Unit 1 - Basic Understanding of Medications

Assistance with Medications:

Assistance with medications may include:

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

Requirements:

A Certified Family Home provider must:

- Report to the appropriate health care professional when a medication __was_____ ____not_____ taken.
- Understand the proper ___use_____and ___side_____ effects of prescribed and over-the-counter medications.
- Know which medication containers are ____correct_____.
- Use proper __measuring_____ devices.
- Keep accurate ____records_____regarding medications. Examples are:
  - Inventory of narcotics.
  - Record of medications taken including ____date_____, time and _____dosage_____.
- Know what to report and document. Examples are:
  - Any medication dosages not ____taken_____.
  - Adverse side effects.
  - A ____decrease_____in the client's ability to self-administer medications.

Unit 2 - Storing and Caring for Medications

Medication Packaging:

Keep the original__ __packaging_____, until all medications it contained are used or disposed. If a pharmacist or licensed nurse _fills_____ a Mediset (a daily plastic dispenser, also known as a pill box) OR a blister pack (pills __individually_____ packaged on a sealed card), retain the label listing the names of the medications, dosages, times to be taken, routes of administration, and any special instructions until all medications it contained are used or disposed.

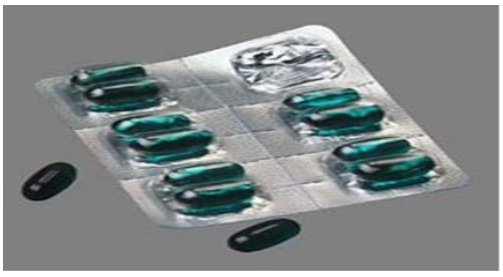
Original Prescription Bottles

*__IDAPA 16.03.19.402. ASSISTANCE WITH MEDICATIONS.__ *The provider must offer assistance with medications to residents who need assistance. Prior to staff assisting residents with medication, the provider must ensure the following conditions are in place:*

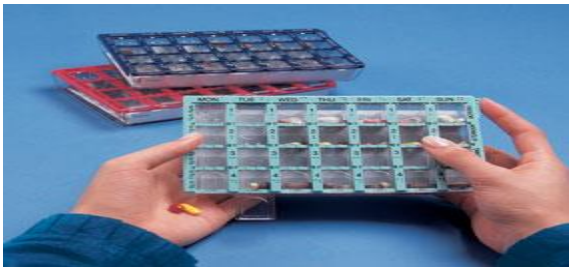
03. ***Containers.*** *The medication is in the original pharmacy–dispensed container with its proper label and directions or in an original over-the-counter container or in a Mediset, blister pack, or similar organizational system. When a Mediset, blister pack, or similar system is used, staff will comply with the following:*

- ***a.*** *The system contains easily identifiable dates and times for medication dispensing.*
- ***b.*** *The system is filled according to the schedule ordered by the resident's healthcare professional for each medication.*
- ***c.*** *Unless filled by a pharmacy or a licensed nurse, the system is filled not more than seven (7) days prior to the scheduled medication dispensing date.*
- ***d.*** *Staff only dispense the specific medication scheduled for dispensing and assist within twenty (20) minutes before or after the specified time.*
- ***e.*** *The original medication container with its proper label is maintained in the home until the medication it contained is completely used or refused by the resident.*
- ***f.*** *Any medication scheduled for dispensing that the resident refuses or that is otherwise missed is immediately removed from the system and disposed of at the earliest opportunity under Subsection 402.07 of this rule.*

Blister Pack



Mediset



Unit 3 - Prescriptions and Pharmacy

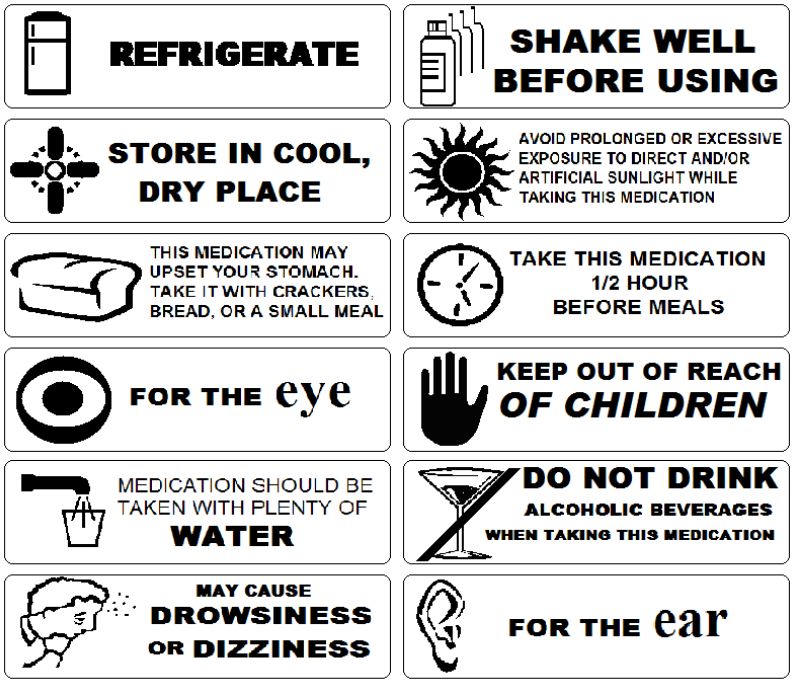
General Information:

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 _obtained____ 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 __person_____ 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 _criminal_____ depending upon the medication involved***.
- **BE ALERT** to medication names that are _similar_____. Make certain the right medication is being taken.

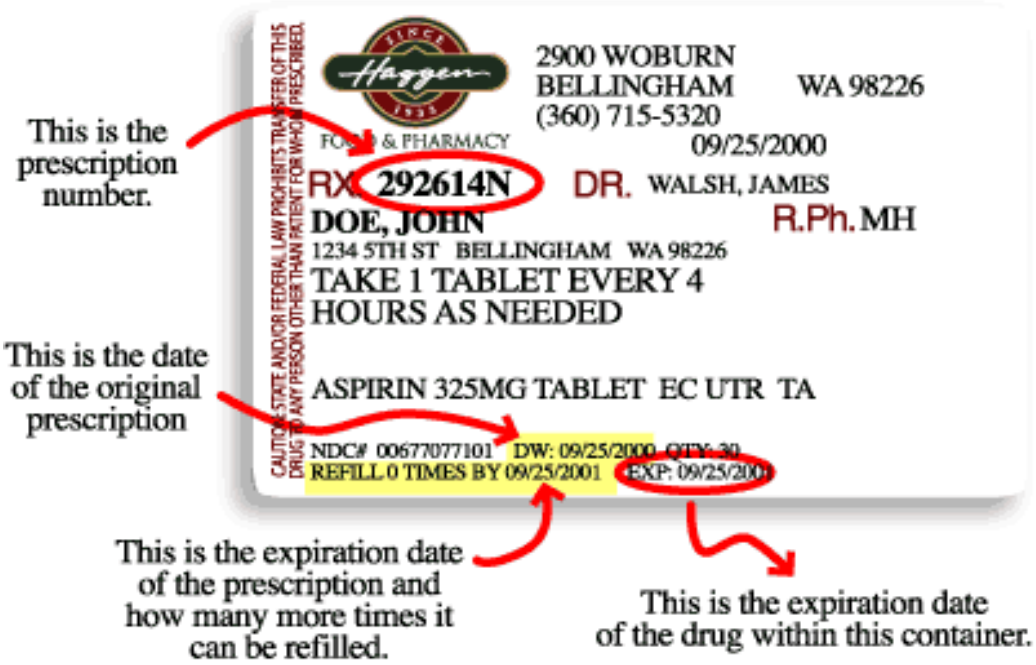
Warning Labels:

WARNING LABELS will be on medications that require special instructions.



Important information on a medication label:

1. __Patient's_____ name.
2. Health care professional's name.
3. __Date_____ filled.
4. __Expiration_____ date.
5. Number of ___refills_____.
6. Names of the medication – Most have two: the __brand___name and the ___generic____ name.
7. __Dose_____ of medication.
8. __Directions_____ for use and how often to take the medication.
9. Any precautions.
10. __Storage_____information.
11. Pharmacy ____contact_____ information.



Medication Information Sheets: All medications come with information sheets. **ALWAYS KEEP** these sheets in your resident's records. The following important information is found within the medication information sheets.

1. __Purpose_____ of the medication
2. Expected ___effect_____of medication
3. Possible ____side_____ effects
4. Adverse reactions
5. What to do if a dose is ____missed_____
6. What to do in case of an ___emergency_____

Filling New Medications:

- When a **new medication** is prescribed, it is **extremely important** that the medication is __filled_____ **immediately** or as soon as reasonably possible.
- Written prescriptions must be kept in a ___safe____ place until given to your pharmacist.
- It is best to use the __SAME__ __PHARMACY_____ 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 _medication_____ 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 _brand_____ and ____generic_____ names for the medication?
2. What is the medication being ___used_____ for?
3. How much is __taken_____ and how often?
4. What do I do if a dose is __missed_____?
5. How ____long_____ will the medication need to be taken?
6. What __side_____ effects could occur?
7. What do I do if side effects ____happen_____?
8. Does this medication interfere with other medications? Can certain ___foods_____ interfere with this medication?
9. Does this medication _replace___ any other medication currently being taken?
10. _Where_____ and how should the medication be stored?

	milligram
NKA:	no known allegeries
NPO:	nothing by mouth
OD:	right eye
OS:	left eye
OU:	both eyes
OTC:	over the counter
pc:	after meal
PO:	by mouth
PRN:	as needed
QID:	four (4) times daily
s:	without
STAT:	immediately
TBSP:	tablespoon
TID:	three (3) times daily
tsp:	teaspoon

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. **NARCOTIC DISCREPANCY REPORT**

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

7. **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 all 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	
Allergies/Congestion	
Cold/Flu	
Constipation	
Diarrhea	
Indigestion	
Pain/Fever	
Vitamin/Supplement	

SPECIAL INSTRUCTIONS

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

_____
_____
_____
_____
_____
_____

HEALTHCARE PROFESSIONAL AUTHORIZATION

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

Printed Name:	Business Phone: ( )
SIGNATURE _____DATE_____	

APPROVAL TO SELF-ADMINISTER MEDICATION

In accordance with IDAPA 16.03.19.401, prior to giving the resident responsibility for administering medications without assistance, the CFH provider must obtain approval from the resident's healthcare 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 ☐

HEALTHCARE PROFESSIONAL APPROVAL

The healthcare 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 healthcare professional may give approval.

Printed Name:	Business Phone: ( )
Practice Name:	
_____ HEALTHCARE 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 16.03.19.402.06, documentation of assistance with medications must be maintained in the home. This includes prescription, over-the-counter, and PRN medications. Document assistance below immediately after giving the resident any medication.
In addition, document the reason for giving PRN medications and missing dosages prescription medications on the Minor Incident Form.

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

Medication, Dosage, and 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.																															
	MiddaY																															
	P.M.																															
	Eve																															
	A.M.																															
	Midday																															
	P.M.																															
	Eve																															
	A.M.																															
	Midday																															
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	Eve																															

MINOR INCIDENT LOG

Per IDAPA 16.03.19.270.04.a and 270.04.d, the provider must maintain in the resident's record documentation of any incident, accident, or change in condition involving the resident.

Examples

INCIDENT	ACCIDENT (NOT REQUIRING MEDICAL INTERVENTION)	CHANGE IN CONDITION
Adverse Reactions to Medications or Missed Dosages	Minor Cuts, Bruises, etc.	Unusual Disorganized Thoughts or Memory Loss
Refusal to Follow a Restricted Diet	Minor Sprains or Other Injuries	Unusual Disorientation
Destructive or Self-Harming Behavior	Falls in which there is No Apparent or Only Minor Injury	Symptoms Treated by a PRN Medication

Complete and submit to the Department a Critical Incident Report if the following apply: elopement, death, hospitalization, visit to an emergency room or urgent care clinic, and/or law enforcement or adult protection investigation. For less serious events, complete the form below and maintain with the resident's records.

Name of Resident:		
DATE AND TIME	DETAILS OF INCIDENT, ACCIDENT, OR CHANGE IN CONDIITION	PROVIDER'S RESPONSE

NARCOTIC INVENTORY

Providers who assist residents with prescribed narcotics are required to document an inventory at least monthly as described in IDAPA 16.03.19.402.04.e. 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.:

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. Use separate Narcotic Inventory forms for each type of narcotic the resident is prescribed. Return medications to their containers after counting the amount on-hand. Newly prescribed narcotics should be inventoried upon filling the prescription. Newly certified homes should inventory existing narcotics 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 <u>at least every 30 days</u>. 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 Actual Amount On-hand from the previous ongoing inventory. Return medications to their containers after counting the actual 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:
Actual Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Expected 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:
Actual Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Expected 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:
Actual Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Expected 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:
Actual Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Expected Amount On-hand:

IDAPA 16.03.19.402.04.e.i-ii: If there is a discrepancy between the actual amount on-hand and the expected amount on-hand, the provider must investigate the cause of the discrepancy and write a summary report of the investigation. Keep this report in the resident's records.

DISCREPANCY REPORT

Date of Inventory: _____

Summary of Investigation: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DISCREPANCY REPORT

Date of Inventory: _____

Summary of Investigation: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION DISPOSAL RECORD

Per IDAPA 16.03.19.402.07, medications that are expired or discontinued by the resident's healthcare professional must be disposed of by the CFH provider within thirty (30) calendar days. Loose medications should be disposed of at the earliest opportunity.

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 healthcare professional. ☐ The medication had passed its expiration date. ☐ Other (please describe): _____	
Method of Disposal:	
Provider Signature:	Date of Disposal:
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 healthcare professional. ☐ The medication had passed its expiration date. ☐ Other (please describe): _____	
Method of Disposal:	
Provider Signature:	Date of Disposal:
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.

SUICIDE HOTLINE 9-8-8

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: https://www.dalecarnegie.com/en

https://www.cdc.gov/handwashing/when-how-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	Gastric tube (GT) medication		
5	Topical medication		
6	Metered dose inhalers (MDI)		
7	Pre-mixed nebulizer medication		
8	Eye drops and ointments		
9	Ear drops		
10	Nasal medication		
11	Rectal medication		
12	Vaginal medication		
13	Filling a Mediset		

Student Signature: _____

Partner's Signature_____

Instructors Signature: _____Date: _____