CERTIFIED
FAMILY HOME PROGRAM

CERTIFIED FAMILY HOMES
BASIC MEDICATION AWARENESS AND INFECTION CONTROL
STUDENT STUDY GUIDE

CFH Provider/Substitute Caregiver:

This course satisfies the requirements of IDAPA 16.03.19.402.01. By accepting the delegated responsibility for assisting a resident with medications, you are acknowledging that you are willing and capable to provide assistance as outlined in this course. You also accept responsibly for your actions or failure to act.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Introduction

Purpose:

The purpose of this course is to educate Certified Family Home (CFH) providers and substitute caregivers regarding medication safety and infection control.

If a resident's needs exceed the curriculum in this training, the CFH provider/substitute caregiver may be required to complete and pass the "Assistance with Medication Course" available through the Idaho Career & Technical Education Program.

Successful completion of this course will consist of participation in skills and written tests with a passing rate of 80% or greater.

This course satisfies the requirements of **IDAPA 16.03.19.402.01**: "*Each person assisting with resident medications must be an adult who successfully completed and follows the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training."*

Department Disclaimer:

By accepting the delegated responsibility for assisting a resident with medications, the CFH provider/substitute caregiver is acknowledging that he is willing and capable to provide the skill required. The CFH provider/substitute caregiver is also accepting responsibly for his actions or failure to act.

Unit 1 - Basic Understanding of Medications

Assistance with Medications:

Assistance with medications may include:

- Breaking or crushing a _____ tablet. (Check with the health care professional before crushing medication).
- _____ eye, ear or nose drops.
- Giving medication through a pre-mixed _____ or gastric (not nasogastric) tube **(with written delegation from a licensed nurse, MD or PA).**
- Assisting with _____ or topical medications.
- Insertion of _____.

Requirements:

A Certified Family Home provider must:

- Report to the appropriate health care professional when a medication _____ _____ taken.
- Understand the proper _____and _____ effects of prescribed and over-the-counter medications.
- Know which medication containers are _____.
- Use proper _____ devices.
- Keep accurate _____regarding medications.

  Examples are:

  - Inventory of narcotics.
  - Record of medications taken including _____, time and _____.
- Know what to report and document. Examples are:

  - Any medication dosages not _____.
  - Adverse side effects.
  - A _____in the client's ability to self-administer medications.

Limitations:

A Certified Family Home provider who is not a licensed health care professional cannot:

- Prepare or give _____.
- Adjust or stop medication dosage without _____ directions to do so by the resident's health care professional.
- Start, stop or adjust any _____ therapy.
- _____ resident's medications to a Mediset.

Self-Administration:

If a client can self-administer medication, they must have a form filled out by their health care professional allowing them to take their own medications and keep them in their rooms. In the case of controlled substances, CFH providers will provide clients a lock box and key to keep the medication in their room or refrigerator (if required).

Unit 2 - Storing and Caring for Medications

Medication Packaging:

All medications MUST* be kept in the original _ _____, UNLESS a pharmacist or licensed nurse _____ and labels a Mediset (a daily plastic dispenser, also known as a pill box) OR a blister pack (pills _____ packaged on a sealed card).

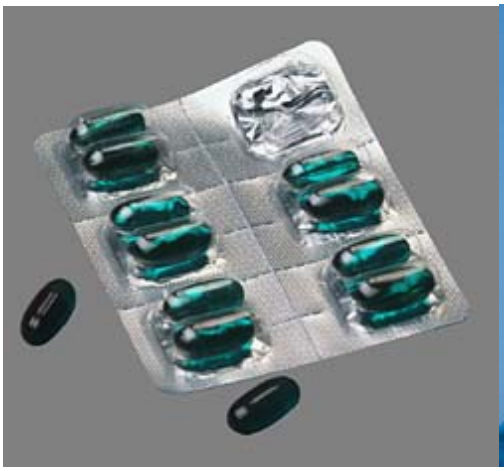
IDAPA 16.03.19.402. **ASSISTANCE WITH MEDICATIONS. The provider must offer assistance with medications to residents who need assistance; however, only a health care professional may administer medications. Prior to assisting residents with medication, the provider must ensure the following conditions are in place:*

04. ***Containers and Labels.*** *The medication is in the original pharmacy–dispensed container with proper label and directions or in an original over-the-counter container.*

- ***a.*** *Each medication must be packaged separately unless in a Mediset, blister pack, or similar system.*
- ***b.*** *Medication may be placed in a unit container by a licensed nurse when the container is appropriately labeled with the name of the medications, dosage, time to be taken, route of administration, and any special instructions.*

Original Prescription Bottles

Blister/Bubble Pack



Mediset filled by a pharmacy or RN

Safe Storage:

Medications MUST be stored safely at all times!

- All medications must be stored _____ for each individual in the home.
- All medications must be stored in a safe place away from _____, teens and visitors.
- If the medication is a controlled substance and/or a member of the household has drug-seeking behavior, medications must be _____ in a container or cabinet. If the client self-administers meds, CFH is to provide the client their own lock box and key for storage of the controlled substance.
- ALWAYS read the "_____ _____" on each medication for specific storage instructions.

Chemical Compounds:

Medications are _____ compounds; their composition and strength can be affected by the way they are stored.

- Store medications in a _____, dry place. Avoid too much light.
- Avoid storing medications in bathrooms because of the steam created in the bathroom.
- Avoid medication exposure to extreme cold or hot temperatures unless medication is required to be refrigerated. Designate a _____ area in the refrigerator as a medication area.

Cautions:
Certified Family Home providers/substitute caregivers should **NEVER** do the following:

- Combine _____ medications into one bottle.
- Store or combine _____ medications in a plastic bag.
- Put an _____ pill back into a bottle. Any pill or capsule that is not recognizable can be taken into the pharmacy for identification.

Inventories:
If the CFH provider is assisting with opioid pain relievers (e.g., Oxycodone, Hydrocodone, Morphine, Fentanyl, etc.), the meds must be inventoried at least every _____ _____. A record of the inventory should be kept with the client's medication records.

Unit 3 - Prescriptions and Pharmacy

General Information:

A Prescription Medication is ordered by a health care professional.

- Once a medication is prescribed, it is the CFH provider's responsibility to make sure the medication is _____ from the pharmacy.
- A prescription medication is ordered by the health care professional to treat symptoms, diseases, or medical conditions.
- The prescription medication is to be taken **ONLY** by the _____ for whom it was prescribed.
- Utilizing a prescription medication for anyone other than for whom it was prescribed is at best negligence, ***and in some cases, could be _____ depending upon the medication involved***.
- **BE ALERT** to medication names that are _____. Make certain the right medication is being taken.

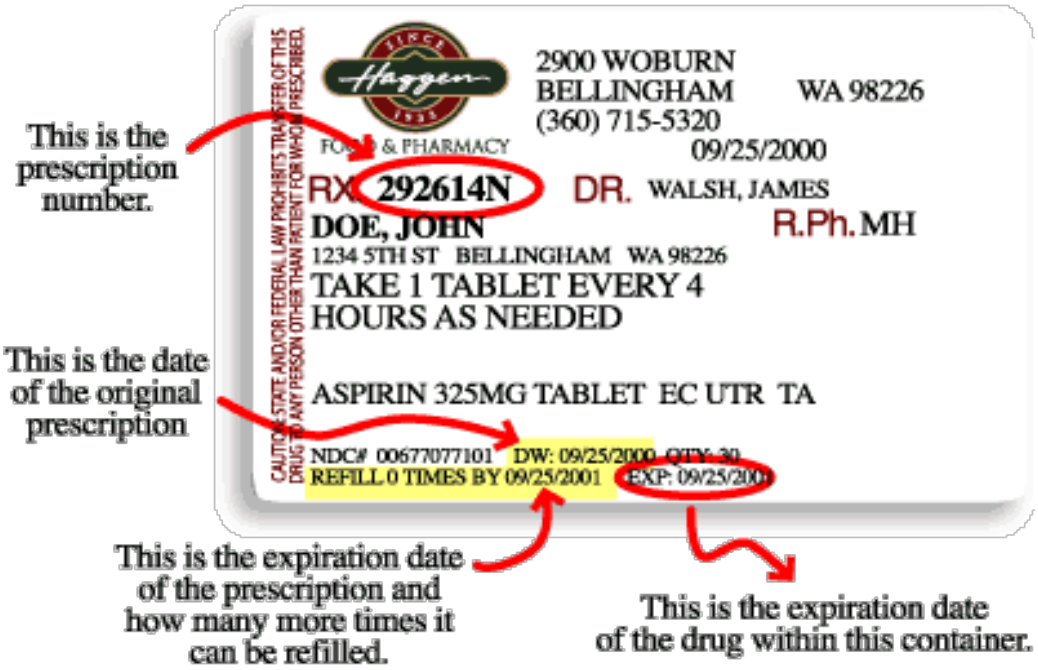
Warning Labels:

WARNING LABELS will be on medications that require special instructions.

Label Information:

Important information on a medication label:

1. _____ name.
2. Health care professional's name.
3. _____ filled.
4. _____ date.
5. Number of _____.
6. Names of the medication – Most have two: the _____brand and the _____.
7. _____ of medication.
8. _____ for use and how often to take the medication.
9. Any precautions.
10. _____information.
11. Pharmacy _____ information.



Medication Information Sheets:

All medications come with information sheets. ALWAYS keep these sheets in your resident records. The following important information is found within the medication information sheet:

1. _____ of the medication
2. Expected _____of medication
3. Possible _____ effects
4. Adverse reactions
5. What to do if a dose is _____
6. What to do in case of an _____

Filling New Medications:

- When a **new medication** is prescribed, it is **extremely important** that the medication is _____ **immediately** or as soon as reasonably possible.

- Written prescriptions must be kept in a _____ place until given to your pharmacist.

- It is best to use the _____ _____ for filling all prescriptions for a resident. The resident must be allowed to choose the pharmacy.

  - **Utilizing the same pharmacy** makes it easy for the PHARMACIST to identify medications that are not recommended for use together.

- The pharmacist has an individual _____ profile to review for drug interactions.

- If you need to fill a **MEDICATION PRESCRIPTION after hours** and your normal pharmacy is not open, you may need to use a 24-hour pharmacy.

Ten Key Questions:

Ask the pharmacist these questions when leaving with a new prescription:

1. Prescription medications have two (2) commonly used names; what are the _____ and _____ names for the medication?
2. What is the medication being _____ for?
3. How much is _____ and how often?
4. What do I do if a dose is _____?

5. How _____ will the medication need to be taken?
6. What _____ effects could occur?
7. What do I do if side effects _____?
8. Does this medication interfere with other medications? Can certain _____ interfere with this medication?
9. Does this medication _____ any other medication currently being taken?
10. _____ and how should the medication be stored?

Refilling Existing Medication Orders:

- Do not run out of a daily prescription medication. Medications must not be stopped when ordered to be taken on a daily basis.

- _____ time to contact the resident's health care professional, pharmacy and/or authorization agencies.

- When a daily prescription medication needs to be refilled, several issues must be considered:
    - Did the health care professional write the prescription for refills?
    - Are refills available at the pharmacy? Does the health care professional need to be contacted to re-order the medication?
    - Does the medication require prior authorization from the insurance company or Medicaid?

- Occasionally, physicians will want to see the resident in their office prior to refilling medications.

- When there are _____ _____ of medication remaining, contact the health care professional or pharmacy for a refill of the prescription medication.

Over-the-Counter Medications:

A non-prescription medication is medication purchased "over-the-counter" (_____) or off the shelf. Non-prescription medications _____ _____ require a special written prescription by the health care professional. However, they <u>do</u> require a _____order.

What to know about non-prescription medications:

- Utilizing non-prescription or "OTC" (over-the-counter) medications may make other conditions worse or _____unwanted side effects.

- When using non-prescription/over-the-counter medications, residents and/or providers overseeing resident's medication needs should _____ **with the health care professional or local pharmacist for possible drug interaction**.

- _____ Instructions on NON-Prescription or OTC Medications. Due to the high risk of drug interaction when using OTC medications, special care must be taken with their use.

- Directions for the use of OTC medication and dosage are printed on the medication labels.

- Pay special attention to the _____ associated with these types of medications.

- You must dispose of all _____ medication (including OTC medication) within 30 days. Expired medication may lose its strength and chemical stability. If chemically altered, a medication could have an unintended impact, which could lead to serious health problems.

- When assisting with OTC medications, it is REQUIRED that you _____ these medications on your medication log sheets, including a notation for the reason the medication was given if it is PRN.

- The supervising health care professional needs to be aware of _____ medications taken by your resident.

Unit 4 – Overseeing Medications

Six Rights of Medication Oversight:

When overseeing medications for a resident, it is MANDATORY to follow the SIX RIGHTS of medication oversight:

1. The **RIGHT _____** is being given.
2. Medication is being given by the **RIGHT _____.**
3. The **RIGHT _____** of the medication is being taken.
4. The medication is being taken at the **RIGHT _____.**
5. The medication is being given to the **RIGHT _____.**
6. The **RIGHT _____** was completed to show the date and time the medication was taken by the resident.

Medications of Newly Admitted Residents:

When accepting a resident, document all medications coming into your home.

- Do not allow any _____ medications into your home.
- Do not allow any medications not currently _____ into your home. If the resident refuses to dispose of it (their right) notify the health care professional.

The Importance of Measuring:

- Never guess when measuring medication dose. Use an _____measuring device.
- Household measuring devices are not always accurate.
- If a liquid medication comes with a measuring cup, use only the cup that came with the medication.
- Purchase a special oral _____or measuring _____ for accurate measuring of liquids.

Recognizing Good Responses:

Know how to recognize “positive” medication responses.

- When a resident starts a new medication, it is the provider’s responsibility to watch the resident for the intended _____.

- To recognize the desired response, the provider must understand the _____ of the prescription.
  - This information is found on the information sheets given when prescriptions are filled.

Recognizing Bad Responses:

Know how to recognize “negative” medication responses.

- When a new medication is started, watch the resident for _____(negative) responses.

If an adverse response occurs, you **must** contact the resident’s health care professional and document the incident.

When do Allergic Reactions/Side Effects appear? Allergic reactions may have many symptoms that may appear immediately or not until several days/weeks or even months/years have passed.

REMEMBER: _____ medication can have an adverse or unexpected effect **anytime.**

Recognizing Medication Allergies/Unfavorable Responses:

Any known _____ to medications should be WRITTEN on the resident’s medication record keeping sheets and always reported to the doctor and pharmacist.

Symptoms/Responses	**Drug Allergy may include:**	**Unfavorable Drug Response may include:**
Mild to Moderate in Nature	• Rash • Itching • Hives	• Nausea • Vomiting • Diarrhea • Muscle aches • Headache • Tired • Drowsy • Unable to sleep
Severe to Emergency care required	• Facial swelling • Difficulty breathing to rapid closing of the windpipe • Dizziness • Faintness • Irregular heart beat	• Abnormal bleeding • Kidney problems • Liver damage • Confusion

Anaphylaxis/Anaphylactic Shock: This is a severe allergic reaction causing swelling and breathing difficulties. This **can lead to death** if emergency treatment is not available**.**

Call 9-1-1 if you suspect an anaphylactic reaction. Provide CPR as needed until the emergency medical personnel arrive. Have the name of the medications and the dose taken ready for the emergency medical personnel.

Alcohol and Illicit Drug Use:

There are risks with using alcohol and/or illicit drugs while taking medications.

- There are MAJOR _____ associated with drinking alcoholic beverages or taking illicit drugs while using prescribed and over-the-counter medications.
- _____ to the medical professional and _____any illicit drug and/or alcohol use by the resident.

Vitamin, Herbs and Homes Remedies:

There are risks with using vitamins, herbs and home remedies.

- Vitamins, herbs, and home remedies may _____ or decrease medication effects.
- The health care professional must be _____ of vitamins, herbs, and home remedy use.
- Vitamins, herbs and home remedies must be written and documented on the medication log sheets and have a form signed by the resident's health care professional that their use is _____.

When to Contact the health care professional:

Call the resident's health care professional for the following concerns:

- _____ to take medications.
- Missed medications.
- Resident _____ medication within 20 minutes of taking.
- Resident is nauseated, vomiting, or having diarrhea.

- Resident has pills or coated tablets in stool/feces/bowel movements.

- Resident shows changes in _____ status—confusion or stupor.

- Any other concerns/problems noticed.

Disposal of Medications:

Expired or unused medications may not be stored in your CFH for longer than 30 days*, unless it is ordered by your health care professional that the resident may need to resume this medication later.

- The disposal of medications needs to be _____ and witnessed by a credible witness (not a resident).

IDAPA 16.03.19.402.08.a-g:

08. Disposal of Medication. *Medication that has been discontinued as ordered by the resident's health care professional, or has expired, must be disposed of by the provider within thirty (30) days of the order or expiration date. A written record of all disposal of drugs must be maintained in the home and must include:*

- ***a.*** *The name of the medication;*
- ***b.*** *The amount of the medication, including the number of pills at each dosage, if applicable;*
- ***c.*** *The name of the resident for whom the medication was prescribed;*
- ***d.*** *The reason for disposal;*
- ***e.*** *The date on which the medication was disposed;*
- ***f.*** *The method of disposal; and*
- ***g.*** *A signed statement from the provider and a credible witness confirming the disposal of the medication.*

Responsible ways of disposing medications include:

- **Pharmacy -** Although pharmacies are not legally required to accept these medications from consumers, some pharmacies will take them and send them to a registered disposal company.

- **Hazardous Waste Facility -** Many cities and towns have household hazard waste facilities that will take medications that need to be disposed.

- **Police Department** – Many police stations have a drop-off bin for unused or expired medications.

- **Accepted in home disposal methods –**
    1. In a ziplock bag mix 1 Tbsp coffegrounds, 1 Tbsp of water and the medication (pill, ointment or liquid). Crush pill if necessary. May now be disposed of in bagged trash.
    2. In ziplock bag mix 1 Tbsp of vinegar, 1 Tbsp of kitty litter or dirt and the medication. May now be disposed of in bagged trash.
    3. A patch may be folded in half and placed in garbage.

Less desirable practices for disposing medications include:

- **Do not** throw any medications in the _____. Residents, children or animals could gain access to it, even after the garbage has been hauled away.

- **Do not** flush any medication down the _____. Many chemicals are not filtered out of our drinking water.

Controlled Substances:

Understand that **narcotics** (opioid pain-relievers), **psychotropic** (mind-altering drugs) and **anti-anxiety medications** may require careful monitoring on the number of pills/tablets being taken.

- Observe that these medications are being taken _____.

- Visitors and/or family members should not be able to access these types of medications.
    - These types of medication should be kept under _____ _____ _____.

- You must ask the pharmacist if the medication is a controlled substance. If so, it must be inventoried every 30 days and recorded (unless the patient is able to self-administer medications).

Unit 5 – Infection Control

General Recommendations:

At times, during care, providers and residents may be exposed to infectious diseases. Here are some general recommendations that can help prevent or minimize the likelihood of infection:

- Practice good personal _____.
- Make sure any _____ wounds are covered.
- Keep _____ up to date.
- Use standard precautions including proper use of Personal Protective Equipment (_____) as necessary.
- Follow good hand-washing _____.
- Promote a healthy immune system by:
  - Eating a proper diet
  - Exercising
  - Getting adequate rest
  - Reducing stress

Importance of Hand Washing:

Hand washing is….

- **Absolutely essential** in the _____ and control of infection.
- The _____ most effective means of controlling infectious disease.
- A habit that must be practiced!

When hand washing is required:

- _____ assisting with medications.
- After use of the toilet.
- After blowing/wiping your nose, or touching your _____.

- Before eating.
- After providing _____ care to a resident.
- When obviously _____.
- After coming in contact with _____ secretions.
- After handling dirty equipment.
- _____ and _____ removing gloves.
- Before _____ preparation.
- After switching between working with raw food and working with ready-to-eat food.

Procedure for Hand Washing:

1. Wet your hands with warm water.

2. Apply a generous amount of soap

3. _____ rub together all surfaces of the lathered hands for at least twenty (20) seconds.

- _____ helps remove dirt and microorganisms.
- Wash around and under rings, around cuticles, and under fingernails.

4. _____ hands thoroughly under a stream of water.

- _____ water carries away dirt and debris.
- Point fingers down so water and contamination won't drip toward elbows.

5. Dry your hands completely with a clean towel.

Alcohol Based Hand Sanitizers:

If water and soap are NOT available, use an ethanol alcohol-based (a minimum 62%) hand sanitizer, preferably in a gel form. (Remember hand sanitizers **do not** kill viruses that are transmitted by spores such as the Clostridium Difficile virus. You must use soap and water.)

Gloves:

Hepatitis B, Hepatitis C and Acquired Immunodeficiency Syndrome (AIDS) are all diseases caused by viruses. These viruses are spread via contact with blood and body fluid of infected individuals. A vaccine is available for Hepatitis B virus, but there is currently no known vaccine or cure for AIDS or Hepatitis C. The use of gloves reduces the risk of transmission of these diseases.

- Wear gloves when coming in _____ with blood, body fluids or open wounds.
- Wear gloves when coming in contact with _____ items.
- Change gloves _____ tasks.
- Change gloves after contacting _____ that may be contaminated.
- Remove gloves _____ after use.
- Remove gloves _____ touching uncontaminated items and surfaces.
- _____ hands after removing gloves.

Home Cleanliness:

- Housekeeping – all providers are responsible for ensuring the home is kept sanitary and clean.
  - Appropriate _____ materials need to be available for use.
  - Keep cleaners _____ away if hazardous.
- Counters, tables and floors – any food spilled should be cleaned in a _____ manner and not allowed to dry.
- Linens and clothing – laundering of linens and clothing should occur at least weekly and _____ if soiled with blood or any body secretions.

Hygiene Issues:

- Peri-care – Some clients may need assistance with toileting. Proper hygiene techniques include wiping _____ to _____ to prevent cross contamination and infection.

- Bathing – all bathing and shower areas need to be thoroughly _____ after each use.

- Personal care items – all clients must have their _____ hygiene items. These items are not shared with other clients (e.g., hair brush, toothpaste, etc.).

Unit 6 - Vocabulary

Definitions:

Allergic Reactions – An abnormal response by the body to a substance. Can range from mild to severe. May include hives, redness, itching, swelling and difficulty breathing.

Analgesic – A pain reliever.

Antibiotic – A chemical having the power to slow the growth of or destroy bacteria and other microorganisms**;** given to treat an infection.

Contamination – A condition of being soiled, stained, touched, or otherwise compromised by harmful agents.

Controlled Substances – Medications that could be habit-forming or addictive that are usually prescribed to control pain, anxiety or promote sleep.

Diabetes – A disease of metabolism; problems with utilizing sugar and starches.

Dietary Supplement – Minerals, vitamins, or other ingredients that are intended to supplement a regular diet.

Discharge – Excretion of fluid, puss or other drainage from an orifice/body opening or wound.

Dosage – the amount of medication taken.

Drug Interactions – When one drug increases or decreases the action of another.

Gastric Tube – A tube inserted directly into the stomach for the instillation of nutrition and medications.

Household Measurements – Measuring devices that are homemade or purchased from a store other than a medical supply store. Household measurements should never be used for measuring resident's medications.

Infection – The invasion of the body by virus or bacteria that cause illness.

Medication Label – Label affixed to a prescription medication explaining who the medication is for, name and dose of medication, directions for use, health care professional's name, precautions, expiration date, pharmacy name and phone number, number of refills remaining, and storage instructions.

Metered Dose Inhaler – A device designed to deliver a measured dose of an inhaled drug.

Minerals – supplemental forms of essential minerals in a pill or tablet form used as a supplement to the diet.

Narcotic Medication – An opioid used to control pain.

Nebulizer – A device for producing a fine spray, reducing a liquid or powder to a fine spray for induction into the airway.

Over-the-Counter (OTC) Medication – Medication that may be purchased off the shelf in a retail setting without a prescription.

Pro Re Nata (PRN) Medication – A medication or treatment ordered by a professional to an individual allowing the medication or treatment to be given as needed and directed.

Prescription Medication – A medication available only after the doctor writes a formal prescription and must be obtained through a pharmacy.

Recording Medications/Recordkeeping – Making a written entry that a medication was taken or not taken.

Scored Medications – Medications that have a groove across the tablet that enables them to be broken.

Side Effects – A secondary and usually adverse effect caused by a medication. Examples are nausea, weight loss or gain, diarrhea.

Suppository – Medication compounded in an easily melted medium for insertion into the rectum, urethra, or vagina.

Topical – Medication that is applied to the top of the skin, such as a lotion or medication patch that absorbs into the skin.

Medical Abbreviations:

BID:	Two (2) times a day
TID:	Three (3) times a day
QID:	Four (4) times a day
PRN:	As needed
HS:	Hours of sleep, bed time
D/C:	Discontinue, Discharge
TSP:	Teaspoon
NKA:	No known allergies
OD:	Right eye
OS:	Left eye
OU:	Both eyes
PO:	By mouth
NPO:	Nothing by mouth
GTT:	Drop
TBSP:	Tablespoon
MG:	Milligram
CC (ML):	Cubic centimeter, milliliter
c:	With
s:	Without
OTC:	Over the counter
Pc:	After meals
Ac:	Before meals
STAT:	Immediately

Medication Forms

1. **Over the Counter Medications** – It is MANDATORY to have a written consent from the resident's health care professional before giving OTC medications.

2. **Approval to Self-Administer Medications** – If the resident self-administers his own medications, it is MANDATORY to have this form completed by the resident's health care professional and retained in the resident's records.

3. **Medication Assistance Record (MAR)** - It is MANDATORY to record on the MAR when prescription medications and OTCs are taken. When PRN medications are given, use the back side of the MAR.

4. **Narcotic Inventory** – It is MANDATORY to inventory narcotic medications being used by a resident you are assisting with medications at least every 30 days.

5. **Medication Disposal Record –** It is MANDATORY to document the disposal of any prescribed medications.

6. **Medication Information Sheets** - The current Medication Information Sheets that accompany the medication from the pharmacy should be maintained in the resident's records.

OVER-THE-COUNTER (OTC) MEDICATIONS

Per IDAPA 16.03.19.400.02.d., the resident's health care professional must approve OTC medications.

CERTIFIED FAMILY HOME PROVIDER

The provider is the adult responsible for maintaining the certified family home and providing care to the resident.

Full Legal Name:	Certificate No.:

RESIDENT

The resident is the vulnerable adult living in the provider's home for whom OTC medications/treatments on this form are requested.

Full Legal Name:	Date of Birth:

OTC MEDICATIONS/TREATMENTS

The following OTC medications and/or treatments are proposed for the resident's use.

CONDITION	OTC MEDICATION/TREATMENT
Acid Stomach/Indigestion	
Allergies/Congestion	
Cold/Flu	
Constipation	
Diarrhea	
Pain/Fever	
Vitamin/Supplement	

SPECIAL INSTRUCTIONS

The health care professional may use the following section to give special instructions regarding the resident's medications.

_____
_____
_____
_____
_____
_____
_____

HEALTH CARE PROFESSIONAL AUTHORIZATION

The health care professional's signature below indicates the OTC medications/treatments listed on this form are approved for the resident's use.

Printed Name:	Business Phone: ( )
Practice Name:	
_____ HEALTH CARE PROFESSIONAL'S SIGNATURE	_____ DATE

APPROVAL TO SELF-ADMINISTER MEDICATION

In accordance with IDAPA 16.03.19.401, before allowing a resident to self-administer his or her medications, the CFH provider must obtain approval from the resident's health care professional.

RESIDENT

The resident is the adult receiving care in the provider's certified family home.

Full Legal Name:	Date of Birth:
Diagnoses: _____ _____	

EVALUATION

This evaluation is based on the resident's current condition assessed today. If his or her condition should change, the certified family home provider must have this assessment reevaluated by the health care professional. The health care professional has evaluated the resident in the following areas:

The resident understands the purpose of each medication.	Yes ☐ No ☐
The resident is oriented to time and place and knows the appropriate dosage and times to take the medication.	Yes ☐ No ☐
The resident understands the expected effects, adverse reactions, or side effects, and knows what actions to take in case of an emergency.	Yes ☐ No ☐
The resident is able to take the medication without assistance or reminders.	Yes ☐ No ☐

HEALTH CARE PROFESSIONAL APPROVAL

The health care professional's signature below indicates the resident listed on this form is approved to self-administer medications. All elements listed in the evaluation must be assessed as "Yes" before the health care professional may give approval.

Printed Name:	Business Phone: ( )
Practice Name:	
_____ HEALTH CARE PROFESSIONAL'S SIGNATURE	_____ DATE

CERTIFIED FAMILY HOME PROVIDER

The provider is the adult responsible for maintaining the certified family home and providing care to residents. Please return this completed form as follows:

Provider Name:		
Telephone Number: ( )	Email:	
Mailing Address:		
Mailing City:	Mailing State:	Mailing ZIP:

MEDICATION ASSISTANCE RECORD

Per IDAPA 16.03.19.400.01-02, the certified family home provider must only assist the resident with medications that are ordered by the resident's health care professional as indicated by written evidence of the order; this includes prescription and over-the-counter medications, supplements, and home remedies. Document assistance with medications below, including the reason for assisting the resident with PRN medications at each instance and the result (use the backside of this form for PRN medications). Document missed dosages of prescription medications as incidents, including why the dosage was missed and the provider's response.

Resident Name:	Provider Name:	Month:	Year:
Known Allergies:			

Medication, Dosage & Route	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	A.M.																															
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	Midday																															
	P.M.																															
	Eve																															

PRN MEDICATIONS

Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	

NARCOTIC INVENTORY

Providers who assist residents with prescribed narcotics are required to document an inventory at least monthly. Narcotic medications are opioid pain-relievers (e.g., Oxycodone, Hydrocodone, Morphine, Fentanyl, etc.).

PROVIDER INFORMATION

The provider is the adult operating the certified family home and responsible for management of the resident's medication.

Provider Name:	Certificate No.:

NARCOTIC & INITIAL INVENTORY

Identify the specific narcotic medication that is the subject of inventories recorded on this form and conduct an initial inventory of that medication. Return medications to their original containers after counting the Amount On-hand. Newly prescribed narcotics should be inventoried upon filling the prescription; existing narcotic prescriptions for newly certified homes within 30 days of certification.

Medication Name:		Dosage:
Prescribed to Resident:		Amount On-hand:
Provider Signature:	Date:	Time: A.M. ☐ P.M. ☐

ONGOING INVENTORIES

Conduct and document ongoing inventories of the narcotic named above at least every 30 days. The Previous Amount On-hand for the first ongoing inventory below equals the Amount On-hand from the Initial Inventory above; subsequently, the Previous Amount On-hand equals the Amount On-hand from the previous ongoing inventory. Return medications to their original containers after counting the Amount On-hand.

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY				RECORDS RECONCILIATION	
Date:	Time:	A.M. ☐	P.M. ☐		Previous Amount On-hand:
Provider Signature:				(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:				(minus)	Amount Given Since Last Inventory:
				(minus)	Amount Destroyed Since Last Inventory:
				(equals)	Records Reconciliation Check:

MEDICATION DISPOSAL RECORD

Medications that are expired or discontinued by the resident's health care professional must be disposed of by the CFH provider for longer than thirty (30) calendar days.

RESIDENT INFORMATION

The resident is the vulnerable adult living in the provider's CFH whose medication is being disposed.

Full Legal Name:	Date of Birth:

DISPOSAL INFORMATION

Medication Name:	Dosage:
Amount Disposed:	
Reason for Disposal: ☐ The medication was discontinued by the resident's health care professional. ☐ The medication had passed its expiration date. ☐ Other (please describe): _____	
Method of Disposal:	
Provider Signature:	Date:
Adult Witness Signature: *(must not be a resident):*	Date:

Medication Name:	Dosage:
Amount Disposed:	
Reason for Disposal: ☐ The medication was discontinued by the resident's health care professional. ☐ The medication had passed its expiration date. ☐ Other (please describe): _____	
Method of Disposal:	
Provider Signature:	Date:
Adult Witness Signature: *(must not be a resident):*	Date:

FIRE - AMBULANCE - POLICE

EMERGENCY
9-1-1

POISON CONTROL..... 1-800-222-1222

If you know or suspect that someone has ingested an unknown medication or taken an overdose of medication, contact Poison Control IMMEDIATELY prior to contacting the physician.

ADULT PROTECTIVE SERVICES

Area I (Coeur d'Alene) 1-800-786-5536
Area II (Lewiston)..... 1-800-877-3206
Area III (Boise) 1-844-850-2883
Area IV (Twin Falls)..... 1-800-574-8656
Area V (Pocatello)..... 1-800-526-8129
Area VI (Idaho Falls) 1-800-632-4813

If you know or suspect that a vulnerable adult has been abused, neglected or exploited.

IDAHO CARELINE ..... 2-1-1 or 1-800-926-2588

If you need help finding health and human services or social services offered through government, non-profit, and community resources.

OTHER IMPORTANT NUMBERS

_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____
_____ ..... _____

Resources

Websites:

Dale Carnegie Training

http://www.cdc.gov/nceh/vsp/pub/handwashing/handwashingtips.htm

http://www.stanford.edu/dept/EHS/prod/researchlab/lab/handwashing.html

https://adminrules.idaho.gov/rules/current/16/160319.pdf

Skills Check List Completion

Name: _____

#	Manual Skill	Satisfactory	Unsatisfactory
1	Hand washing		
2	Removing contaminated gloves		
3	Oral medication		
4	Topical medication		
5	Metered dose inhalers (MDI)		
6	Pre-mixed nebulizer medication		
7	Eye Drops		
8	Ear Drops		
9	Nasal Medication		
10	Suppositories		

Student Signature:

_____

Partner's Signature:

_____

Instructors Signature:

_____

Date: _____