes Individual/Parent/Guardian Information Sheet* which explains forms of cannabis we can accept and packaging rules.

ACCEPTABLE FORMS OF CANNABIS

1. TCE will only accept cannabis from a licensed producer, in a measurable form that allows staff to count doses, in the following forms for administration:

    a) Dry leaf to be sprinkled on food,

    b) Infused Oil,

    c) Infused tea,

    d) Edible items such as cookies, brownies, breads that contain cannabis.

2. Cannabis must be supplied from a licensed producer, in a manner that allows staff to count the amount on hand at each shift. This would include:

    a) Single dose syringes or sachets,

    b) Graduated bottle where the measurement scale is not obstructed by labels,

    c) Individually wrapped edible

    d) Infused tea divided into single serving storage containers,

    e) We cannot accept bottled that are not graduated or bags of loose dry cannabis.

    f) All packages must be clearly labeled indicating it contains cannabis.

ADMISSION TO TCE PROGRAMS WITH CANNABIS

1. Ensure that the cannabis is accompanied by a label from a licensed provider. The label must indicate brand name, lot number, potency (percentage) of ingredients, net weight, and packaging date of the cannabis.

2. Cannabis will only be accepted from a licensed provider.

3. A "Narcotic Tracking Form" will be initiated upon admission and receipt of cannabis for medical purposes. The amount received and details of who it is received from must be verified by two (2) signatures. If the individual is capable or the parent is present, they will sign as the second verification. If the individual or parent is not signing, then two staff members trained in medication administration will count and sign the count sheet.

4. Any amounts in excess of what we as agents are legally allowed to possess will be returned to the family home immediately.

5. Once counted, store cannabis in the medication room in accordance with our Medication Administration policy. Cannabis products must be stored in airtight containers to decrease odour in the medication room.

6. Edible products containing medical marijuana must be clearly labelled and kept locked.

7. If cannabis is wasted it must be witnessed and signed by two (2) staff members in accordance with our medication policy and procedures.

RELEASE FROM TCE PROGRAMS

1. The "Narcotic Tracking Form" will be closed off with a final count of the amount of cannabis being returned to the individual or family. It must be verified by two (2) signatures. If the individual is capable or parent is present, they sign as the second verification. Otherwise, two staff members count and sign verifying the amount being returned.

RELATED FORMS:

Narcotic Tracking Form
Cumulative Transfer of Medication Tracking Sheet

TCE
Total Communication Environment
Making Connections For Life

Cannabis for Medical Purposes Individual/Parent/Guardian Information Sheet

Total Communication Environment (TCE) is committed to providing our clients with reasonable access to cannabis when it is medically indicated and is a treatment prescribed by a Physician, in accordance with Health Canada's *Access to Cannabis for Medical Purposes Regulations* (ACMPR).

IN ORDER TO ADMINISTER CANNABIS FOR MEDICAL PURPOSES WE WILL NEED THE FOLLOWING:

1. TCE only accepts a Practitioner's Order, from a Physician, which authorizes the possession of and consumption of cannabis. We will take a photocopy and return the original to you. Please bring us the original document to be scanned. The order must include the following:
    a) the client's full name and date of birth,
    b) the name of the prescriber, profession, full business address, province of practice and registration number,
    c) the client's daily quantity to be used in grams, and
    d) the name and contact information of the Licensed Producer
    e) the expiry date of the client's registration,
    f) a Physician's signature and date of order.
2. The Physician's Order is valid for a one year period. Please provide an updated order for our records on or before the current order expires. We are not permitted to administer cannabis without a valid order.
3. All cannabis must be accompanied by a label from a Licensed Provider. The label must indicate brand name, lot number, potency (percentage) of ingredients, net weight, and packaging date of the cannabis. We cannot accept cannabis without this label.

ACCEPTABLE FORMS OF CANNABIS

1. TCE will only accept cannabis from a licensed producer, in a measurable form that allows staff to count doses, in the following forms for administration:
    a) Dry leaf to be sprinkled on food,
    b) Infused Oil,
    c) Infused tea,
    d) Edible items such as cookies, brownies, breads that contain cannabis.

2. Cannabis must be supplied from a licensed producer. Cannabis is a controlled substance under the *Controlled Drugs and Substances Act* (S.C. 1996, c. 19). We therefore must be able to count all cannabis at each shift change. This count is performed by two (2) staff members and recorded on a *Narcotic Tracking Form*. In order to do this we require all cannabis to be supplied in the following manner: :
    a) Single dose syringes or sachets. You can draw up the prescribed amount of oil into syringes
    b) Graduated bottle where the measurement scale is not obstructed by labels.
    c) Individually wrapped Edible, clearly marked that they contain cannabis.
    d) Infused tea divided into single serving storage containers clearly marked.
    e) We cannot accept bottles that are not graduated or bags of loose dry cannabis.

UPON ADMISSION

1. Upon admission, we will record the amount of cannabis you are providing and you will be asked to sign to verify the count. We will also count the cannabis with you upon discharge and ask that you sign to verify the amount we are returning.
2. The administration of cannabis must comply with our smoke-free environment policy and therefore clients are not permitted to smoke or vaporize cannabis on our property.
3. In accordance with the ACMPR, we can only accept the lesser of 150 g or 30 times the authorized daily quantity of dried cannabis for an individual. In the case of oils, teas, and edible items, the measurement is on the amount of dried cannabis it took to make the item.

Cannabis for Medical Purposes Individual/Parent/Guardian Information Sheet -Created August 23, 2018