



Medication Administration in Adult Care Homes

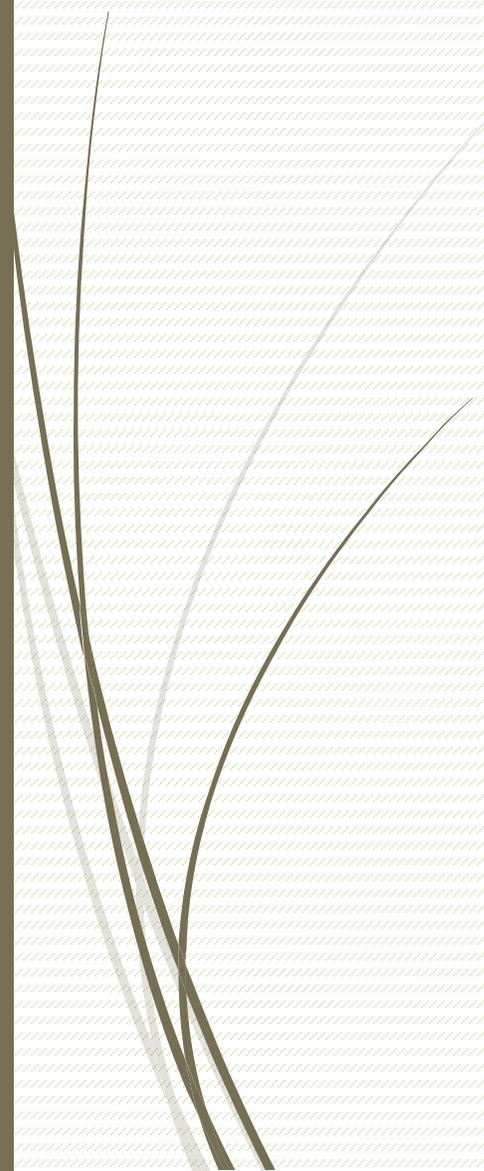
The Division of Health Service Regulation
Adult Care Licensure Section



Disclaimer: The information in this training is a general guide to assist providers with following the rules and guidelines of Medication Administration. This training is not all-inclusive and should be used only for the sole purpose of provider education.



Medication Administration in Adult Care Homes

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- ▶ Objectives:
 - ▶ Access and utilize the medication administration regulations for Adult Care Homes
 - ▶ Monitor and encourage medication administration rule compliance in Adult Care Homes using a systematic approach



Rule Reference



- ▶ 10A NCAC 13F/G .1002(a) Medication Orders
- ▶ 10A NCAC 13F/G .1004 Medication Administration
 - ▶ .1004(a) Medications administered as ordered
 - ▶ .1004(j) Accuracy of Medication Administration Records (MARs)



Total Cites by Rule Area

07/01/21 – 04/29/22

Rule Cited	ACH	FCH	Total
13F/G .1004(a)	179	30	209
13F/G .1002(a)	24	6	30
13F/G .1004(j)	66	26	92



Policy & Procedure



- ▶ The facility is required to have written Medication Policies and Procedures available for review (may include but is not limited to):
- ▶ Who is responsible for doing what? how?, when?, etc.
 - ▶ Receiving orders
 - ▶ Sending orders to the pharmacy
 - ▶ Reviewing orders
 - ▶ Receiving medication and ensuring they are available
 - ▶ Administering medications
 - ▶ Reordering medications
 - ▶ MAR audits
 - ▶ Medication cart/storage audits
 - ▶ Emergency back up pharmacy procedures
 - ▶ Infection control procedures related to medication administration

10A NCAC 13F/G .1002(a)

Medication Orders

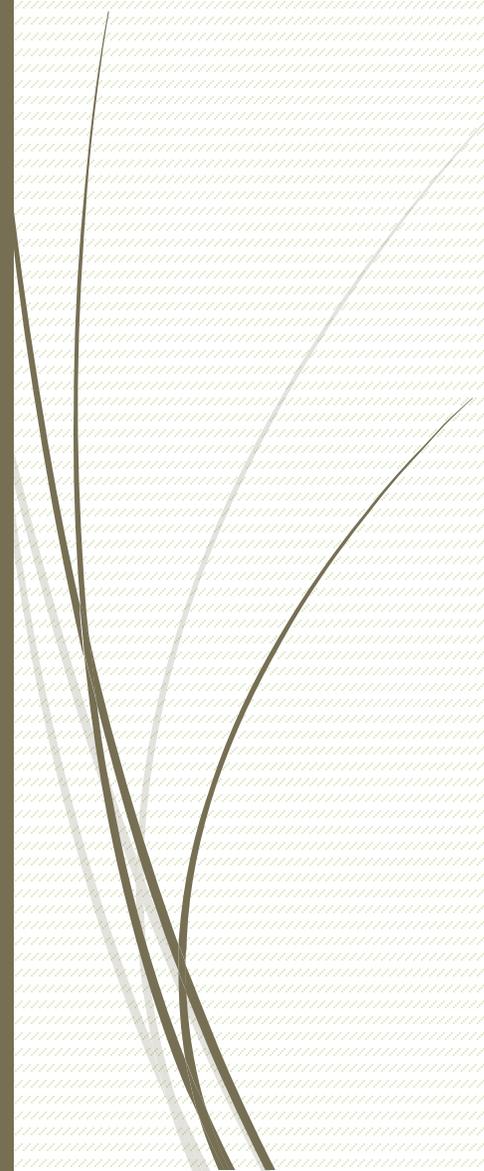
- ▶ (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
 - ▶ (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
 - ▶ (2) if orders are not clear or complete; or
 - ▶ (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same
- ▶ The facility shall ensure that this verification or clarification is documented in the resident's record.

- Processing medication orders:
 - Resident's Record
 - Telephone order vs. written
 - Pharmacy

Medication Orders



Medication Orders can be found on the following forms:

- FL-2 or Discharge Summary
 - Report of Health Services Form
 - Telephone Order Slips
 - eScript
 - Medication Review Recommendation Form
 - Six-months physician orders
 - Prescriptions
 - Physician's Order Sheet
 - Contracted Agencies
 - Other: Lab Reports
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Medication Orders

- ▶ Medication name / strength
- ▶ Dosage of medication to be administered
- ▶ Route of administration
- ▶ Specific directions for use, including frequency, and if ordered PRN (as needed), an indication for use

Medication Orders

- Receipt of new medication orders
 - Who is qualified to receive?
 - Procedures for ensuring complete medication orders
 - Quality assurance system





Medication Orders



Clarification of orders.

Contact with physician

Documentation of contacts

Is order now clear & complete?

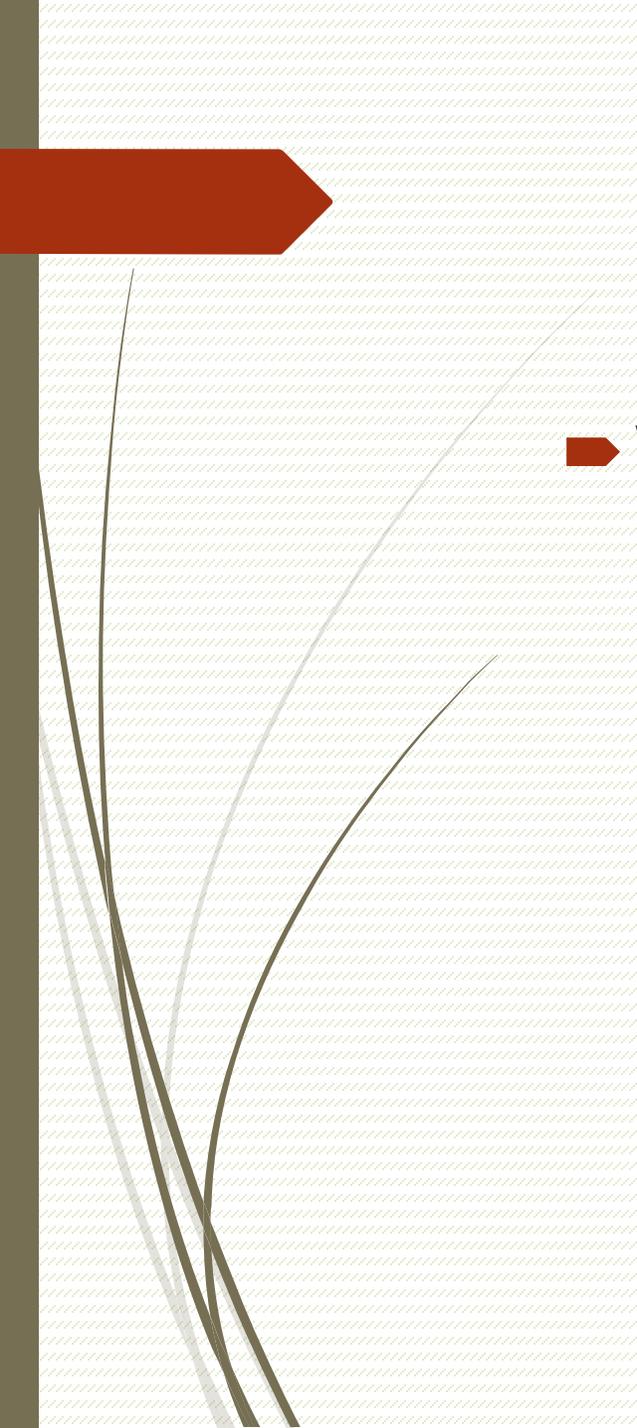


Who is responsible for obtaining clarification?

Back-up?



Who should you contact if there are questions?

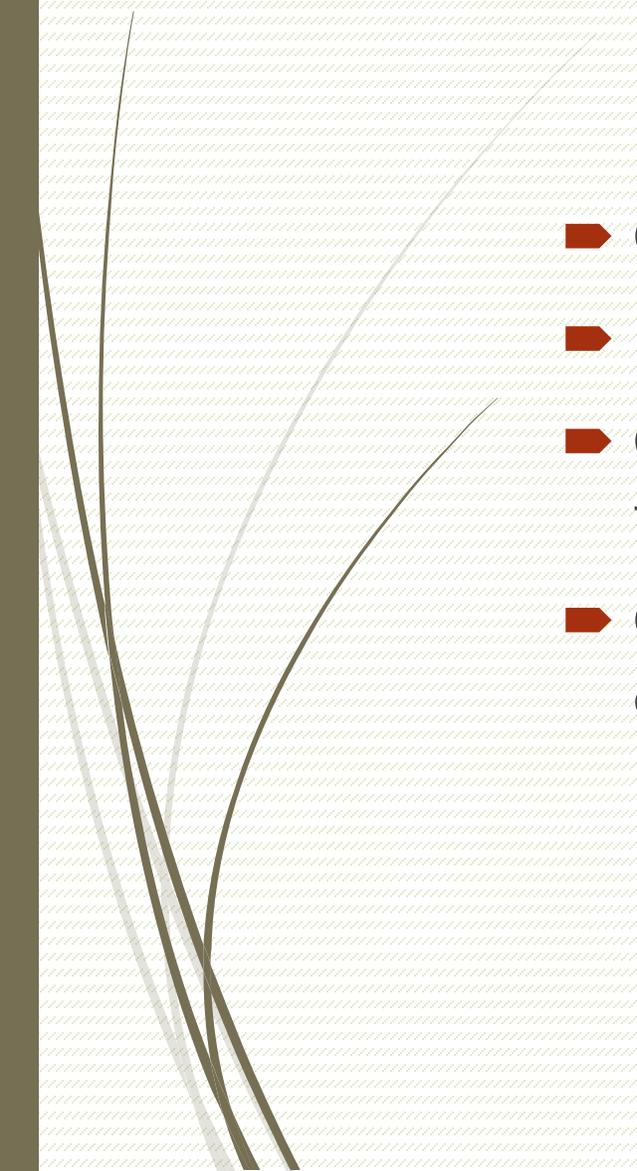


Medication Orders

- ▶ When obtaining clarification, ask questions:
 - ▶ Replace existing order?
 - ▶ In addition to an existing order?
 - ▶ Specific timeframe for administration
 - ▶ Ex: for 7 days, until healed / cleared?
 - ▶ Specific instructions
 - ▶ Ex: with meals, at bedtime, etc.?



Medication Clarification Example

- Current dose: Seroquel 25mg by mouth at bedtime
 - Primary Care Physician writes an order for Seroquel 50mg
 - Clarify if 50mg is an increase from 25mg or in addition to the previous order
 - Clarify when and how often the Seroquel should be administered
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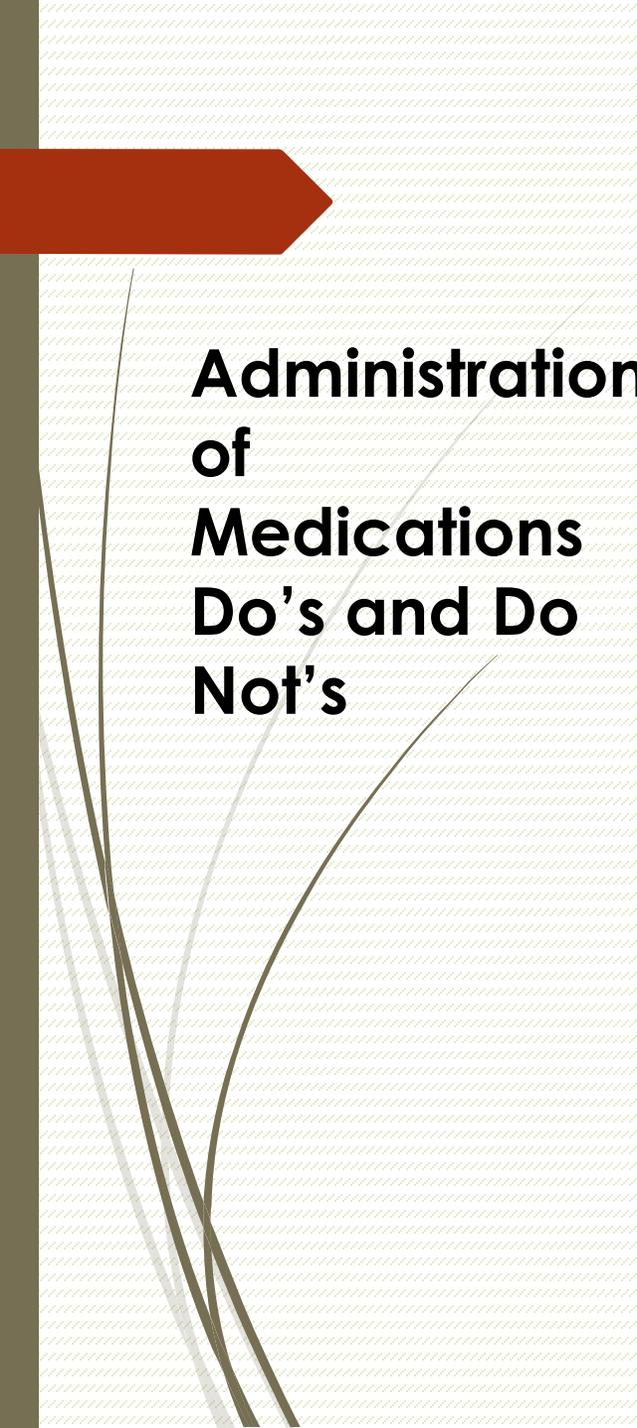
10A NCAC 13F/G .1004(a) Medications Administered As Ordered

- ▶ (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
 - ▶ (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
 - ▶ (2) rules in this Section and the facility's policies and procedures.



Follow the “6R’s”

1. **Right Resident:** Ask the resident their name and date of birth. Utilize labeled photographs. Ensuring you have the right resident is of the utmost importance.
2. **Right Medication:** Compare the medication to the order on the MAR
3. **Right Dose:** Compare the dose to the order on the MAR
4. **Right Time:** Ensure the time is correct according to the MAR. Medications should be administered in a two-hour timeframe (one hour before and one hour after the prescribed or scheduled time).
 - ▶ Ex: If Lasix 40mg by mouth daily is listed on the MAR to be administered at 8:00am, the medication aide should administer the Lasix between 7:00am-9:00am.
5. **Right Route:** Compare the route (oral, ophthalmic, topically, transdermal, subcutaneously, etc.) to the order on the MAR
6. **Right Documentation:** Documentation on the MAR should be accurate and done immediately following administration and observation of taking the medication



Administration of Medications Do's and Do Not's

Standard of practice: NEVER administer a medication prepared by someone else

Regulations for Adult Care Homes allow pre-pouring of medications if the container is appropriately labeled, and other requirements of the rule areas are met (Refer to 10A NCAC 13F/G .1004(c)(d)(e)(f)(h) Medication Administration)

Do ensure medications ordered are received and available to be administered

Never document a medication was administered prior to administering the medication



Examples of Medications Not Administered as Ordered

- ▶ Administering 1 puff instead of 2 puffs of an inhaler
- ▶ Eye drops administered in the wrong eye
- ▶ Measuring the wrong amount, such as 1 teaspoon instead of 1 tablespoon of a liquid medication
- ▶ Timing errors – administering a medication ordered at bedtime during the morning medication pass
- ▶ Crushing and administering a medication that should not be crushed such as extended-release medications

10A NCAC 13 F/G .1004(j)

Medication Administration Record Accuracy

(j) The resident's medication administration record (MAR) shall be accurate and include the following:

- (1) resident's name;
- (2) name of the medication or treatment order;
- (3) strength and dosage or quantity of medication administered;
- (4) instructions for administering the medication or treatment;
- (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
- (6) date and time of administration;
- (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
- (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).



Medication Administration Record (MAR)

- ▶ Transcription of orders
 - ▶ Part of medication aide qualifications
 - ▶ Transcribe from order, **not** pharmacy label
 - ▶ No Abbreviations
 - ▶ Transcribed immediately with order date and transcriber's initials
 - ▶ Discontinue orders are stopped and marked as discontinued on the MAR/eMAR

Medication Administration Record (MAR)

- Legal Document
- Shows exactly how medications were administered

Example Order:

Lopressor 50mg by mouth twice daily
(25mg tablets sent by pharmacy)

MAR documentation should not be:

Lopressor 50mg, two tablets by mouth twice daily.

MAR documentation should be:

Lopressor 25mg, two tablets by mouth twice daily

- ▶ Review of MARs at the beginning of the month
- ▶ Transcription of orders with unusual directions
- ▶ Incorrect transcription of medication orders account for many of the medication errors identified during inspections conducted by the Adult Care Licensure Section and the County Department of Social Services.

Medication Administration Record (MAR)

Medication Administration Record (MAR)

Refusals and omissions

Reason / effectiveness of PRN administration

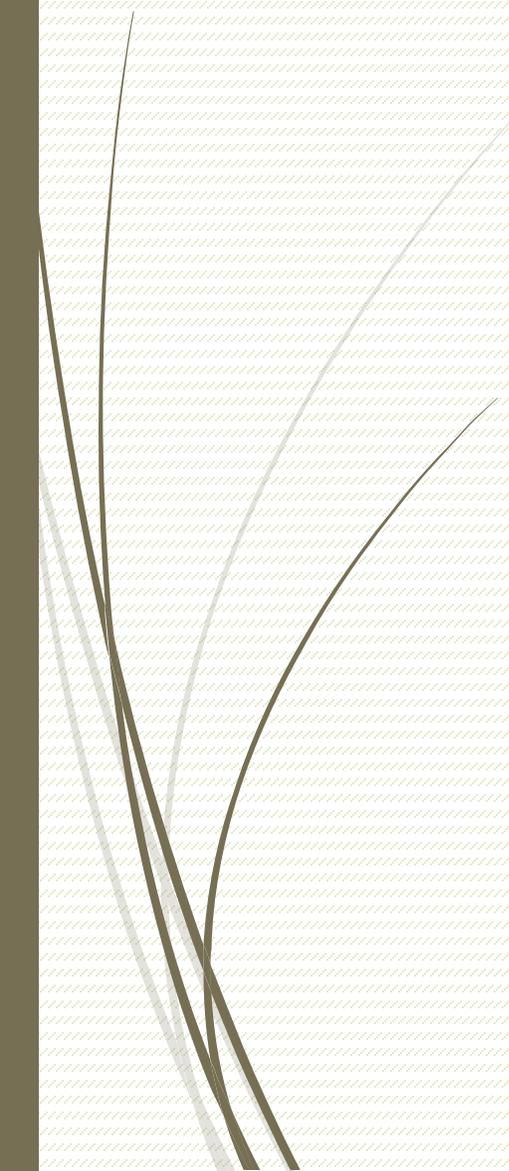
Any deviation from physician's order due to refusal, resident out of facility, medication unavailable, etc.

Initials / equivalent signature of medication aide(s)

Document the administration of the medications on the MAR immediately after they are administered to each resident before going to the next resident. If a medication is not administered, document the reason the medication was not administered.



Accuracy of MAR – Examples of Errors

- ▶ A medication entered on the MAR with no time of administration.
 - ▶ Not documenting effectiveness of prn medications.
 - ▶ Sliding scale insulin documented as administered and **no** blood sugar amount documented
- 



Quality Assurance

MARs

- Match MAR to current physician's orders
- Examine times of administration
- Review of blanks, omissions, refusals, other reasons med not given
- PRN documentation – reason given/ effectiveness documented
- Pre-charting is not allowed



Quality Assurance

Medications On-Hand

- Stored appropriately
- Labeled appropriately
- Correct medication & strength
- Reordered according to policy
- Remove discontinued medications immediately
- Remove expired medications



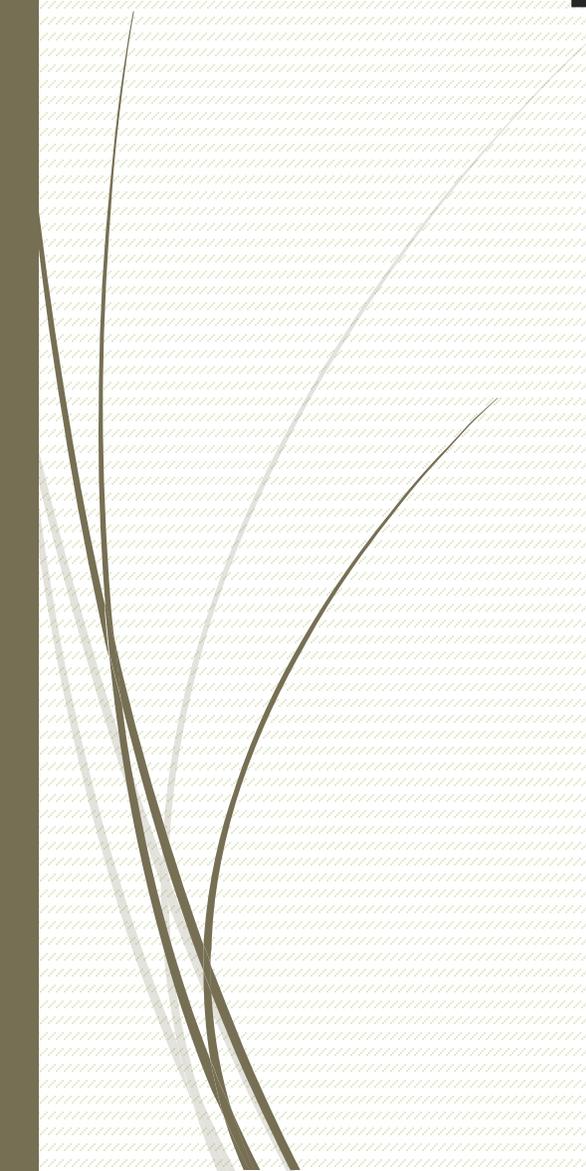
Benefits of Quality Assurance

Improve resident care and quality of life

Establish a safe and effective medication system

– reduce medication errors

Prepare for surveys/inspections



Sliding Scale Insulin

Name of Facility: _____

Resident's Name: _____

Date of Sliding Scale Order: _____

Sliding Scale Parameters: _____

MONTH/YEAR:

Date	FSBS	Units Admin.	Should have received	FSBS	Units Admin.	Should have received	FSBS	Units Admin.	Should have received	FSBS	Units Admin.	Should have received
1												
2												
3												
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Sliding Scale Insulin QA Tool





ACLS Resources

- **ACLS Raleigh Office: 919-855-3765**
- **For general/non-urgent questions, please email:**
DHSR.AdultCare.Questions@lists.ncmail.net